I. Course Description

CNEP 5322 Family Counseling Strategies This course focuses on the application of major theoretical models of family counseling. Emphasis is on related interventions and strategies that facilitate change in the counseling process, addressing addictions, violence, suicide and related problems confronting diverse family systems. Techniques are demonstrated from a systemic perspective.

II. Rationale

This course is essential for graduate students in counseling or related fields that work with couple and family systems. It is required for licensure in marriage and family therapy, certification in family therapy and in the marriage, couple, and family counseling program. Several CACREP required competencies are included within this course as well as state proficiencies.

III. Proficiencies for Counselors

A. School counselor (state adopted)
   1. Learner Centered Knowledge
   2. Learner Centered Communication
   3. Learner Centered Professional Development
B. Professional Counselor (academic areas required by Texas State Board of Examiners of Licensed Professional Counselors)
   1. Counseling theories/techniques
   2. Social, cultural, and family issues
   3. Ethics and professional issues
C. Marriage and family therapist (academic course areas required by Texas State Board of Examiners of Licensed Marriage and Family Therapists)
   1. Theoretical Foundations
   2. Assessment and treatment
   3. Human development

IV. ExCET Competencies

A. Competency 001 Human Development
B. Competency 002 Environmental Influences
C. Competency 003 Diversity
D. Competency 006 Responsive Services
E. Competency 009 Consultation and Collaboration with School Personnel
F. Competency 010 School-Home Relations
G. Competency 011 School Community Relationships
H. Competency 012 Ethical, Legal, and Professional Standards
V. Course Objectives and Student Learning Outcomes:

CACREP Standards met in this class

(CACREP Standard B-2) Demonstrate the ability to select models or techniques appropriate to couples’ or families’ presenting problems.

(CACREP Standard C-2) Recognize specific problems (e.g., addictive behaviors, domestic violence, suicide risk, immigration) and interventions that can enhance family functioning.

(CACREP Standard C-4) Understand professional issues relevant to the practice of marriage, couple, and family counseling, including recognition, reimbursement, and right to practice.

(CACREP Standard D-3) Uses systems theories to implement treatment, planning, and intervention strategies.

(CACREP Standard D-4) Demonstrates the ability to use procedures for assessing and managing suicide risk.

(CACREP Standard G-2) Understands marriage, couple, and family assessment tools and techniques appropriate to clients’ needs in a multicultural society.

(CACREP Standard H-1) Applies skills in interviewing, assessment, and case management for working with individuals, couples, and families from a system’s perspective.

Student Learning Outcomes for the Course

Students will:

Demonstrate the ability to select models or techniques appropriate to couples’ or families’ presenting problems. (ratings on demonstration rubric during class demonstrations throughout the semester) CACREP Standard B-2

Recognize specific problems (e.g., addictive behaviors, domestic violence, suicide risk, immigration) and interventions that can enhance family functioning. (ratings on case studies rubric and in class demonstrations when working with these cases and problems, final examination ratings) CACREP Standard C-2

Understand professional issues relevant to the practice of marriage, couple, and family counseling, including recognition, reimbursement, and right to practice. (demonstrated through the final written examination) CACREP Standard C-4

Use systems theories to implement treatment, planning, and intervention strategies. (ratings on in class counseling demonstration rubrics and completed treatment plans with intervention strategies, and final written examination) CACREP Standard D-4

Understand marriage, couple, and family assessment tools and techniques appropriate to clients’ needs in a multicultural society (as measured by ratings on the final examination and in class demonstrations) CACREP Standard G-2

Demonstrate the ability to use procedures for assessing and managing suicide risk. (case studies rubric, and in class demonstration)
Apply skills in interviewing, assessment, and case management for working with individuals, couples, and families from a system’s perspective. (ratings on counseling demonstrations in class and information on the treatment plans in class and on the final examination) CACREP Standard H-1

(Several rubrics used to assess student learning outcomes are attached to this syllabus)

VI. Course Topics
Major topics considered are essential counseling strategies and current theoretical foundations of marriage, couple, and family counseling including key interventions related to theories, initial and post assessment issues, ethical practices, gender, class, and multicultural issues when working systemically with diverse couples and families.

VII. Instructional Methods and Activities
A. Each student will demonstrate knowledge of the course learning objectives through reading, videos, presentations, lecture, cooperative learning, role play, class activities, case studies and examinations.
B. Students will learn therapeutic interventions of different approaches through reading, observation, interactive learning experiences, videos, demonstrations of family counseling strategies, and role play.
C. Students will demonstrate skills in working with families and will demonstrate techniques in working with couples & families (30 points).
D. Students will actively participate in class demonstrations & discussions (20 points).
E. Students will complete a take home examination (20 points) & and an in class final examination (30 points).

VIII. Evaluation and Grade Assignment
A. Methods and Percentage of Final Course Grade Each Assessment Constitutes

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<tr>
<th>Assessment</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Examination(s)</td>
<td>50 Points</td>
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<tr>
<td>Class demonstrations</td>
<td>30 Points</td>
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<tr>
<td>Class participation</td>
<td>20 Points</td>
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<tr>
<td>Semester Grade</td>
<td>100 Points</td>
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B. Grading Scale
A = 90-100 points
B = 80-89 points
C = 70-79 points
D = 60-69 points
F = <60 points

IX. Course Schedule and Policies
A. Tentative Course Schedule and Assignments

<table>
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<tr>
<th>Sessions</th>
<th>Topics</th>
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<tr>
<td>7-9-12</td>
<td>Overview of class: systemic thinking, family counseling professional issues including recognition, reimbursement, and the right to practice, developmental issues, gender, and culture. Problems faced by families impeding their functioning including addictions in the family, self harm, and family violence. The process of family counseling/therapy and the practice of family therapy are covered. A family counseling demonstration is presented by the professor followed by family assessment/planning (GARF etc.). (Ch 1- Developmental framework, individual functioning, problem severity, therapy</td>
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models, case integration; Ch.2- Applying family therapy models; Ch 3- Themes- Gender, race and culture, transitions, family structure; Ch 4- Common themes or practices- The therapeutic relationship (joining), family strengths, instilling hope, reframing resistance, the self as the therapist.

Session 2 7-11-12 Conducting an opening session with a family, Family counseling techniques lecture/discussion working with the family and individuals, textbook discussion, assignment of technique demonstrations and counseling session demonstrations of working with families including addiction issues, domestic violence, self harm. Working with immigrant families or families with immigration issues. Designing families and identifying techniques used in working with families facing diverse issues.
(Ch 5- Assessment- the referral process, the intake process, beginning questions-interviewing skill development)

Session 3 7-16-12 Family movie/video Diagnosing a family (use of the DSM, GARF), characteristics of interviews, developing a treatment plan, and managing the cases from a systems perspective.
(Ch 6- Treatment Planning- Organizing treatment, defining the problem(s), addressing relational functioning, completing the GARF, setting goals, starting the treatment plan)

Session 4 7-18-12 Family session demonstration using systems theories Debriefing on the use of theory and treatment plans Couple/Family techniques demonstrations
(Ch 7- Relational assessments- genograms, tracking longitudinal sequences, timelines, hypotheses Developmentally appropriate treatment plans)

Session 5 7-23-12 Working with diverse family systems, stepfamilies, single parent families, gay and lesbian families- Family sessions - Debriefing Couple/Family techniques demonstrations
(Ch 8-Interventions for beliefs, behaviors, and emotions; assessing individual and relational functioning, problem severity, reconstructing belief systems, experimenting with new behaviors, homework)

Session 6 7-25-12 Working with families in crises and emergency counseling, Family sessions – Debriefing Couple/Family techniques demonstrations Take home final: Cases on assessing and managing suicide risk. Identifying professional issues in mcfc; recognition issues, reimbursement, and right to practice.
(Ch 9- Evidence-based family therapy models, Case management & collaboration with schools, health care professionals, & other team members)

Session 7 7-30-12 Couple/Family techniques demonstrations Family presentations (Assessing & treating substance abuse, violence, and suicide in families) Debriefing

Session 8 8-01-12 Integrative Family Therapy: Illness in the family, Family challenges, Special Needs Family sessions addressing issues with immigrants and using case management processes Couple/Family techniques demonstrations

Session 9 8-06-12 Mixed marriage families, dual career families, rural families Family sessions - debriefing Couple/Family techniques demonstrations (Web enhanced)

Session 10 8-08-12 Final Exam : In class written examination over cases involving domestic violence, addictions, self harm, and immigration, identifying interviewing techniques, assessment measures, and case management plans.
B. Class Policies

Reading assignments, class attendance, and participation are considered mandatory. Many learning objectives will be met during class time and your active participation will enhance the learning experience for yourself and others. Incomplete grades will not be given after the university deadline for dropping a course except in the case of medical emergencies.

X. Textbooks

A. Required:


B. Supplemental:


XI. Bibliography


XII. Grade Appeals

As stated in University Rule 13.02.99.C2, Student Grade Appeals, a student who believes that he or she has not been held to appropriate academic standards as outlined in the class syllabus, equitable evaluation procedures, or appropriate grading, may appeal the final grade given in the course. The burden of proof is upon the student to demonstrate the appropriateness of the appeal. A student with a complaint about a grade is encouraged to first discuss the matter with the instructor. For complete details, including the responsibilities of the parties involved in the process and the number of days allowed for completing the steps in the process, see University Rule 13.02.99.C2, Student Grade Appeals, and University Procedure 13.02.99.C2.01, Student Grade Appeal Procedures. These documents are accessible through the University Rules Web site at http://www.tamu.edu/provost/university_rules/index.html. For assistance and/or guidance in the grade appeal process, students may contact the Office of Student Affairs.

XIII. Disabilities Accommodations

The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you believe you have a disability requiring an accommodation, please call or visit Disability Services at (361) 825-5816 in Driftwood 101.

If you are a returning veteran and are experiencing cognitive and/or physical access issues in the classroom or on campus, please contact the Disability Services office for assistance at (361) 825-5816.
RUBRIC FOR MARRIAGE, COUPLE, AND FAMILY & TECHNIQUES DEMONSTRATIONS USING SYSTEMS APPLIED TO CASES PRESENTED IN CLASS

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<tr>
<td></td>
<td>Very little demonstration of knowledge or skill</td>
<td>Minimal demonstration of knowledge or skill</td>
<td>Demonstrated both knowledge and skills</td>
<td>Very good demonstration of knowledge and skills</td>
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RUBRIC FOR KNOWLEDGE-BASED EXAMINATION IN MARRIAGE, COUPLE, AND FAMILY COUNSELING

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<td></td>
<td>Unclear, failed to address the question</td>
<td>Confusing, failed to address the full question</td>
<td>Addressed parts of the question, minimal depth</td>
<td>Moderate answer, some key points addressed</td>
<td>Good answer with minor omissions</td>
<td>Excellent, in-depth answer expressed with clarity</td>
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<td>Problem(s)</td>
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<td>In Session Techniques</td>
<td>Between Session Techniques</td>
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<td><strong>Diagnosis:</strong></td>
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<td><strong>General Family-Related Problems:</strong></td>
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Suicide Assessment

This article lays out helpful information on suicidal patients and interviewing them.

First, remember to do three things:
1) consult - this allows for another opinion, better care, and protects you
2) document, document, document! Everything you do, everyone you talk to, every question you ask the client should be documented
3) evaluate the client’s risk

Risk Factors

a) mental diagnosis, especially depression and substance abuse, or Borderline Personality Disorder which increase risk
b) over 45 years old are higher risk
c) sex (men try more lethal means, women try more often)
d) marital status (unmarried are lowest risk, never married, divorced, widowed, recently sep are highest risk)
e) recent job loss increases risk
f) chronic illness is higher risk
g) recent loss of loved one increases risk, as does the anniversary of the loss and fantasies of reuniting with the deceased

h) hospitalized and discharged with improvement; this may seem counterintuitive, but many suicidal people feel better once they have made the decision to kill themselves, and have the energy to wrap up loose ends, see others and say goodbye...
i) Caucasian - ethnic minorities have a lower suicide risk
j) previous attempts - this is one of the best predictors
k) gay/lesbian youth - may be at 3 to 5 times the risk for suicide as heterosexual Caucasian youth
l) extensive and detailed plans, or plans using a highly lethal means
m) history of suicide in their family
n) history of impulsive or reckless behavior

Questions to Ask
Do you have thoughts of suicide?
Are they related to current stressors going on in your life, or have you had such thoughts before?
Do you have a plan? Tell me.
Ask if they have access to the components of their plan, like a gun, pills, etc...

Signs of depression
sleep, energy, weight, or appetite changes
decreased interest in sex and other pleasurable activities
feelings of helplessness and hopelessness
social isolation and withdrawal from others

Level of Risk
none - no suicidal ideation
mild - some ideation, no plan
mod - ideation, vague plan, low on lethality, wouldn’t do it
severe - ideation, plan specific and lethal, wouldn’t do it
extreme - ideation, plan specific and lethal, will do it

Highest risk group has suicidal ideation (thoughts of killing self), a plan (any plan so long as it is definite and detailed is high risk), high lethality (guns and walking in front of busses are more serious than overdosing on
Tylenol and slashing wrists), few inhibitors (few reasons not to kill self), low self-control (especially drinking or using drugs - can decide not to kill self but fail to act to reverse events and accidentally kill themselves)

4) **Empathize with the client**
They are experiencing crises and stress, hopelessness, and helplessness. Offer that there is a part of them that wants to live, since they were cooperative with you. Offer too that services and referrals, as well as social support could be helpful to use now too.

**Make a No-Suicide Contract**
This is best when the client has support, is low risk, and can give clear reasons why they would not kill themselves; the client agrees they won’t hurt themselves, and if they feel they can’t stop themselves, they will call 911, an ER, a crises line, a therapist, or another designated special person, and will return for help on next appointment. Make the patient sign it and get a witness.

**Family Intervention**
This is best is there is high support and low impulsiveness in the client. The clients agree with you to contact their family. They stay with the family member until the suicidal thoughts have been addressed in treatment, and the family is briefed on who to contact for help in an emergency. The family also takes an active role to remove drugs, guns, or other means of suicide from the home, and promises 24 hour supervision.

**Hospitalization**
This is best if there is little family support, or mental illness, substance use or impulsiveness. Try voluntary admission, but use involuntary if needed.
What is Case Management?

The Interim Standards of Practice adopted the Case Management Society of America’s definition of case management.


The Case Management Society of Australia has chosen to adopt this new definition to assist with international communication and comparisons.

**Definition of Case Management:**

*Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost effective outcomes.*

The definition of case management notes the focus upon the meeting of a client’s health needs. Within the Australian context, case management can be placed within a social model of health. This framework allows for the client and case manager to work on the various aspects of the client’s life that influence the client’s health.

A social model of health is described as: A conceptual framework within which improvement in health and well-being are achieved by directing efforts towards addressing the social and environmental determinants of health, in tandem with biological and medical factors. (Department of Human Services (Vic.), 2002, p. 42)

We are open to contributions from our members as this definition will continue to evolve.

First and foremost **Case Management** is a service delivery approach now widely adopted across diverse settings in the human services and health sectors.

The best practices in **Case Management** require organizational arrangements to support service delivery, staff who have been trained for the approach and its application to the particular practice setting and strategies to ensure that the organization can be responsive to evidence from practice and advocate for systemic and policy change to support service delivery.
The principles that underpin Case Management are individualized service delivery based on comprehensive assessment that is used to develop a case or service plan. The plan is developed in collaboration with the client and reflects their choices and preferences for the service arrangements being developed. The goal is to empower the client and ensure that they are involved in all aspects of the planning and service arrangement in a dynamic way.

The Case Manager coordinates the process, consulting informal carers and key service providers to ensure that the plan is developed appropriately, clearly contracted and monitored for effective and financially accountable service provision based on specified and desired outcomes. The case manager and the organization are expected to maintain quality in service provision for individual clients and the wider target population.

In clinical settings the case manager may also provide specialist services to address particular needs of the client.

The Case Management approach assumes that clients with complex and multiple needs will access services from a range of service providers and the goal is to achieve seamless service delivery. This assumption highlights that the concept of Case Management is based in service provision arrangements that require different responses from within organizations and across organizational boundaries. Case management is described as a boundary spanning strategy to ensure service provision is client rather than organizationally driven.

Case Managers provide the coordinating and specialist activities that flow from the particular setting, program and client population. However it is usual to identify the following process as core to Case Management: screening, assessment/risk management, care planning, implementing service arrangement, monitoring/evaluation and advocacy.

Where is Case Management used?

Case Management has been adapted to a wide range of settings including community care for the aged, and people with disability and mental health issues; acute health settings; injury management and insurance related areas; correctional services; court systems; in the management of chronic health conditions; child and youth welfare; at risk populations in schools; managed care and employment programs.

Who are the Case Managers?

Human service, health and allied health professionals, people with experience in the particular sector where Case Management is implemented, administrative staff designated to the role.
Society seeks to widen the interest in **Case Management** as a service delivery approach, advocate for policy strategies that adequately resource programs based in a **Case Management** approach and lobby for policy change to address identified gaps in resources that mitigate against effective service arrangements for clients and their careers. The Society is affiliated with a number of like organizations internationally and maintains a commitment to these links.