PSYCH 695: Advanced Practicum in Clinical Psychology II
Empirically Supported Treatment for Depression and Anxiety in Adults: A Cultural Perspective
Spring 2013; Mon 1-5, PSC

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Overview

In the fall, this diprac provided you with foundational skills in treating depression and anxiety. You learned to develop broad conceptualizations of the symptoms of these disorders from a cognitive-behavioral framework, as well as develop individual case formulation skills. You also learned empirically-supported therapeutic and assessment techniques for depression and anxiety. We also focused on solidifying your skills in maintaining professional and ethical behavior.

During the spring semester, we will continue to focus on treating depression and anxiety using the models that we covered in the fall. One objective of the second semester then is to strengthen the *competencies* that you developed in the first semester, specifically following Persons (2008) model in carrying out case formulations of your cases and applying the cognitive behavioral treatments that we covered.

A *new* objective for this semester is to learn to integrate a cultural perspective in your clinical work. In particular, you will be trained in a model of cultural competence referred to as *Shifting Cultural Lenses* that Lopez and colleagues developed. The specific competencies associated with this model include: (a) learning the model's conceptual foundation with particular attention to a social versus an ethnic conception of culture; (b) learning to identify what is at stake in a given case and how to integrate that notion in treatment; (c) learning the three classes of therapist's behavioral indicators of cultural competence; (d) identifying or coding the behavioral indicators in treatment sessions; (e) applying the coding to your clinical sessions and reaching a moderate level of each of the three classes of therapist behaviors; (f) learning how to assess the potential cultural competence of treatment manuals; (g) learning how to identify aspects of the treatment manual that might require adjustments; and (h) testing cultural and linguistic hypotheses in clinical assessment. The readings will address each of these domains.

Clinical Requirements

Like the first semester, students in their first year of di-prac are required to carry an average of 3 therapy hours per week, and those in their second year and beyond are required to spend an average of 4 hours per week in direct clinical service. Given increasing hours needed for internship, it is recommended that students carry at least 4 hours throughout most of their training at USC. It is required that at least half of your clinical hours are related to this di-prac, and suggested that you maintain at least 3 cases in the di-prac to obtain the best training experience. Any more than 2 cases outside di-prac should be approved by the instructors. In

addition, each week you should enter clinical hours you accumulate into Time2Track. We should be able to obtain an accurate reflection of your clinical hours and experiences at any time throughout the year to help us work together to identify what you need in your clinical training. Finally, it is also expected that you adhere to all clinic procedures.

Class Structure

Like last semester, the clinical portion will continue to be comprised of group supervision of ongoing cases, intake reviews, and the assignment of new cases. It is expected that you contact an assigned case shortly after it is given to you, and to follow up appropriately (e.g., you should be able to contact the client and set up an appointment prior to the next class meeting). You should *be prepared* for supervision. This includes taking some time to think about your cases, evaluate what went well/wrong with the therapy session, devising plans for upcoming sessions, being able to articulate your impressions of the case or what you need help with, etc. We will also try to keep our focus on the case conceptualization, which we will revisit and revise as necessary in order to devise treatment plans based on formulation. Supervision will also be supplemented with individual supervision as needed**.**

For the didactic portion, we will continue to conduct the class meeting much like a graduate seminar except with occasional exercises or role plays to apply some of the concepts from the reading. For this part of the course, students are expected to review the readings and bring at least two or more key issues from the articles that you find worth discussing

Video Recording

Please remember to record all sessions, and to check that the equipment is in proper working order. You should review your sessions and bring segments of at least 15 minutes in length for feedback and fostering discussion. We may also request to view sessions in their entirety.

Progress Notes and Intakes

You should complete a note for your session in a timely fashion (i.e., within 24 hours). If there is any instance of risk assessment or mandatory reporting, these notes are required to be completed immediately (i.e., minutes after you see the client), and we should also be contacted in these instances. You should also document **every single contact** with the client, including any messages, emails, or letters. As part of quality clinical care, you should also periodically complete follow-up assessments with your clients and these should be documented in your progress notes. As noted last semester, the level of detail required for notes varies on the type of progress note (contact note, session note, or incident note). Intake and termination reports should be completed in a timely fashion, specifically one-week following the completion of the intake or completion/termination of treatment.

Case Presentation and Report

You will be asked to prepare a final case presentation and present it on the last class of the semester. For the oral segment of the case presentation you are expected to spend about 15-20 minutes providing: client background information, primary presenting problems, case conceptualization, assessments and measures used with the client, interventions employed and

outcomes. This is an opportunity to get feedback about your conceptualization and treatment plan in a more formal way, and to practice relaying clinical information to an audience.

You will also prepare a report which should include: a 5-7 page de-identified case study, including conceptualization and process and/or outcome data. This is also due on the last class meeting of the semester.

Also at the end of the semester, please prepare and submit to the instructors via email a printed summary of your cases, including number of sessions/hours with each case, demographic background and presenting problem of each client.

Classroom Etiquette

It is expected that you attend every class and are on time. If there is any reason you will be late or absent, please notify us by email as soon as you have this information. Please silence your phone during class and only monitor it if you are expecting an emergency phone call. Please do not use phones or laptops for checking email, surfing the web, instant messaging, etc.

Blackboard

We will use the University's Blackboard system to post nearly all the course readings. The readings are comprised of primarily journal articles with selected book chapters. We will be using only one book for this semester.

Required Books

Kleinman, A. (2006). *What really matters: Living a moral life amidst uncertainty and danger.* New York: Oxford University Press.

Persons, J. B. (2008). *The Case Formulation Approach to Cognitive-Behavior Therapy*. New York: Guilford.

Course Organization			**Readings**
Wk 1	Jan 14	Introduction: Culture Matters	1
Wk 2	***Jan 21***	***Martin Luther King Holiday***	
Wk 3	Jan 28	Introduction: How to Consider Culture	2
Wk 3	Feb 4	Conceptualization of Culture I	3, 4
Wk 4	Feb 11	Conceptualization of Culture II	5
Wk 5	Feb 18	***Presidents' Holiday***	
Wk 6	Feb 25	A Cultural Competence Model: Shifting Cultural Lenses	6, 7

Wk 7	March 4	Shifting Cultural Lenses: Behavioral Indicators	8
Wk 8	March 11	Shifting Cultural Lenses: Coding Sessions	8
Wk 9	***March 18***	***Spring Break***	
Wk 10	March 25	Cultural Adaptation	9, 10
Wk 11	April 1	Cultural Evaluation of Treatment Manuals	10
Wk 12	April 8	Other Models of Cultural Competence	11, 12
Wk 13	April 15	Status of Evidence-Based Treatments for Minorities	13
Wk 14	April 22	Language and Assessment	14, 15, 16
Wk 15	Apr 29	Case Presentations/Conclusion	

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READING LIST

1. Hinton, D. E., Um, K., & Ba, P. (2001). A unique panic-disorder presentation among Khmer refugees: The sore-neck syndrome. *Culture, Medicine and Psychiatry, 25,* 297-316.

2. Lopez, S., & Hernandez, P. (1986). How culture is considered in the evaluation of mental health patients. *Journal of Nervous and Mental Disease, 174*, 598-606.

3. Nagayama Hall, G. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues, *Journal of Consulting and Clinical Psychology, 69*, 502–510.

4. Kleinman, A. & Kleinman, J. (1991). Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry*, *15*, 275-301.

5. Kleinman, A. (2006). *What really matters: Living a moral life amidst uncertainty and danger.* Oxford: Oxford University Press. (pp. 80-122;162-195).

6. Lopez, S. R. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision*. New York: Wiley.

7. Lakes, K., Lopez, S. R., & Garro, L. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, Practice and Training, 43,* 380-396.

8. Ribas, A., Lopez, S. R., et al. (2013). *Towards evidence-based cultural competence: A*

coding system of clinicians' in-session behaviors. Unpublished Manuscript.

9. Lau, A. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13,* 295-310.

10. Lopez, S. R., Kopelowicz, A., & Cañive, J. (2002). Strategies in developing culturally competent family interventions for schizophrenia: The case of Hispanics in Madrid and Los Angeles. In H. P. Lefley & D. L. Johnson (Eds.), *Family interventions in mental illness: International perspectives* (pp. 61-90). Westport, CT: Greenwood.

11. Sue, D. W., Arredondo, P. & McDavis, R. (1992). Multicultural counseling competencies and standards: a call to the profession. *Journal of Counseling Development,* 70, 477-486.

12. Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

13. Huey, S. J., Jr., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth: A review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology, 37*, 262-301.

14. Del Castillo, J. C. (1970). The influences of language upon symptomatology in foreign-born patients. *American Journal of Psychiatry, 127*, 160-162.

15. Marcos, L. R., Urcuyo, L., Kesselman, M., & Alpert, M. (1973). The language barrier in evaluating Spanish-American patients. *Archives of General Psychiatry, 29*, 655-659.

16. Hsieh, E. & Kramer, E. M. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling, 89*, 158-162.

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