THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Department Of Psychiatry and Behavioral Sciences

Clinical Psychology Internship Training Program Policy & Procedure Handbook

2010-2011 Orientation

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WELCOME TO THE UNIVERSITY OF OKLAHOMA
HEALTH SCIENCES CENTER!

Please take note of the following important information:

To have your **ID Card/Badge** made, go to the Service Center Building, Room 118 D. They are open from 8:00 - 5:00 pm, with lunch 12:00 – 1:00 pm. You will need to take your driver's license with you. There is no charge for the first ID Card/Badge. If you lose your ID Card/Badge, however, the cost for a replacement is $15.00. This cannot be done until you “are in the system”, we will let you know when you are in the system, which will take approximately one week.

**Parking Cards & Decals** – A parking space application will be given to you during orientation along with parking assignments. The cost of the parking card is $22.00 per month. (You can pay out each month.) You are not “Benefit Eligible” so this will not be able to be deducted from your pay check. (You may be able to park in the Resident Lot next to William’s Pavilion)

Will Redding always needs a current local address and phone number. If you should move during the course of your internship, please keep him advised. If you change offices after a rotation, please make sure Will Redding always has your current extension number and room number. If you change pagers for any reason, I always need to have your current pager number as well.

You are entitled to the following leave periods. All interns get 15 days per year. Please see the following Leave Policy regarding types of leave available.

<table>
<thead>
<tr>
<th>Leave Type</th>
<th>Days</th>
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<tbody>
<tr>
<td><strong>Vacation</strong></td>
<td>10 days – Neuropsych and Pediatric</td>
</tr>
<tr>
<td></td>
<td>13 days – VA</td>
</tr>
<tr>
<td><strong>Academic Leave</strong></td>
<td>5 days – Neuropsych and Pediatric</td>
</tr>
<tr>
<td></td>
<td>2 days – VA</td>
</tr>
<tr>
<td><strong>Holidays</strong></td>
<td>Approximately 11 days</td>
</tr>
</tbody>
</table>

We maintain a record of your vacation, sick, and academic leave. Please send my Senior Administrative Assistant (Will Redding) a leave form if you are absent for any reason. Dr. Leber’s Administrative Assistant at the VAMC (456-3140) also needs a copy of the leave form for the VA interns. Also, call my office if you are going to be out. **This applies to all interns. You must list who will be responsible for your patients if an emergency happens and get that person's approval and have them initial your leave form.** If you do not, the leave form will be returned to you. Usually your rotation supervisor will cover for you in emergency situations. Have your primary supervisor sign the leave form prior to sending the leave form to Will Redding for Dr. Adams’ signature.

It is important to take note of the different holiday schedules (pages 9 and 10). Health Sciences Center funded interns (Pediatric and Child Clinical Psychology, and OU Medical Center) will follow the OU Medical Center Schedule, and VA interns will follow the VA Holiday Schedule.
**Student health insurance** is available through the Health Sciences Center. VA interns receive their health insurance through the VA. We will provide health insurance cost information for non-VA intern spouses during orientation week.

Paydays: VA interns’ paydays are every other Friday, direct deposit is mandatory (direct deposit paperwork is in your VA packet). You should receive your first paycheck in approximately three weeks after your start date. However, the paycheck should only be for approximately two weeks in July due to the one-week lag time in issuing checks.

Health Sciences Center interns are paid once a month on the last business day of the month. Direct Deposit is mandatory. The pay period runs from the first day of the month to the last day of the month. The gross amount of each check will be approximately $1,790 minus taxes, and social security. For your first paycheck you will need to check with Julie Ehrhart at ext. 47675 to check and see if your check has been direct deposited or if you need pick up your pay check at the Bursar’s Office, Room 118, Service Center Building.
PHILOSOPHY AND OBJECTIVE OF TRAINING AND CLINICAL ORIENTATION

Philosophy and Goals and Objectives of Training

Our program subscribes to the scientist-practitioner model. Although we believe the internship should be devoted primarily to clinical activities, science provides the backbone for much of our clinical practice. The majority of our faculty are involved in research projects. The core of the intern's training is in the clinical activities on the various rotations, and each intern will be active in a wide range of clinical activities. Our program is a General Internship, and as such, interns gain experience working with both adults and children. The term General Internship means interns have experiences in psychotherapy and assessment with both children and adults. Our major goal is to prepare students for the practice of professional psychology, particularly clinical and counseling psychology. Choices an intern makes allow for specialized training in pediatric and child clinical psychology, child maltreatment, clinical neuropsychology, and health psychology while maintaining a general internship philosophy.

Clinical Orientation

The theoretical orientation of the clinical training program is as diverse as the various contributing faculty members. This diversity is reflected in the specific rotations, which comprise the training program. It is the goal of the internship to provide a number of models for you to aid in your search for a professionally meaningful orientation or framework. To that end, the clinical psychology faculty are aware of and utilize a variety of techniques and approaches for understanding and effecting behavior (e.g., cognitive, dynamic, behavioral, family, group, etc.). Interns are encouraged to gain experience in these varied approaches from which we expect each intern will achieve some integration of theory and practice over the course of the internship year.

Our internship is designed to accomplish the following goals and objectives:
1. To prepare student for the practice of professional psychology, specifically clinical psychology and counseling psychology.
2. To accomplish the above mentioned outcomes the intern will:
   • Develop Professionally (Goal 1)
   • Integrate Science and Practice (Goal 2)
   • Practice high ethical standards (Goal 3)
   • Be sensitive to Cultural Diversity Issues (Goal 4)
   • Administer and interpret psychological assessment tools with both adults and children (Goal 5)
   • Apply therapeutic approaches with both Adults and Children (Goal 6)

Program Experiences:
To accomplish the above mentioned goals the program is designed to provide the following experiences:
1. To provide the necessary professional experience, didactics, and supervision necessary for internship training to qualify the intern for licensure in any state the intern chooses.
2. To provide interns general internship training experiences. We specifically define General internship experiences as: (1) clinical experience working with patient in multiple settings, (2) clinical experience working with both adults and children, and (3) clinical experiences in psychotherapy and in assessment with both children and adults.

3. Not all interns receive identical training. We provide interns the opportunity to make major and minor rotation choices which will greatly impact their training experience. Intern rotation choices can result in a specialized track within our general internship program. The tracks available include pediatric and child psychology, child maltreatment, and clinical neuropsychology.
POLICIES AND PROCEDURES
FOR THE INTERNSHIP PROGRAM

1. Our program subscribes to the scientist-practitioner model. We believe the internship year should be devoted primarily to gaining clinical experiences, as much of the remaining graduate school years deal with research. The core of the intern's training is in the clinical activity of the rotation experiences, and each intern will be active in a wide range of clinical areas. This is a general internship program and, as such, interns must gain rotation experiences working with both adults and children. Each intern should have at least one adult and one child rotation. Two minor child rotations are equivalent to one major child rotation and two minor adult rotations are equivalent to one major adult rotation.

2. The internship year is divided into three four-month rotations. Possible rotation sites include the following:

   The specific clinical rotations are as follows:
   1. Adult Neuropsychology Assessment Laboratory (OU Medical Center)
   2. Pediatric Neuropsychology Assessment Laboratory (OU Medical Center, Children’s Hospital and Outpatient Clinics)
   3. Primary Care (Veterans Affairs Medical Center)
   4. Pediatric Psychology (OU - Children's Hospital/OU Children's Physicians)
   5. Center on Child Abuse and Neglect -- CCAN (OU Children's Physicians)
   6. Child Behavioral Medicine
   7. Outpatient Child Mental Health Service (OU Children's Physicians)
   8. Substance Abuse Treatment Center (Veteran's Affairs Medical Center)
   9. Health Psychology Clinic (Veteran's Affairs Medical Center)
  10. Ambulatory Mental Health Clinic (Veteran's Affairs Medical Center)
  11. Neuropsychology (Veteran's Affairs Medical Center)
  12. Post Traumatic Stress Recovery Program (Veterans Affairs Medical Center)
  13. Family Mental Health Program (Veterans Affairs Medical Center)
  14. Psychiatry Inpatient Unit (Veterans Affairs Medical Center)
  15. Community Living Center (Formerly Extended Care Unit) (Veterans Affairs Medical Center)
  16. OIF/OEF – VA

   Intern interest will play a major role in the selection of rotations; however, the needs of the unit, funding sources, and faculty availability also play an important part. The intern's supervisory committee may in certain circumstances, require specific rotational experiences with the approval of the Training Director. The Training Director will assume this responsibility (until a committee is formed.) An average of 25 hours per week should be spent on rotation activities. These hours include all time spent on the unit, plus time spent writing reports and making chart notes. Time beyond the 25 hours can be spent if the intern, on his or her own initiative and without pressure, chooses to spend the time.

3. Interns are to spend approximately five hours per week seeing individual outpatients in individual and/or group treatment and associated supervision and charting activities. This work will be done under the supervision of the primary psychotherapy supervisor.
4. Interns are to choose a primary psychotherapy supervisor during the first three weeks of the internship year. The intern primarily makes this choice, but no faculty member should be primary supervisor for more than one intern. The intern is required to meet at least one hour per week with the primary supervisor, the primary supervisor is to be a licensed clinical/counseling psychologist working in the HSC complex. A list of possible primary supervisors can be found in this Policy and Procedure Handbook. The primary supervisor is aware of all the activities of the intern, and the supervisor guides and directs the intern during the course of the year. The choice of second and third rotation should be discussed with and approved by the primary supervisor.

The primary supervisor is responsible for writing a letter, cosigned by the Training Director, which will be sent to the intern's graduate school at the end of the internship year. This letter is a complete evaluation of the intern's progress during the year. Primary supervisors should come to CTC meetings, especially when intern progress is discussed.

Should an intern and a primary supervisor feel their working relationship is unproductive, they should discuss this with the Training Director. The Training Director will attempt to facilitate the relationship between the intern and the supervisor. If this becomes unproductive, the Training Director may change the intern’s primary supervisor assignments.

5. Each clinical rotation assignment should have a designated clinical psychologist faculty supervisor. If multiple individuals are to supervise the intern on a given rotation, one supervisor should be specified as the primary rotation supervisor.

   a. Non-VA Interns: Interns will have a total of 10 days vacation during the internship year. In addition, interns have five days of academic leave (total=15). The intern may choose this leave whenever he/she wants with the following exceptions: The rotation supervisor must approve the leave in writing on the leave form and indicate it does not interfere with active case management on the unit. Similarly, the Internship Director must approve all leave. This leave form should be in the Director’s office two weeks before the leave is to be taken. We recommend interns either take leave at the beginning of a given rotation or at the end of rotation to minimize interference with patient care. We suggest, although not require, the intern distribute this leave over all rotations.

   b. VA Interns: VA Interns receive 13 days of vacation per year plus 2 days of administrative leave (total=15). VA Interns earn leave at the rate of 4 hours per pay period. There are 26 pay periods. VA Interns cannot take leave until it is accrued. VA Interns likewise accrue sick leave at a rate of 4 hours per pay period and this leave is not available until it is earned.

6. Interns will also attend the Intern Seminar, the Psychotherapy Case Seminar, and the Behavioral Medicine Teaching Conference. All these conferences are to be case centered wherever possible.
7. Interns will select three minor rotations. These 15 hour minor rotations are of four months duration. A considerable amount of flexibility is given in the choice of minor rotations. The approved minor rotations are as follows: OUHSC Neuropsychological Assessment Lab, Child Clinical & Pediatric Psychology, Center on Child Abuse and Neglect (CCAN), Outpatient Child Mental Service, VA Substance Abuse Treatment Center, VA OEF/OIF Readjustment Program, VA Health Psychology Clinic, VA Ambulatory Mental Health Clinic (AMHC), VA Neuropsychology, VA PTSD Clinic, VA Family Mental Health Program, and Community Living Center. The intern should negotiate their minor rotations with the minor rotation supervisors.

8. Since we feel more than adequate internship experience is gained through the activities supervised by the primary, major, and minor rotation supervisors, any carry over cases from one rotation to the next must be a part of the case load supervised by the primary, new major, or new minor supervisor or approved in writing by the Training Director. Any work outside of rotational activities not supervised by primary, new major, or new minor supervisors must be approved in writing.

9. All OU Medical Center funded interns and other interns on OU Medical Center rotations must see up to eight Medicaid patients per week. VA interns must see at least four Medicaid patients per week if they have OU Medical Center minor rotations.

10. Our internship is organized in certain time-based activities. In other words, a rotation experience is 25 hours a week and minor rotation is 15 hours per week. These time frames (25 hours and 15 hours) include all activities related to a rotation. Activities such as outside reading, travel time to rotations, report writing, etc., are all considered part of the rotation time allotment. The total amount of time is $52 \pm 3$ hours on average.

The intern should monitor their activities and alert the supervisors when they exceed the time limit. Obviously, some interns choose to work over these time limits, but this is not required or expected. An intern can do a perfectly satisfactory job on this internship in a $52 \pm 3$ hours per week average time.
The University of Oklahoma Holiday Schedule for FY 2010-2011 is indicated below. The schedule incorporates an extended Winter Break. Please note the days (*) to be used as mandatory paid leave.

<table>
<thead>
<tr>
<th>Holiday</th>
<th>FY 10-11 Dates</th>
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<tbody>
<tr>
<td>Independence Day</td>
<td>Monday, July 5, 2010</td>
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<tr>
<td>Labor Day</td>
<td>Monday, September 6, 2010</td>
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<tr>
<td>Thanksgiving</td>
<td>Thursday, November 25, 2010</td>
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<td></td>
<td>Friday, November 26, 2010</td>
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<tr>
<td>Winter Break</td>
<td>Thursday, December 23, 2010</td>
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<td>Friday, December 24</td>
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<td></td>
<td>Monday, December 27</td>
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<td>Tuesday, December 28</td>
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<td>Wednesday, December 29</td>
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<td>Thursday, December 30*</td>
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<td></td>
<td>Friday, December 31*</td>
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<tr>
<td>Martin Luther King, Jr. Day</td>
<td>Monday, January 17, 2011</td>
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<tr>
<td>Memorial Day</td>
<td>Monday, May 30, 2011</td>
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</tbody>
</table>

*Thursday, December 30 and Friday, December 31 are not a paid holidays. These days must be charged against earned compensatory time (for hourly employees only), paid leave if available, or as leave without pay.

To be eligible for paid holidays, employees must be appointed on a continuous basis for .50 FTE or more. Students and other temporary employees are not eligible for paid holidays.

Health Sciences Center offices will be officially closed on the published holidays, except where continuous operations must be sustained to avoid conflicts with patient care, teaching schedules and service-related functions. Employees who are required to work on these specific dates will be provided alternative time to be taken on date(s) to be scheduled between supervisors and affected employees. To receive compensation for holidays, an employee must be at work or on approved leave with pay on the day preceding or the day following the holiday.
VAMC Federal Holidays and Celebrations

Monday, July 5, 2010, Independence Day*
Monday, September 6, 2010 Labor Day
Monday, October 11, 2010 Columbus Day
Thursday, November 11, 2010 Veterans Day
Thursday, November 25, 2010 Thanksgiving Day
Friday, December 24, 2010 Christmas Day**
Friday, December 31, 2010 New Year's Day***
Monday, January 17, 2011 Martin Luther King’s Birthday
Monday, February 21, 2011 President’s Day
Monday, May 30, 2011 Memorial Day

*July 4, 2010 (the legal public holiday for Independence Day), falls on a Sunday. For most Federal employees, Monday, July 5, will be treated as a holiday for pay and leave purposes.

**December 25, 2010 (the legal public holiday for Christmas Day), falls on a Saturday. For most Federal employees, Friday, December 24, will be treated as a holiday for pay and leave purposes.

***January 1, 2011 (the legal public holiday for New Year’s Day), falls on a Saturday. For most Federal employees, Friday, December 31, 2010, will be treated as a holiday for pay and leave purposes.
<table>
<thead>
<tr>
<th>Time</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>08:00-08:30</td>
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<td>8:15 – 9:50 SUPPORT GROUP*</td>
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<td>08:30-09:00</td>
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<td></td>
<td>8:30 – 10:00 Neuropsychology Case Conf WP 3460 (optional)</td>
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<td>09:00-09:30</td>
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<td>10:00-10:30</td>
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<td>10:00 – 11:50 INTERN SEMINAR* Assessment &amp; Professional Issues WP Room 3350</td>
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<td>10:30-11:00</td>
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<td>12:00-12:30</td>
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<td>4th Tuesday Only 12:15 – 1:30 CTC Meeting Children’s Physician Office Building B-2410 Intern Rep Only</td>
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<td>12:30-1:00</td>
<td>2ND Monday 12:15 – 1:30 CTC Meeting Children’s Physician Office Building B-2410 Intern Rep Only</td>
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<td>1:00 – 1:30</td>
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<td>4:30 – 5:00</td>
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* Attendance REQUIRED
ABSENCE REPORTS

All non-VA funded interns need to complete an absence report and return to Internship Director’s Office. Included with this Orientation Handbook is a copy of the Absence Report (or Leave Form) which must be completed each time you are going to be absent for any reason, including vacation, sick leave, or academic leave. Please note if you are sick, you must take sick hours out of vacation time. The intern should complete this form at least two weeks in advance (if possible). You, your Rotation Supervisor, and the Internship Director must sign this form then turn it in to Will Redding, Senior Administrative Assistant. Please be aware these two additional signatures are required before this form will be valid. You may obtain the three part form from Will Redding.

All VA interns can electronically request regular leave on the VA VISTA system and it automatically alerts the timekeeper of the date, and time (hours/days) they wish to take. If the intern is on in the computer, interns discuss with their supervisor and it is noted on form SF-71 (VA) and given to the timekeeper for record keeping. For Academic leave (travel/out of town/attending a meeting) VA funded Interns should check with their VA supervisor or Dr. Leber. A copy of the VA Leave Form should be given to Will Redding when it is completed so Dr. Adams has a record of all leave taken. This form can be used instead of filling out the OUHSC leave form.

Please note you need to make arrangements for patients under your care. For example, if you are going to be out of town and you have a patient who is suicidal, you must make arrangements for someone else to follow-up the person’s case, if this seems in order clinically. For this reason, it is necessary for you to designate who will be covering for you during your absence. In most cases, your rotation supervisor will provide this coverage. Obviously, you must get the other person's approval and signature to cover for you prior to your departure. If no one other than your rotation supervisor will be covering for you, the supervisor needs to initial on the “coverage” line and sign the form as well. If you do not mark who is covering for you the form will be returned to you for signature.

Based upon these reports, we will keep a record of your absences in your file. For this reason, if you are sick on a given day you need to call to let us know you will not be coming in, and complete an Absence Report when you return.
INTERN LEAVE POLICY

Non-VA interns are entitled to two weeks (10 days) of paid leave during the internship year. VA interns have a different policy which will be explained at the VA orientation.

Non-VA interns are also entitled to one week (5 days) of paid educational/academic leave during the internship year. Loosely defined the educational/administrative leave of non-VA interns can include: time spent working on intern’s dissertation or defense of same at the intern’s graduate school, attendance at conferences or workshops, visits to prospective fellowship, or visits to prospective academic employment interviews.

VA Interns’ annual and sick leave are earned at the rate of 4 hours (each) every pay period and cannot be used until earned. There are 26 pay periods.

Non-VA interns must fill out a Leave Form two weeks in advance of leave except when sick, then fill out the form immediately upon return to work.

AS PREVIOUSLY STATED, YOU NEED TO LIST WHO WILL COVER YOUR RESPONSIBILITIES WHILE YOU ARE ON VACATION AND GET THEIR INITIALS BY THEIR NAME ON THE LEAVE FORM. IF YOU DO NOT GET THE FORM INITIALED, THE FORM WILL BE RETURNED TO YOU.
**UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE**

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES**

**ABSENCE REPORT**

Name: ___________________________  □ Student  Filing Date ___________________________

□ Non-Student

**COVERAGE**

Administration ____________________  Teaching ____________________

Service ___________________________  Supervision ______________________

**PURPOSE OF LEAVE:**

|---------------|-----------------|--------------------|-----------------------|----------------------|----------------|----------------|----------------|----------|-----------------|-----------------|----------------|----------------|----------------|

Holiday Time ______________________

NOTES ________________________________

____________________________________

(Destination • Name of Meeting • Title of Presentation)

**TOTAL TIME ABSENT:**

Hours ________  Minutes ________

Beginning Date ________________  Beginning Time ________________

Return Date ________________  Return Time ________________

Signature of person requesting leave ___________________________

Emergency Telephone __________________________

Signature of Supervisor ___________________________

Department Head or Designee ___________________________

**** COMPLETE FOR ADMINISTRATIVE LEAVE ONLY ****

SOURCE OF FUNDS:  □ Research Council  □ Education Council  □ Budget Director

□ Chairman’s Contingency  □ AAC  □ IPA

Other ___________________________

(Explain) Grant ___________________________

(Name and Account Number)

**ESTIMATE OF TRAVEL COST:** (If Not Using Personal Funds)

Coach Plane Fare ________________  Bus or Train Fare ________________  Auto @ $0.28 Per Mile

Lodging Standard In-State @ $40/Night ________  No. Days In-State ________  Meals @ $25/Day ________

Lodging Standard Out-of-State @ $40/Night ________  No. Days Out-of-State ________  Meals @ $25/Day ________

Lodging Hi-Rate Out-of-State @ $65/Night ________  No. Days Out-of-State ________  Meals @ $25/Day ________

Lodging (Designated) @ 100%/Night ________  No. of Days ________  Meals @ $26/Day ________

Registration Fee ___________________________

Miscellaneous (Taxi, Etc.) ___________________________

TOTAL REQUESTED $ ________  TOTAL APPROVED $ ________

COUNCIL NAME ___________________________

SIGNATURE ___________________________

**DO NOT DETACH UNTIL ALL AUTHORIZED SIGNATURES HAVE BEEN OBTAINED**

White - Administration Copy  Yellow - Employee’s Copy  Pink - Office Manager’s Copy
UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
POLICIES AND PROCEDURES

5.24 GRIEVANCE PROCEDURE FOR COMPLAINTS BASED UPON DISCRIMINATION, SEXUAL HARASSMENT, SEXUAL ASSAULT, CONSENSUAL SEXUAL RELATIONSHIPS, RETALIATION OR RACIAL AND ETHNIC HARASSMENT
(revised 1-14-97)

Who may use procedure - the grievance procedure embodied herein shall be available to any person who, at the time of the acts complained of, was employed by, was an applicant for employment, or was enrolled as a student at the University of Oklahoma.

Filing of Complaint - Persons who have complaints alleging discrimination based upon race, color, national origin, sex, age 40 or above, religion, disability, status as a veteran or complaints alleging sexual harassment, consensual sexual relationships, retaliation, or racial and ethnic harassment shall file them in writing with the Equal Opportunity and Affirmative Action Officer, hereafter referred to as EO/AA Officer, or with their department head/chair, academic dean, campus judicial coordinator, Vice Provost for Educational Services, or administrative supervisor. These individuals and the EO/AA Officer or the EO/AA Officer's designee are referred to as "Administrator."

Complainants who exercise their right to use this procedure agree to accept its conditions as outlined. Where multiple issues exist, (i.e. sexual harassment and violation of due process or grade appeal), the complainant must specify all of the grounds of the grievance of which the complainant should have reasonably known at the time of filing. A grievance filed under this procedure may normally not be filed under any other University grievance procedure. Depending on the nature of the issues involved, the complainant will be advised by the EO/AA Officer or his/her designee about the appropriate procedure(s) to utilize.

Timing of Complaint - Any complaint must be filed with the EO/AA Officer or other appropriate administrator within 180 calendar days of the act of alleged discrimination or harassment. All other time periods may be reasonably extended by the administrator.

Administrative Action - The University recognizes its obligation to address incidents of discrimination and harassment on campus when it becomes aware of their existence even if no complaints are filed, therefore, the University reserves the right to take appropriate action unilaterally under this procedure.

With respect to students, the Vice President for Student Affairs/Vice Provost for Educational Services or other appropriate persons in authority may take immediate administrative or disciplinary action which is deemed necessary for the welfare or safety of the University Community. Any student so affected must be granted due process including a proper hearing. Any hearing involving disciplinary suspension or expulsion shall be conducted by a campus disciplinary council in accordance with Title 13, Section 1.2. of the Student Code. Lesser administrative or disciplinary action may be appealed to the Vice President for Student Affairs/Vice Provost for Educational Services. Such requests must be in writing and filed within seven calendar days following the summary action. The Vice President for Student Affairs/Vice Provost for Educational Services will
issue a written determination to the student within three working days following the date the request is received.

With respect to employees, upon a determination at any stage in the investigation or grievance procedure that the continued performance of either party's regular duties or University responsibilities would be inappropriate, the proper executive officer may suspend or reassign said duties or responsibilities or place the individual on leave of absence pending the completion of the investigation or grievance procedure.

Withdrawal of Complaint - The complainant may withdraw the complaint at any point during the investigation or prior to the adjournment of a formal hearing.

Confidentiality of Proceedings and Records - Investigators and members of the Hearing Panel are individually charged to preserve confidentiality with respect to any matter investigated or heard. A breach of the duty to preserve confidentiality is considered a serious offense and will subject the offender to appropriate disciplinary action. Parties and witnesses are admonished to maintain confidentiality with regard to these proceedings.

All records, involving discrimination or harassment, upon disposition of a complaint, shall be transmitted to and maintained by the EO/AA Officer as confidential records except to the extent disclosure is required by law. This includes records of complaints handled by administrators.

Proceedings

1. Investigation - Upon receipt of a complaint, the EO/AA Officer or other appropriate administrator is empowered to investigate the charge, to interview the parties and others, and to gather any pertinent evidence. The investigation should be completed within 60 calendar days of receipt of the complaint, or as soon as practical. The investigator shall prepare a written record of the investigation.

In arriving at a determination of a policy violation, at any stage of the proceedings, the evidence as a whole and the totality of the circumstances and the context in which the alleged incident(s) occurred shall be considered. The determination will be made from the facts on a case by case basis. Upon completion of the investigation, the EO/AA Officer or other administrator is authorized to take the following actions:

a. Satisfactory Resolution - Resolve the matter to the satisfaction of the University and both the complainant and the respondent. If a resolution satisfactory to the University and both parties is reached through the efforts of the EO/AA Officer or other administrator, the administrator shall prepare a written statement indicating the resolution. At that time the investigation and the record thereof shall be closed.

b. Dismissal - Find that no policy violation occurred and dismiss the complaint, giving written notice of said dismissal to each party involved. Within 15 calendar days of the date of the notice of dismissal, the complainant may appeal said dismissal in writing to the EO/AA Officer by requesting a hearing according to the provisions of
the section entitled "Hearing." If no appeal is filed within the 15 calendar day period, the case is considered closed.

c. **Determination of Impropriety** - Make a finding of impropriety and notify the parties of the action to be taken. Either party has the right to appeal said determination in writing within 15 calendar days of the date of notice of determination to the EO/AA Officer by requesting a hearing according to the provisions of the section entitled “Hearing.” If no appeal is filed within the 15 calendar day period, the case is considered closed.

In the case of a complaint against a faculty member, the administrative investigator may determine that the evidence is sufficiently clear and serious so as to warrant the immediate commencement of formal proceedings as provided in the Abrogation of Tenure, Dismissal Before Expiration of a Term Appointment, and Severe Sanctions section of the Faculty Handbook. If the President concurs with the administrator's finding, the case may be removed at the option of the accused from the grievance proceedings contained herein and further action in the case shall be governed by the Abrogation of Tenure, Dismissal Before Expiration of a Term Appointment, and Severe Sanctions section in the Faculty Handbook. Otherwise, this policy and procedure shall apply.

2. **Hearing**

   a. **Request for a Hearing** - Appeals and complaints unresolved following an investigation may result in a hearing before a Hearing Panel selected from the membership of the Committee on Discrimination and Harassment as described below. For the Norman campus, faculty versus faculty grievances heard by the Faculty Appeals Board. The request for a hearing is to be addressed to the EO/AA Officer. The request for a hearing must contain the particular facts upon which the policy violation allegation is based as well as the identity of the appropriate respondent(s). A copy of the request shall be given to the proper respondent(s) by the EO/AA Officer. Written response to the request for a hearing must be sent to the EO/AA Officer within 10 calendar days of receiving notice that a hearing has been requested. A copy of the response shall be given to the party requesting the hearing.

   b. **Selection of a Hearing Panel** - Within 10 calendar days following receipt of the written request for a hearing, the EO/AA Officer shall initiate the process to determine the members of the Hearing Panel who are to conduct a hearing. A five-member Hearing Panel will be selected by drawing from: on the Health Sciences Center, the twenty-four (24) member Committee on Discrimination and Harassment; and on the Norman Campus, from the sixteen (16) member Committee on Discrimination and/or the fifty (50) member Faculty Appeals Board. In the case of faculty versus faculty complaints on the Norman Campus, the party requesting the hearing may request that the panel members be drawn only from the Faculty Appeals Board.
A Committee on Discrimination and Harassment shall be established on each campus and composed of: on the Health Sciences Center, eight (8) staff members, eight (8) students, and eight (8) faculty members; and on the Norman Campus, eight (8) staff members and eight (8) student members, with faculty representation being selected from the Faculty Appeals Board. On the Norman Campus, five (5) staff will be appointed by the Staff Senate and five (5) students will be appointed by UOSA; the President will appoint three (3) staff and three (3) students. At the Health Sciences Center, eight (8) faculty will be appointed by the Faculty Senate, eight (8) staff members appointed by the Employee Liaison Council, and eight (8) students by the Student Government Association. The terms of appointment shall be for three (3) years with initial terms of 1, 2, and 3 years in each category to provide the staggered membership, except that each student shall be appointed for a one year term.

The EO/AA Officer or his/her designee shall preside at a drawing to determine the members of the Hearing Panel. The drawing shall be from the pool of names as outlined in the above paragraph. Names of persons shall first be removed from the pool who; (1) have direct involvement or knowledge of the incident involved; (2) are employed in the same budget unit; and (3) are related to either party in the grievance. The remaining names shall be placed in a container, and the drawing shall be made to determine the five members who are to serve on the Hearing Panel. Prospective panel members who have been determined by the drawing shall be asked to disqualify themselves should there be any possibility of their having a biased opinion concerning the grievance. For example, a close friend shall disqualify himself/herself. When, for any reasons, prospective panel members disqualify themselves, additional names shall be drawn from the container until a full panel is constituted. Either party to the complaint may ask the EO/AA Officer to disqualify any member of the Hearing Panel upon a showing of cause.

c. Conference - Within 10 calendar days of receiving notification, or as soon as practical, the EO/AA Officer shall convene the Hearing Panel for an orientation conference and an informal discussion of the grievance. The panel will select a Chair of the Hearing Panel (hereafter referred to as the Chair) from the group of five Hearing Panel members. The EO/AA Officer shall be present during the informal discussion. At the beginning of the conference, the EO/AA Officer shall conduct an orientation for the panel members. Each panel member shall be given a copy of the written complaint, the request for a hearing, and the written response. No witnesses will be heard during the orientation conference. After the selection of a Chair and after the orientation is delivered to the panel members, the EO/AA Officer shall be excused. At that time the Hearing Panel will reach a decision as to whether there exist adequate grounds for a hearing. If the Panel decides at its pre-hearing conference that there is no basis for a hearing, it shall report the determination in writing to the proper executive officer with a copy to the President and the EO/AA Officer. The Executive Officer shall render his or her decision on the matter in writing to each of the parties involved in the informal proceedings.
d. **Informal Hearing** - In the event the Hearing Panel determines that there is a basis for a hearing, the Chair shall convene the panel for an informal hearing. Each panel member shall be given a copy of the Hearing Guidelines. The parties involved will be present at the informal hearing. No witnesses will be heard. The Chair of the Hearing Panel shall notify the parties of the date, time and location of the informal hearing. The hearing shall be scheduled to reasonably ensure that the complainant and respondent are able to participate. Upon request of the Chair, Legal Counsel may serve as an adviser to the Hearing Panel.

At all meetings, each party may be accompanied by an adviser. In the event that a party chooses to be advised by an attorney he/she may do so at his/her expense. If an adviser is used, the name of the person so assisting must be furnished to the Panel and the other party 10 calendar days in advance of the hearing conference. Advisers may advise their clients but may not directly address the Hearing Panel.

In the event the matter is resolved to the satisfaction of all parties prior to the formal hearing, a written statement shall indicate the agreement recommended by the parties and shall be signed and dated by each party and by the Chair. The recommendation will be referred to the appropriate Executive Officer for final determination.

In the event the panel by a majority vote decides at the informal hearing that there is no basis for a formal hearing, it may recommend that the grievance be dismissed. The panel shall report the recommendation in writing to the appropriate Executive Officer, with a copy to the President and the EO/AA Officer. The Executive Officer shall render his or her decision on the matter in writing to each of the parties involved in the informal hearing.

e. **Formal Hearing** - In the event that the panel determines the need for a formal hearing, The Chair will convene the panel and the parties for a formal hearing. The Hearing Panel procedures shall be established with reference to the Hearing Guidelines and shall provide that the parties may present all of the evidence that they consider germane to the determination. Further, the parties may call witnesses to testify and may cross-examine witnesses called by the other party. The hearing shall be closed unless all principals in the case agree to an open hearing. Audio tape recordings of the proceedings shall be arranged by the Chair and paid for by the University. Transcripts may be charged to the requesting party. In cases of alleged sexual assault on students, the accuser and the accused are entitled to the same opportunities to have others present during a campus disciplinary proceeding and both shall be informed of the outcome of the proceeding. The Chair shall notify the parties of the date, time and location of the formal hearing. Parties are responsible for giving such notice to their witnesses. The hearing shall be scheduled to reasonably ensure that the complainant, respondent, and essential witnesses are able to participate.

In the event the matter is resolved to the satisfaction of all parties prior to completion of the formal hearing, a written statement shall indicate the agreement recommended
by the parties and shall be signed and dated by each party and by the Chair. The recommendation will be referred to the appropriate Executive Officer for final determination.

f. Panel's Findings and Recommendations - In the event that no solution satisfactory to the parties is reached prior to the completion of the formal hearing, the Panel shall make its findings and recommendations known to the proper executive officer, with copies to the President and the EO/AA Officer. The Panel's report, with its findings and recommendations, shall be prepared and properly transmitted within seven (7) calendar days after conclusion of the formal hearing. g) Executive Officer's Decision - Within 15 calendar days of receipt of the Hearing Panel's findings and recommendations, the proper executive officer shall inform the complainant and the respondent of the findings of the Hearing Panel and the officer's decision. A copy of the officer's decision shall be transmitted to the Chair of the Hearing Panel, with copies to the President and the EO/AA Officer. In a case investigated initially by an administrator, the administrator also shall be informed of the officer's decision. In the event the allegations are not substantiated, reasonable steps in consultation with the accused may be taken to restore that person's reputation.

The Executive Officer's decision may be appealed to the President within 15 calendar days of being notified of prospective action or of action taken, whichever is earlier. If the President does not act to change the decision of the Executive Officer within 15 calendar days of receiving the appeal, the decision of the Executive Officer shall become final under the executive authority of the President. To contact the Equal Opportunity and Affirmative Action Office:

Norman Campus: Health Sciences Campus:
Evans Hall, Room 102 Services Center, Room 113
Telephone (405) 325-3546; Telephone (405) 271-2110
www.ou.edu/ohr/handbook
5.20 SEXUAL HARASSMENT/SEXUAL ASSAULT POLICY  
(Revised 1-14-97)

Statement

The University of Oklahoma explicitly condemns sexual harassment of students, staff, and faculty. Sexual harassment is unlawful and may subject those who engage in it to University sanctions as well as civil and criminal penalties.

When criminal action is pursued in addition to an administrative grievance under this policy, the EO/AA Office will coordinate its investigative actions with the University or local law enforcement authorities to ensure that criminal prosecution is not jeopardized. The EO/AA Officer may defer administrative action at the request of University or local law enforcement authorities pending completion of the criminal investigation. Where review by the EO/AA Officer or other university executive officer determines that immediate administrative action is necessary for the safety, health and well-being of the campus community, such action may be taken in advance of resolution of criminal charges.

Since some members of the University community hold positions of authority that may involve the legitimate exercise of power over others, it is their responsibility to be sensitive to that power. Faculty and supervisors in particular, in their relationships with students and subordinates, need to be aware of potential conflicts of interest and the possible compromise of their evaluative capacity. Because there is an inherent power difference in these relationships, the potential exists for the less powerful person to perceive a coercive element in suggestions regarding activities outside those appropriate to the professional relationship. It is the responsibility of faculty and staff to behave in such a manner that their words or actions cannot reasonably be perceived as sexually coercive, abusive, or exploitive. Sexual harassment also can involve relationships among equals as when repeated advances, demeaning verbal behavior or offensive physical contact interfere with an individual's ability to work and study productively.

The University is committed to providing an environment of study and work free from sexual harassment and to insuring the accessibility of appropriate grievance procedures for addressing all complaints regarding sexual harassment. The University reserves the right, however, to deal administratively with sexual harassment issues whenever becoming aware of their existence. Records of all complaints, except for hearings before the Faculty Appeals Board, shall be transmitted to and maintained by the University Equal Opportunity and Affirmative Action Officer as confidential records.

The University encourages victims to report instances of sexual assault or other sex offenses, either forcible or nonforcible. In addition to internal grievance procedures, victims are encouraged to file complaints or reports with campus police or local law enforcement agencies by telephoning 911, as soon as possible after the offense occurs in order to preserve evidence necessary to the proof of criminal offenses. The campus police department is available to assist victims in filing reports with other area law enforcement agencies.
**Definition of Sexual Harassment** - Sexual harassment shall be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature in the following context: 1) when submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic standing, or 2) when submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual, or 3) when such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive working or academic environment.

**Examples of Prohibited Conduct** - Conduct prohibited by this policy may include, but is not limited to: 1) Unwelcome sexual flirtation; advances or propositions for sexual activity. 2) Continued or repeated verbal abuse of a sexual nature, such as suggestive comments and sexually explicit jokes; 3) Sexually degrading language to describe an individual; 4) Remarks of a sexual nature to describe a person's body or clothing; 5) Display of sexually demeaning objects and pictures; 6) Offensive physical contact, such as unwelcome touching, pinching, brushing the body; 7) Coerced sexual intercourse; 8) Sexual assault; 9) Rape, date or acquaintance rape, or other sex offenses, forcible or nonforcible; 10) Actions indicating that benefits will be gained or lost based on response to sexual advances. Retaliation- Any attempt to penalize or retaliate against a person for filing a complaint or participating in the investigation of a complaint of sexual harassment will be treated as a separate and distinct violation of University policy.

**Sanctions** - Appropriate disciplinary action may include a range of actions up to and including dismissal and/or expulsion.

**Complaint Procedure** - Complaints alleging a violation of the Sexual Harassment/Sexual Assault Policy shall be handled in accordance with the Grievance Procedure for Complaints Based upon Discrimination, Sexual Harassment, Sexual Assault, Consensual Sexual Relationships, Retaliation Or Racial and Ethnic Harassment. To contact the University Equal Opportunity and Affirmative Action Office: Norman Campus, Room 102, Evans Hall, Phone: 325 - 3541, Health Sciences Center Campus, Room 113 Service Center, Phone 271-2110.
IF YOU ARE A VICTIM OF SEXUAL HARASSMENT:

Tell the harasser to stop. Let the person know their conduct is unacceptable to you. Confront the person in as clear, direct, and explicit way as possible.

Examples:

“When you make sexual comments or statements to me or in my presence, it makes me uncomfortable and interferes with my ________ (work, studying, thinking). Please stop.”

“I don’t like it when you put your hand on my shoulder or pat my knee. Please stop.”

“I have already told you it bothers me when you ________. If you don’t stop then I will report it to __________ (attending, supervisor, program director, hospital Chief of Staff)”.

Keep a journal or record of repeated incidents. Include specific content, date, time, your responses, and any witnesses.

Tell someone. Discuss your situation with a peer, colleague, supervisor, or official. Even if you do not wish to file any formal complaint at this point, it is useful to have the support and ideas of another person. If you later decide some formal action is necessary, then the person you tell can corroborate your responses to the situations.

Utilize complaint processes. Both educational and large employment settings have formal processes for investigating and dealing with sexual harassment. An organization has a legal responsibility to take complaints seriously and respond with some action. In small employment settings, you may have to speak to an attorney to assist you with a formal process.
SITUATION FOR DISCUSSION:

You are working on an inpatient psychiatry unit with a team which includes an attending psychiatrist and two medical students, one male, the other female. On several occasions while talking with the students about the patients assigned to your team, one of the students tells “dirty jokes.” After two weeks, the other student talks to you alone and says they are uncomfortable with the jokes. They ask your advice about how to handle the situation. What would you say?
IF YOU ARE CONFRONTED BY SOMEONE AND TOLD YOUR BEHAVIOR IS REGARDED AS SEXUAL HARASSMENT:

Take the problem seriously. Do not discount or dismiss the problem, or immediately attribute it to “the other person.” If the complaint is unclear ask for specifics about what you did or what you are being asked to do or not do in the future.

Monitor your behavior. You may be doing or saying objectionable things without intending to do so.

Discuss the situation with someone else to get neutral input. Getting another person’s perspective may help you understand the situation, and will help you document you have taken the complaint seriously.

Do not repeat the problem behavior.
I HAVE READ AND UNDERSTAND THE SEXUAL HARASSMENT/SEXUAL ASSAULT POLICY OF THE UNIVERSITY OF OKLAHOMA

Sign name: ____________________________  Date: ______________________

Print Name: ____________________________
IN THE SELECTION PROCESS OF PRIMARY SUPERVISORS, I PREFER:

_____1. Intern group to discuss this among themselves and arrive at assignments. If this does not work, Internship Director will make assignments.

_____2. Internship Director to make assignments based on intern preference choices.
PRIMARY SUPERVISION

An important part of your training here will be the primary supervision you receive. As you know, **primary supervision encompasses approximately five hours per week.** This includes time seeing patients, supervision involved, and time for case write-ups.

As much as possible, we try to leave the determination of the primary supervisor up to the intern.

The list of Clinical Training Committee members who have agreed to serve as primary supervisors this year are included in this orientation manual. We suggest you personally contact faculty members who seem appropriate for you and talk with them about the possibility of supervision.

On the list of primary supervisors they give details of their areas of interest, theoretical orientation, and types of patients served. This information will assist you in making your choices. Please note the list of prospective primary supervisors is to be turned into Dr. Adams no later than the **3rd week of July** at the Director's Meeting.
DISTINCTION BETWEEN BASIC 
AND PRIMARY SUPERVISION

Primary supervision is the supervision of psychotherapy cases which transcend the full year. Basic supervision is a term used by the Oklahoma licensing law.
PRIMARY SUPERVISOR DUTIES

1. The Primary Supervisor serves as a mentor for the intern. This individual is aware of all the activities of the intern and should guide and direct the intern during the course of the year. The Primary Supervisor should discuss and approve the choice of the intern’s second and third major and minor rotations.

The Primary Supervisor also supervises the psychotherapy cases within the 5 hour per week time allotment. These psychotherapy cases are usually long-term; however, an intern may have a series of short-term psychotherapy cases.

Please note the Primary Supervisor has an evaluative function with respect to the intern. That is, he/she evaluates the psychotherapy experience, and writes, with the Training Director's approval, the final letter to the intern's graduate school. Since the function is supervisory in nature, the Primary Supervisor is specifically not an advocate of the intern, as we think the intern needs no advocate in a non-adversary environment.

2. The intern selects the Primary Supervisor with the approval of the Training Director. The Primary Supervisor must be working in the Health Sciences Center complex and be licensed as a psychologist. The Primary Supervisor is responsible for meeting with the intern on a weekly basis. These meetings should be a minimum of one hour per week.

3. The Primary Supervisor should attend the Clinical Training Committee meetings on a regular basis. It is extremely important that the Primary Supervisor be at these meetings to discuss the intern's progress.

4. The Primary Supervisor also regularly completes evaluation forms concerning the intern's performance during the course of the year. The Primary Supervisor will complete these forms at mid-rotation of the first rotation and at the end of the second and third rotation. If problems arise, mid-rotation evaluations should be completed for all rotations.

5. The Primary Supervisor is responsible for writing a final evaluation letter concerning the intern. This letter is co-signed by the Training Director and sent to the intern's graduate school. A copy of the letter will remain in the intern's file in the Director's office. The Primary Supervisor should complete this letter around the middle of June of any given training year.

6. If the intern experiences problems with any other supervisor, they are encouraged to discuss this issue with the Primary Supervisor, who attempts to discover the source of the problems. Discussion with that individual supervisor would be in order. If no solutions are forthcoming, a discussion with the Training Director would be in order.
POSSIBLE PRIMARY SUPERVISORS

ADAMS, RUSSELL L., Ph.D.
I feel supervision is the primary method by which one learns psychotherapy skills. For this reason, I try to listen to audio tapes or view a video tape of the therapy sessions where possible. This gives us an opportunity to focus in the session on therapeutic style and treatment issues. Moreover, I prefer to supervise one or two cases intensely, rather than having a larger number of cases with less supervision per case. My style of therapy is cognitive behavioral.

CULBERTSON, JAN L., Ph.D.
My psychotherapy orientation is primarily behavioral and cognitive behavioral, incorporating developmental issues and attachment theory in my approach as well. I supervise cases involving child/adolescent behavioral and emotional problems, particularly when the child has chronic or acute medical problems, neuropsychological dysfunction, learning disorders, ADHD, or has been abused or neglected. I can also supervise Parent-Child Interaction Therapy cases as part of the Behavior Clinic at Child Study Center. My approach to supervision is flexible, based on the needs of the intern, but I would typically use either audio or videotape review along with weekly supervision sessions to plan treatment strategies and review progress. I view the supervision process as collaborative, with the intern and I working together to conceptualize the cases and treat the patients. I am happy to meet with interns to discuss their interests and internship goals, and how these would match with my own interests/expertise.

DYCUS, BILL, Ph.D.
My general approach to clinical supervision begins with having a solid understanding of the experience, strengths, and interests that the intern brings into the internship, and then using those assets to build new skills and professional confidence. My own clinical training involved a balance of cognitive-behavioral, psychodynamic, and family systems approaches. I also have expertise in trauma recovery, particularly trauma related to sexual violence. As a result of my varied training experiences, my clinical approach can best be described as “whatever works,” meaning that I choose the interventions that will be most effective for the client. I value flexibility and creativity in clinical thinking. The supervision session is a collaborative effort. My supervision style is direct but not directive; the intern is given space to search for answers and hone their own style, but I will not hesitate to address an issue where it is needed. Overall, I see the primary therapist role as being one of a professional mentor, not only addressing aspects of direct service, but also navigating and operating within a large healthcare system. As well, I take an active interest in the intern’s current research progress, opportunities for interaction with other clinicians, future goals, and self-care. My goal is for the intern to emerge as a confident, well-rounded practitioner.

GECZY, BELA, Ph.D.
My theoretical orientation is essentially behavioral, although in practice I use a rather eclectic approach depending on the needs and level of functioning of the patient. I view my role as an intern supervisor as a mentor, with the goal of maximizing learning in what always seems a very limited amount of time. As such I try to monitor the overall functioning of the intern and adjust the workload and stress level to optimize learning. During supervision we often focus not just on the immediate issues of patient care, but also how the clinical decisions fit into the administrative and political framework of the hospital and of society. My experience has been that given their level of training psychologists inevitably become involved in administration, and I try to place considerable emphasis on helping interns in develop a modicum of administrative abilities before they graduate and have to face those issues on their own.
GILLASPY, STEPHEN, Ph.D.
My therapeutic perspective is generally cognitive-behavioral approach within a family systems framework. I also incorporate elements of interpersonal therapy when warranted. My clinical work generally includes pediatric inpatient consultation, pediatric primary care consultations, and pediatric outpatient therapy and I supervise interns in all three of these areas. My supervisory style is collaborative and very hands on, with much supervision occurring outside of scheduled supervision time. I also view supervision important to personal and professional development. In general, I don’t require audio- or video-taping of sessions, but may use this approach if warranted by unique case features or at the intern’s request.

HUDSON, PEGGY, Ph.D.
My psychotherapy orientation is primarily interpersonal process, integrating cognitive-behavioral and psychodynamic theories. I generally see adult patients diagnosed with PTSD, depression and personality disorders. My supervision style is open and supportive, and I emphasize finding one’s voice in therapy. Supervision time is dedicated to exploring use of self; review of videotapes, case conceptualization and relevant treatment issues; and addressing the intern's internship experience and future professional goals. Integration of theory and evidenced based approaches into practice is encouraged. I view the internship year as one of both professional and personal development, and encourage interns to gain more independence as the year progresses. Types of cases include individual and group therapy.

LEBER, WILLIAM, Ph.D.
My primary therapy orientation is cognitive behavioral, but I use elements of psychodynamic theory and interpersonal psychotherapy in my conceptualizations and sometimes in interventions. My greatest experience has been in treating adults with depressive or anxiety disorders. I like to use video recordings for supervision and prefer that the trainee have identified some issues upon which to focus in supervision. Therapy supervision would include discussion and role play. In addition to clinical supervision, professional issues, cultural diversity, and career development would be addressed as needed during supervision.

JONES, DAN E., Ph.D.
My psychotherapeutic orientation is primarily cognitive, with occasional leanings toward cognitive behavioral. I appreciate opportunities to do joint therapy in groups with the supervisee and that possibility certainly exists in the PTS Recovery Program at the VA if the intern would elect that as a rotation. For individual therapy cases, I also would use a case discussion format and would encourage the use of audio and video recordings. It is my belief primary supervision should not focus exclusively on psychotherapy. Professional and personal growth issues are welcomed as topics within supervisory sessions. I am only on campus until 2:00 pm each day. I am in private practice after that time. I would be glad to work with interns regarding private practice issues, so my split time could prove to be an asset throughout the training year as an aid to our work together.

LINCK, JOHN, Ph.D.
I typically see individuals for psychotherapy who have behavioral or emotional difficulties resulting from a neurological disorder/injury. Cases will typically come from the pool of neuropsychological referrals (i.e. Polytrauma/TBI, mild cognitive impairment, and stroke) although at times patients may present for therapy in the clinic for psychiatric distress not resulting from a neurological
illness/disorder. My therapeutic orientation is primarily cognitive-behavioral. I consider supervision to be a collaborative process in which the intern and I will work together to conceptualize the case and treat the patient. Professional and personal development are also relevant issues in the context of supervision and will be discussed over the course of the internship year.

MORGAN, JEAN, Ph.D.
I believe primary supervision involves both long-term psychotherapy supervision as well as professional mentoring. In psychotherapy supervision, I tend to conceptualize psychodynamically with an interpersonal focus; however, in terms of techniques; we utilize what the individual case suggests and frequently would be employing cognitive, cognitive-behavior, as well as other types of techniques. Cases come from the AMHC caseload and are drawn from a wide variety of case types with cases assigned on the basis of the intern’s interest, previous experience, and preference. Our number one diagnosis in the AMHC is PTSD with combat, sexual trauma, and “other” included as the precipitating traumas. Additionally, it is a great opportunity for work with different types of personality disorders as well as the typical cases of Bipolar, anxiety, depression, etc. I support a model of primary supervision that provides an opportunity for the intern to process ongoing internship issues, future professional goals and planning, and other areas as needed by the intern. I also have an interest in mental health administration and am happy to encourage interns’ interest in this area.”

SCOTT, JIM, Ph.D.
My therapeutic perspective is generally a cognitive-behavioral approach to treating behavioral and emotional disorders. I generally work with individuals who have central nervous system disorders and their subsequent emotional/behavioral reactions to these disorders. Treatment is generally pragmatic and follows a rehabilitation model of coping skills, compensation techniques, and emotional adjustment. I occasionally see behavioral medicine and more traditional psychotherapy cases and regularly supervise interns on such cases.

THRASH, LEE, Ph.D.
My clinical work primarily involves seeing families at the VA. I utilize a humanistic/client centered approach when working with individuals/families. I will also utilize a cognitive-behavioral approach with many of the clients I see. I generally utilize the humanistic approach in my supervision with interns and fellows. I attempt to meet the intern where they are in terms of their professional development as a psychologist. The intern’s theoretical framework they choose to utilize is something that is valued and respected in the supervision process. I encourage their professional development in the supervision process. Supervision is a collaborative process where professional and personal developmental issues can be addressed as related to growth as a psychologist.
MY PREFERENCE LIST FOR
PRIMARY SUPERVISORS IS AS FOLLOWS.

My preferences are listed in order.

1. ________________________________________________________________

2. ________________________________________________________________

3. ________________________________________________________________

Intern signature: ___________________________ Date: ____________________

Print name: ________________________________________________
CLINICAL TRAINING COMMITTEE (CTC) DESCRIPTION

Although the Internship Director has overall responsibility for the internship program, input from the Clinical Training Committee is sought. This Committee is composed of a chairman, who is the Director of Clinical Psychology Internship Training, an Associate Director representing the Veteran's Administration Hospital, and all of the psychologists who have direct clinical contact with the interns. Because intern input is of crucial importance, an intern representative attends these meetings.

The Committee meets monthly, usually on the fourth Tuesday of the month, from 12:15 pm to 1:30 pm. The interns may select one or two representatives to attend these meetings, except when intern evaluations are on the agenda.

This committee discusses many policy decisions related to the Clinical Internship Training Program and makes recommendations to the Internship Director who is ultimately responsible for the internship program.

A retreat is held near the end of the internship year to allow the Clinical Training Committee members and interns to (a) evaluate the current training year's activities and (b) plan for the next year's program.

One of the functions of the Clinical Training Committee is that of evaluation. Interns have many different activities during the course of the week (primary supervision, secondary rotation, etc.) and have contact with many different faculty members. Some faculty members may only interact with you a brief period of time (as a seminar presenter). Others may have daily interaction with you. Each quarter the Clinical Training Committee discusses intern performance and all faculty members having contact with interns have input into this process. The purpose of this is to let all faculty members know how an intern is doing.

Our internship has APA approval and, in addition, our faculty have accountability for the quality of training we give. As a result, the faculty obviously has a commitment to training and want to make sure interns know what they are required to know.

* If you ever get discrepant information concerning internship policies from the Internship Training Director or any other supervisor, inform the Training Director of this discrepancy so the discrepancy can be worked out.
Clinical Training Committee (CTC)
Intern and Postdoc
Full-time and Adjunct Faculty Members

Russell L. Adams, Ph.D., Professor
Director Psychology Internship Program &
Director Psychology Postdoctoral Training
Program
271-4488, ext. 47680, Room WP-3440
Russell-adams@ouhsc.edu

Sandra F. Allen, Ph.D., Professor
Supervisor, Psychology Internship Training
Program, Director, Emotional Health Center
Director of Professorial Rounds & Director
Tuesday Child Outpatient Clinic, Outpatient
Children’s Mental Health
WP 3039, 271-5251, ext. 47614,
secretary Joan Willard 47607
Sandra-allen@ouhsc.edu

Tatiana Balachova, Ph.D., Adjunct
Associate Professor
Co-Director, ITP/ITIUC, CCAN
Developmental and Behavioral Pediatrics
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AVAILABLE POSSIBLY TO COUNSEL INTERNS
AT A REDUCED FEE

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Midwest City; 840-3793
Will see interns at ½ fee -- $45.00/hr.

Kay Goebel, Ph.D.
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Oklahoma City; 843-1998
Will see interns at reduced fee

Mike Kampschaefer, Ph.D.
50 Penn Place
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Will see interns at reduced fee

Patrick J Mason, Ph.D.
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Richard Sternlof, Ph.D.
1000 W. Wilshire, Ste. 123
Oklahoma City; 848-8489
Will see interns at reduced fee – based on income

Charlotte Rosko, Ph.D.
1125 N. Porter
Norman; 364-3804
Will see interns at reduced fee
GRADUATE SCHOOL AUTHORIZATION

I authorize The University of Oklahoma Health Sciences Center Clinical Psychology Internship Program to communicate with my graduate school concerning the evaluation of my performance during this year.

______________________________
Print name

______________________________
Signature

______________________________
Date
PROCEDURE FOR PLACING AN INTERN ON PROBATION
OR FOR TERMINATING THE INTERN FROM OUR PROGRAM

If significant problems are noted concerning a given intern by any of his/her supervisors, then a special supervisory subcommittee meeting, chaired by the intern's primary supervisor, is called. Those invited to attend this meeting include the intern, primary supervisor, major rotation supervisor, minor rotation supervisor, internship director, and any other faculty member having significant contact with this intern. A vote taken by the supervisory subcommittee is by the majority of faculty present. During the supervisory subcommittee meeting, the specific problems are outlined and suggested corrections to the problems are discussed. The specific suggestions for an intern are reduced to writing and a copy is given to the intern, together with the corrections that need to be made in order to overcome the deficiency. A copy is sent to the intern's graduate school training director. At the meeting, a time limit is given during which time these problems are to be remedied.

At the meeting the supervisory subcommittee, by simple majority vote, can make a recommendation to:

1. Place the student on probation and require him/her to meet specified requirements by a specific time.
2. Not place the student on probation, but require him/her to meet specified requirements by a specific time.
3. Recommend termination to the CTC.

The decision of the supervisory subcommittee to place an intern on probation is effective immediately, but is brought to the Clinical Training Committee (CTC) for review and concurrence. The Primary Supervisor and the Internship Training Director will work with the intern to assist the intern in addressing the problems noted.

The subcommittee can recommend a CTC meeting be called to consider termination. Termination prior to probation would occur only in a case where blatant irresponsibility or gross unethical behavior is performed by the intern (e.g., an intern having a sexual relationship with a patient). The Director of the Internship Program also has the authority in a situation such as described above to suspend an intern from the program pending a CTC review.

The termination recommendation of the supervisory subcommittee will then be presented at the next CTC meeting or a specially-called CTC emergency meeting. Decisions of the CTC will be on the basis of a simple majority vote of CTC members present. The CTC faculty will recommend the intern training director either (1) support the recommendation of the supervisory subcommittee for termination, or (2) not support the termination recommendation.

If, by the time limit specified by the supervisory subcommittee and affirmed by the CTC and the internship training director, the problem leading to probation still exists, another meeting of the subcommittee is held, and again the problems are presented and reduced to writing. However, at this time, the supervisory subcommittee by majority vote will recommend one of the following to the CTC:
1. The intern is removed from probation.
2. The intern continues on probation.
3. The intern be terminated pending CTC review.

No CTC approval is needed for points 1 or 2.

The primary supervisor will assist the intern placed on probation in overcoming his/her deficits. If termination is recommended by the Supervisory Subcommittee (#3 above), the intern's case is again discussed at a CTC meeting. The CTC may recommend to the internship director that the intern:

1. Continue on probation.
2. Be terminated. If termination is recommended, then the intern graduate school is so advised. The intern will be notified in writing of the decision.

No intern can graduate from our program if he or she is still on probation. The internship training director will notify the intern of his/her decision.

The intern has the right to appeal the Director's decision to terminate within 30 days of notification. Initiative for the appeal rests with the intern. The intern will make this appeal before the Appeals Committee. A faculty advocate may represent the student. The appeals committee will be composed in the following manner:

1. Directors of the other three educational programs (Adult Psychiatry, Child Psychiatry, and Undergraduate Medical Education) and the Director of Biological Psychology (an alternate may be named by any of the above Directors).
2. Another intern from the training program and a student from another program chosen by the Education Council.
3. A representative of the Department Executive Committee, chosen by the Executive Committee. This person will serve as Chair of the Appeals Committee.
4. An adjunct faculty member from the same discipline chosen by the Director of the program in which the student is enrolled.

The Appeals Committee will meet as soon as possible after notice of an appeal. A quorum comprises the presence of 75% of the Committee. They will make their decision by simple majority vote.

Approved by CTC vote, September 1996
INTERN GRIEVANCE PROCEDURE

During the course of the year, an intern may have some grievance against a faculty member or against some other program related issue. If this comes up, our procedure is for the intern and the individual(s) involved meeting together to try to work through the problem. If this procedure does not resolve the problem, then the intern would follow the usual chain of command in resolving the problem. The first step would be to consult with the primary supervisor. If this is unsuccessful, then the Director of Internship Training should be consulted. Again, if the problem is not solved in this manner, it can be discussed in the Clinical Training Committee.

**Formal Appeals Process**

If an intern is not satisfied with the decision of the Clinical Training Committee, the intern then has the option of entering The University of Oklahoma Health Sciences Center formal academic appeals process and can follow the procedures outlined in the Faculty Handbook (Appendix M, pages 70-71).

**Informal Appeals Process**

At any point during the above-mentioned formal process, the intern could elect to have his concern addressed at the informal level through the use of the intern grievance committee. The purpose of this committee is to provide an informal avenue to resolve any grievance the intern may encounter. The committee will focus on an informal resolution, not fault-finding. The desired outcome is to allow the intern an outlet to be heard and to have issues addressed. The informal procedure is described on the following page.
DEPARTMENTAL GRIEVANCE FOR INTERNS

Membership:

The Grievance Committee will consist of two selected faculty and one intern. One faculty will be selected by the intern class in June of each year to serve a two-year tenure on the Committee, beginning the next month, and running from July 1 to June 30. (The first year, the intern class will select two faculty, one to serve a one-year tenure, and one to serve a two-year tenure). His/her intern peers will select the intern candidate by the end of July each year, to serve until the end of their internship.

Purpose of the Committee:

To provide an informal avenue to resolve any grievance issues interns may encounter during their internship. This Committee will focus on informal resolution, NOT fact and fault finding. The desired outcome is to allow interns an outlet to be heard and to have issues addressed informally without going through the formal grievance procedure.

Procedures for the Committee:

The Grievance Committee will meet initially each year to discuss the role of the Committee and will be chaired by the faculty member who has served the previous year as well. After the initial meeting, the Grievance Committee will meet only as called together to address a specific issue brought by an intern.

To bring an issue to the Committee an intern should contact one of the members to request a meeting.

The Committee will meet with the intern present to hear their complaint and discuss options for resolving the issue. These meetings are highly confidential, and matters will not be discussed with anyone outside of the meeting without the intern’s explicit permission. The first option to explore should be direct discussion with the alleged offender, but in some cases, this may not be possible. Other options may include, but are not limited to: (i) a meeting between the alleged offender and the intern with the Committee present to mediate the issue; (ii) the Committee meeting with the alleged offender to explore the issue; (iii) no action by the Committee, etc. Disciplinary action is not an option for this Committee to determine, as this Committee does not have the power or authority to do so. The Committee may, however, with the intern’s permission, suggest to the Departmental Chair the matter be further investigated through the current procedures in place.

The intern determines the extent of the inquiry and the extent of the processing of the complaint; s/he may withdraw the complaint at any time. The intern may also choose to go directly through the formal University Grievance Procedure.
1. For each training program within the Department of Psychiatry & Behavioral Sciences there shall be a written set of guidelines outlining both the procedures and frequency of periodic evaluations of trainees and the first level of the appeals process. These guidelines will be placed on file in the Office of the Department's Vice-Head for Education.

2. A designated individual within each training program (usually the Director of the program) will have the responsibility for implementing the evaluation procedures.

3. As a rule, the trainee will be provided a written summary of an evaluation made. This document will include information about (a) problem areas or deficiencies, as well as strengths, (b) specific recommendations and timetable for correcting any deficiencies, and (c) a date for any re-evaluation.

4. If the trainee does not fulfill the stipulated requirements by the date set, the training program faculty or an appropriate subgroup of that faculty will convene to determine the trainee's status. The trainee will be notified in writing of the decision of the faculty that:

   a. the trainee will be allowed to continue in the training program under conditions to which the trainee must comply (PROBATION); or

   b. the trainee will receive an unsatisfactory evaluation (DISMISSAL) and will be dismissed from the program.

5. Any decision to dismiss a student will be communicated in writing to the Department Head through the Vice-Head for Education and then to the Dean of the trainee's college (usually to the Dean of the College of Medicine, but to the Dean of the Graduate College in cases of Thesis or Dissertation evaluations).

6. If a student appeals a decision then it goes to the appropriate respective College as outlined in the Faculty/Student Handbook.

Accepted by Education Council 2/2/89
GUIDELINES FOR INTERN SUPPORT GROUP

The Intern Support Group was initiated at interns' requests.

The purpose of the support group is to allow the interns to interact with each other and to obtain mutual social support among peers. Information discussed in the group is confidential.

Efforts should be made to focus the group discussion on the intern-related activities of the interns. This experience is not to be viewed or to function as group psychotherapy. Our hope is the group will not be confrontive with each other, and an individual intern can decide to remain relatively passive in the group if he/she wants to.

A clinical faculty member will serve as group facilitator. It has been decided the clinical faculty member should not serve as a therapist or supervisor for any of the current interns. The group facilitator and the interns will not report on the activities of the group to anyone, including the Director of Training, so the group interaction will remain confidential. The group facilitator will also not talk about the group process, even without identifying individuals in the group, as this would be inappropriate.

As stated earlier, a major purpose of the support group is to foster a social support network among the interns. Requiring the interns to attend would be counter-productive. However, if the interns vote, by secret ballet, to have the group, all interns must attend.

Interns will vote to have (or not have) the group on a five week trial basis at the beginning of the year. After five weeks, the interns will take another vote to see if they want to continue the group for 6 months of the internship year.

The group will meet from 8:00 am until 9:50 am on Fridays. Interns must be on campus by 10:00 am for the start of Intern Assessment Seminar. The Training Director must approve any changes in the schedule of this meeting.
IN THE SELECTION PROCESS OF FIRST ROTATION ASSIGNMENTS, I PREFER:

_____1. Intern group to discuss this among themselves and arrive at assignments. If this does not work, Internship Director will make assignments.

_____2. Internship Director to make assignments based on intern preference choices.
ROTATION SELECTION FOR PSYCHOLOGY INTERNS

The Clinical Training Committee (CTC) is committed to providing a well-rounded internship experience for all interns. Interns typically choose their first rotations during orientation week and make tentative plans for the remainder of the year. Interns often modify these initial selections as the year progresses.

As outlined in our program description, we are a generalist internship, striving to provide interns with opportunities to do both assessment and psychotherapy with both adults and children.

Interns should discuss their major and minor rotation choices with their primary supervisors. At times, more than one intern may wish to do a particular rotation and/or an intern may wish to repeat a rotation. In these cases, we will guide rotation selection by the following principles:

1. The intern will meet funding source obligations.
2. The intern will select rotations to ensure adequate experience with both adults and children.
3. The intern will select rotations to ensure adequate experience performing both assessment and psychotherapy.
4. The intern will talk to potential supervisors at least one month prior to the beginning of the rotation to ensure adequate supervision will be available (including office space, patient load, supervisor time, etc.).
5. If the demand for a given rotation is greater than can be accommodated, priority will go to (a) the intern from the funding site, and then (b) the intern who has not already had the rotation.
6. An intern may choose to repeat a given major or minor rotation. This situation may arise if the intern needs additional training in a specific area OR if he/she wishes more experience in an area given his/her long-term career plans.
7. If the primary supervisor is uncertain about the appropriateness of the intern’s wishes, he/she may bring the issue to the Internship Director.

Approved by Clinical Training Committee on 6-7-02
PSYCHOLOGY INTERNS ROTATIONAL EXPERIENCES

Since our clinical psychology internship is a general predoctoral program, we feel interns need one four month rotation experience in both child and adult areas respectively. However, given the variety of experiences interns have prior to coming here, some flexibility in this requirement is in order. If an intern can demonstrate to the Training Director that s/he has obtained, prior to coming here, an extensive experience equivalent to a rotation in either the child or the adult area, then a modified program could be set up for this intern.

A rotation currently consists of a minimum of 25 hours experience on a particular unit. For those interns who feel they already have sufficient experience in either the child or adult area, this requirement of having both a child and adult rotation could be met by the following procedure:

1. If an intern is interested in taking three child rotations, then s/he can satisfy the need for an adult rotation requirement by obtaining a minimum of 400 hours of supervised experience in the adult area. The 400 hour requirement is roughly equivalent to a 25 hour rotation experience for four months. The specific means that the intern plans to use in meeting this 400 hour requirement should be outlined in a proposal written by the intern and approved by the Training Director. For example, an intern may wish to select an adult supervisor and see mostly adult cases in primary supervision. S/he may want to supplement this by additional hours of secondary supervision in the adult area. However, in all cases, s/he must meet the 400 hour requirement. Similarly, if an intern is interested in taking three adult rotations, s/he must develop a specific proposal for meeting the 400 hour requirement in the child area.

2. The experiences outlined in the intern's proposal should include both psychotherapy and psychological evaluation experiences. This proposal should be completed prior to the assignment of the primary supervisor, which usually occurs at the end of the second week of the internship.

The purpose of the above procedure is to allow some flexibility for a selected group of interns. It is our intent that when appropriate, interns will continue to have both a child and adult experience in our internship. In instances when there is intern competition for a given rotation, preference will be given to interns who plan to have both an adult and child rotation. For example, an intern asking for only one child rotation will be given priority over an intern requesting three child rotations.
ROTATION CONSTRAINTS

Although intern preference for rotations is an important element in rotation assignment, other constraints must be considered. In order to give you as complete a picture as possible of the various parameters on rotation assignments, I have included below a list of the major items to consider. Please keep in mind that others may also be needed.

1. **Major Rotation** - A major rotation is defined as a funding site. Interns will spend 25 hours per week on their major rotation for the entire year. Within each major rotation there are specific rotations. Major and specific rotations are listed below.

   OU Medical Center – Children’s Tower – 2 interns
   Child Clinical & Pediatric Psychology

   OUHSC Neuropsychology Lab – 2 interns
   Adult and Pediatric Neuropsychological Assessment Lab Activities

   Veterans Administration Medical Center – 4 interns
   Substance Abuse Treatment Center
   Health Psychology Clinic
   Ambulatory Mental Health Clinic
   Neuropsychology
   Post Traumatic Stress Recovery Program
   Family Mental Health Program
   Community Living Center
   Mental Health Primary Care Inpatient Unit
   Primary Care
   OIF/OEF
   Day Treatment Center

   **Priority Specific Rotations:**

   1. Child Clinical & Pediatric Psychology
   2. Adult Neuropsychological Assessment Lab

   Interns are assigned to these priority specific rotations for the entire year. Interns assigned to these rotations have already been recruited for those specific rotations.

   **V.A. Hours** - Interns funded by Veterans Administration can meet the 1500-hour V.A. requirement by having all three major rotations at the V.A. and either one minor rotation at the V.A. or have their primary at the V.A. Seminar time counts as V.A. hours.

2. At the VA Intern’s offices are very tight. Lack of an office space may be an issue depending on how many interns chose a certain combination of VA rotations.
LISTED BELOW, IN ORDER OF PREFERENCE, ARE MY FIRST ROTATION CHOICES:

1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

_____________________________________________________
Signature

_____________________________________________________
Print Name

_____________________________________________________
Date
LISTED BELOW, IN ORDER OF PREFERENCE, ARE THE ROTATIONS I WOULD LIKE TO HAVE DURING MY INTERNSHIP. I REALIZE MY PREFERENCES MAY CHANGE AND I AM NOT COMMITTED TO THESE CHOICES.

1. ____________________________________________________________

2. ____________________________________________________________

3. ____________________________________________________________

4. ____________________________________________________________

_____________________________ ______________________________
Signature     Print Name

________________________________
Date
MONITORING OF INTERN TIME

Our Clinical Psychology Internship is a very busy program requiring 52 ± 3 hours to complete all required activities. Obviously, the amount of hours spent in any given week may vary, but overall the program can be completed in a perfectly satisfactory manner in a 52 ± 3 hour average work week.

As you know, one of the advantages of our program is a tremendous amount of experiential activities available to interns. If you choose to put in extra time with optional rotation supervisors, you may. Following discussion with your primary and rotation supervisors, you may arrange to be involved in activities that will exceed the 52 ± 3 hour week. You can choose to do research, carry additional cases, do additional assessments, attend seminars, etc. The choice of the additional activities is up to you.

Your primary supervisor will take responsibility for assisting you in deciding whether or not you will take on additional activities. There should be no pressure or expectation for you to exceed the 52 ± 3 hour work week; however, if you desire to do so, this is certainly allowed.

The faculty has the right to specify activities they expect you to perform within the 25 hours for major rotations and 15 hours for minor rotations work week, and you have the right to determine which activities you undertake after required activities are completed. We suggest you discuss this issue with your primary supervisor as soon as possible, so the issue is clarified from the beginning of your internship year.

In order to assist the primary supervisor and intern in documenting the intern's work load and the intern's satisfaction with the work requirements, we would like for you to review these issues and sign the attached form.

<table>
<thead>
<tr>
<th>TIME MONITOR</th>
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<tbody>
<tr>
<td>☐ Mid 1st Rotation ☐ End of 1st Rotation ☐ Mid 2nd Rotation</td>
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<tr>
<td>☐ End of 2nd Rotation ☐ Mid 3rd Rotation</td>
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</table>

Each supervisor has discussed the above issues with me.
Currently, I am working _____ hours on this __________rotation primary supervision experience.
___ 1. This number of hours is acceptable to me.
___ 2. I feel these hours are too much, and should be reduced.
___ 3. Comments__________________________________________________

Currently, I am working _____ hours on this __________major rotation
___ 1. This number of hours is acceptable to me.
___ 2. I feel these hours are too much, and should be reduced.
___ 3. Comments__________________________________________________

Currently, I am working _____ hours on this __________ minor rotation

Please check one:
___ 1. This number of hours is acceptable to me.
___ 2. I feel these hours are too much, and should be reduced.
___ 3. Comments__________________________________________________
## Patient Log

<table>
<thead>
<tr>
<th>PATIENT INITIALS</th>
<th>PATIENT AGE</th>
<th>ETHNICITY</th>
<th>DATE SEEN</th>
<th>CHART #</th>
<th>PAYOR SOURCE</th>
<th>SUPERVISOR</th>
<th>ROTATION SEEN</th>
<th>BILL FORM TURNED IN</th>
<th>SERVICE</th>
<th>HRS SPENT THIS DATE</th>
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**Patient Log**

**Intern Name**

**YES OR NO**

1. Intern
2. Assessment
3. 1st Therapy
4. Consultation
5. Other
6. Case Mgmt
7. Op Therapy
8. Family Therapy

**Amount of time billed**

Include all time spent on patient on this date. Indicate all time spent on assessment concerning patient in question.
SUPERVISION EVALUATION QUESTIONNAIRE

Rotation: ___________________________ dates: ___________________________

Please complete the attached form which deals with important characteristics of the supervisor (primary, secondary, or rotational) which affect the quality of training in the Internship Program. Indicate your critique of the supervisor in each characteristic listed. Be sure and indicate the supervisor’s strengths and weaknesses with respect to the characteristics listed below. Please feel free to write any additional comments you deem appropriate. A complete and candid evaluation of the supervisor is appreciated as it provides a basis for examination and change. Note this form is to be discussed with the supervisor involved, and signed by the supervisor.

| Intern’s Name: ___________________________ | Supervisor’s Name: ___________________________ |

<table>
<thead>
<tr>
<th>A. Availability of Supervisor</th>
<th>Strengths in these areas</th>
<th>Weaknesses in these areas</th>
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<tr>
<th>B. Adequacy of Supervision</th>
<th>Strengths in these areas</th>
<th>Weaknesses in these areas</th>
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<tr>
<td>C. Method or Style of Supervision</td>
<td>Strengths in these areas</td>
<td>Weaknesses in these areas</td>
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<tr>
<td>D. Attention to Diversity Issues in Supervision (Give examples of how this was addressed by your supervisor. For example, recommended readings, resources on campus or in the community, event, lectures on campus, etc.)</td>
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<td>E. I would recommend this supervisor to others:</td>
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<td>1 2 3 4 5 6 7</td>
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<td>- no</td>
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<td>- yes, but with some reservations</td>
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<td></td>
<td>- I would strongly recommend this supervisor</td>
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</tbody>
</table>

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Supervisor’s Signature & Date
INTERN PROGRESS REPORT

Internship in Clinical Psychology
Department of Psychiatry and Behavior Sciences
University of Oklahoma Health Sciences Center

Name of Intern: _____________________  Name of Supervisor: _____________________

Dates covered by this evaluation:  _________________ to  _____________________

☐ Mid 1st Rotation  ☐ End of 1st Rotation  ☐ End of 2nd Rotation  ☐ End 3rd Rotation

Please provide information about the training provided:

A. Major Rotation ☐  Minor Rotation ☐  Primary Supervision ☐

B. Assessment Experiences Provided ☐  Therapy Experiences Provided ☐

C. Training Provided in the Following Specialty:

☐ Behavioral Health ☐  Responding to Child Maltreatment ☐
☐ Neuropsychology ☐  Pediatric Psychology ☐  No Specialty ☐

Please indicate the average number of hours (per week) supervision you provided:

Individual Supervision ☐  Group Supervision ☐

If available, please include a copy of your rotation specific objectives with this evaluation form (See item G).

Please rate the intern on their motivation and effort given their level of training during this supervision period:

5 – Excellent  4 – Good  3 – Satisfactory  2 – Fair  1 – Poor

Ratings are to be provided for each of the following areas of competency based on the following scale:

5  Far exceeds competency in all areas (Extraordinary Intern at end of year)
4  Exceeds some expectations in some areas and clearly meets all areas of competency given the level of intern training
3  Meets all expectations in this area given level of intern training (Midpoint). This is the minimum level of performance that is required by end of internship
2  Does not yet meet at least one area of competency in this area given level of intern training
1  Does not yet meet several areas of competency

We expect all Interns to have ratings of at least 4 by the end of their internship year in each area of competency. Interns who have had minimal or no experiences in an area (e.g., no previous child therapy experiences) will begin internship with ratings lower than a 4 because they have not yet had experiences to reach competency. If a rating lower than a 4 is due to the intern having no prior experience in the area, this will be noted by the supervisor for clarification. If a rating of a 3 or lower is given, the supervisor must provide information on specific weaknesses and plan to increase the intern's competency.
A. **Professional Development**
This area includes professional maturity, acceptance of responsibility, initiative and interprofessional relations.

Provide a rating on this Intern on Professional Development:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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</table>

B. **Integrating Science and Practice**
This area includes the ability to integrate science and clinical practice as evidenced by a critical and scientific theoretical approach to their thinking process. This area also includes issues of scholarly inquiry.

Provide a rating on this Intern on Integrating Science and Practice:

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<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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C. **Ethical Conduct**
Provide a rating on this Intern on Ethical Conduct:

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<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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D. **Cultural Competencies**
This includes awareness and sensitivity to cultural issues.

Provide a rating on this Intern on Cultural Competencies:

<table>
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<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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</table>
E. Assessment

This area includes overall skills in psychological testing, scoring, report writing, and ability to do intake and evaluation. A rating of 4 would indicate the intern is demonstrating satisfactory skills in intellectual and psychosocial/personality assessment, diagnostic interviewing, and application of the DSM-IV.

The rating is on: Child Assessment ☐ Adult Assessment ☐ Both Child and Adult ☐ No Opportunity to Evaluate ☐

Provide a rating on this Intern on Assessment: _____

This is a new area of training for the intern: Y N

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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F. Psychotherapy

This includes individual, group, and family psychotherapy skills and skills at case conceptualization, developing treatment plans, and providing treatment consistent with the goals in treatment. A rating of 4 indicates the intern is demonstrating satisfactory skills at developing rapport with the clients, developing case conceptualizations, developing treatment plans, and demonstrating knowledge and skills in the intervention.

The rating is on: Child Therapy ☐ Adult Therapy ☐ Both Child and Adult ☐ No Opportunity to Evaluate ☐

Provide a rating on this Intern on Psychotherapy: _____
This is a new area of training for the intern: Y N

<table>
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<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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</table>
G.  Other

This includes rotation specific objectives and competencies and/or other goals on which the intern has been evaluated.

1. Consultation
2. Supervision
3.
4.
5.

Provide an overall rating on this Intern on the above: ______

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<tr>
<th>Strengths</th>
<th>Areas in Need of Improvement</th>
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If intern will remain at this rotation, please list future goals and plans.

H. Provide overall summary rating* __________

__________________________________________________________________________
Intern Signature & Date                                          Supervisor signature & Date

*This need not be an arithmetic average of the individual ratings.

Instructions to the Primary Supervisor on how to combine the ratings across the year to give final overall ratings.
--- Caution when combining ratings when one rating much lower than others
--- Caution to not to just use averages as they will be making progress across the years
--- The final ratings of each area of competency should reflect their skills at the end of the year.
ACTIVITY FORMS

Attached is a copy of an Activity Schedule. This Activity Schedule is to be completed by each intern and returned at mid-1st, end-1st, mid-2nd, end-2nd, and end-3rd rotations during Director’s Meeting. The purpose of this form is to document the number of patients seen by interns and the amount of supervisory contact. Please note that we would like to know not only the number of actual contacts you have had with a supervisor about a given case but the approximate number of hours of supervision. Please feel free to use the back of this form to list other activities you perform but which are not readily describable in the categories. This form will be used in a variety of ways. From time to time, we have to document to our funding agencies that interns, in fact, are seeing large numbers of patients, which is benefiting the system. Furthermore, the form helps us to insure interns are receiving sufficient supervision.

Thank you for your cooperation in completing this form.
INTERN PROGRAM  
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES  
UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER  

ACTIVITY REPORT*

NAME: ____________________________  ROTATION  
__________________________________  

This form covers: Specify one –  
☐ Major Rotation  ☐ Minor Rotation  ☐ All Rotations  ☐ Current Rotation  
Other ________________

☐ Mid 1st Rotation  ☐ End of 1st Rotation  
☐ End of 2nd Rotation  ☐ End 3rd Rotation  ☐ Combined End of Year

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<tr>
<th>Activity</th>
<th>Age Range</th>
<th>Sex</th>
<th>Total # Hrs Seen</th>
<th>Total # Hours Supervisory Contact</th>
<th>Activity</th>
<th>Age Range</th>
<th>Sex</th>
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<th>Total # Hours Supervisory Contact</th>
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<td>Co-Therapy With Supervisor</td>
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<td>Family Counseling</td>
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<td>Number of Patients</td>
<td>Age Range</td>
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<td>DIAGNOSTIC INTERVIEW (e.g., mental status exam only)</td>
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<td>INPATIENT CONSULTATION AND/OR CASE MANAGEMENT</td>
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<td>DIDACTICS (List names of didactic or case conference and total time attended)</td>
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OTHER ACTIVITIES AND TIME INVOLVED: (Any other activities not listed above including Readings, Telephone Calls and Travel. You may organize this section anyway you choose, but be sure to include the activity and total amount of time.)
<table>
<thead>
<tr>
<th>Name Of Supervisor:</th>
<th># Contacts/ Week</th>
<th># Hours Per Week</th>
<th>Activity (E.G. Therapy, Assessment, Research)</th>
<th>Total # Hrs</th>
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Summary for Time Period covered by this report:

Total hours spent on Internship

____________________

Total number of clinical hours and all activities associated with clinical hours (Includes clinical supervision and clinical seminars)

____________________

Total hours of individual supervision

____________________

Total hours of group supervision

____________________

Average number of hours worked per week including readings

____________________

*This report should capture all time you spend on internship.*
# ROTATION EVALUATION QUESTIONNAIRE

The questions below deal with important characteristics of the rotations which affect the quality of training in the Internship Program. Indicate your rating of each characteristic by marking the appropriate space on the scale. The exact point at which you rate is less important than the general impression. Write in beside each rated question (i.e., under each guide question) any additional comments which you wish to make. Your complete and candid evaluation of the rotation is appreciated as it provides a basis for examination and change.

Rotation ______________ Dates covered __________________  Intern ______________

<table>
<thead>
<tr>
<th>Rated Questions</th>
<th>Guide Questions</th>
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<tbody>
<tr>
<td>1. Did you clearly understand the aims and objectives of the rotation?</td>
<td>How could the presentation of aims and objectives have been improved and made clearer?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 no partly completely</td>
<td></td>
</tr>
<tr>
<td>2. To what degree were rotation objectives reached?</td>
<td>In what respects did success or failure to objectives occur? For what reason?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 no partly completely</td>
<td></td>
</tr>
<tr>
<td>3. Was the rotation challenging?</td>
<td>In what respects was the rotation too easy or too hard?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 too easy appropriate-too hard</td>
<td></td>
</tr>
<tr>
<td>4. Was this rotation what you thought it would be?</td>
<td>How did it differ from your expectations?</td>
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<tr>
<td>not</td>
<td>partly</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>at all</td>
<td></td>
</tr>
</tbody>
</table>
5. Did you enjoy being on the rotation? Why or why not?

1  2  3  4  5  6  7
not partly completely
at all

6. How effective was the supervision on the rotation? How might supervision be improved?

1  2  3  4  5  6  7
not partly completely
at all

7. How useful was the rotation in the development of your psychotherapy skills? What specific skills?

1  2  3  4  5  6  7
not partly completely
at all

8. How useful was the rotation in the development of your psychodiagnostic skills? What specific skills?

1  2  3  4  5  6  7
not partly completely
at all

9. How useful was the rotation in the development of your teaching skills? What specific skills?

1  2  3  4  5  6  7
not partly completely
at all

10. How useful was the rotation in the development of your research skills? What specific skills?

1  2  3  4  5  6  7
not partly completely
at all
11. How useful was the rotation in the development of your administrative skills? What specific skills?

1 2 3 4 5 6 7
not partly completely not at all

12. How useful was the rotation in the development of professional maturity (i.e., acceptance of responsibility, reliability, judgment, autonomy)? Comment:

1 2 3 4 5 6 7
not partly completely not at all

13. How useful was the rotation in increasing your involvement in any given area or in your profession overall? Comment:

1 2 3 4 5 6 7
not partly completely not at all

14. To what extent has the rotation fostered self introspection and personal growth? How has the rotation helped?

1 2 3 4 5 6 7
not partly completely not at all

15. How useful was the rotation in increasing your adaptability in working with other professionals? How was it useful?

1 2 3 4 5 6 7
not partly completely not at all
16. How useful was the rotation in helping you clarify future professional goals and interests?  Comment:

1 2 3 4 5 6 7
not partly completely
at all

17. Evaluate the rotation on ___________ Comment: (You fill in the blank)

1 2 3 4 5 6 7
not partly completely
at all

18. Evaluate the rotation on ___________ Comment: (You fill in the blank)

1 2 3 4 5 6 7
not partly completely
at all

19. What did you like best about this rotation?
20. How might the rotation be improved?

21. List the number of those questions which were most useful in evaluating the rotation. 1, 2, 3, 4, 5, etc.

22. List the questions which were less useful. Question 5, 7, 9, etc.

23. Please make suggestions for modification of this form (i.e., additions, deletions, etc.).

_________________________    __________________________
Intern Signature      Supervisor Signature

Interns/Rot-Eval
Computer User Account Policy

OUHSC computer accounts are available to current faculty, staff, students, and affiliates of the University of Oklahoma Health Sciences Center who require an account for an official university activity/endavor or to conduct official university business. To obtain an account, carefully read the policy stated herein and follow the instructions at the bottom of this page.

By using University information systems or computing resources, you agree to abide by and comply with the applicable policies, procedures and laws. Acceptable use must be ethical, reflect academic honesty, and show responsible use in the consumption of shared resources. Information stored on university computer resources and networks may be subject to the Oklahoma Open Records Act.

User Responsibilities

- Each user must use only his/her personal account accessible via a personal user ID/password combination and must not allow others to use their account.
- Passwords must be a minimum of eight (8) alpha, numeric, and special characters, must not be revealed to anyone else, must be changed at least every 180 days, and must not be written down in plain sight. If you must write it down, store it in a secure location such as your wallet, purse, locked drawer or safe.
- Users are responsible for their actions regarding personal account security, respect of others and the computing environment, copyright violations, and unauthorized access of OUHSC computer resources.
- Users may be held liable for illegal or damaging use of OUHSC computer resources.
- If discovered that their account has been accessed by another individual, users should immediately change their password and inform their account sponsor or Information Technology personnel of the situation.
- Users must comply with all University policies, procedures, and local, state, and federal laws.
- Users must access only information that is their own, that is publicly available, or to which they have been given authorized access.
- Users are responsible in their use of shared resources (refrain from monopolizing systems, overloading networks, degrading services, or wasting computer time, connect time, disk space, printer paper, manuals, or other resources.)

Unacceptable Use

- use of another person's system, files, or data without express authorization;
- use of another individual's user ID or password;
- use of computer programs to decode passwords or access control information;
- attempt to circumvent or subvert system or network security;
- engaging in any activity that might be harmful to systems or to any information stored thereon, such as creating or propagating viruses, disrupting services, damaging files, or making unauthorized modifications to or sharing of university data;
- use of university systems for commercial, private, personal, or political purposes such as using electronic mail to circulate advertising for products or for political candidates;
- harassing or intimidating another person including, but not limited to, broadcasting unsupervised, unsolicited messages, repeatedly sending unwanted or threatening mail, or using someone else's name or user-ID;
- wasting computer resources or network resources including, but not limited to, intentionally placing a program in an endless loop, printing excessive amounts of paper, or sending chain letters or unsupervised mass mailings;
- attempt to gain access to information or services to which he/she has no legitimate access rights.

Failure to adhere to this policy may result in the suspension of computer access privileges as well as other action deemed appropriate by the user's department/college, OUHSC Information Technology, and/or the University of Oklahoma Health Sciences Center.

Instructions: Please print your name and your primary department or college in the box below, sign and date this policy agreement (page 1), and proceed as instructed for either an OUHSC Employee* or an OUHSC Affiliate**.

---

I have read and understand the above policy and agree to abide by this policy in my use of OUHSC computer resources.

Computer User:__________________________________________

Last Name:________ First Name:________ Middle Initial:________ Department or College:________

User's Signature:________________________________________ Date:____________

Complete the Computer Account Request form (page 2) and forward along with the Computer User Account Policy (page 1) to your college/department's computer account sponsor or business manager.

---

Form SEC01(c) Revised 3/3/06
The University of Oklahoma Health Sciences Center
Information Technology
Computer Account Request

* Please Print Clearly *

User's Name:__________________________
LAST FIRST MIDDLE INITIAL

National ID # (SSN):__________________________ EMPLID:__________________________

OUHSC Department/College:__________________________ Dept Phone #:__________________________

* OUHSC Status (check all that apply)*

___ OUHSC Employee (paid by OUHSC) ___ Special Pay ___ OUHSC Student ___ OUHSC Affiliate* ___ Ecory
___ Faculty ___ Adjunct Faculty ___ Volunteer Faculty ___ Staff ___ Temp Staff ** ___ Resident ___ Intern ___ Fellow

* Name of Affiliated Organization:__________________________

** Length of contract with OUHSC:__________________________

* Computer Account Sponsor Only *

Access Preferences: Indicate each type of access required.

On Campus
___ Email, Internet, Personal Folders on Moon file and print server
    (includes remote access via the modem pool)
___ PeopleSoft Applications**

Remote Access via the VPN Client
___ VPN-Group-1 (Allows the following access)
    - Exchange 2000 email via the MS Outlook client
    - Personal folders on Moon file and print server
    - Intranet web servers

** PeopleSoft access requires additional form(s) located at http://www.ouhsc.edu/financialservices/forms.asp

Specify the department where this account should be placed: ____________________________ 
___ New ___ Existing

Preferred method of acquiring personal access codes: ___ Campus Mail ___ Email notification ___ Pick up in person

As a computer account sponsor, I (1) agree to assume limited responsibility for the use of this user account as outlined in the OUHSC Information Technology Computer Account Policy and (2) state that this user account is necessary for an official university activity/endavor or to conduct university business.

Sponsor's Name:__________________________ Title:__________________________
Print or Type

Sponsor's Signature:__________________________ Date:__________________________

Account Sponsor ~~ send this form to:
IT Account Management, SCB-101 (fax 271-2126) or IT Help Desk, Student Center 105.

Form SEC01(c) Revised 3/3/06
Since you are a temporary resident of the state, The Department of Public Safety of Oklahoma informed us there is no need to get an Oklahoma driver license or Oklahoma license plates for your vehicle.

If your driver license expires during the time you are in Oklahoma, you should contact the DPS office, in your home state to see about renew in your license by mail.

You should also be able to renew your license plates by mail with a registration form from your home state’s Tax Commissioner.
ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT 2002

History and Effective Date Footnote

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The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A – E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics
Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriate, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

PREAMBLE
Psychologists are committed to increasing scientific and professional knowledge of behavior and people’s understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostian, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES
This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence
Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists’ obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists’ scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility
Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues’ scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity
Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice
Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect For People’s Rights And Dignity
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues
1.01 Misuse of Psychologists’ Work
If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.

1.04 Informal Resolution of Ethical Violations
When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations
If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees
Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any
confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints
Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents
Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence
2.01 Boundaries of Competence
(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.
(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.
(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.
(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.
2.02 Providing Services in Emergencies
In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.
2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.
2.04 Bases for Scientific and Professional Judgments
Psychologists’ work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts
(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment
Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist’s activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons’ age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationships could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest
Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services
When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships
Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.09 Cooperation With Other Professionals
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)
3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)
(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.
(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.
(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered To or Through Organizations
(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.
(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services
Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client’s/patient’s relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy And Confidentiality
4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)
4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording
Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy
(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.
(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.
(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes
Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements
5.01 Avoidance of False or Deceptive Statements
(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists’ Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees
6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)
(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.
(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists’ withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment
Psychologists may not withhold records under their control that are requested and needed for a client’s/patient’s emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements
(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.
(b) Psychologists’ fee practices are consistent with law.
(c) Psychologists do not misrepresent their fees.
(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)
(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients
Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources
In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the
diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees
When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. Education and Training
7.01 Design of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.
7.03 Accuracy in Teaching
(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)
(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information
Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy
(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)
(b) Faculty who are or are likely to be responsible for evaluating students’ academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.
(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees
Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication
8.01 Institutional Approval
When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research
(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that
may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants’ rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research
Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants
(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.
(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research
Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants’ employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation
(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.
(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research
(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study’s significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.
(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.
(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)
8.08 Debriefing
(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.
(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.
(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.
8.09 Humane Care and Use of Animals in Research
(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.
(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.
(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)
(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.
(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.
(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.
(g) When it is appropriate that an animal’s life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.
8.10 Reporting Research Results
(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)
(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.
8.11 Plagiarism
Psychologists do not present portions of another’s work or data as their own, even if the other work or data source is cited occasionally.
8.12 Publication Credit
(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student’s doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment
9.01 Bases for Assessments
(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.
9.02 Use of Assessments
(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.
(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.
(c) Psychologists use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues.
9.03 Informed Consent in Assessments
(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.
(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.
(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data
(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists’ notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)
(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction
Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results
When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences that might affect psychologists’ judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons
Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results
(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.
(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services
(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.
(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)
(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results
Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11. Maintaining Test Security
The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy
10.01 Informed Consent to Therapy
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)
(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)
(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families
(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist’s role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy
When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others
In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client’s/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy With Former Sexual Partners
Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients
(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.
(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client’s/patient's personal history; (5) the client’s/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy
When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event
that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy
(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

History and Effective Date Footnote
This version of the APA Ethics Code was adopted by the American Psychological Association's Council of Representatives during its meeting, August 21, 2002, and is effective beginning June 1, 2003. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA web site, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints regarding conduct occurring prior to the effective date will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:
Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.

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PHYSICIANS

S.E.R.V.I.C.E. Competencies
They are the competencies that are taught in Operation S.E.R.V.I.C.E.... A New Beginning

Satisfaction
*Customers* - Treats everyone as their customer in a respectful, friendly, and caring manner with no exceptions.

Empathy
*Uses Empathy* - Good use of empathy phrases when interacting with patients and customers
*Diffusing Upset Customers* - Uses the principles learned in LEAD properly to diffuse an upset or angry patient or customer
*Listening* - Listens well, uses proper body language for effective listening, and maintains focus on the patient or customer

Responsibility
*Moment of Truth* - Is consciously aware of the environment that they are in and strives to deliver positive moments of truth throughout the day
*Responsibility* - Recognizes opportunities to change the environment and takes responsibility for that improvement.

Values
*Core Values* - Exemplifies the OU Physicians Core Values. Incorporates them in their work routine.
  Core values - Integrity, Service Orientation, Respect for People, Personal Accountability, Teamwork, Empowerment, Innovation, and Focus.

Involvement
*Fun* - Consciously makes the effort to make the workplace fun.
*Make their day* - Goes out of their way to make a customer’s day special.
*Be there* - Focuses on the customer's needs.
*Choose Your Attitude* - Displays a good attitude about work, the environment and the patient/customer.

Courtesy
*Acknowledge* - Acknowledges the patients and all customers in a friendly and timely manner on a regular basis. Smiles, makes eye contact and greets the customer. Uses the customer's name in the interaction.
*Appreciate* - Thanks all customers and patients for their help, patience, or their caring.
*Affirm* - Uses affirming statements with patients and customers. Gives positive feedback to others.
*Assure* - Shares statements of comfort or confidence with the patient or customer when they seem unsure.

Excellence
*The extra mile* - Goes the extra mile for the patient or customer. Something that is beyond the scope of their job.
Improvement - Behavior reflects the desire to improve the service they provide within the organization.

PHYSICIANS

Group Values

We win, earn and maintain the trust of those we serve through the following:

1. INTEGRITY
   • We are straightforward and adhere to the facts. We express ourselves clearly and correctly, and live up to our word.

2. SERVICE ORIENTATION
   • Our priorities are established by the needs of our patients.

3. RESPECT FOR PEOPLE
   • We treat people with respect. We celebrate successes, both personal and professional. We enjoy our work.

4. PERSONAL ACCOUNTABILITY
   • We know our responsibilities and do not blame others or seek excuses. We recognize achievement and address marginal performances.

5. TEAMWORK
   • The word "we" refers to everyone required to serve the patient (the physicians, central staff, departmental staff, etc.). We act in the best interest of the team, are accountable for the results of the entire team, and together share our successes or failures. We have an atmosphere of openness, honesty, and trust.

6. EMPOWERMENT
   • We have a bias for action and expect all employees to be proactive in decision making and problem solving. We delegate authority to match responsibility and expect decision-making to occur at all levels.

7. INNOVATION
   • Nothing will stand in the way of serving patients and others well. We change anything to improve our service. We are dedicated to learning.

8. FOCUS
   • We have a sense of urgency in pursuit of our mission. We will not waste our time or energy on unproductive attitudes or activities.
The National Association of Private
Psychiatric Hospitals

PATIENT RIGHTS AND
RESPONSIBILITIES GUIDELINES

Entering a psychiatric hospital for treatment is a difficult step for both patients and their families. Knowing what to expect can help to reduce anxiety. That is why the National Association of Private Psychiatric Hospitals has developed these guidelines. The guidelines have been endorsed by the NAPPH Board of Trustees.

The guidelines outline both the rights you have as a patient or family member within the hospital setting and the responsibilities you share in maintaining a safe, therapeutic environment. At the same time, they outline basic approaches you can expect from the hospital. The hospital may also have additional information and guidelines for the program to which you are assigned and will provide that information to you.

This hospital is a member of the National Association of Private Psychiatric Hospitals, which was founded in 1933 to represent the nation’s private, non-governmental psychiatric hospitals. NAPPH is devoted to continued improvement in psychiatric hospital treatment and to the advancement of professional education in psychiatry, hospital administration, and allied fields.

PATIENT RIGHTS

In these cases, the right shall extend to the parent or the legal guardian of minors.

1. You have the right to considerate and respectful treatment and recognition of your personal dignity.
2. You have the right to impartial access to treatment, regardless of race, religion, sex, age, ethnicity, or handicap.
3.* You have the right to obtain information about your condition and prognosis from your physician.
4.* You have the right to be advised of alternative treatment settings.
5.* You have the right to obtain information regarding treatment recommendations and alternatives.
6.* You have the right to participate in treatment decision.
7. You have the right to receive individualized treatment.
8. You have the right to expect all communications and records pertaining to your treatment should be treated as confidential, except as otherwise required by law.
9. You have the right to expect any restriction of freedom (e.g., of mail, telephone privileges) shall be done for therapeutic reasons, explained to you, implemented with respect, and documented in the medical record.
10. You have the right to know what the hospital rules are and how they apply to your conduct as a patient.
11.* You have the right to be told what medications you are given.
12.* You have the right to be told of any experimental treatment approach recommended for you, and you must give your written informed consent before any such approach can be used.

13.* You have the right to be involved in planning your own discharge. You may leave against medical advice (unless prohibited by law), and there shall be a process in place in the hospital through which you may request to leave.

14.* You have the right to be informed of the alternatives available to you when you leave the hospital, and you will be given a specific plan outlining recommended follow-up treatment.

15.* You and your family/significant others have the right to request an in-house review of the practices and procedures for ensuring patients’ rights and for addressing questions or complaints about your individual treatment plan. The request for review should be made initially to the administrator of the hospital.

16. You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer.

17. You will be provided adequate and humane services, regardless of your source of financial support, within the least restrictive environment available for your safety and the community’s.

PATIENT RESPONSIBILITIES

1. You have the responsibility to respect others regardless of their race, religion, age, sex, ethnicity, or handicap.

2. You have the responsibility to keep confidential all clinical information communicated to you personally or in groups.

3. You have the responsibility to keep therapeutic appointments with the therapists.

4. You have the responsibility to discuss differences of opinion concerning treatment with staff.

5. You have the responsibility neither to give nor to take non-prescribed drugs.

6. You have the responsibility not to bring illicit drugs, alcohol, weapons, or other hazardous materials into the hospital.

7. You have the responsibility to be familiar with the hospital’s guidelines on patients’ rights and the code of conduct within your treatment program.

National Association of Private Psychiatric Hospitals
1319 F Street, NW, #1000
Washington, DC 20004
202/393-6700

Approved by NAPPH Board of Trustees, October 1990
“BILL OF RIGHTS FOR VETERAN PATIENTS”

1. **Right to Use the Benefits:** Veterans shall be entitled to full use of the health benefits for which they are eligible, if the treatment is deemed necessary by the veteran and the treating professional, and the treatment modality recommended is clinical effective. Veterans have the right to access emergency services when and where the need arises.

2. **Right to Parity of Benefits:** Veterans shall be eligible for mental health treatment in the same way as they are eligible for the treatment of other conditions. Benefit plans for the treatment of mental/psychiatric and addictive disorders shall be comprehensive i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by all competent licensed professionals and should provide identical coverage and funding to those benefits covering other illnesses, with the same provision, lifetime benefits, and catastrophic coverage.

3. **Right to Know:** Veterans shall be informed, in language they can understand, of the extent of their health benefits and of the appeal and grievance processes available to them. **Disclosure:** Veteran shall be informed by the licensed, credentialed, and privileged health care professional providing their treatment of any arrangements, restrictions, and/or covenants established between VA management and the professional that may influence their treatment, at no jeopardy to the veteran or the professional. They should be informed of the risks and benefits of proposed interventions and of alternatives, which fall within the accepted practices of health care. They are entitled to know the professional training and experience of their clinicians and, the accreditation status, the quality indicators, and the consumer satisfaction of their scores healthcare facility.

4. **Right to a Choice of Provider:** Veterans shall have the right to choose their professionals from among all duly licensed, credentialed and privileged health care professionals unless that choice would be detrimental to their care. Veterans shall have access to services and a choice of clinicians within a full continuum of network based health services, including peer support programs. Veterans have the right of consultation from allied professionals (e.g. chaplains, psychologists, social workers, and readjustment counselors). Clinicians are to be accountable to veterans and to the VHA by documenting the positive clinical outcomes and consumer satisfaction they deliver.

5. **Right to Participate in the Determination of Treatment:** Decisions regarding treatment shall be made by credentialed and privileged health care professionals in conjunction with the patient and/or his or her family as appropriate. Veterans have the right and obligation to participate in the development and review of their treatment plan. They have the right to know alternative courses of treatment, their risks, and benefits.

6. **Right to Respectful Care:** Veterans have the right to be treated in the least restrictive setting and with dignity and respect. They have the right to refuse treatment and to be discharged from treatment unless otherwise specified by an order of a Court of Jurisdiction.

7. **Right to Non-discrimination:** Veterans have a right to treatment without regard to physical or mental handicap, race, color, national origin, religion, or sexual orientation. Veterans who have undergone mental health treatment shall not be discriminated against by health, disability, life, or other insurance entities, or benefit offices.
8. **Rights of Confidentiality:** Veterans shall be guaranteed the confidentiality of their relationship with their health care professional except when ethics and good clinical judgment and/or law dictate otherwise to assure their safety or the safety of others. The exchange of information between treating professionals and the VHA for review for clinical effectiveness and care coordination for the purpose of improving the quality and efficiency of healthcare delivery shall be held in the strictest confidence.

9. Veterans have the right to review their records unless such disclosure would be detrimental to their well being, as determined by their principal caregiver. They alone have the right to approve release of information from their records.

10. **Right to Review:** To ensure the review of treatment processes are fair and valid, veterans shall be assured that any final review of their treatment shall be done by a reviewer with the same health care training, credentials, and licensure as the health care professional providing the treatment. The reviewer shall not have a conflict of interest. The professional reviewer must be in practice in the same geographic area in which the treatment is being provided, and must be familiar with the VA’s national practice guidelines and their local adaptation.

11. **Right to Appeal:** Veterans shall have available to them fair, reasonable, and timely procedures for appeals of coverage and treatment. These should be conducted by health care professionals who are appropriately credentialed and are free of conflict of interest and who were not involved in the initial decision. Appeals should follow a standard of review promoting evidence-based decision making.

12. **Right to Accountability:** VA clinicians and management both shall be held accountable for the quality and outcome of services delivered. All parties treating or managing benefits for the patient shall be held accountable for any injury caused by negligence in their services. Providers and management both are responsible for implementing the VA health plan’s benefit structure.

13. **Veteran Consumer Responsibilities:** In a health care system that protects veteran consumers’ rights, it is reasonable to expect and encourage veterans to assume reasonable responsibilities. Such Responsibilities include:

- Taking responsibility for maximizing healthy habits,
- Becoming involved in specific health care decision,
- Working collaboratively with clinicians in developing and carrying out treatment plans,
- Disclosing relevant information and clearly communicating wants and needs,
- Using the VHA’s complaint and appeal processes to address concerns,
- Avoiding knowingly spreading disease,
- Recognizing the reality of limits of the science of medical care and the human fallibility of the health care professional,
- Being aware of a health care provider’s obligation to be equitable in providing care to other patients,
- Showing respect for other patients and health workers,
- Making a good-faith effort to meet financial obligations if any,
- Abiding by administrative and operational procedures of the VHA, and
- Reporting wrongdoing and fraud to appropriate legal authorities.
<table>
<thead>
<tr>
<th>Building</th>
<th>Description</th>
<th>Address</th>
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<tbody>
<tr>
<td>BMSB</td>
<td>Biomedical Sciences Bldg</td>
<td>940 Stanton L Young Blvd</td>
</tr>
<tr>
<td>BRC</td>
<td>Biomedical Research Center</td>
<td>975 NE 10th St</td>
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<td>BSEB</td>
<td>Basic Sciences Education Bldg</td>
<td>941 Stanton L Young Blvd</td>
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<td>CH</td>
<td>Children's Hospital Professional Building</td>
<td>940 NE 13th St</td>
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<td>CHB</td>
<td>College of Health Bldg</td>
<td>801 NE 13th St</td>
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<td>College of Nursing Bldg</td>
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<td>DC</td>
<td>Dermatology Clinic</td>
<td>619 NE 13th St</td>
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<td>DCSB</td>
<td>College of Dentistry (Dental Clinical Sciences Bldg)</td>
<td>1100 N Stonewall</td>
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<td>Dean McGee Eye Institute</td>
<td>608 Stanton L Young</td>
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<tr>
<td>JKSH</td>
<td>John Keys Speech &amp; Hearing Center</td>
<td>825 NE 14th St</td>
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<tr>
<td>LIB</td>
<td>R M Bird Health Sciences Library</td>
<td>1000 Stanton L Young Blvd</td>
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<tr>
<td>MID</td>
<td>MID (Interim) Bldg (DHS)</td>
<td>1100 NE 12th St</td>
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<td>OCC</td>
<td>Oklahoma City Clinic</td>
<td>701 NE 10th St</td>
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<td>OMRF</td>
<td>Oklahoma Medical Research Fndn</td>
<td>825 NE 13th</td>
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<tr>
<td>ORI</td>
<td>O'Donoghue Rehabilitation Institute</td>
<td>1122 NE 13th</td>
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<tr>
<td>PT</td>
<td>Presbyterian Tower</td>
<td>NE 13th &amp; Lincoln</td>
</tr>
<tr>
<td>RB</td>
<td>Research Bldg</td>
<td>800 NE 13th</td>
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<tr>
<td>ROB</td>
<td>Rogers Bldg</td>
<td>800 NE 15th St</td>
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<tr>
<td>SU</td>
<td>Student Union (David L. Boren SU)</td>
<td>1106 N Stonewall</td>
</tr>
<tr>
<td>SCB</td>
<td>Service Center Bldg</td>
<td>1100 N Lindsay</td>
</tr>
<tr>
<td>VAMC</td>
<td>Veterans Affairs Medical Center</td>
<td>921 NE 13th</td>
</tr>
<tr>
<td>WP</td>
<td>Williams Pavilion</td>
<td>920 Stanton L Young</td>
</tr>
</tbody>
</table>
NOTICE: For the convenience of patients who are not familiar with the medical center, we are providing this map to give directions to Children's Hospital from the O. Rainey Williams Pavilion and, of course, the other way around. Please feel free to distribute this map to patients as you may see fit.
Everything We Needed to Know
We Learned in Director’s Meeting . . .

Structure is your friend.
In times of trouble, refer to your blue book.
Fish for the right job.
The difference between ignorance and apathy
(I don’t know and I don’t care).

Structure is your friend.
Where does it fit in your schedule?
Check with Holly.
Spell psychology correctly.
Never carry cases over from one rotation to another
and never terminate patients prematurely.

Structure is your friend.
You may choose to exceed the 52 hours per week,
but this is neither required nor expected.
No, you’re not listening to me.
Pay attention - no one will remember me saying this.
See your medicaid.
In times of trouble, refer to your blue book.

ALWAYS REMEMBER . . .
Structure is your friend!

To: Russell L. Adams, Ph.D.
From: the 1981-82 Psychiatry Interns
Overview of Library Services

Find Links To The Resources Listed Below & All Of The Information You Need At: http://library.ouhsc.edu

**Online Catalog.** Use Webcat, the library’s online catalog, to find which books, journals, and non-print materials are owned by the Library, where they are located, and whether or not they are checked out. Webcat also provides access to the catalogs for the libraries at University of Oklahoma-Tulsa/Schusterman Center Library, Dean McGee Eye Institute, and OUHSC Department of Surgery. Please note that at the present time journal holdings are only available for Bird Library and for the Schusterman Center Library.

**Ovid System.** Several databases are currently searchable through Ovid, a powerful and user-friendly search interface. Databases available to OUHSC users include MEDLINE, Best Evidence, PsycINFO, CINAHL, and the ochrane Database of Systematic Reviews. Ovid also provides access to full text articles from approximately 175 professional journals.

**Electronic Journals.** Visit http://library.ouhsc.edu/serials/ejournals.cfm to see a complete list of titles. The Bird Library has subscriptions to the electronic editions of many journal titles. In addition, the Library has selected peer reviewed electronic journals and other periodicals, such as government serials, which are within the scope of campus programs. Most titles have only the last few years available; few have extensive electronic back files. Many of the journals on this page have been provided for faculty, staff, and students of the University of Oklahoma Health Sciences Center. Others are available without restriction. Be aware that your computer must be connected to the OUHSC secure network for full access to restricted journals.

**MDConsult.** The Library provides access for OUHSC students, faculty, and staff to MD Consult, an extensive clinical information service online. MD Consult allows users to simultaneously search journal articles, reference books, drug information, and practice guidelines. Numerous full text items are available. Users can register with MD Consult so that customization features within the resource can be utilized. Access to a non-password restricted “Generic Edition” is available for those who choose not to register.

**Micromedex.** Micromedex is a resource tool available to OUHSC faculty, students, and staff which offers an easy-to-use search interface. Users can retrieve detailed summaries and full text monographs with information on a variety of topics including drugs and herbal medicines, toxicological managements, reproductive risks, and acute/emergency care.

**Web of Knowledge.** Linking to ISI’s Web of Knowledge provides access to numerous resources including Current Contents (all editions), Science Citation Index & Social Science Citation Index, and Journal Citation Reports.

**Other Electronic Resources.** The library provides access to a number of other resources. To see a comprehensive listing visit http://library.ouhsc.edu/databases.cfm.
LIBRARY SERVICES

Reference and Instructional Services. Reference librarians provide professional assistance in all aspects of library research including classroom instruction and mediated searching. The Reference Desk, located on the east side of the third floor, is staffed Monday through Friday, from 8:00 a.m. to 5:00 p.m. Reference librarians may also be contacted by phone at 271-2285, x 48752 or by sending e-mail to bird-reference@ouhsc.edu. A number of public information workstations for searching and research purposes are available to library users in the Reference area.

Photocopying. The library offers a wide range of photocopying services. For a full description of services and links to online forms visit http://library.ouhsc.edu/access/libpcs.cfm. Contact a staff member in Photocopy Services at 271-2285, x 48751 for further information.

Checkout and Renewal. Complete information about the circulation and return of library materials may be found at http://library.ouhsc.edu/access/libacc.cfm. Renewals may be made in person or by phone (271-2285, books x 48701, non-print media x 48756) as long as no “holds” have been placed on the materials by another patron.

Loan periods: Monographs: Two weeks  
Non-print Media: One week  
Journals: Non-circulating

Interlibrary Loan (ILL) Requests. ILL provides access to materials not owned by the Robert M. Bird Health Sciences Library at no charge to OUHSC faculty, students, and staff. To request an item through ILL fill out the appropriate form at the third floor Service Desk or complete the online form and submit your request electronically. Complete information about ILL services and access to the online form is available at http://library.ouhsc.edu/access/libill.cfm. Please note that you must allow, on average, seven to ten working days for an ILL request to be filled.

PC Lab. A microcomputing lab is available in the northwest corner of the Library’s third floor. Workstations in this area provide users with access to email and software applications such as word processing.

Library Hours

Monday through Thursday 7:00 a.m. to Midnight  
Friday 7:00 a.m. to 11:00 p.m.  
Saturday 8:00 a.m. to 9:00 p.m.  
Sunday Noon to Midnight  
Holiday Hours Library closed on major holidays

QUESTIONS? ASK A LIBRARIAN!  
bird-reference@ouhsc.edu  
(405) 271-2285 X 48752  
1-800-522-0222 (TOLL FREE IN OKLAHOMA)
SEVERE STORMS PROCEDURE

When the warning sirens sound:
1. If outside, move indoors as quickly as possible.
2. Move to the first floor of Williams Pavilion (not floor A which is an open parking garage), to an interior hallway, at the north end of the building, or to the underground tunnel between the Biomedical Sciences Building (BMSB) and the Robert M. Bird Library.
3. Avoid upper floors, large glassed areas, and windows.
4. Stay out of parking garages, auditoriums, and exterior walkways.
5. Stay away from electrical appliances.
6. Use the telephone for emergency calls only.
7. Stay calm and alert.
8. Call Campus Police and Public Safety, extension 1-4911, to report any damage.

TORNADOES

The following information will be helpful in providing an insight as to what a tornado is; what it can do; where to go to avoid personal injury, and what not to do when a tornado is imminent.

In the event of a tornado, where the campus would be in imminent danger, the campus warning siren would be sounded, with a solid tone, for three minutes. Warning messages would be generated from the OU Police and Public Safety Department notifying all building coordinators of impending danger. These messages will be transmitted via the telephone, fax, and computer, depending upon the capabilities of the receiver, and the time of day. Notification would also depend upon the time of the initial warning by the National Weather Service (NWS), and the arrival of the impending storm. OU Police Officers would also utilize external speaker systems on their patrol vehicles, when necessary, to warn pedestrians who may be outside of protective buildings or cover.

The siren is tested once per month, on a Saturday, at Noon. The siren will not be tested during the period of a TORNADO WATCH or WARNING.

WHEN THE SIREN IS ACTIVATED for an actual sighting of a tornado in the local vicinity of the Campus:

• If outside, move indoors as quickly as possible.
• Move to an interior hallway, basement or tunnel.
• Avoid upper floors, large glassed areas, and windows.
• Stay out of parking garages, auditoriums, and exterior walkways.
• Stay away from electrical appliances.
• Use the telephone for emergency calls ONLY
• STAY CALM AND ALERT.
• Call the OU Police, (1+4911) to report any damage.
EMERGENCY INFORMATION

- The best protection during a tornado is an interior room on the lowest level of a building, preferably a basement, storm cellar, or designated shelter.
- Tornadoes strike with incredible velocity. Wind speed may approach 300 miles per hour. These winds can uproot trees and structures and turn harmless objects into deadly missiles, all in a matter of seconds. Mobile homes are particularly vulnerable to tornadoes.
- Injury or death related to tornadoes often occur when buildings collapse, people are hit by flying objects, or caught trying to outrun or escape the tornado in a vehicle.
- Tornadoes are most destructive when they touch ground. Normally, a tornado will stay on the ground for 20 minutes or less. However, one tornado can touch the ground several times in different areas.

WHAT IS A TORNADO?

- A tornado is a violent windstorm characterized by a twisting, funnel shaped cloud. It is spawned by a thunderstorm, (or sometimes as a result of a hurricane), and produced when cool air overrides a layer of warm air, forcing the warm air to rise rapidly. The damage from a tornado is a result of the high wind velocity and wind-blown debris. Tornado season is generally March through August, although tornadoes can occur at any time of year. Tornadoes tend to occur in the afternoon and evening - over 80 percent of all tornadoes strike between noon and midnight.

DID YOU KNOW?

- That - tornadoes can be nearly invisible, marked only by swirling debris at the base of the funnel. Some are composed almost entirely of windblown dust, and still others, are composed of several mini-funnels.
- That - on average, the United States experiences 100,000 thunderstorms each year. Approximately 1,000 tornadoes develop from these storms.
- That - although tornadoes do occur throughout the world, the United States experiences the most intense and devastating tornadoes.
- That - tornadoes produce the most violent winds on earth. Tornadoes can approach speeds as high as 300 miles per hour, travel distances over 100 miles, and reach heights over 60,000 feet above ground.
- That - according to the National Weather Service, about 42 people are killed because of tornadoes each year.

PREPARE FOR A TORNADO, AT HOME; BEFORE IT HAPPENS Make sure that disaster supplies are on hand, such as:

- A good flashlight and extra batteries.
- Portable battery operated radio and extra batteries.
- First aid kit and first aid manual.
- Emergency non-perishable food and at least one gallon of water per person.
- Non-electric can opener.
- Essential medicines.
- Cash and credit cards.
- Sturdy shoes.
- Work gloves.
• Extra clothing.
WATCHES AND WARNINGS

**Tornado Watch:** A tornado watch is issued by the National Weather Service when weather conditions are such that tornadoes are likely to develop. This is the time to remind family members where the safest places within your home are located, and listen to the radio, or television, for further developments.

**Tornado Warning:** A tornado warning is issued when a tornado has been sighted or indicated by radar. The danger is very serious, and everyone should go to a safe place, turn on a battery operated radio and wait for further instructions.

**TORNADO DANGER SIGNS**

- **Large Hail:** Tornadoes are spawned from powerful thunderstorms and the most powerful thunderstorms produce large hail. Tornadoes frequently emerge from near the hail producing portion of the storm.
- **Calm Before The Storm:** Before a tornado hits, the wind may die down, and the air may become very still.
- **Cloud of Debris:** An approaching cloud of debris can mark the location of a tornado, even if a funnel is not visible.
- **Funnel Cloud:** A visible rotating extension of the cloud base is a sign that a tornado may develop. A tornado is evident when one or more of the clouds turn greenish (a phenomenon caused by hail), and a dark funnel descends.
- **Roaring Noise:** The high winds of a tornado can cause a roar that is often compared with the sound of a freight train.
- **Calm Behind The Storm:** Tornadoes generally occur near the trailing edge of a thunderstorm. It is not uncommon to see clear, sunlit skies behind a tornado.

**DURING A TORNADO AT HOME**

- Go at once to the basement, storm cellar, or the lowest level of the building.
- If there is no basement, go to an inner hallway or small inner room without windows, such as the bathroom or closet.
- Stay away from windows. If they are up - leave them up, if they are down - leave them down. Do not waste time ...your life may depend on seconds.
- Stay away from corners in a room - corners tend to attract debris.
- If you are unable to reach adequate shelter, get under a sturdy piece of furniture such as a workbench; heavy table, or desk - and hold onto it.
- Use your arms to protect head and neck.
- If in a mobile home, get out, and seek shelter elsewhere.

**DURING A TORNADO ON CAMPUS**

- LISTEN for the 3-minute warning siren located at the Service Center Building.
- GO to the designated shelter, basement, or to an inside hallway at the lowest level of the building.
• AVOID places with wide span roofs, such as auditoriums, cafeterias, large hallways, and parking garages.
• STAY AWAY from windows.
• GET under a sturdy piece of furniture such as a workbench, heavy table, or desk - hold onto it.
• USE arms to protect your head and neck.
• IF OUTDOORS, and if possible, get inside a building. If building shelter is not attainable, crouch near a strong building, and protect your head and neck as indicated above.
• IF IN A VEHICLE - NEVER try to out drive a tornado. Tornadoes can change direction quickly, and lift up a car or truck, and toss it through the air. Get out of the vehicle, and take shelter immediately.

LINK:
http://www.fema.gov/fema/trop.html
FOR FURTHER INFORMATION, CONTACT:
OU POLICE AND PUBLIC SAFETY,
THE EMERGENCY MANAGEMENT AND SAFETY OFFICE
Emergency - 1+4911 (Off Campus - 271-4911)
Non-Emergency - 1+4300 (Off Campus - 271-4300)
Campus Weather Information - 1+6499 (Off campus - 271-6499)
Last Updated: 10/09/02
### FORMS DUE DURING THE YEAR

<table>
<thead>
<tr>
<th>Mid 1&lt;sup&gt;st&lt;/sup&gt; Rotation (to include Aug. 31)</th>
<th>End of 1&lt;sup&gt;st&lt;/sup&gt; Rotation (to include Oct. 31)</th>
<th>Mid 2&lt;sup&gt;nd&lt;/sup&gt; Rotation (to include Dec. 31)</th>
<th>End of 2&lt;sup&gt;nd&lt;/sup&gt; Rotation (to include Feb. 28)</th>
<th>Mid 3&lt;sup&gt;rd&lt;/sup&gt; Rotation (to include April 30)</th>
<th>End of 3&lt;sup&gt;rd&lt;/sup&gt; Rotation/ Total Year (Due last week in June)</th>
</tr>
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<tbody>
<tr>
<td><strong>Progress Rating Form</strong> 1.  2.  3.</td>
<td><strong>Progress Rating Form</strong> 1.  2.  3.</td>
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<td><strong>Patient Log</strong></td>
<td><strong>Patient Log</strong></td>
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<td><strong>Patient Log</strong> (hard copy and e-mail)</td>
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<td><strong>Activity Report</strong></td>
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<tr>
<td><strong>Supervisor Evaluation (if appropriate)</strong> 1.  2.  3.</td>
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<td><strong>Supervisor Evaluation (if appropriate)</strong> 1.  2.  3.</td>
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<td><strong>Rotation Evaluation (if appropriate)</strong> 1.  2.  3.</td>
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<td><strong>Rotation Evaluation (if appropriate)</strong> 1.  2.  3.</td>
</tr>
<tr>
<td><strong>Training letter by Intern</strong></td>
<td><strong>Training letter by Supervisor</strong></td>
<td><strong>Summary of Clinical Hours</strong></td>
<td><strong>Intern Goals &amp; Objectives</strong></td>
<td><strong>APA Self Study</strong></td>
<td><strong>APA Self Study</strong></td>
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This chart is meant as a guideline and some items may change.
In Edmond, NW 192 is Danforth.

From Danforth turn south on Teeside Blvd. (Fairway Estates)

Turn right on the first street (Outabounds)
1117 Outabounds is on the right (west) side of the street.

Dr. Adams home number is 341-7897, if you get lost.
LONG DISTANCE TELEPHONE CALLS
AND PHOTOCOPYING AT WILLIAMS PAVILION

Interns will occasionally need to make long distance telephone calls concerning patient care activities. At the VA hospital, the policy concerning the use of the telephone must be cleared through the intern's rotation supervisor.

We do have a WATSBOX arrangement at TUH, but each call is separately listed and the department is charged separately for each call. Long distance calls should by no means be made for personal business, nor should they be made to call potential employers, graduate schools, etc. These calls are considered an expense that the interns must bear themselves.

Concerning patient care, however, interns may make calls as they deem clinically necessary. Each call must be approved by the rotation supervisor.
The Audiovisual Studio primarily supports departmental educational programs and their trainees. Any and all media needs should be coordinated through Gerri Wright, Staff Secretary, by calling ext. 47678 or stopping by her office (WP3440). These needs might include:

1. **Scheduling of rooms for taping or viewing.** This can be done by sending an e-mail to PSYBS-AV (HSC) with the time and date you want to reserve the room. Rooms should be scheduled at least 24 hours in advance. This includes notifying Gerri of lateness or cancellation of a previously scheduled time. **IF ROOM IS VACANT 15 MINUTES AFTER SCHEDULED TAPING TIME, THE ROOM WILL BE CONSIDERED AVAILABLE.**
   a. If you require assistance in setting up a videotaping session you **MUST notify Gerri** when you are ready to tape so she can start the machine. If video tapes are left in technician's area over 30 calendar days, they will be erased.
   b. It is your responsibility to inform Gerri of changes in your weekly patient schedule with regards to AV rooms.

2. **Scheduling of portable equipment for classrooms (meetings, case conferences, etc.)** All departmental equipment is confined to use on the 3rd floor of the Williams Pavilion. Please be aware AV studios are to be used for meetings/seminars only as a last resort. **Please coordinate meeting or conference rooms through Gerri Wright at ext. 47678 or by sending a request through e-mail to PSYBS-AV (HSC) before signing up in the main education cluster for this purpose.**

3. **Checking out blank 1/2" videotapes for use when taping therapy sessions.** A maximum of five (5) tapes per trainee is allowed at any one time. A card for each tape will be filed with your name and current extension number. Before changing rotations or transferring, it is necessary to turn in all tapes so your name may be cleared. If special circumstances necessitate your keeping tapes longer (an upcoming presentation, continued therapy with a particular patient), please notify Gerri to arrange this. **Due to the cost of the videotapes, a $20 fee will be assessed for each tape not returned at the end of the training year. Failure to turn in tapes or pay the fee will prevent graduation from the program.** Blank audiotapes are furnished through individual rotations or purchased by individuals wishing to use them.

4. **Assistance in operation of equipment.** Coordinate with Gerri Wright, Staff Secretary, by calling 1-4488 or stopping by her office WP3440.

5. **Checking out books and educational tapes from Departmental Resource Center (library).** To check out books or educational tapes contact Kim Hees, ext. 47681 or stop by her desk in WP 3440.
In all cases, as much notice as possible is requested to ensure the needed room or equipment is available. Your cooperation and consideration will be greatly appreciated in keeping the AV area running smoothly.
RESERVING A ROOM AND A/V EQUIPMENT  
AT WILLIAM'S PAVILION

Anyone that needs to reserve the Library, one of two conference rooms, or audio visual equipment at William’s Pavilion should e-mail your request to psybsav@ouhsc.edu which is PSYBS-AV (HSC) in the Global Address List in Outlook. This will send an e-mail to Gerri Wright, Jeannie Brown, and Julie Desai. They ask that you email this request so that they all see it and enter it on the calendar to prevent room/equipment shortages. Also, if you have a presentation and you have it ready please give it to Gerri Wright as much in advance as you can. If you have any questions, you can contact them by e-mail or by phone.

Gerri Wright – ext. 47678
Jeannie Brown – ext 47679
Julie Desai – ext. 47604
The University of Oklahoma Health Sciences Center  
Department of Psychiatry & Behavioral Sciences  
PROGRESS NOTE

Patient Name: ________________________ DOB:   ___________ SSN: ____________________
Medical Record # _____________________ DATE: ___________ TIME: ___________________

[ ] Medication Management   [ ] Individual Therapy   [ ] Cognitive-Behavioral Therapy
[ ] Supportive Therapy    [ ] Insight/Oriented    [ ] Marital Therapy     [ ] Family Therapy

Interval History, Progress and Observations:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
________________________________________________________________________________

Mental Status Examination – On Reverse
Medical Evaluation (evaluation of co-morbid medical conditions and physical examination)
[ ] Not done during this visit  [ ] Findings _________________________________________

Results and Interpretation of Laboratory/Medical Diagnostic Studies
[ ] No New Data   [ ] New Data ________________________________________

Medication Allergies and/or Drug Reactions
_____________________________________________

Current Medications  [ ] Continue  [ ] Changes Made
_________________________________________________________________________________
_________________________________________________________________________________

Treatment Plan Update and Decisions __________________________________________________
___________________________________________________________________________

Diagnosis:  
AXIS I     ___________________________________________________________
AXIS II    ___________________________________________________________
AXIS III   ___________________________________________________________
AXIS IV    ___________________________________________________________
AXIS V     GAF___________ (current)

Anticipated # of sessions to reach goal __________
Expected Outcome of treatment _______________________________________________________
Prolonged treatment due to __________________________________________________________
Reassessment after _________ visits

Provider Signature _______________________________  Date:  ____________________
Supervisor Signature        Date:  ____________________
Patient Name: ______________________________  Date: __________________________

Appearance and Behavior:
[ ] Patient is alert and cooperative; appropriately groomed and dressed.

Speech:
[ ] Patient’s speech is coherent and goal directed, demonstrating no disorder of thought progression. No neologisms are noted.
[ ] It is delivered in a normal intensity and with normal variation in pitch.
[ ] Reaction time to verbal stimuli and the amount of verbal productivity are both with normal limits.

Emotional State and Reactions:
[ ] Mood is described as ______________________________________________________
[ ] Affect is _________________________________________________________________
[ ] No self or other harmful ideation or intent is described
[ ] If present, is there a plan  Yes ________ No _______

Special Preoccupations and Experiences:
[ ] No hallucinatory experiences are described

Sensorium and Intellect:
[ ] Patient is well oriented in all spheres
[ ] Patient’s memory is intact

Use of Tobacco:
[ ] None  [ ] No change after first recorded
[ ] Smokeless  Estimation of amount per day ________  Duration of use _______
[ ] Smoking  Estimation of amount per day ________  Duration of use _______
[ ] Desires to change

Provider Signature _____________________________________________
Date: __________________________
1. Identifying Data

2. Chief Complaint
   By Patient

   By Others

3. History of Present Illness

3. Past History
   Psychiatric/Substance Use
6. Social History

Social Support (List)

7. Legal History

8. Mental Status
   Appearance/behavior/articulation/level of consciousness/relationship to examiner

   Speech (Include rate, volume, articulation, coherence, and spontaneity with notation of abnormalities)

   Thought processes (Include rate of thought, tangentiality, circumstantiality, association)
Thought content (include delusions, preoccupation with violence, obsessions, key associations)

Abnormal or psychotic thoughts (include homicidal or suicidal ideation)

Estimated intellectual level (include general knowledge, abstraction, computation, fund of knowledge, etc.)

Judgement

Insight

Orientation (include time, place, and person)

Memory (include immediate, recent, and remote)

Attention span and concentration
Language

Perceptual abnormalities (include hallucinations, illusions. For children, include visual/auditory processing problems)

Mood and affect (include subjective, objective, psychological signs, appropriateness to context)

Intellectual functioning / abstraction

9. Individual and Family Dynamic Formulation (include predisposing, precipitating, and maintaining factors)
Patient Name: _________________________________  Date: _________________________________

10. Diagnosis  DSM-IV #  _________________________________
    Axis I

    Axis II

    Axis III

    Axis IV

    Axis V *(include GAF)*

11. Strengths
    Strength of patient

    Strength of family
12. Plan
   a. Statement of medical necessity
   b. Anticipated length of treatment
   c. Objectives
   d. Therapeutic intervention and modalities (including medications)
   e. Expected outcomes and dates
TEACHING PHYSICIAN SECTION

I have reviewed the resident's history and physical exam and after my examination and interview of the patient, my comments are:

HISTORY

PSYCHIATRIC HISTORY

MENTAL STATUS

PLAN

Teaching Physician Signature

GC: ________ check if resident involved.

Date
<table>
<thead>
<tr>
<th>Psychological Testing</th>
<th>Developmental Testing</th>
<th>Pharmacologic Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider: Adams</td>
<td>CPT Code: 96117</td>
<td>Inpt</td>
</tr>
<tr>
<td>Medical Record #: 1870692</td>
<td>DOS 5-9-91</td>
<td>Clinic</td>
</tr>
<tr>
<td>Patient History/Disposition/Mental Status</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Psychodiagnostic assessment performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactive interview for physical aids and non-verbal communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory or Other Diagnostic Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication with Family or Other Sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maladaptive and/or Medical Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan and Medical Decision Making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Chart Meets Approved Guidelines | Agree | Disagree |

Comments:  

Recommendation:  

Mary Dresser  

Audit Evaluation  

Extended testing in chart for 4-12-91
EMERGENCY PROCEDURE & CONTACTS FOR
ADULT PSYCHIATRIC INPATIENT ADMISSIONS

1. Evaluate patient in the Outpatient Screening Clinic.
   a. Determine the need for inpatient admission (See attached Adult Inpatient Admission Protocol).

2. Consult with Immediate Clinical Supervisor.
   a. Discuss the rationale for inpatient admission and solicit her/his input.
   c. James G. Scott, Ph.D., ABPP, 271-8001, extension 47646, Pager # 690-2815.

3. Contact the appropriate Intake Coordinator at the Adult Inpatient Unit.
   After 4:30 PM:
   b. Identify the appropriate ON-Call Resident by consulting by O.D. Roster (See example).
   c. Page the On-Call Resident at 1-8888 +Pager # (on campus).
   d. If the Resident does not respond within 15 min, page again and add 9-1-1 after the pager number.

4. Transfer patient to Emergency Department at the University Hospital.
   a. If admission is denied at the Adult Inpatient Unit and IBH cannot provide appropriate alternative, contact Emergency Room (ER) personnel at 1-4363.
   b. You may transfer the patient directly to the ER or request assistance from Campus Security.
   c. Campus Security will assist with transfers only to the Adult Inpatient Unit or the Emergency Room on campus. (See #7 below).

5. Notify Oklahoma County Crisis Intervention Center.
   a. If necessary (i.e., failures with #3-#4), county officials will assist with patients on an emergent basis. Note the Crisis Intervention Center provides 24-hour response for emergencies.

6. Consult with Immediate Clinical Supervisor.
   a. If all else fails, (i.e., failures with #3-#5), your supervisor should assist you in identifying an appropriate alternative for hospitalization of the patient.
   b. Ultimately, it may be necessary for your supervisor to directly contact other facilities in the local community regarding admission of the patient.

7. Unmanageable and Non-voluntary Patients.
   a. For agitated/unmanageable patients or for assistance in transferring patients on campus: contact Campus Police at 1-4911.
   b. If an Emergency Order of Detention (EOD) is required, always contact the Intake Coordinators at the Adult Inpatient Unit who will provide assistance.
I. SAFETY PROCEDURES FOR THE ADULT OUTPATIENT SCREENING CLINIC

Emergency Situations Involving Agitated Or Dangerous Patients

Assess the degree of dangerousness and the urgency of the problem.
If the clinician’s safety is threatened, initiate the following emergency procedures:
1. Remain calm, but notify another individual of the situation as soon as possible.
2. Contact either a colleague or one of the secretaries in the Adult Outpatient Clinic (271-5253).
3. Indicate the need for assistance from "Dr. C."
4. Activate a "panic button" that automatically alerts Campus Security. Both of the secretaries located directly across the hall from the Screening Clinic office (WP-3532) have panic buttons at their desks.

NOTE: Panic buttons are mobile and trainees may take them into the Screening Clinic Office.

II. ADULT INPATIENT ADMISSION PROTOCOL *

Inclusion Criteria for Admission

1. Patient is an adult (at least 18 years of age).
2. Patient is medically stable and in ambulatory condition.
3. Patient meets DSM criteria for diagnosis of mental disorder.
4. Patient is either:
   • Danger to self
   • Danger to others
   • Unable to care for self
5. Patient is likely to benefit from the services of the Inpatient Unit (e.g., adequate intellectual ability and language capacity to understand and respond to psychotherapeutic services).

NOTES: The patient must meet ALL of the above criteria for admission. The Adult Inpatient Unit also will accept, under special circumstances, individuals who need specialized assistance for medication management.

Exclusion Criteria

- Patients in law enforcement custody (DOC) are not eligible.
- Patients primarily in need of alcohol/drug rehabilitation are not appropriate.
- The unit does provide detoxification services but does not have a formal substance abuse rehabilitation program.
- Patients who are currently in other residential or nursing facilities are generally not appropriate for admission (check whether the patient may be presenting here AWOL or AMA).
- Make sure this admission does not remove the patient from appropriate long-term care (e.g., loss of a nursing home bed).
- Patients under guardianship CANNOT consent to admission and may be admitted only with written permission of a guardian.

Details of Appropriate Evaluation

- Patient should be evaluated or referred by an appropriate mental health professional or physician.
- Self-referral or the recommendation of family members is not an adequate basis for admission.
- In such cases, the patient should be evaluated personally, or referred to another clinician, or to the Emergency Room.
*For informational purposes. Only psychiatrists/psychiatric residents have admitting privileges. Adult Outpatient Screening Clinic Emergency Procedures - 1998/1999 Prepared by WDR - Approved 10/27/98
SAD PERSONS


The SAD PERSONS scale is a 10 item checklist of demographic variables found in the literature.

The author’s guidelines for proposed clinical actions based on the scores are as follows: “send home with follow-up (0-2); “close follow-up (3-4); “strong considered hospitalization, depending on confidence in follow-up arrangement” (5-6); and “hospitalization or commit” (7-10).

The Presence of 10 of these factors would indicate the highest level of self-destructive behavior; high scores in general would suggest a need for prompt professional intervention.

S  **Sex**
Women attempt suicide more frequently than do men, yet men are much more likely to actually kill themselves than are women.

A  **Age**
Persons who are adolescents and young adults are at risk. Men over 45 and women over the age of 55 are also at risk.

D  **Depression**
Persons who are depressed are higher risk for suicide. The presence of depressive symptoms – especially feelings of hopelessness, worthlessness, helplessness – along with the absence of future plans are a risk factor.

P  **Previous Attempt**
Persons who have made prior suicide attempts are at higher risk for suicide. About half of those who kill themselves have previously attempted suicide.

E  **Ethanol and Drug Abuse**
Persons who abuse and/or are addicted to alcohol, drugs, or both are at risk for suicide.

R  **Rational Thinking Loss**
Suicide risk is high when judgment and rational thought are impaired. If the individual is hearing voices telling them to hurt herself/himself and is experiencing paranoid delusions, the risk is very high.

S  **Social Supports Lacking**
Persons who have made prior suicide attempts are at higher risk for suicide. About half of those who kill themselves have previously attempted suicide.

O  **Organized Plan**
The individual who has a specific plan that uses an available, lethal method is at high risk.

N  **No Spouse**
Separated, divorced, widowed, and single persons have a higher risk of suicide

S  **Sickness**
Chronic, debilitating, severe, and painful illnesses and disease are a suicide risk factor.
OU MEDICAL CENTER
Adult Mental Health Unit
POLICY AND PROCEDURE

Subject: Admission to the Adult Mental Health Unit

Section: II-B        Page: 1 of 3
Origination Date: 4/98      Revision Date: 8/03, 2/04
Coverage: ALL EMPLOYEES

Purpose: To establish procedures for legal and appropriate admission of patients ages 18 and above to the Adult Mental Health Unit. Patients may be admitted to the unit through the hospital emergency room, other hospital floor, or directly through the Medical Director or designee.

Policy:

An emergency room physician may request a psychiatric consult on any patient seen in the emergency room that he/she feels may need mental health treatment. The ER physician may request a consult from the Psychiatric Attending or Resident on call. The mental health unit may provide evaluation assistance to the psychiatrist through the Intake Coordinator as needed. After medical screening exam by the ER physician and Psychiatrist, the Intake Coordinator will meet the patient in the emergency room to gather information, to assist in the admission, or to assist in referral of the patient to a more appropriate facility, if deemed necessary by the Consultation & Liaison or On Call physician.

Qualified Mental Health Providers (e.g., Community Mental Health Centers) in the community, other acute care facility, or caretakers (e.g., Nursing Homes) may contact the Department of Psychiatry Attending or Resident Physician on call to refer a patient for admission through the Transfer Center. The accepting physician will contact the Intake Coordinator and the Unit of the pending admission.

According to Title 43 A Mental Health Law, 8-103:

“Any person alleged to be mentally ill within the meaning of this act, and who is not in confinement on a criminal charge, and who has no criminal charges pending against him may be admitted to a private institution or hospital as defined in the act by compliance with any one of the following procedures:

On voluntary application, or;
On court certification.”

Admission and exclusion are at the discretion of the admitting physician. Relatives of current patients will be admitted at the discretion of the admitting physician. Attempts will be made to find
the relative an appropriate treatment facility if accommodations cannot be made at OU MEDICAL CENTER. With treatment, a patient must be able to participate in the therapeutic milieu. Indications for admission or exclusion include, but are not be limited to, the following criteria:
### Admission Criteria:

#### Danger To Self:
A person who because of a mental illness represents a risk of harm to self or others as defined by: **Danger to one's self:** is assessed based upon a thorough evaluation of behavioral signs and symptoms. This criterion requires evidence of current suicidal thoughts with a specific plan to carry out the suicide or a recent suicide attempt with an ongoing attitude of hopelessness.

#### Danger To Others:
A person who because of a mental illness represents a risk of harm to self or others as defined by: **Danger to others:** is assessed through evaluation of current threats of harm by the individual toward another person or group of persons. This criterion is based upon the extent of the assaultive or homicidal ideation, specific plan, ability to carry out the threat, past attempts, and history. This criterion is evident if release of the patient would give rise to duty to warn pursuant to the Tarasoff rule.

#### Acute Exacerbation of a Mental Illness
A person who appears to require inpatient treatment: (a) for a previously diagnosed history of schizophrenia, bipolar disorder, major depression, or other serious mental illness and (b) the main reason for admission is due to a mental illness, not a medical problem.

#### Self Care:
Inability to care for one’s self due to mental illness: is assessed through evaluation of the person’s ability to identify the basic necessities of life and formulate plans to provide for these needs.

#### Changes in Mental Status:
Disturbances and psychomotor abnormalities unrelated to neurological causes. This criterion is not fulfilled by financial inability to provide food, clothing, or shelter if unaccompanied by psychiatric disorder.

### Exclusion Criteria:

#### Chronic Dementing Illness:
OU MEDICAL CENTER’s Adult Mental Health Unit does not have programs available to treat: a person whose mental processes have been weakened or impaired by reason of an Alzheimer related illness.

#### Mental Retardation:
OU MEDICAL CENTER’s Adult Mental Health Unit does not have programs available to treat: a mentally retarded person as defined in Title 10 of the Oklahoma Statutes as “a person afflicted with mental defectiveness from birth or from an early age to such an extent that he is incapable of managing himself or his affairs, who for his own welfare or the welfare of others or of the community requires supervision, control, or care, and who is not mentally ill or of unsound mind to such an extent as to require his certification to an institution for the mentally ill.” Patients whose treatment needs are determined to be related to mental retardation will not be admitted to the unit. The Adult Mental Health Unit does not have a program designed for the mentally retarded.

#### Uncontrolled Seizure Disorder:
OU MEDICAL CENTER’s Adult Mental Health Unit does not have programs available to treat: a person with an uncontrolled seizure disorder.

#### Brain Injury:
OU MEDICAL CENTER’s Adult Mental Health Unit does not have programs available to treat: a person whose primary problem is a traumatic brain injury without specific psychiatric conditions treatable on an inpatient mental health unit.
Medical Instability:
Admission to the Adult Mental Health unit will not occur if, for medical reasons, the patient cannot benefit from the mental health program. The unit is staffed to provide only minimal medical care to patients and admission is not appropriate for patients who are unable to engage in therapy modalities and self care groups on a daily basis. The acceptance of patients using medical equipment such as IV’s or oxygen are at the discretion of the admitting physician based on the patient’s suicide risk or the risk the equipment would present to other patients on the unit. Patients presenting for admission who are not medically appropriate will be referred to an appropriate medical/surgical consult for consideration of an admission to a medical unit.

Drug & Alcohol:
The unit does not admit patients for primary drug and alcohol detoxification or rehabilitation services. Patients with a blood alcohol level at or above 250 are considered to be medically unstable and will be referred for a medical consult. Patients will not be admitted to the unit with a blood alcohol level at or above 250 without approval of the Attending Physician.

Patients who meet admission criteria also receive care/treatment for minor medical conditions (e.g., asthma, hypertension, diabetes, minor injuries) or conditions, which require support services (e.g., physical/occupational/respiratory therapy, wound/ostomy care) while admitted to the unit. However, patients experiencing a psychiatric crisis who are not medically appropriate (as determined by a physician) or who require medical procedures beyond the scope provided on the unit will not be admitted. The Psychiatry Consultation & Liaison team may consult with the appropriate service (e.g., Cardiology, Neurology, Med/Surg) if these patients are admitted elsewhere. When medical stability is achieved these patients can be transferred to the Adult Mental Health Unit provided they:

Meet the criteria for admission to a locked in-patient psychiatric unit and;
Their condition on the unit (in close proximity to other patients in psychiatric crisis) does not put them or others at risk for serious injury (e.g., neck fracture patient required to wear a halo brace).

Approved by the Chair for the Department of Psychiatry & Behavioral Sciences,
Dr. B. Pfefferbaum/Dr. H. Patel 8/15/03
Supersedes Policies: Adult Psychiatric Unit 2-01; Senior Choice 2.201
# Sample Billing Sheet

**Oklahoma University Physicians**

**Psychiatry and Behavioral Sciences**

Address: 6000 S. Western Ave., Suite 5200

Tel: (405) 271-5253

E-Mail: ou-psych@ou.edu

**Sample Details:**

- **Patient Name:** [Name]
- **Address:** [Address]
- **Phone:** [Phone]

### Table: Description of Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99001</td>
<td>Evaluation/Interview</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>99004</td>
<td>Individual Psychotherapy 15-30 Mins</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>99005</td>
<td>Individual Psychotherapy 30-60 Mins</td>
<td>$90</td>
<td></td>
</tr>
<tr>
<td>99006</td>
<td>Individual Psychotherapy 60-90 Mins</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>99007</td>
<td>Individual Psychotherapy 90-120 Mins</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>99008</td>
<td>Individual Psychotherapy 120-180 Mins</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>99009</td>
<td>Individual Psychotherapy 180-240 Mins</td>
<td>$300</td>
<td></td>
</tr>
<tr>
<td>99010</td>
<td>Family Psychotherapy (Without Patient)</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>99011</td>
<td>Family Psychotherapy (With Patient)</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>99012</td>
<td>Psychotherapy, Group</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>99013</td>
<td>Psychotherapy, Group</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>99014</td>
<td>Psychological Testing, ADHD</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>99015</td>
<td>Psychological Testing, ADD</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>99016</td>
<td>Psychological Testing, ADHD</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>99017</td>
<td>Psychological Testing, ADD</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>99018</td>
<td>Psychological Testing, ADD</td>
<td>$300</td>
<td></td>
</tr>
</tbody>
</table>

**Total Charges:** $[Total]

---

**Provider Signature:** [Signature]

**Date of Service:** [Date]

**Next Appointment:** [Time]

---

**Billing Summary:**

- **Payment Due:** $[Due]

---

**Billing Copy:**[Billing Copy]

**Patient Copy:**[Patient Copy]

**Provider Copy:**[Provider Copy]
CTC POLICY CONCERNING MEDICATION RECOMMENDATIONS BY TRAINEES

The Education Council, on March 2, 2004, unanimously passed a policy concerning supervision of trainees in the Department of Psychiatry and Behavioral Sciences and this policy is attached. The psychology Clinical Training Committee endorses this Department of Psychiatry and Behavioral Sciences policy. Trainees will only provide clinical interventions or make recommendations for treatment which are within the scope of practice of their supervising faculty’s profession.

Therefore, psychology trainees should not prescribe or make medication recommendations with regard to specific medications or dose level.

Please sign and return a copy of this policy to your training directors, as acknowledgement of its receipt.

Signature: __________________________  Date: ___________________

Print Name: __________________________
POLICY FOR SUPERVISION OF TRAINEES
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

1. All trainees affiliated with the Department of Psychiatry and Behavioral Sciences will be supervised by the appropriate faculty member. Supervision will be documented in patient’

2. Trainees will only provide clinical interventions or make recommendations for treatments that are within the scope of approved hospital practice privileges of their supervising faculty member.

(Passed unanimously by Education Council on March 2, 2004)
University of Oklahoma Board of Regents Equal Opportunity Statement
This University in compliance with all applicable federal and state laws and regulations does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, political beliefs, or status as a veteran in any of its policies, practices, or procedures. This includes but is not limited to admissions, employment, financial aid, and educational services.

President's Statement of Commitment to Affirmative Action
The University of Oklahoma, recognizing its obligation to guarantee equal opportunity to all persons in all segments of University life, reaffirms its commitment to the continuation and expansion of positive programs which reinforce and strengthen its affirmative action policies. This commitment stems not only from compliance with federal and state equal opportunity laws but from a desire to ensure social justice and promote campus diversity. The University will continue its policy of fair and equal employment practices for all employees and job applicants without insidious discrimination on the basis of race, color, national origin, sex, age, religion, political affiliation, disability or status as a veteran. The University will maintain a critical and continuing evaluation of its employment policies, programs and practices. Each budget unit bears a responsibility for constructive implementation of this Plan, and whenever possible, to the overall progress toward employment opportunity and participation in all University programs and activities. Our commitment to the concept of affirmative action requires sincere and cooperative efforts throughout all levels of our employment structure. We will continue to strive to reach the goals of fair and equal employment opportunities for all.

Norman Campus Office
660 Parrington Oval, Room 102 - Norman, OK 73019
Telephone: (405) 325-3546 or Fax: (405) 325-3540

Health Sciences Center Campus Office
P.O. Box 26901, Service Center Room 113 - Oklahoma City, OK 73190
Telephone: (405) 271-2110 or Fax: (405) 271-1548

OU-Tulsa Employees may contact either the Norman or HSC Offices.

Last Updated: March 13, 2008 2:57 PM
WHAT ARE EQUAL OPPORTUNITY, EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION?
Equal Opportunity is the right of all persons to enter, study and advance in academic programs on the basis of merit, ability, and potential without regard to race, color, national origin, sex, disability or status as a veteran.

Equal Employment Opportunity is the right of all persons to work and to advance on the basis of merit, ability, and potential without regard to race, color, national origin, sex, religion, disability, age or status as a veteran.

Affirmative Action requires the employer to do more than ensure employment neutrality. As the phrase implies, Affirmative Action requires employers to make additional efforts to recruit, employ, and promote qualified members of groups formerly limited or excluded.

WHAT ARE THE LEGAL BASES OF EQUAL OPPORTUNITY, EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION?
Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin in all programs or activities which receive federal financial assistance.

Title IX of the Education Amendments Act of 1972 prohibits discrimination on the basis of sex against employees and students.

Title VII of the Civil Rights Act of 1964 prohibits discrimination in employment based on race, color, religion, sex, or national origin.

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination on the basis of age in hiring, promotion, discharge, compensation, terms, conciliations or privileges of employment.

The Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 prohibit discrimination based on disability in employment and access to educational programs, public buildings and activities. The Rehabilitation Act requires that Affirmative Action programs be developed and implemented for qualified individuals with a disability.

The Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, prohibits job discrimination and requires affirmative action to employ and advance in employment qualified Vietnam era veterans, qualified special disabled veterans, recently separated veterans, and other protected veterans.
Executive Order 11246 prohibits discrimination against any employee or applicant for employment because of race, color, religion, sex, or national origin. The Order requires that Affirmative Action programs be developed and implemented for qualified minorities and women.

The Oklahoma Anti-Discrimination Act prohibits discrimination in employment based on race, color, religion, sex, national origin, age or disability.

WHO IS RESPONSIBLE FOR THE IMPLEMENTATION OF THE EQUAL OPPORTUNITY, EQUAL EMPLOYMENT OPPORTUNITY, AND AFFIRMATIVE ACTION PLANS, POLICIES AND PROCEDURES AT THE UNIVERSITY OF OKLAHOMA?
1. All individual staff and faculty members have a shared responsibility to see that Equal Opportunity and Affirmative Action procedures are considered in all academic and employment practices - admissions, grading, recruiting, hiring, transfers, promotions, compensation, discipline, benefits and other terms, conditions, benefits and privileges associated with academia or employment.
2. All department chairs, directors, administrative officers, deans, and executive officers are individually responsible for supervising the implementation of the Affirmative Action Plans in their respective areas.
3. The President of the University bears ultimate administrative responsibility for the implementation of the Affirmative Action Plans.

HOW ARE THE EQUAL OPPORTUNITY, EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION PROGRAMS COORDINATED AT THE UNIVERSITY OF OKLAHOMA?
The Office of Equal Opportunity monitors the implementation and administration of all elements of the Affirmative Action programs, interprets for the University the regulations related to Equal Opportunity, Equal Employment Opportunity and Affirmative Action. Disseminates such information; prepares official University reports to federal and state compliance agencies; serves as an administrative liaison to standing or special University committees to provide guidance on Equal Opportunity, Equal Employment Opportunity and Affirmative Action; reports directly to the President on the status of plan implementation and coordinates equal opportunity and affirmative action activities with the Provost and other university officials.

WHAT IS COVERED IN THE AFFIRMATIVE ACTION PLAN?
2. Procedures for implementing the Plan.
3. A work force analysis which identifies the representation of women and minorities by job group.
4. Hiring goals for overcoming any deficiencies.
5. Action-oriented programs, specific in nature and result-oriented, for achieving hiring goals.

UNIVERSITY POLICIES AND PROCEDURES
The University of Oklahoma stands fully committed to a multicultural, multiethnic and multiracial university family. The University has written policies prohibiting racial, ethnic and sexual harassment. The University will not tolerate such harassment and perpetrators will be subject to disciplinary action as set forth in the policies, codes or procedures.
Recognizing that faculty and staff members may be in a position to exert authority and control over students, the University of Oklahoma has a written Consensual Sexual Relationships Policy. Consensual sexual relationships between faculty or staff and students are prohibited where the faculty or staff member has authority or control over the student.

The University of Oklahoma will reasonably accommodate otherwise qualified individuals with a disability. In recognition of its obligations, the University has instituted a Reasonable Accommodation Policy.

Individuals who have complaints alleging discrimination based upon any of the above mentioned policies may file them with the University's Office of Equal Opportunity in accordance with prevailing University discrimination grievance procedures. Copies of the entire policy or policies and grievance procedures may be obtained from the Office of Equal Opportunity or online at the Office of Equal Opportunity web site.

WHAT IS THE UNIVERSITY STAND ON GRIEVANCES?
The University recognizes the right of applicants, students, staff and faculty to express their grievances and to seek a solution concerning disagreements arising from working relationships, working conditions, employment practices, or differences of interpretation of policy which might occur between the University and its applicants, students or employees. If a grievance cannot be resolved informally, a formal grievance procedure is available that guarantees a prompt and impartial review of all factors involved in the grievance, without fear of coercion, discrimination, or reprisal because of exercising rights under University policy. Below are listed the offices where one may obtain details on the University's formal grievance procedures.

1. Students: Office of Equal Opportunity, Office of Student Affairs, University of Oklahoma Student Association (UOSA - Norman campus) and University of Oklahoma Student Association Health Sciences Center (UOSAHSC - Health Sciences Center).
2. Staff: Office of Equal Opportunity, Office of Human Resources, Staff Senate.
3. Faculty: Office of Equal Opportunity, Office of the Provost, College Deans, Department Chairs, Faculty Senate Office.
Multicultural Student Services (MSS) exists to create and maintain a culturally diverse student environment, provide educational opportunities on the varying cultures on campus, optimal recruitment, advisement and support services to prospective and current students.

Diversity Advisory Board

Multicultural Student Services joins forces with HSC Student Association and the Diversity Board to sponsor this annual event which showcases our multicultural students. This annual week-long event in late February/early March is filled with cultural education, cultural food, cultural activities and fun within our campus community. Please enjoy our 2008 Diversity Week Celebration Photo Gallery

MSS Organizations

• **African-American Student Association (AASA):** A campus-wide organization opened to all students for membership and involvement. The organization strives to celebrate the African-American culture through campus-wide programming and events. Involvement provides a wonderful opportunity for our community to unite, discuss and serve the needs of the African-American community.

• **Asian American Professional Student Association (AAPSA):** The Asian American Professional Student Association’s mission is to promote Asian cultural awareness on the University of Oklahoma Health Sciences Center campus. AAPSA is a campus-wide organization open to all students for membership and involvement. The organization celebrates the Asian American culture through campus-wide programming and events. Involvement provides a wonderful opportunity for our community to unite, discuss and serve the needs of the Asian American community.

• **Hispanic American Student Association (HASA):** The purpose of the Hispanic American Student Association is to promote involvement and cultural awareness in the Hispanic American community among students of the University of Oklahoma Health Sciences Center campus. HASA is dedicated to reaching out to the Hispanic-Latino community through providing health care services and activities that celebrate the cultures, promote education, opportunities and facilitate a sense of community of students, faculty and staff.
• **International Student Organization (ISO):** The purpose of the International Student Organization is to provide a broader spectrum of our great world. This organization provides social events, cultural programs, and as well as support to international students. ISO promotes cultural exchange between the campus and the community and represent almost every area of the world.

• **Native American Student Association (NASA):** NASA is a campus-wide organization open to all students for membership and involvement. The organization strives to celebrate the Native American culture through campus-wide programming and events. Involvement provides a wonderful opportunity for our community to unite, discuss and serve the needs of the Native American community.

• **Oklahoma City Chinese Students & Scholars Association**

HSC Cousins

• **All About HSC Cousins** Established in January 2003, HSC Cousins provides understanding, friendship and unity among American and International/Exchange students on the HSC campus. The program provides numerous venues for social interaction and opportunities for cultural exploration. Active participation in HSC Cousins includes: attending the official Cousins activities (approximately 3 are held each semester); spending informal time with your HSC Cousin (for example: meeting your cousin for lunch or a meal, taking a study break together, doing something social together, etc.); maintaining communication with your Cousin via phone and/or e-mail; sharing traditions of your culture; and being committed to participate once you are matched. You and your Cousin determine your level of interaction – be creative and have fun with this program!

• **HSC Cousins at a Glance** Through this program, students are matched according to hobbies, majors, and countries of special interest. Each International or exchange student is matched with one or two American students and invited to participate in monthly programs that are free of charge. In addition, students are encouraged to get together outside of official Cousins events and share their respective cultures with one another through normal daily life.

• **Online Application**
• **Different Things to Do with Your Cousins**
• **What's Happening?**

International Student Services

• **New International Student Information**

For any information regarding Multicultural Student Services, please contact: **Tanya Mustin,** Coordinator of Multicultural Student Services

tanya-mustin@ouhsc.edu

(405) 271-2416
http://student-affairs.ouhsc.edu/services/MultiCultural.asp
2010-2011
HEADS UP DATES TO REMEMBER

September 10, 2010 – Mid First Rotation reports due (covers July 1 – August 31)
November 8, 2010 – End First rotation reports due (covers July 1 – October 31)
December 3, 2010 – Mock Orals
December 2010 – Internship Christmas Party (date to be determined)
    (Interns traditionally provide entertainment e.g. Skit)
January 14, 2011 – Mid Second rotation reports due
    (covers November 1 – December 31)
March 11, 2010 – End Second rotation reports due
    (covers November 1 – February 28)
May – Intern Pictures (date to be determined)
First of May – Determine faculty awards to be presented at Graduation –
    (date to be determined)
Mid May – White paper due (date to be determined)
End May – Intern Retreat (date to be determined)
First Friday in June – Graduation – every effort should be made to attend
Saturday in June – Going away party at Dr. and Sue Adams (date to be determined)
End of June – Third rotation and End of year reports due,
    Exit interview with Will Redding and Exit interview with Dr. Adams.
INTERN HANDBOOK RECEIPT

My signature below acknowledges:

A - I have received a copy of the Intern Handbook and

B - My responsibility to abide by all the material contained herein

___________________________________  ______________________________________
Print Name & Date     Signature