Auburn University Marriage and Family Therapy Center Handbook

Department of Human Development and Family Studies, Auburn University, Marriage and Family Therapy Center at Glanton House, 312 Quad Drive, Auburn, Alabama 36849-5604

Last updated 03-31-2018

The release of a new edition of the Handbook will occur when significant changes in policies and/or procedures are instituted.

The Auburn University Marriage & Family Therapy Program and the Auburn University Marriage & Family Therapy Center provide education, employment, and clinical services without regard to age, ethnicity, gender, disability, race, religion and spiritual beliefs and/or affiliation, sexual orientation, gender identity, socioeconomic status, health status, relationship status, and/or national origin.

Contents

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The local community mental health center is:

East Alabama Mental Health Center
2506 Hamilton Road
P.O. Box 2506
Opelika, AL 36801 (334) 742-2700

MFT Center Policies and Procedures

Carefully study, learn and follow the policies and procedures. Students are accountable for knowing how the Center functions.

Marriage and Family Therapist Code of Ethics

Whenever students are practicing or observing therapy, they **must** follow the standards of ethical conduct set forth by the Alabama Board of Examiners in Marriage and Family Therapy (ABEMFT) and the AAMFT. The ABEMFT ethical standards are modeled after the AAMFT Code of Ethics; however, there are various additions, just as there may be subtle differences among the standards from state to state. The *AAMFT Code of Ethics* and the *ABEMFT Standards of Ethical Conduct*, found in *Appendix D*. If there are differences between the two sets of Standards then follow the higher Standard related to any particular issue. Failure to follow the professional code of ethics could result in dismissal from the program and/or receiving a lowered grade in the MFT Labs or MFT Internship, depending on the infraction. (See *Appendix G*)

Liability Insurance

Auburn University carries clinical students under a blanket liability insurance policy that covers students at their on-campus and off-campus sites. Additionally, you are also covered by the AAMFT liability policy as a student member.

MFT Clinical and Supervision Monthly Report Form

Once students begin doing therapy, they must complete an MFT Clinical Hours Report Form (pink sheet) at the end of each month (Appendix H). This form provides important information used to evaluate clinical training, assess the status and needs of the MFT Center, and maintain AAMFT accreditation. Forms are to be turned in to the MFT Admin the first Friday of each month.

The MFT Clinical Hours Report Form (Appendix H) tallies therapy and hours.

Definitions of terms:

THERAPY HOURS: Hours the student is the therapist in direct client contact.

TEAM THERAPY HOURS: T h e ho urs the student therapist is behind the mirror functioning as a team member. This entails taking notes for the therapist during each session and participating from the beginning until termination.

INDIVIDUAL SUPERVISION: This includes all the hours the student therapist is conducting therapy while a supervisor is viewing the session. It also includes face-to-face interaction with the supervisor and the student therapist concerning the treatment of marital and family therapy cases. Dyadic supervision (when two supervisees are present with the supervisor), is considered individual supervision.

GROUP SUPERVISION: All hours when a group of 3-6 therapists and a supervisor are discussing cases, including live supervision behind the mirror and audio and video tape presentation of cases.

Appendix A

Clinical and Supervision Monthly Report Form

Name:_____ Month/Year:_____

Category: F = Family, I = Individual, C = Couple, G = Group

New Cases at MFT Center:

Client ID#	Category	Presenting Problem

		Client Contact Hours					Supervision Hours					
Site Name	Modality	Ind.	Couple (relational)	Family (relational)	Relational add CPL + & Family 250hrs	Total Client Hours 500 hrs	Case Report	Live raw data	Video raw data	Audio Raw data	Direct Obs add aud+vid+ live 50	Total Hrs Supervision 100 hrs
	IND											
	GRP											
	TEAM											
	IND											
	GRP											
	TEAM											
	IND											
	GRP											
	TEAM											
Cumulative Totals add hrs earned all						Aa						bb
Ratio of supervision to client contact (1:5) = bb/aa =_____(Should equal .20 or greater)												

Accounting of Contact and Supervision Hours during Clinic Nights

Use the following standardized procedure and criteria for students/supervisors when accounting for therapy contact and supervision during clinic nights. The following procedure assumes that each group consists of six students (or less) and that the supervisor divides his/her time equally between the cases during each therapy hour. If these assumptions do not apply, the supervisor will instruct you how to count the supervision.

1) During a therapy hour when there is only one session in progress, the following applies:
   a) The primary therapist receives one hour of therapy and one hour of individual live supervision.
   b) The teammate receives one hour of team therapy contact and one hour of group live supervision unless no one else but the supervisor observed with them then they receive individual live supervision.
   c) All other students present for the session receive no therapy contact but do receive an hour of group live supervision if they participate in the supervision discussion.

2) During a therapy hour when there are two sessions in progress, the following applies:
   a) The two primary therapists each receive one hour of therapy contact and one half hour of individual live supervision.
   b) The two teammates each receive one hour of team therapy contact and one-half hour of the group live supervision; unless no one else but the supervisor observed in which case they receive one half hour of individual live supervision.
   c) All other students present who participate in the supervision discussion receive no therapy contact but do receive an hour of group live supervision if they move with the supervisor, or one-half hour if they stay with one of the cases.

3) During a therapy hour when three sessions are in progress, the following applies:
   a) The three primary therapists each receive one hour of therapy contact and one-third of an hour of individual live supervision.
   b) The teammates each receive one hour of team therapy contact and one-third of an hour of individual live supervision

In addition to the live supervision, second year MFT students have group case-report or video supervision prior to seeing clients (this has traditionally been from 2-4:00 p.m. on Tuesdays.)

During the clinic night for first- year students, which typically runs from 4-10:00 p.m., the supervisor usually assists students in calculating the appropriate amount and kind of supervision.

Appendix B

Explanation of Certain Provisions of the Child Abuse and Neglect Reporting Law

The 1975 Alabama Legislature has made considerable changes in the reporting of child abuse and neglect by the passage of Act No. 1124, (*now codified in Code of Alabama 1975, Sections 26-14-1 through 26-14-13*) which amended and reenacted the former Child Abuse Reporting Act.

The purpose of this law is to protect children whose health and welfare could be adversely affected by abuse and neglect, by providing for the reporting of such cases to duly constituted authorities.

The statute provides certain key definitions. Abuse has been defined as harm or threatened harm to a child's health or welfare which can occur through non-accidental physical or mental injury, sexual abuse, or attempted sexual abuse; or sexual exploitation or attempted sexual exploitation. Sexual abuse includes rape, incest, and sexual molestation, as Alabama law defines those acts. Sexual exploitation includes allowing, permitting, or encouraging a child to engage in prostitution; and allowing, permitting, encouraging or engaging in the obscene or pornographic photographing, filming, or depicting of a child for commercial purposes. Neglect is defined as negligent treatment or maltreatment of a child, including the failure to provide adequate food, medical treatment, clothing, or shelter.

A special exception has been made by a parent or guardian legitimately practicing his religious belief in the provision of medical treatment for a child. A child has been defined as a person under the age of 18 years. Professionals and institutions are *required by law* to report known or suspected child abuse or neglect *under a penalty of a misdemeanor fine or sentence*. Those who are required *by statute to report are*: hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, school teachers and officials, peace officers, law enforcement officials, pharmacists, social workers, day care workers or employees, mental health professionals, or any other person called upon to render aid or medical assistance to a known or suspected victim of child abuse or neglect.

Besides those persons who are required by law to report child abuse and neglect, any person may make such report, if such person has reasonable cause to suspect that a child is being abused or neglected.

The initial report should be made orally either in person or by phone, normally to your local chief of police (if in a city), county sheriff (in rural areas), or your local County Department of Human Resources. Also, a written report will be made containing all of the prescribed information that is known.

The law also contains *immunity* provisions so that any person participating in the good faith making of a report under the statute is immune from any civil or criminal liability that might otherwise be incurred or imposed.

The law further provides that all allegations of child abuse and neglect, be investigated by the Department of Human Resources, and certain other records of child abuse and neglect are to be considered *confidential* under penalty by criminal law. However, the disclosure of certain information

contained in the reports and files is permitted to individuals, such as physicians or law enforcement officials, under rules and regulations established by the Department of Pensions and Security. The law explains the various duties of the Department of Pensions and Security in following up a report of child abuse or neglect. It contains provisions for protective custody when the child's life or health is in imminent danger. The law also provides for the appointment of attorneys to serve as guardian for abused or neglected children when they are involved in judicial proceedings and changes certain evidentiary requirements concerning the doctrine of privileged communication in court proceedings.

If you desire more specific information on the content of *Code of Alabama 1975, Sections 26-14-1 through 26-14-13,* then contact your local probate judge, sheriff, a lawyer, or clerk of the register of your circuit court, or the local County Department of Human Resources to review a copy of the statute.

Mandatory Reporting

Persons and institutions specifically identified by statute as required to report are: all hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, school teachers and officials, peace officers, law enforcement officials, pharmacists, social workers, day care workers or employees, mental health professionals or any other person called upon to render medical assistance to any child when such child is known or suspected to be a victim of child abuse or neglect. *Code of Alabama 1975, Section 26-14-13* also provides that any person who shall knowingly fail to make the report required by the Act shall be guilty of a misdemeanor and shall be punished by a sentence of not more than six months or a fine of not more than $500. If the worker/supervisor has knowledge of a mandatory report (acting in his/her official position) failing to report child abuse and neglect, the local District Attorney should be notified in writing.

Because child abuse and neglect are problems which must be approached with assistance from many different disciplines, effective communication, coordination, and cooperation among all community resources are essential. The County Department has the responsibility to persons and institutions mandated to inform them of this responsibility, provide them with reporting forms and instructions, and acquaint them with the protective services available. Prompt response to reports referred to these persons and institutions and sharing information as to the Department's decision on the referral are critical components in maintaining a cooperative relationship.

When a report is made to a law enforcement official, such official subsequently shall inform the department of pensions and security of the report so that the department can carry out its responsibility to provide protective services to the respective child or children. (*Acts 1965, No. 563, p. 1049, §1; Acts 1967, No. 725, p. 1560; Acts 1975, No. 1124, § 1.)*

Permissive Reporting

In addition to those persons and institutions mandated to report child abuse and neglect, *Code of Alabama 1975, Section 26-14-4* provides that any person may make such a report if that person has reasonable cause to suspect that a child is being abused or neglected.

Appendix C

MFT Building Security and Parking Guidelines

Security and Keys

Therapists need to be constantly aware that there are legally sensitive documents within the Auburn University Marriage and Family Therapy Clinic. It is easy to become complacent with security issues because the clinic is such a quiet place with few non-client visitors. Areas of security concerns are building Access, Client files, and Video/Computer equipment.

Building Access

Since you will frequently be using the center on evenings or weekends, you should obtain an outside door key by filling out an Auburn University Key Request Form, which is available online as a pdf. The Office Administrator can help you to finish the form after you have initiated the request by filling in your own information. The form must then be signed by the Program Director and submitted to the Access Control Center. They will then email you when the key is ready to be picked up.

The outside door key will open the conference room, the reception area, the graduate student office, and the basement. It will not open faculty offices or the therapy/observation/equipment rooms upstairs. A community key ring, large enough to prevent it from being accidentally carried off, is located inside the Center and contains keys for the three therapy rooms and the equipment room. Keep this key ring in its proper place so others can find it!

Confidentiality of client files and expensive equipment require that the MFT Center be locked unless someone is present who is responsible. When you leave the Center, secure the building and determine whether another responsible person is available to lock-up. It is not an acceptable excuse to say, "I thought that someone else was in the building, or Dr. Smith was in the building". Make the extra effort to verify if others are in the building. (Faculty do not count as "someone in the building.")

If you and your team member(s) are doing therapy on a non-clinic night, then please make sure that the building is as secure as possible. All office doors other than the main entrance and the reception area need to be locked. We must make sure that no one can enter the building or access anything inside while you are doing therapy.

Being responsible also means making sure that filing cabinets are locked, lights and equipment are turned off, and inside doors and windows are closed and locked. It is your responsibility to make sure that everything on all three floors is secured before leaving.

Client Files

Client case files are stored in two locations. Active client files are stored in a locked filing cabinet, behind closed doors in the graduate student office. The door to this office needs to be **closed at all times**, and locked when the therapists are:

1) All on the second floor
2) Out of the building, or

3) After hours
4) Or if there is no therapist or office worker in the immediate area (lobby or file room)

The filing cabinet is locked at all times unless a therapist or clinic staff member is in the room. Closed client files are stored in the bottom file drawer in the graduate student office. The filing cabinet is locked at all times except during clinical or financial audit, or files are being removed from the cabinet. The door remains closed while therapists or staff are accessing files.

Stored client files are found in the basement storage room. These files contain ten years of client information, so it is imperative that the storage door is always locked and that the filing cabinet holding these records is always locked. When leaving the room, remember to lock the door.

Equipment

The digital audio and video equipment are to remain behind locked doors and turned off when not in use. It is imperative that the audio and video equipment be off when not in use as to avoid overheating and permanent damage. Only MFT faculty, student therapists, and authorized clinic staff through their individual log-in/password procedure have access to the computer equipment, data, and video files. Walter Tolbert, our CHS computer specialist, has developed this computer security system and serves as our ongoing consultant.

Case Summary

A template for the Session Summary Form is stored on the clinic computers. This form should be completed on the computer and then printed front and back on light green paper for the supervisor's co-signature. The Session Summary cannot be saved on the hard-drive. A student can use and encrypted hard drive to save sensitive client data if 1). The Flash drive is saved in the bottom drawer of the client file cabinet. 2). The encrypted flash drive never leaves the clinic. Once the supervisor signs the documents, then the digital copy must be deleted. Remember that **no client data, in any format, is to leave the building without the prior consent of your University clinical supervisor.**

Phone

1. To make calls locally press 9 + the 7-digit number. Personal calls allowed with phone number 844-4481. 844-4478 is only for business calls. It is the responsibility of MFT Interns to answer the phones or to remove messages from the answering machine whenever the admin is unavailable.

2. To make out-of-state calls and non-local calls in Alabama, you must use the phone in the student work area. Please follow the posted directions and remember all long distance calls must pertain to MFT Center business.

3. Evenings and/or when no one is covering the front office, all 844-4478 calls go directly to the MFT Center voice mail. MFT Interns should answer the 844-4478 phone and/or check voice mail message when the admin is not available.

Dress Code

Your work at the MFT Center represents a professional position, and your attire needs to reflect that position. Grooming and Attire are to be ***professional***. Clothing that reveals too much cleavage, your back, your chest, your stomach or your underwear is not appropriate for a place of business. Clothing should not be wrinkled. Torn, dirty, or frayed clothing is unacceptable. All seams must be finished. Any clothing that has words, terms, or pictures that may be offensive to other employees or clients will require faculty review. Dress and skirt length should be no higher than the knee and allow you to sit comfortably in public. Mini-skirts, skorts, shorts, sun dresses, beach dresses, and spaghetti-strap dresses are inappropriate for conducting therapy. Remember that some employees are allergic to the chemicals in perfumes and makeup, so wear these substances with restraint. This dress code is in effect when seeing clients, or representing the Center or the MFT Program.

Room Use

You must schedule all therapy sessions in the appointment book. If you do not, you may find yourself with no place to conduct therapy. Additionally, appointment book entries are part of our internal auditing for fee collection. Please note and follow the rule of only scheduling clients on the hour after 4:00 p.m., except in the case of MFT Lab II and III. A client scheduled on the half hour does not mean the room will be available for two hours instead of just one.

Equipment Use

When you read and understand the directions for our audio/video system, it is available for your use. If you have not read or do not understand the instructions to the audio/video system, you must be trained before you may use the equipment.

Smoke-Free Facility

Smoking and Vaping are not allowed in the MFT Center.

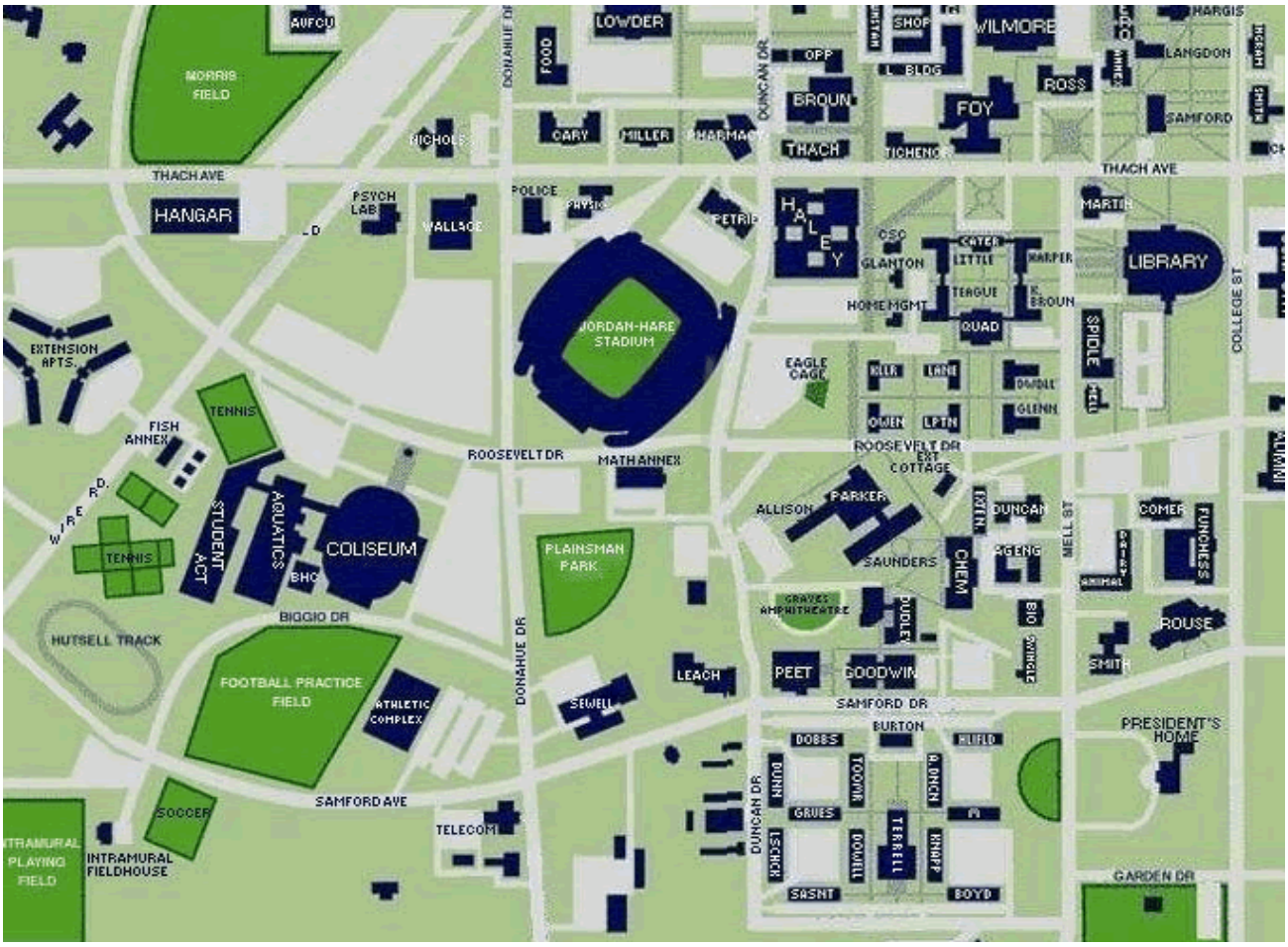
Giving Directions/Maps/Parking Permits

The following are directions to the MFT Center:

Take College Street to Thach (Thach & College is the main gateway to the University); go west on Thach (toward Stadium) to the first street. (Mary Martin Hall will be on the left). Turn left on Mell Street. Go south on Mell and turn right into the first parking lot on the right, before the light. Continue on the service road past the Quad Center. Turn right at the cul-de-sac in the west lot. There is parking in the North West corner of this lot. You may also turn right (north) up the wide driveway and park behind the building. The MFT Center is the middle of the three smaller brick buildings, and it looks like a two-story house. You may park in any of the Marriage and Family Center parking spaces. We will give you a parking permit for your car.

MFT students may not use parking passes for any reason. Students caught using clinic parking passes will be turned over to parking services, which could result in fines, elimination of campus parking privileges, and/or legal charges. (It is a crime to steal parking passes).

If a client is not familiar with the campus, and there is sufficient time, you should send them a map



before your first appointment. Maps are available in the file cabinet with other MFT Center forms.

Detailed Map to Parking for MFT Center

Severe Weather Action Plan

I. PURPOSE

To have an orderly transition to safety in the event of a SEVERE WEATHER WARNING

II. AUTHORITY

Auburn University

III. ALERTS

A. SEVERE THUNDERSTORM WATCH - Means weather conditions are such that a severe thunderstorm could develop and may affect those areas stated in the weather bulletin.

B. SEVERE THUNDERSTORM WARNING* - Means weather conditions are such that a severe thunderstorm has developed and may affect those areas reported in the weather bulletin.

C. TORNADO WATCH - Means weather conditions are such that a tornado or severe thunderstorm could develop.

D. TORNADO WARNING* - Means weather conditions are such that a tornado or funnel cloud has formed and been sighted, and may affect those areas stated in the bulletin.

*Warnings (B and D) will be announced by the sounding of the Severe Weather Sirens. Those on the first and second floors of Glanton House should immediately take shelter in the office in the basement. Tune to a local radio station for additional information.

IV. EMERGENCY NOTIFICATION SYSTEM

A. EXTERNAL NOTIFICATION: Severe Weather Alerts are transmitted by way of sirens mounted on poles 50 feet above the ground with a rotating horn. The siren will last for three (3) minutes. Sirens are stationed at specific locations around the campus, three on campus and one at the Vet complex. The siren nearest to Glanton House is mounted on the side of the Quad Center. The sirens are activated by the Lee County Emergency Management Agency (EMA) or by the Auburn University Police Department when directed by the EMA. The sirens are activated when a severe thunderstorm and tornado warnings are in effect for the local area. There will be no "ALL CLEAR" sounded. Tune to a local radio station for information.

B. INTERNAL NOTIFICATION: When the Severe Weather Alert Siren is sounded all personnel should move to the basement within 30-60 seconds of this warning. A tornado traveling at 60 mph can cover a mile in one minute. In no instance should it take longer than two minutes to find the basement. The warning will last for one hour unless subsequent sounding of the sirens occurs. After the threat has passed, normal activities can resume.

V. ACTIONS

A. SEVERE THUNDERSTORM WATCH: Means weather conditions are such that a severe thunderstorm could develop, but has not at this time. This alert usually lasts for five or six hours. There will be no warning siren for a watch.

B. SEVERE THUNDERSTORM WARNING: Means a severe storm has developed and will probably affect those areas stated in the alert message. When the siren is sounded, turn off equipment, close all windows and doors and move immediately to the basement. Be prepared to assist any student or client with hearing, sight or mobility impairments. Remain in a shelter for the duration of the time specified.

C. TORNADO WATCH: Means weather conditions are such that a tornado could develop but have not at this time. This alert usually lasts for five or six hours. There will be no siren for this warning.

D. TORNADO WARNING: the same action should be taken as in a Severe Thunderstorm Warning. Tornadoes are most likely to occur during the afternoon and evening. If you are out on campus, go immediately to the nearest building. Avoid glass and interior and exterior door areas. Avoid areas where chemicals are stored. Remain in the shelter for the designated time.

Listen to a battery-operated radio.

E. AFTER ACTION/WITHOUT DAMAGE: Resume normal activities.

F. RECOVERY ACTION/WITH DAMAGE: If light damage occurs to the building, such as fallen tree limbs, broken glass, broken water lines, etc., appoint one person to go outside after the all clear to direct emergency crews or to notify proper personnel of any damage to the building. If there is significant structural damage, the work crews will know where to go. In the event of injuries to persons, apply first aid and notify authorities. The first aid kit is located in the top drawer of the cabinet in the Glanton House bathroom on the second floor. The Child Study Center and Glanton House will coordinate on checking with each other after the storm for damages and possible injuries. If injuries occur at Glanton House, one of the trained staff from the Child Study Center will assist at Glanton House.

Emergency Phone Numbers

911 - (if this line is busy use one of the following numbers)
Emergency Operations Center 749-8161

Upon hearing the sirens, First and second floors of Glanton House will evacuate to the office in the basement.

Case Management – Policy, Files, and Forms

Confidentiality

To maintain client confidentiality, you are to store your client files and all sources of client data in the locked file cabinets in the second-floor graduate student office, the locked equipment room upstairs, or on the secure hard drive.

NOTE: Confidentiality at the MFT Center means that no client files, video images, or electronic media containing identifiable client information of any kind may leave the building without the prior consent of your university clinical supervisor. If authorized, any transportation of confidential materials from the Center or any internship must be in a locked box or briefcase, locked in the car trunk. Violating client confidentiality is a serious breach of the ethical code and may result in repercussions of failing internship, dismissal from the MFT program, and potential legal problems.

Taking Referrals over the Phone

1. The person receiving a call requesting MFT Center services is to obtain the information needed to complete a Referral Form (gold sheet).

2. Inform the caller about the MFT Center services and training component, the therapists and supervisors, the sliding scale fee, plus the first session fee.

3. The person taking the call then schedules an appointment for the client using the Referral Form kept at the secretary's workstation. Instruct clients to arrive 30-45 minutes before the therapy

session to complete the intake assessments (initial paperwork), or to print the paperwork from the website at www.mftcenter.auburn.edu, and bring completed paperwork to the first session.

4. For every new scheduled appointment, a client file should be prepared using the appropriate procedures noted below.

Appointment Request Form (OFFICE USE ONLY)

Therapist ID#: _____

Client #:_____

Client Name: _____ Date:____/____/_____

First Last

Which type of therapy are you seeking (Circle One):

Individual Therapy Couple Therapy Family Therapy

Who, if anyone, will attend (first and last name) and what is their relationship to you:

1. _____
   First Last Relationship
2. _____
   First Last Relationship
3. _____
   First Last Relationship
4. _____
   First Last Relationship

Mailing

Address:_____

Phone Number:_____ Alternate: _____

☐ Permission to call and leave messages at the provided phone numbers?

How did you hear about us?_____

NOTES FOR THERAPIST:

_____

_____

_____

_____

☐ Print and fill out paperwork on website OR ☐ Come 45 minutes early to fill out at clinic

APPOINTMENT DATE & TIME _____

NOTES ABOUT PRICING (Please find out the Client Income and provide estimated quote based on proof of income, etc.)

_____

Person taking Information_____

COMPLETE REVERSE SIDE

I would like to ask you four basic questions to gather a little information about yourself before services begin. Looking back over the last week, including today, rate how well you have been feeling on a scale from 1 to 100 in the following areas.

Individually
(Personal well-being)

Low levels I----------I High levels

Interpersonally
(Family, close relationships)

Low levels I----------I High levels

Socially
(Work, school, friendships)

Low levels I----------I High levels

Overall
(General sense of well-being)

Low levels I----------I High levels

Preparation of Client Files

Admin Duties:

1. The MFT Admin maintains a supply of file folders which are color coded by the month of initial use: yellow or manila for Jan, May, Sept; red for Feb, June, Oct; green for Mar, July, Nov; and blue for April, Aug, Dec.

2. You will assure that client files contain the following forms which are supplied in file cabinets near the front desk:

Left Side (Bottom to Top):

1. Interview Appointment/ Fee Record
2. Informed Consent for Treatment
3. Assessments
4. Intersession Reports

Right Side (Bottom to Top):

1. Referral Form
2. Informed Consent
3. Referral Form
4. Release of Information
5. Treatment Plans
6. Case Notes

A. Maintain the Client Codes. The first new client in January of each year will have the code of Year01001, e.g. in 2004 the number is 200401001, and the second client in January would be 200401002. The first client in February would have 200402###, with ### dependent on what the last new client number was in January.

B. Prepare Assessment Packets for various client types (individual, couple, family) and sessions (intake, follow-up).

ID# _____

MFT CENTER
Auburn University

Therapist #_____
Fee Amount _____

APPOINTMENT / FEE RECORD

Audit Check	Appointment Date	Kept/Reschedules/No-Show (K, R, NS)	FEES			Comments
			Charged	Paid	Balance	

Form Configuration

Audit Check. The auditor initials here when they have reviewed that the appointment date matches the case note date, and the fee amount matches the receipts.

Appointment Date. The date of the therapy appointment. Complete this line for each appointment date. Record sessions, cancellations, and no-shows.

Fees. Record the amount charged and the amount paid. Record the discrepancy as the balance if the amount charged does not match the amount paid. The balance should be zero (0). If the balance is not zero, then the therapist notifies the supervisor.

Comments. Therapists write comments regarding any unusual activities or actions. If the therapist needs to reschedule, which is only for ILLNESS, then the therapist is required to record this in the comments section. Therapists notify supervisors concerning cancellations. Therapists cannot cancel two sessions consecutively.

Fee Policy and Schedule

The MFT Center collects fees because of budgetary or administrative needs, and the conviction that learning how to reach fee agreements, to understand the interpersonal dynamics related to fees, and to deal with deviations from fee agreements are essential elements in the clinical training of marriage and family therapists.

Establishing specific fee arrangements is critical for defining the relationship between client and therapist. You will have the opportunity to practice determining the fee with your clients at the Glanton House. Once the therapist and client have reached an agreement concerning the amount of the fee and the terms of payment, a good foundation for a working alliance exists, and the respective roles of the clients and therapist have begun to take form. The lack of an opportunity to practice establishing fee arrangements with clients during their initial training results is a difficult transition to the outside professional world for student therapists. Center therapist may make a case for client fees to adjust below what the sliding fee scale dictates to the primary Center supervisor when they believe the client is under extreme financial hardship.

The fee amount is for a 50-minute therapy session. Treatment fees will not vary as a function of the number of therapists working on the case (e.g., use of team therapy or co-therapy) or the number of clients included in the session (e.g., individual, couple, or family therapy).

Auburn University Marriage and Family Therapy Center

First Session Assessment Fee

The first session fee is $70.00 (unless client brings proof of income for a reduced rate).

Fee Schedule per Session

* Revised 02/2017 * * * * * * * * * * * * * * * * * *

INCOME RANGE FOR **FIRST SESSIONS** (First Session includes a $20 administrative fee)

# Fam	UNDER $10,000	$10,000 $14,999	$15,000 $19,999	$20,000 $24,999	$25,000 $29,999	$30,000 34,999	$35,000 39,999	$40,000 44,999	$45,000 49,999	$50,000 54,999	$55,000 59,999	$60,000 64,999
1	$30	$40	$45	$55	$60	$65	$70	$70	$70	$70	$70	$70
2	$30	$35	$40	$45	$50	$55	$60	$65	$70	$70	$70	$70
3	$30	$30	$35	$40	$45	$50	$55	$60	$60	$65	$65	$70
4	$30	$30	$35	$40	$45	$50	$50	$55	$60	$65	$65	$70
5	$30	$30	$35	$35	$40	$45	$50	$50	$55	$60	$65	$65
6	$30	$30	$30	$35	$40	$40	$45	$50	$55	$55	$60	$65
7+	$30	$30	$30	$30	$35	$40	$45	$45	$50	$55	$60	$60

****The fee for individual clients who are Students with an active student ID is $20 per First Session and $10 per 2nd session and onward. The same fees also apply to a couple if one of them is a student. If one member of the couple is Active Military with current ID, they may receive free couples therapy or free**

individual therapy for the active military member for the first twelve sessions. All other client fees will be determined according to the regular sliding fee scale.

Second Session and Onward Fees

The fee for the second session and onward is $50 (unless client brings proof of income to qualify for a reduced rate).

INCOME RANGE FOR **SECOND SESSION AND ONWARD**

# Fam.	UNDER $10,000	$10,000 $14,999	$15,000- $19,999	$20,000- $24,999	$25,000- $29,999	$30,000- 34,999	$35,000 39,999	$40,000 44,999	$45,000 49,999	$50,000 54,999	$55,000 59,999	$60,000 64,999
1	$10	$20	$25	$35	$40	$45	$50	$50	$50	$50	$50	$50
2	$10	$15	$20	$25	$30	$35	$40	$45	$50	$50	$50	$50
3	$10	$10	$15	$20	$25	$30	$35	$40	$40	$45	$45	$50
4	$10	$10	$15	$20	$25	$30	$30	$35	$40	$45	$45	$50
5	$10	$10	$15	$15	$20	$25	$30	$30	$35	$40	$45	$45
6	$10	$10	$10	$15	$20	$20	$25	$30	$35	$35	$40	$45
7+	$10	$10	$10	$10	$15	$20	$25	$25	$30	$35	$40	$40

Fee Collection Policies and Procedures

1. Fees will be charged according to the approved Fee Schedules. When clients call for the initial appointment, they will be informed that the center's fee is $70 initial session and $50 thereafter and that those clients may be eligible for a lower cost sliding scale fee depending on family size and income. Disclosure of the sliding fee scale occurs during the initial phone call, and eligibility is determined at the initial session. We accept cash, checks and credit cards. Checks should be made payable to Auburn University. We do not file insurance, but clients may be able to file their insurance for reimbursement of therapy cost.

2. Following the initial greeting and discussion of the MFT Center Policies with the clients, the next order of business in the initial session will be determining the gross family income and inform the client of the fee amount assessed for each session. If the client takes issue with the assessed fee, the therapist will determine if there is merit to his/her rationale (e.g., extensive medical bills, funeral costs, or debt consolidation). The therapist may present the client's rationale to his/her supervisor for a fee reduction. **No client fees will be entirely waived.**

3. Present the adjusted fee agreement before or at the beginning of the next session. If the client does not agree to the adjusted fee for service, then offer at least two referrals.

4. The therapist is to collect the fees at the end of each session. Write the client a receipt and schedule the next session in the appointment book. A receipt is completed for all fee payments whether or not the client desires one. DO NOT remove the pink copies; these remain in the book. If you make a mistake on a receipt, DO NOT THROW IT AWAY. Write VOID on it and leave all three copies (white, pink, and yellow) in the receipt book. Put the yellow copy of receipt in an envelope as part of step 5.a. The receipts are numbered and audited sequentially. Keep the receipt book near the appointment book.

5. Record all appointments in the appointment book. The appointment book is a key component to maintaining our accounting records. The financial accounting statement is part of the end of

the month audit of client files as well as to verify the information written on the Interview Appointment/Fee Record Form. Annotate cancellations "C," no-shows "NS," and reschedules "R" in the scheduling book.

a. Payment (via check, cash, coin, or card) received from the client is to be placed in an envelope with a receipt. In the case of cash payment, the therapist and a witness both sign their respective names across the back of the sealed envelope, writing the fee amount and form of payment on the outside front of the envelope, before putting the envelope t in the collection box. For other types of payment, only the signature of the therapist is required on the envelope. The therapist must also maintain an accurate and up-to-date Interview Appointment/Fee Record Form for each client with all sessions attended, canceled sessions, rescheduled sessions, or no-show appointments. The completed Interview Appointment/Fee Record Form attaches to the top left side of the file folder.

6. If the client fails to pay for a session, the therapist will tell him/her that he/she will need to pay for two sessions at the **beginning** of the following session. If the client arrives without payment, a second unpaid session can occur, but the therapist must address the issue of the non-paid sessions. A good faith plan for resuming regular fee payments according to the fee agreement needs to occur to meet again. Payment needs to happen at the beginning of the session until the unpaid fees are balanced. If a satisfactory plan is not obtained or carried out, the therapist and supervisor will discuss referring the client. It is by dealing with this type of situation that the therapist will gain valuable experience. Charge an administrative fee of ½ the session rate to clients if they do not show up for the session or do not call to cancel the day before the session. Therapists may, one time, choose to forgive the no-show fee for an unusual circumstance.

9. The MFT Office Administrator is responsible for removing the fees and receipts on a regular basis of at least once a week and more frequently if collections warrant. The AU MFT Center utilizes Auburn University compliant auditing procedures. The office administrator will check the receipts against the appointment book to ascertain the status of all scheduled appointments to ensure the accuracy of the appointment schedule. Any financial discrepancy in daily records is the responsibility of the therapist.

10. The MFT Admin and undergraduate interns will audit the account of every open case once each month. Each therapist will resolve all of their cases in which the audit determines account discrepancies exist. When a client has not made payment in accordance with his/her fee agreement, the Office Administrator will promptly issue the therapist and supervisor a written statement detailing the particulars of the client's outstanding charges. The responsibility of dealing with unpaid fees for active clients lies with the therapist and the supervisor. Contact clients who leave an unpaid balance in writing with a copy of the letter connected with the file.

11. Returned Check Procedure. Returned Checks go back into the client's file and a note placed in the therapist's box regarding the check. The therapist will make a phone call to the client with the concern. We can accept post-dated checks to avoid returns (these should be annotated on the payment envelope as post-dated). Clients may need to file a new income evaluation, or they may require special consideration for a lower fee.

Following a phone referral:

1. Determine Client Code Number from the Client Database called Bubbles (learn password as the file is protected) located on the secretary's computer. Place the Client Code Number on the referral form, the client file folder, and in the database.

2. Using the Client Code Number and the therapist's name, record the appointment in the Appointment Book, write a number 1 with a circle around it, to indicate a new first session client.

3. Put the client name, address, and code number into the Bubbles file at the Office Administrators workstation.

4. Inform the therapist of his/her new client in any of the following ways: phone, text, e-mail, or in person. Please be aware that no client names or identifying information (phone number, address, etc.) should be used in e-mails or other unsecured means of communication. In addition, you may put a note in the therapist's mailbox indicating date and time of new appointment.

Assignment of Clients from Phone Referrals

1. To receive client referrals, you must keep the MFT Administrator posted of your current client load, including each relational client load (Individuals, Couples, Families) updated on a weekly basis, inform the Administrator of your desire to have additional clients, and check your mailbox and email regularly for messages.

2. Upon receiving a referral, note the time of the appointment. Calling the day before the first session to confirm the appointment may increase the probability of the client coming. During the phone call, you can inform the client(s) as to whom you wish to see in the first session and begin to establish therapy norms.

3. **Be on time for your clients.** For example, the therapist needs to arrive at the Center by noon if the client is scheduled to begin completing Center paperwork at 12:15 p.m. The therapist will assist their client(s) complete assessments.

Clinical Intake Assessment and Procedures

MFT Center Assessment Process

The clinical assessment of clients and the therapeutic process at the Marriage and Family Therapy Center provides an evaluation of clinical outcomes of MFT Center clients.

The goals of this process are to accomplish the following:

1. Develop and refine an assessment process that directly and indirectly benefits individuals, couples, and families.
2. Measure progress of clients presenting with a wide variety of problems.
3. Provide students with the opportunity to learn how to integrate assessment and clinical practice.
4. Provide opportunities for the integration of research and clinical practice.
5. Provide information that is beneficial to training clinicians and researchers.
6. Provide clinical research opportunities for students.

The Clinical Assessments Handbook is updated as changes occur in the specific assessments and protocols for collecting the assessments.

Presentation of Assessments to Clients before Beginning of First Session

Informed Consent for Treatment

Clients must have the opportunity to read the Informed Consent for Treatment form before the Intake Assessment Packet is given. See the Clinical Assessments portion of the Handbook for specifics on the Intake Assessment Packet. The therapist or someone who can explain the Informed Consent for Treatment should be present to address any concerns voiced by the clients.

The informed consent provides clients with information concerning confidentiality parameters, client rights, payment requirements, and research information. It is important that the therapist not only allows the client to sign the informed consent but also review the different sections of the informed consent. After the 12^{th} session, the therapist should again provide the client with the informed consent information reminding them of their rights and have them sign and date the agreement again.

The therapist needs to be present to assist clients with the Informed Consent for Treatment and the Intake Assessment Packet. The exception to this is if the therapist is in class or in session at the time. If this is the case, it is then the responsibility of the therapist to solicit a peer to assist th e m with the paperwork or to check to see if the secretary is available to assist the client.

If the client decides against receiving services at that the MFT Center, then offer the client a referral to two other service providers. Referral Lists are available in the files containing MFT Center forms located near the admin workstation. See Forms Section of this Handbook.

Assessment Packet

The evaluation process is part of the MFT Clinic just as the video cameras, and the two-way mirrors are part of the clinic. Make clear to the clients that the assessments are part of treatment planning, in-house clinical training, and to learn about the therapy process.

When presenting assessments to clients, it is important to touch on the following points:

- □ Information clients provide, is confidential. At no time will their names or identity be associated with any research findings.
- □ Stress the importance of being honest in their responses. If they have questions, let them know it is all right to ask you for clarifying information.
- □ Inform the clients that the information obtained from the assessments has a two-fold purpose. One, it is used to help them as well as 2) to determine the effectiveness of services provided at the clinic.
- □ It may be useful to use a metaphor such as going to a doctor when encountering resistance from a client in relation to completing assessments. Rarely does a doctor treat a patient without some basic information such as body temperature or blood pressure?

Informed Consent Form

AUBURN UNIVERSITY
MARRIAGE & FAMILY THERAPY CENTER
Auburn University, Alabama 36849-5604

Human Development
& Family Studies

Telephone: (334) 844-4478
FAX: (334) 844-4515

INFORMED CONSENT FOR TREATMENT

Welcome to the Auburn University Marriage and Family Therapy Center (AU MFT Center) at the Glanton House. We are here to serve individuals, couples, and families associated with Auburn University and the rest of East Alabama. Marriage and family therapy graduate student therapist-in-training provide all clinical services at the AU MFT Center. The student therapists are under the direct supervision of the clinical faculty in the Department of Human Development and Family Studies. The clinical faculty are American Association for Marriage and Family Therapy (AAMFT) Approved Supervisors and Licensed Marriage and Family Therapist in the state of Alabama.

Since one of our primary functions is to train clinicians in their chosen specialty, we require permission to audio and/or videotape interviews and to observe the treatment sessions either live or video stream. The use of observation, taping, and supervision is crucial to your treatment and allows for instruction and/or supervisory input ensuring the highest quality services possible. Please discuss any questions about this practice with your therapists.

The discussions that take place in therapy are confidential, and thus will not be shared without your written permission. Information about you or your family cannot be shared without your written consent. To protect client confidentiality, we adhere to the following procedures:

- Written, telephone or personal inquiries about clients will not be acknowledged without your consent. You must sign a consent to release information before any information about you is given to anyone outside the center. Even then, we may advise you to withhold information if we feel it is in your best interest.
- All records, tapes, or other identifying materials are kept confidential.

There are, however, some exceptions to the confidentiality policy.

- By law, there are specific limits to confidentiality. By the Laws and Regulations

of the State of Alabama, your confidentiality does not apply when: There is a clear and imminent danger to you or others, by court order, or when there is suspected child abuse or neglect. Your therapist will take reasonable steps to protect those at risk including, but not limited to, warning any identified victims and informing the responsible authorities.

- The therapist-in-training will testify in any court proceeding if ordered by the judge.

Additional rights and principles are outlined so that you may be informed before consenting to and participating in individual, marital, or family therapy.

- Your therapist is bound by the AAMFT Code of Ethics, of which you may request a copy.
- As a part of the services offered the clinic provides a packet of assessments to complete at the beginning, throughout the therapy relationship, and at the termination of treatment. These assessments are one way we use to monitor the outcomes of the therapy process. We would request that you be honest in completing the forms, as this could facilitate the therapy process. Your therapist can answer any assessment question.
- You have the right to end therapy at any time without any moral, legal, or further financial obligations other than those already incurred.
- You have the right to refuse and/or discontinue any service you have already started. You can seek alternative therapeutic services from another licensed therapist, even if ordered by the court or directed by the Department of Human Resources.
- You have the right to confidentiality of records. All identifying information about your assessment and treatment is confidential. Within the MFT Center, information regarding your case is shared only with professionals-in-training and/or supervisors working together. The office staff is only associated with your case at intake, in the periodic auditing of records, and ensuring assessment completion.
- You have the right to ask questions about any administrative or clinical function. Specific questions about the clinical techniques and approaches are welcome.
- By entering therapy, you will be working on changing personal or family difficulties. There are potential benefits and risks involved in making these changes. Some of the possible benefits may include improved coping with marital and family relationships, a greater understanding of personal and family goals, and improved well-being. Some of the potential risks associated with relationship therapy may include intense feelings of anger, fear, depression, and frustration. You may experience discomfort and increased conflict while you work to resolve problems and disputes. There may also be unintended changes

in your relationship

- You understand that the AU Marriage and Family Therapy Center is not available for after-hours emergencies. Emergency phone numbers we provide for after-hours services: East Alabama Emergency Room, 528-1150; East Alabama Mental Health Center, 742-2700; Crisis Center, 821-8600; and 911 for other emergencies.
- The Auburn University MFT Center does not employ a physician or psychiatrist. We do maintain contact with some psychiatrists for medical referrals.

RESEARCH

All clients at the AU MFT Center complete assessments and other paperwork. The primary purpose of these forms is to help clinicians make informed decisions regarding assessment and treatment. Ongoing assessment is systematic across the course of therapy to track progress. Since the AU MFT Center is part of the educational and research efforts of Auburn University, the assessments are also included in that effort.

Additionally, you may have the opportunity to participate in the aspect of clinical research that includes a collection of physiological or biological data. If the opportunity arises to take part in this portion of the research and you agree, your therapist will answer any questions you may have after reading this consent form. Participation earns a waiver of up to $20 of the cost of therapy. Similar to the routine tests taken for a physical exam at a doctor's office, we would take readings of your heart, respiration, and skin conductance. Electrodes and a respiration belt, which you may be familiar with from your doctor's appointments, are part of data collection. The equipment used does not send any signals to your body and should not cause any physical pain or discomfort; they merely take readings of your body's processes.

Ongoing research is necessary so that we can continue to improve the way we provide services at the Center. Biographical and clinical assessments are available to graduate students. Removal of all identifying names, places, and events occurs when a research project includes information from AU MFT Center records so that we may protect the privacy of our clients.

PAYMENT AGREEMENTS

I understand that my fee is due at the time the student therapist renders their time and expertise. I agree and expect to assume the financial responsibilities outlined below:

I have discussed the fees for therapy with my therapist, and agree that my fee will be $_____per clinical hour. The fee for time spent in therapy beyond the clinical hour is the same as the fee for my therapy appointment.

If I must reschedule or cancel an appointment, I understand that it is my responsibility to call my therapist at least 24 hours in advance. I understand that I can be billed for up to ½ of the session rate if I do not show up for a scheduled session or call to cancel the appointment within less than 24 hours notices prior the scheduled appointment time.

I understand that the fee for time engaging in telephone, written, or face-to-face meetings with my therapist, at my request, is the same as the fee for my therapy appointments.

PARKING PROCEDURES

Park in one of the 15 spaces designated for "RESTRICTED AREA: CLIENT PARKING WITH PERMIT ONLY." These parking spaces are either; 1) on the traffic island in the second lot or 2) up the only driveway on the right of the second lot outside the Glanton House.

- Obtain a BLUE PARKING PERMIT from the MFT office and put on your dashboard above your steering wheel.
- If NONE of these 15 spaces are available, or your permit is expired notify your therapist or the secretary. Do not just park anywhere.

NEVER PARK in any other type of restricted parking space or on a yellow curb. We cannot help you with a ticket received for these violations.
BETWEEN 5:00 pm and 7:00 AM is the ONLY time you may park in an A or B zone space. There are a couple of these spaces in the first parking lot after you turn left from Mell Street. The Library parking deck behind Spidle Hall is also an A/B lot.
Not following these guidelines may result in a $50 parking ticket.

GIFTS

Because the therapeutic relationship you are entering into is a professional one, interns at the Center for Family Services are not allowed to give or receive gifts from clients.

COURT TESTIMONY

The Center for Family Services does not perform court-related evaluations for child custody nor do we testify in hearings involving child custody issues. In addition, we do not appear voluntarily at any court or administrative hearing. Because therapists at the Center are interns in training, it is usually not in your best interest to ask that they testify

for you, no matter what issue is involved. If you, or your attorney, choose to subpoena a Center therapist or other personnel for court testimony, including depositions or administrative hearings, you will be charged $100 per hour for any preparation time Center staff spend getting ready to appear, and $750 per 4 hour block of time our staff spend being "on call" to testify, traveling to and from court, waiting to appear, and/or testifying. These charges will apply even if Center personnel are ultimately excused from testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. By signing this agreement, you agree to pay these charges. Should it become necessary for the Center to commence collection proceedings or retain an attorney to collect any fees due hereunder, you agree to pay the attorney's fees and costs of collection incurred by the Center.

By signing this form, you indicate that:

You understand that the services at the MFT Center will be supervised by core faculty and program supervisors, which will include case consultation by audio/videotape recording or direct observation and review of treatment notes.

You understand the confidentiality policies of the MFT Center and agree to them.

You understand your rights/responsibilities as a client at the MFT Center and agree to them.

Client	Date	Client	Date
Client	Date	Client	Date
Client	Date	Client	Date

Auburn University

Auburn University, Alabama 36849-5604
College of Human Science

Department of Human Development & Family Studies
Marriage and Family Therapy Center, Glanton House

Telephone: (334) 844-4478

FAX: (334) 844-4515

Minor Consent

Date: _____

This is to certify that I/we,_____, have legal custody or guardianship of the following child or children: (list all participating children under the age of 19)

Name Date of Birth

_____

_____

_____

_____

_____

and I/we give consent for him/her/them to receive individual and/or family therapy. We also consent to information about them included in the Auburn University Clinic research.

_____

Legal Custodial Parent/Guardian Date

_____

Legal Custodial Parent/Guardian Date

_____

Therapist Signature (Witness) Date

Auburn University
Auburn University, Alabama 36849-5604
College of Human Science

Department of Human Development & Family Studies Marriage and Family Therapy Center Glanton House

Telephone: (334) 844-4478
FAX: (334) 844-4515

Authorization for Bi-Lateral Information Release

TO: _____ RE: _____

ATTN: _____ DOB: _____

I hereby authorize AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CENTER and the agency or individual listed above to discuss and/or exchange the following information and/or reports:

_____Social History/Intake Summary
_____Psychological/Psychiatric Exam
_____Educational Testing
_____Medical History/Diagnosis
_____Treatment Notes
_____Hospitalization Records
_____Other-Specify

I release the parties mentioned from any and all liability for revealing and releasing such information. It is understood that this information, once obtained, is not to be released to any other agency or individual.

The contact person at AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CENTER is: _____.

Date: _____ _____
Signature of Client or

_____ _____
Witness
Signature of Person Authorized to act on behalf of the client

_____
Relation to Client

Before Initial Session Begins

Review paperwork for any empty spaces and "red flags" or -Items of Interest- (see Clinical Assessments Handbook). If it appears that a client may be suicidal or a danger to others, then obtain a No Harm Contract form before beginning the session. Suicide assessment procedures can be found under EMERGENCIES. Remember that a suicide contract is not sufficient in securing an agreement with the client that they will not harm themselves.

If anyone has not completed the assessment, briefly discuss their reasoning for leaving certain questions blank after your opening spiel. If you have concerns about clients' comprehension of the questionnaires, check the information with the client to make sure they understood the questions and that their responses are accurate.

At the Beginning of the First Session

At the start of the first session, the therapist will verbally highlight the information contained in the Informed Consent for Treatment. This verbal presentation is often called "the first session spiel" at the MFT Center. After any of the clients' questions have been answered, and the fee for therapy has been determined, all clients age 12 and up are to sign the Informed Consent for Treatment before therapy begins.

At the Close of the Session

At the conclusion of the session, the therapist will follow the MFT Center policies and procedures regarding client fees, session paperwork, case management, and rescheduling.

On-going Case File Management

1. IMPORTANT NOTICE – maintaining files that are accurate and current is part of the MFT ethical standard of conduct. Students will be considered in violation of ethical conduct if their client files - including session summaries, assessments, and case closures - are not current. Breaches of ethical standards of conduct may result in dismissal from the program and/or a reduced grade in MFT Lab II & III or MFT Internship.

2. All appropriate client forms, assessment procedures, policies and procedures, and research materials are to be maintained as outlined in the Auburn University MFT Program and MFT Center handbooks.

3. The MFT Administrator will notify each therapist individually, either in person or by a note in his/her mailbox, if the therapist has failed to follow Center policy regarding fees, case closures, scheduling of clients, or other specific policy with which the Administrator is associated. The Administrator will document each notification, and if at any time deems that a therapist has consistently failed to follow policy, he/she will provide the documentation on <u>all</u> therapists to the current supervisor.

4. The therapist's supervisor is responsible for signing-off on all case management materials.

5. For all Court or DHR referred clients, a Release of Information should be obtained for contact with the referring agency, not just a specific person. For other cases with specific external agents that are related to the current client problems, obtain a Release of Information to contact and obtain information that may be helpful in client assessment and treatment.

6. Following each session, the therapist will complete the Session Summary Form located on the Z drive under -Therapists Documents. The form is completed on the computer and automatically logs the date. It is to be completed within 24 hours of the session.

7. After sessions in which clients have completed assessments, scoring should be done before the next session. Unless notified otherwise, therapists are responsible for scoring their client's assessments. The scores from the questionnaires can then be used in treatment planning and setting therapeutic goals.

8. If a therapist goes more than three weeks without contact with a client (other than school breaks), then the therapist is to initiate case closure proceedings. A final notification to the client either via phone or letter is necessary. This contact is to be documented in the file.

9. The therapist is to complete the Case Closure Form one week after the final notification to the client either via phone or letter. The case will also need to go through a case audit before the supervisor signs the Case Closure Form. Therapists initiate a case review by first auditing the case file and addressing all case organization concerns. The office administrator or the Intern in charge of auditing should be notified that the file has received the first audit, and has been placed in the file drawer to await the second audit.

AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

CASE NOTE

Case #:	**Session Date:**	**Original Notes:**	**Date: 3/23/2017**
Session # **Session Duration:** 50 min. **Therapist:** Select Therapist **Co-Therapist:** Select Therapist **Team:** Select Therapist		**Session Type:** Select Type **Primary Therapy Orientation:** Select Type **Live Supervisor:** Select Supervisor **Live Supervised Duration:** 50 min. **Supervisor:** Select Supervisor	
Name of Clients Present:			
Rate each client present during the session. When rating multiple clients, rate them in the order they are listed on the "name of clients present" line. The 3rd client is always the "identified child," in family therapy.			
1. Client Affect Regulation during session: 1st client: N/A	2nd client: N/A	3rd client: N/A	
2. Client Receptivity to Therapeutic Interventions: 1st client: N/A	2nd client: N/A	3rd client: N/A	
3. Rate the Within Session Client Progress: 1st client: N/A	2nd client: N/A	3rd client: N/A	
4. Rate the client's progress toward achieving treatment goals: 1st client: N/A	2nd client: N/A	3rd client: N/A	
5. Rate the Couple Alliance Within Session (Alliance between Couple/Partners): 1st client: N/A	2nd client: N/A	3rd client: N/A	
6. Rate the Therapeutic Alliance Within Session: 1st client: N/A	2nd client: N/A	3rd client: N/A	
7. The Overall level of Couple or Family Alliance? (Only for Multiple Clients) N/A			
Goal(s) Addressed:			
Interventions:			
Progress and Plans:			
Date of next session:			
Therapist Signature:_____ Date: 3/23/2017 Supervisor Signature:_____ Date: _____			

Supervisor Comments:

AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

TREATMENT PLAN

Case Number: Session #: Date: 3/23/17

People who will be participating in therapy:

Presenting Problems (list in order of importance):

1)
2)
3)
4)

Goals for therapy:

OBJECTIVES/TASKS	COURT ORDERED	TYPE	DATE TO BE ACCOMPLISHED
1)	☐	Select Type	
a.			
b.			
c.			
2)	☐	Select Type	
a.			
b.			
c.			
3)	☐	Select Type	
a.			
b.			
c.			

Case History (Make sure to briefly address key dynamics, and history pertinent to the case):

Therapist Name: _____

Therapist Signature:_____ Date: 3/23/2017

Supervisor Signature:_____ Date: _____

Appendix D Emergencies

Emergencies

The Center does not have a 24-hour emergency service, so it is the therapists' responsibility to:

1) Inform clients that we do not have after hours services on-site
2) Provide their clients with the crisis line number if so indicated by the client's situation. (Crisis Center - 821-8600), and
3) Inform their clients that they should proceed to the nearest hospital emergency room in the case of a psychiatric emergency.

Please Note: Be sure the MFT Administrator knows where to contact you, even during **breaks** and **holidays**. Procedures for handling suicide threats are included below.

Procedures for Adult Suicidal Threats

Purpose:

To assure that suicide threat made by adult clients are dealt with in a manner which:

1) is prompt in employing intervention
2) provides maximum protection to the client to preserve their health and well-being
3) meets the ethical and legal standards for professional practice, and
4) protects the Center from questions of legal liability.

Policy:

In the event of a client making overt threats to do harm to him/herself, clinical faculty, and/or students will exert the maximum reasonable effort to protect the safety and well-being of the client as contained in the following procedure.

Procedure:

1) When a client makes overt threats or admission of suicide ideation, it is the primary therapist's responsibility to assess the realistic potential for a suicide attempt. The following are among the areas to be explored.

a) History of suicide attempts - Attempt to determine if the client wanted to die or if it was a suicide gesture, (i.e., a plea for help, angry acting out, etc.)

b) The family history of suicide. If a family member has committed suicide, it increases the potential for suicide in all family members.

c) Assess the presence, degree, and duration of anxiety followed by depression.

d) Consider the client's personality style, diagnosis, and current situation (stresses, etc.). Clients who suffer from anxiety and have addictions like alcohol demonstrate higher rates of actual suicide attempts. Be aware of personality disorders or Bi-Polar depression which contain impulsive oriented behaviors.

e) Explore the clients' potential for pain tolerance. High pain tolerant people are more likely to attempt suicide. In conjunction gather information about cutting or self-mutilation.

f) Assess whether the client has a concrete plan and actual intent to follow the plan. Clients who have reached the stage of having a plan and intent are typically serious.

g) Assess the availability of a means (i.e., **guns**, medications, etc. that client could use).

h) Determine if the client is psychotic and hears voices telling him/her to harm him/herself. These cases are more severe and demand immediate intervention. Medical professional with more training that you need to decide the potential need for a non-voluntary petition.

i) Evaluate whether the client has suffered from a prolonged anxiety/depression and has had a sudden mood shift. Typically a cheerful lifting mood indicates that the client has made a decision and is experiencing the relief of knowing an end to their pain is in sight. Attempt to establish a concrete reason for the sudden lifting of their mood, although this is not always reliable.

j) Assess if the client has been systematically visiting friends and relatives and/or giving away their possessions. These activities are indicators of a decision being made and, if present, should be taken seriously. Likewise, consider the future orientation of the client. Are they looking forward to a future event like a wedding, the family vacation, or a church social?

2) After these areas have been assessed, the primary therapist should be able to judge the severity of the threat. If they are still unclear, the primary therapist will keep the client at the center and pursue a consultation with the current supervisor(s) or the director. Another clinical faculty can be of assistance when the aforementioned people are not available.

3) If the primary therapist's judgment following a thorough evaluation and consultation with his/her supervisor is that the threat is not immediately pressing, the primary therapist will attempt to negotiate a no-harm contract with the client and to make the client aware of the emergency services that are available when the therapist cannot be reached. The client will also list several therapeutic behaviors that will be followed to address suicidal ideation or behaviors. This action and the justification will be thoroughly documented in the client's clinical record, with a counter signature from the student's supervisor.

4) If in the primary therapist's judgment, following a thorough evaluation and consultation with his/her supervisor, there is a serious potential for the client to follow through on a suicide threat, the primary therapist will attempt to protect the client through one of the following methods considered effective but least restrictive.

a) If the client has an intact and functional support system (i.e. family, friends, etc.) there, involvement should be pursued. The client's agreement is necessary for including family member and friends but is a strong strategy in securing a no-harm intentionality from the client. Sometimes intensive monitoring by family or friends is needed until the crisis passes. In this situation, the primary therapist will have direct contact with the support system and assess their ability to provide adequate support as well as inform them of the situation and how to handle potential crises.

b) If a support system is not available or the client is in very severe distress, the primary therapist will

promote voluntary hospitalization. A family physician of the client may be your best resource for getting the client admitted to the hospital during regular hours. If the client is not local, does not have a regular physician, or it is after regular hours then 24/7 you can call **East Alabama Medical Center, One West, 528-1010 (Psychiatric Unit)** and explain who you are and what you need. The staff will take clinical information from you and will then talk with the psychiatrist who is on-call or who has last treated the patient. You will be called to let you know that the patient has been accepted and to tell you to have the patient go to the emergency department (ED). Staff will notify the ED that the patient is coming and to whom the patient is to be admitted. When the patient arrives, the ED physician will do a quick physical and then admit the patient to psychiatry. If you are working for East Alabama Mental Health, admissions are arranged through Robin Craft, the Outreach Coordinator, and the Hospital Liaison. He can be reached at 742-2863 or 528-1010. If all else fails: Call One West, 528-1010 and ask them to page Psychiatric Unit Director. Send the patient to the emergency department.

To arrange for transport to the emergency room for voluntary hospitalization, first attempt to contact a responsible adult (family member, friend) who can drive the client to the emergency room. The Auburn Police will transport to the emergency room at the request of the psychiatrist/physician if there is no other source. The psychiatrist/physician office must make the request.

c) After arranging for transport, call the ER at 334-705-1150 and tell the charge nurse that the person is being transported or follow instructions from the EAMH emergency services.

d) If the client will not agree to go to the hospital, call East Alabama Mental Health Outreach Services, 742-2877, and request their assistance in obtaining a court order for involuntary admission. You should seek help from a relative of the client in this process if possible. You may also contact the probate judge's office at 745-9761. If the patient arrives at the ED and then refuses admission, EAMC personnel will pursue obtaining a court order, if appropriate. If the patient is out in the community, call One West, 528-1010, and ask them to page Debra Owen and she will help. Or call Auburn Police Department-911 for assistance. FYI - the police will only transport the person after applying handcuffs.

5) If the suicide threat is made over the telephone, and the client will not come to the center, the primary therapist is advised to:

a) Assess the client's availability of weapons and potential for hostility.

b) If the client indicates the presence of weapons or is hostile, the primary therapist is not to go to the client's residence; rather, the therapist should contact the EAMHC for a consultation and possibly contact the police department for a welfare check and/or accompaniment on a home visit. (Auburn Police 334-821-3000; other communities on front cover of phone book).

6) In all the above, it is essential that the primary therapist obtains the maximum amount of consultation available from his/her clinical supervisors or the Center Director. All efforts and justification should be documented in the clinical record, and countersigned by clinical supervisor(s).

Crisis Hot Line **Phone number: 821-8600**

Procedures for Suicidal Threats/Behavior in Children and Adolescents

Purpose:

To ensure that suicidal threats/actions made by children or adolescents are properly assessed, and appropriate interventions are made that will ensure the safety and well-being of the client, meet ethical and legal standards of professional practice and protect the Center from legal liability.

Policy:

In the event that a client under 18 years of age makes suicidal threats, has engaged in suicidal behavior or in extremely dangerous high risk-taking behavior, the clinical staff will make a maximum effort to ensure the safety and well- being of the client by following the procedures outlined below.

Procedure:

1) The therapist should assess the suicidal risk by a careful inquiry into the following areas. a)

   Lethality (seriousness) of suicidal threat or behavior.

b) Motivations for suicide range from lowest risk (i.e. to influence someone else's behaviors and still survive) to the higher risk (i.e. a wish to escape an intolerable situation by death). Younger children often do not have a concept of death, as irreversible. Hence suicidal risk may be high even though death is not perceived as final nor intended as the eventual outcome.

c) The degree of effective preparation or planning.

d) Access to lethal resources to carry out the plan.

e) Prior suicidal attempts or seriously hazardous, high risk-taking behaviors.

f) Suicidal behavior that has occurred in immediate family or environment.

g) The extent to which suicidal behavior represents impulsive act, or is the outcome of irrational thought processes.

h) The presence of clinical depression should always lead to an inquiry about suicidal ideas and past suicidal behavior. In children and adolescents in addition to usual clinical signs, depression may also be manifested by behaviors described below:

-Withdrawal from family and friends
-Drop in school achievement or school refusal
-Excessive sleeping (or reversal of normal sleep-wake pattern)
-Withdrawal from sports or other school activities in which the child/youth has been engaged
-Running away from home
-Other noticeable changes in behaviors (i.e., increased irritability, decreased responsiveness)

i) If the client is described as having been depressed but shows abrupt lifting of depression or "improved attitude," this may represent a critical and high-risk period.

j) The presence of acute family conflict may be significant contributing factors of suicidal ideation or behaviors in children and adolescents.

k) Among adolescents, conflicts revolving around sexual identity, relationships, etc. may be critical and should be evaluated.

2) The assessment for suicidal risk should be thoroughly documented in the chart, including consultations with clinical supervisors.

3) After these areas have been assessed, the therapist should be able to judge the severity of the threat. If they are still unclear or judge the threat to be serious, the therapist will keep the client at the center and pursue a consultation with the Supervisor or other MFT clinical faculty if the supervisor is unavailable.

4) If the therapist's judgment of high risk is supported by consultations as outlined above, the therapist should protect the client by using the most appropriate following methods.

a) Complete a no-harm contract with the child and outline with a responsible parent or guardian the procedure for providing intensive monitoring of the child until the crisis passes.

b) In addition, the therapist will immediately begin helping the child and family to improve communication and make him or herself available to the child during the crisis.

c) If the client is deemed too unstable or uncontrollable for monitoring by parent or guardian, seek hospitalization of the minor through voluntary hospitalization with parent/guardian agreement or commitment by parent/guardian. A family physician of the client may be your best resource for getting the client admitted to the hospital during regular hours. If the family physician is not available, hospitalization can be done by calling the East Alabama Medical Center Emergency Room at 334-705-1150 to arrange for the on-duty psychiatrist to admit the client. If it is after hours, call the East Alabama Mental Health Emergency Service at 334-742-2877.

d) To arrange for transport to the emergency room for voluntary hospitalization, first attempt to contact a responsible adult (family member, friend) who can drive the client to the emergency room. The Auburn Police will transport to the emergency room at the request of the psychiatrist/physician if there is no other source. The psychiatrist/physician office must make the request.

e) After arranging for transport, call the ER at 334-705-1150 and tell the charge nurse that the person is being transported or follow instructions from the EAMH emergency services.

f. If the client will not agree to go to the hospital and will not sign a no-harm contract, see if a relative is willing to commit them and if this fails, call APD -911 for assistance. If the client is hostile, the police will only transport the person after applying handcuffs.

f) If the parents and/or therapist have problems getting cooperation from the child in going to the hospital, contact the APD for assistance 911.

5) If the suicidal risk is not deemed immediately serious (after thorough assessment), the therapist will:

a) Contract with the client in which the client promises to contact the therapist or the crisis line (334-821-8600) prior to carrying out any self-destructive or life-threatening act in return for which the therapists arranges for follow-up contact within 24-48 hours.

b) Contact parent or guardian regarding child/adolescent's suicidal concern.

c) Arrange to have a client or parent/guardian called each day.

d) Make the clients (or family) aware of emergency services available when the Center is closed. (The emergency room is available on a walk-in basis.)

e) Review the case with the clinical supervisor as expeditiously as possible.

6) In the event a suicide call is received on the telephone, and the client will not come to the center, the therapist should:

a. Assess availability of suicidal means.
b. Ascertain location of the client.
c. If a person is calling and suicidal act is underway (i.e. ingested pills), an ambulance and police should be dispatched.

7) In all the above, it is essential that the primary therapist obtains the maximum amount of consultation available from his/her clinical supervisors or the Center Director. All efforts and justification should be documented in the clinical record, and countersigned by clinical supervisor(s).

Crisis Hot Line Phone Number: 821-8600

Self-Harm and Potential Suicide

Case # _____

Written Contract with Client

I,_____, agree not attempt to harm myself, or kills myself during the period from (date):_____until the time of the next appointment.

I realize that I am responsible for my own actions and that if I feel things in my life aretoo difficult, I will contact a therapy at: _____

If I cannot reach a therapist, I will contact the **Crisis Center of East Alabama (334) 821-8600** or **911 services.**

Behaviors that are followed to prevent self-harm:

1. _____
2. _____
3. _____
4. _____

Use the following lines to specify conditions needed to sign the document.

_____

_____

I agree that these conditions are part of my therapy contract with

Signed_____Witnessed_____

Date:

Case Closure Policies

Case Closures (Planned or Unplanned) and Therapy Breaks

The Case Closure Form (available on the Z drive under -Therapists Documents|) is to be completed following the closure of a case or if an extended therapy break is planned (extended is more than a month). This form provides the supervisor and Center with summary information about the disposition of cases. Case Closure Forms for planned closures or therapy breaks are due one week from the last appointment. When the secretary does the monthly audit of the files, therapists will be questioned regarding open cases which have not been seen since the previous audit and for whom a case closure has not been completed. Failure to follow case closure policy may result in a lowered grade in the MFT Labs II & III or in the MFT Internship.

Before the supervisor signs the Case Closure Form, the therapist must complete a Case Audit Form to ensure that the client file is in order. Upon receiving the signed Case Closure Form back from the supervisor, place the form in the client file and put the file in the folder marked CASE CLOSURES or TERMINATIONS (ready for secretary).

Cancellations/Reschedules

When a client calls to reschedule an appointment, the rescheduled appointment is to be written in red in the appointment book. After a second consecutive reschedule, the therapist needs to evaluate whether the client has justifiable reasons for missing therapy. The policy indicates that after two consecutive missed sessions, the therapy hour should be opened for the scheduling of a new client.

REMEMBER: If you have a therapy hour on the chart, but have not seen a client in that hour for two weeks, you are potentially wasting your time and failing to provide services to new clients. Close the case.

No-Show New Client

If a client misses their first session and does not call to reschedule, the therapist is to mark NS using red ink in the appointment book. The therapist then places the file in the -miscellaneous for the secretary folder and sends an email to the administrative assistant notifying of the file. The therapist should then list the client as a "0" in the "attend column" which designates attendance of the first session in the Client Database on the secretary's computer. The identifying information of the potential client will be eliminated from the database, and marked as "Never Attended." The database will maintain a record of the reason for referral, referral source, income, and ORS symptoms. The folder materials will be recycled.

No-Show Established Client

At the time of the no-show, the therapist is to mark NS using red ink in the appointment book and call the client within the subsequent 2-3 days to determine if the client wishes to reschedule an appointment. If the client cannot be reached by phone, the therapist can send a Missed Appointment

Letter. If the client does not respond within a week of the failed appointment o r follow-up, the therapist can open the appointment time.

Note: All confidential materials to be given to the secretary are to be placed in the secretary's Confidential Work File in the top file drawer, not at the workstation. The workstation is not a secure area when not attended by staff. A note may be left on the secretary's desk to indicate that confidential material is in the confidential work file.

Session summaries and case closures for review by the supervisor are to be placed in the To be Signed by Supervisor File in the top drawer of the left workroom file cabinet. Please paperclip all of your session summaries and case closures together. After the supervisor has reviewed these forms, they will be placed in the Signed File folder. It is your responsibility to check this file for signed forms. After the supervisor has signed case closures, the therapist is to place the complete client file in the folder marked Completed Case Closure Folders (ready for secretary).

Marriage & Family Therapy Center
Auburn University, Alabama 36849-5604

Phone (334) 844-4478
FAX (334) 844-1924

October 21, 2016

Missed Appointment Letter

Ms. [client] [Street Address] Auburn, AL 36830

Dear [client]:

Since you have not been in touch with me to reschedule an appointment, and you did not attend your appointment on [date], I will be placing your file on the inactive list unless you notify me before [future date].

Your account shows a balance of $??.00. We would appreciate your forwarding this amount (or any payment you are able to make towards this amount until you can clear the balance) to the address shown on this letter.

Thank you. Let me know if we can be of further assistance to you. Sincerely,

[therapist's name]
Marriage and Family Therapy Intern

Court/DHR Report

If the case you are closing is a court or DHR referred, you will need to send a report copy of the case to the judge or caseworker. The supervisor must co-sign these reports.

AUBURN MARRIAGE AND FAMILY THERAPY CLINIC

Case Closure Form

Case Number: **Therapist: Select Therapist** **Date: 3/23/17**

The reason for case closure: Select Reason

	Number of Sessions
Total Completed	
Missed or no showed by Client	**0**
Missed or no showed by Therapist	
Rescheduled by the Client	
Rescheduled by the Therapist	
Couple/Marital Sessions:	**0**
Family Sessions:	
Individual Adult Sessions:	
Individual Adolescent Sessions:	**0**
Individual Child Sessions:	**0**
Group Sessions:	**0**

List the goals of the treatment plan:

GOAL	RATE PROGRESS FOR EACH GOAL
1) d. e. f.	Select Progress
2) d. e. f.	Select Progress
3) d. e. f.	Select Progress

List any additional presenting problems that were addressed in therapy but not listed on the treatment plan. Please rate the amount of progress for each additional goal:

Additional Presenting Problem	Rating of Change
1.	**Select Progress**
2.	**Select Progress**
3.	**Select Progress**

During therapy did you have to break confidentiality for any of the following reasons (Check all that apply):

- ☐ **Report Child Abuse/Neglect**
- ☐ **Report Elder Abuse**
- ☐ **Duty to Warn/Client hurt others**
- ☐ **Suicide/Client hurt them self**
- ☐ **Court Order**

Please provide dates of any crisis and explain the reason for the crisis:

None

What agencies or people did you coordinate with while serving the client(s)?

None

Did you collect all assessments throughout the course of therapy? Select Yes/No
If no, explain each missed or incomplete assessment:

Treatment Summary: (Please address the progress of each client, prognosis for maintaining change, and relapse prevention strategies):

Therapist Signature: _____ **Date:** **3/23/17**

Supervisor Signature: _____ **Date:** _____

AUBURN MARRIAGE AND FAMILY THERAPY CENTER Final Case Audit Form

Case Number:_____ Therapist:_____# SESSIONS = _____

LEFT SIDE OF FILE

	Possible/Completed	**Therapist Initial/Auditor Initial**
Billing Dates = Treat Dates	_____/_____	_____/_____
$ Billed = $ Paid	_____/_____	_____/_____
	Male / Female / Child	
Intercession Reports	___/___/___/___	_____/_____
Missing Intersession Reports:	___/___/___	_____/_____
Assess Completed	Male / Female / Child	
Scoring Sheet Completed	/_____/_____/	_____/_____
1st Session Paperwork	/_____/_____/	_____/_____
4th Session Paperwork	/_____/_____/	_____/_____
8th Session Paperwork	/_____/_____/	_____/_____
12th Session Paperwork	/_____/_____/	_____/_____
20th Session Paperwork	/_____/_____/	_____/_____

RIGHT SIDE OF FILE **Therapist Initial/Auditor Initial**

Case Closure Form Completed:		_____/_____
Case Notes Completed:	_____/_____	_____/_____
Session Numbers for Missing Case-notes:	_____	_____/_____
Treatment Plans Completed:	_____/_____	_____/_____
Release of Information:		_____/_____
Informed Consent:		_____/_____
Referral Form:		_____/_____
Additional Paperwork/Fee Documents		_____/_____

AUDITOR'S CONCERNS/THERAPIST'S EXPLANATIONS:

Therapist's Signature:_____Date:_____

Auditor's Signature:_____Date: _____

Policy for Data Use and Collection

Student Access to Archival Data

Students wishing to use archival data from the Auburn University MFT Clinic Database must go through a two-step process. First, the Marriage and Family Therapy (MFT) faculty must approve the project. To gain approval students must attend one of the regularly scheduled faculty meetings to discuss their proposed project. One week before attending the meeting a 1-2 page outline or synopsis of the proposed project should be distributed to the faculty. Upon faculty approval, students must then submit the project to the Institutional Review Board (IRB) for approval. Students who use the archival database for their thesis are also expected to spend the equivalent of two months assistantship time cleaning the data (this is a form of giving back).

Changes in the Data Collection Process

Students who wish to carry out a research project that includes additional data collection not currently under way must follow a similar procedure. First, the MFT faculty must approve the project. Again, approval is gained by attending a regularly scheduled faculty meeting to discuss the proposed project. One week prior to the meeting a 1-2 page outline or synopsis of the proposed project, along with additional questionnaires or interviews should be distributed to the faculty. Upon faculty approval, students must then submit the project to the IRB for approval.

Distribution and Handling Data

Once the IRB has approved, the project students will be given a copy of the data that includes the number and type of requested cases and the variables of interest. Students will agree to not keep the data on their personal computers or any other computer on a permanent basis. At the conclusion of the project, students must return an electronic copy of the data that will be stored for future access for verification of findings or other issues. After 5 years the data set used by the student will be destroyed. Students will delete or destroy all other copies of the data used in the project.

IF VIDEOTAPES ARE USED: All video streams used for the purpose of analysis will be viewed in a location that protects the confidentiality of the participants. Further, students will agree not to copy any portion of the session videos without the permission of the participants on the video. Upon conclusion of the project, all videotapes will be returned.

Ethical Research and Confidentiality

Students using archival data will adhere to the American Association for Marriage and Family Therapy Ethical Code and will pay special attention to the sections of the code pertinent to research. If while analyzing any videotape sessions the student, or anyone working with the student, realizes that they know a client on the videotapes, they will stop viewing the session and not use the case in any further research.

AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

Committed Relationship Intersession Report (BEFORE the Session)

	Almost Never			*Half the Time*			*Almost Always*
I feel nervous, anxious, or unsettled	1	2	3	4	5	6	7
I feel hopeless, depressed, or down	1	2	3	4	5	6	7
I think about ending my life	1	2	3	4	5	6	7
	Very Poor			*Moderate*			*Excellent*
I would rate my ability to function at work, school, or home	1	2	3	4	5	6	7
Satisfaction with my personal relationships has been	1	2	3	4	5	6	7
I rate the positive sentiment, support, and collaboration in my life as	1	2	3	4	5	6	7
I would rate the progress towards therapy goals as	1	2	3	4	5	6	7
The likelihood of my problems being resolved are	1	2	3	4	5	6	7
I would rate the quality of my sleep as	1	2	3	4	5	6	7

1. The number of days it took me longer than 30 minutes to fall asleep:

0 1 2 3 4 5 6 7

2. The number of days I woke up during the night and took more than 30 minutes to fall back asleep:

0 1 2 3 4 5 6 7

3. The number of times I exercised/meditated during the past week:

Exercise	0	1	2	3	4	5	6	7 or more
Meditate	0	1	2	3	4	5	6	7 or more

4. The number of hours I exercised/meditated (circle) during the past week:

Exercise	0	1	2	3	4	5	6	7 or more
Meditate	0	1	2	3	4	5	6	7 or more

5. I would rate my average level of exercise/meditation intensity as:

	Extremely easy	Very easy	Easy	Middle	Hard	Very hard	Extremely Hard
Exercise	1	2	3	4	5	6	7
Meditate	1	2	3	4	5	6	7

Questions on Back Page.

Appendix E

Assessment Process

The assessment process at the Marriage and Family Therapy Clinic was started to evaluate clinical outcomes of individuals, couples, & families receiving therapy at the clinic. The goals of this process are to accomplish the following: 1) design an assessment process that directly and indirectly benefits individuals, couples, and families, 2) measure progress of clients presenting with a wide variety of problems, 3) provide students with the opportunity to learn how to integrate assessment and clinical practice, 4) provide opportunities for the integration of research and clinical practice, 5) provide information that is beneficial in training clinicians, and 6) provide clinical research opportunities for students.

Presentation of Assessments at Initial Phone Call

In addition to other required information given to prospective clients, people who contact the MFT Clinic should be informed that:

- As part of therapy, they will be asked to complete some questionnaires.
- We recommend a booster session six months after the final session, provided free of charge.
- Clients need to arrive 25-30 minutes early to the initial session to complete the paperwork.

Presentation of Assessments to Clients at Initial Session

Informed Consent

It should be made clear to the clients that the assessments are used for treatment planning, in-house clinical training, and to learn about the therapy process.

When presenting questionnaires to clients, it is important to touch on the following points.

- The information clients provide is confidential.
- Stress a need for honesty. It is all right to ask you for clarifying information.
- Inform the clients that the information will be used to help them as well as determine the effectiveness of services provided at the clinic.
- When encountering resistance from someone, it may be useful to use a metaphor such as going to a doctor. Rarely does a doctor treat a patient without some basic history and brief medical information.

Before Initial Session Begins

- Review paperwork for any empty spaces and "red flags" or -Items of Interest. If anyone partially completes the assessment, briefly discuss the reasoning for leaving specific questions

blank.

- If you have concerns about clients' comprehension of the questionnaires, check the information with the client to make sure they understand the questions and that their responses are accurate.

Assessment Forms

Adult in Committed Relationship

These are the order of items in the SPSS file as they are entered in order from the assessment forms. To see the codebook section for that assessment, click on the assessment name.

Couple Satisfaction Index	16 items
MFT COR Sexual Satisfaction Items	3 Items
Sex Subscale of the Trauma Symptom Checklist 40	8 items
Martial Power Scales Subscale: power process Subscale: power outcome	15 items total 9 items 6 items
Conflict Tactics Scale	12 items (6 for individual and 6 for partner)
Gottman IAI	8 items
ECR Short Form	12 items
Hopelessness Scale	6 items
R-URICA (Process of Change in Therapy) Subscale: action Subscale: seeking Subscale: ambivalence	12 items each subscale has 4 items
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Demographic (height and weight)	2 items
SF12	12 items (8 on the form, some multi-part)
MOS-6 (Sleep Scale)	6 items
Perceived Stress Scale (PSS)	10 items
Demographics	15 items
ACEs	1 multi-part item on the form; 22 items in SPSS
Demographics	6 items

Adult in Committed Relationship Follow-Up

Couple Satisfaction Index	16 items
MFT COR Sexual Satisfaction Items	3 Items
Sex Subscale of the Trauma Symptom Checklist 40	8 items
Conflict Tactics Scale	12 items (6 for individual and 6 for partner)
Gottman IAI	8 items
ECR Short Form	12 items

Hopelessness Relationship Scale	6 items
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Demographic (height and weight)	2 items
SF12	8 items on the form (some multi-part); 12 items in SPSSS
Healthcare Utilization Scale	5 items (if they specify on the last item)
MOS-6 (Sleep Scale)	6 items
Perceived Stress Scale (PSS)	10 items

Individual Adult Intake

These are the order of items in the SPSS file as they are entered in order from the assessment forms. To see the codebook section for the assessment, click on the assessment name.

Sex Subscale of the Trauma Symptom Checklist 40	8 items
R-URICA (Process of Change in Therapy) Subscale: action Subscale: seeking Subscale: ambivalence	12 items each subscale has 4 items
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Demographic (height and weight)	2 items
SF12	12 items (8 on the form, some multi-part)
MOS-6 (Sleep Scale)	6 items
Perceived Stress Scale (PSS)	10 items
Demographics	15 items
ACEs	1 multi-part item on the form; 22 items in SPSS
Demographics	6 items

Individual Adult Follow-Up

Sex Subscale of the Trauma Symptom Checklist 40	8 items
ECR Short Form	12 items
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Demographic (weight)	1 items
SF12	8 items on the form (some multi-part); 12 items in SPSS
Healthcare Utilization Scale	3 items (if they specify on the last item)
MOS-6 (Sleep Scale)	6 items
Perceived Stress Scale (PSS)	10 items

Family Adult Intake

These are the order of items in the SPSS file as they are entered in order from the assessment forms. To see the codebook section for the assessment, click on the assessment name.

Couple Satisfaction Index	4 items
MFT COR Sexual Satisfaction Items	3 Items
Conflict Tactics Scale	12 items (6 for individual and 6 for partner)
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Demographic (height and weight)	2 items
SCORE-15 INDEX OF Family Functioning	15 items
OHIO Youth Problem, Functioning,	20
OHIO Youth Satisfaction	20
SF12	12 items (8 on the form, some multi-part)
SF10-Health Survey for Children	10 items (9 on the form, some multi-part)
MOS-6 (Sleep Scale)	6 items
Demographics	15 items
ACEs	1 multi-part item on the form; 22 items in SPSS
Demographics	6 items
Healthcare Utilization Scale	5 items (if they specify on the last item)

Family Adult Follow-Up

MFT COR Sexual Satisfaction Items	3 Items
Conflict Tactics Scale	12 items (6 for individual and 6 for partner)
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
SCORE-15 INDEX OF Family Functioning	15 items
OHIO Youth Problem, Functioning,	20
OHIO Youth Satisfaction	20
Demographic (weight)	1 item
SF12	12 items (8 on the form, some multi-part)
SF10-Health Survey for Children	10 items (9 on the form, some multi-part)
Healthcare Utilization Scale	5 items (if they specify on the last item)
MOS-6 (Sleep Scale)	6 items

Family Adolescent Intake

These are the order of items in the SPSS file as they are entered in order from the assessment forms. To see the codebook section for the assessment, click on the assessment name.

Conflict Tactics Scale	**12 items (6 for individual and 6 for partner)**
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
R-URICA (Process of Change in Therapy) Subscale: action Subscale: seeking Subscale: ambivalence	12 items each subscale has 4 items
Hopelessness Scale	6 items
Demographic (height and weight)	2 items
SCORE-15 INDEX OF Family Functioning	15 items
OHIO Youth Problem, Functioning,	20
OHIO Youth Satisfaction	20
Self-Regulation Questionnaire	9 items
IPPA	25 items
SF10-Health Survey for Children	10 items (9 on the form, some multi-part)
MOS-6 (Sleep Scale)	6 items
Demographics	15 items
ACEs	1 multi-part item on the form; 22 items in SPSS
Demographics	4 items

Family Adolescent Follow-Up

MFT COR Sexual Satisfaction Items	3 Items
Conflict Tactics Scale	12 items (6 for individual and 6 for partner)
MDI (Depression Inventory)	10 items (12, but for two items you take the max—see below)
GAD-7 (Anxiety Inventory)	8 items
Hopelessness Scale	6 items
SCORE-15 INDEX OF Family Functioning	15 items
OHIO Youth Problem, Functioning,	20
OHIO Youth Satisfaction	20
Self-Regulation Questionnaire	9 items
IPPA	25 items
Demographic (weight)	1 item
SF10-Health Survey for Children	10 items (9 on the form, some multi-part)
MOS-6 (Sleep Scale)	6 items

ACEs

The Adverse Childhood Experiences (ACE) Study scale includes questions about adverse experiences such as abuse and neglect, family dysfunction, and health-related behaviors. The summed score of the ACEs reflects a cumulative picture of these negative early experiences (for example, see Brown et al., 2009; Dube et al., 2001).

References:

Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., & Giles, W. H. (2009). Adverse childhood experiences and the risk of premature mortality. *American Journal of Preventive Medicine, 37*, 389-396.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*, 217-225.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Jama, 286*, 3089-3096.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*, 245-258.

See also: http://www.cdc.gov/violenceprevention/acestudy/

Instructions	Please answer the following questions for the family in which you grew up. *Frequency Items*	
aces1f	A. Emotional Abuse: Swearing, insults, threats	N/A (0) Once (1) Some (2) Often (3)
aces2f	B. Physical abuse: Slapping, hitting, throwing things	N/A (0) Once (1) Some (2) Often (3)
aces3f	C. Sexual abuse: Being touched or touching someone	N/A (0) Once (1) Some (2) Often (3)
aces4f	D. Emotional Neglect: Unloved, ignored, rejected	N/A (0) Once (1) Some (2) Often (3)
aces5f	E. Physical Neglect: Not properly clothed, not fed,	N/A (0)

		Once (1) Some (2) Often (3)
aces6f	F. Mother Was Treated Violently: She was pushed, bit	N/A (0) Once (1) Some (2) Often (3)
aces7f	G. Substance Use and Abuse: Alcohol Abuse, drug use, or Prescription abuse	N/A (0) Once (1) Some (2) Often (3)
aces8f	H. Household Mental Illness: Depression, Mental Illness	N/A (0) Once (1) Some (2) Often (3)
aces9f	I. Attempted Suicide or Suicide	N/A (0) Once (1) Some (2) Often (3)
aces10f	J. Incarcerated Household Member	N/A (0) Once (1) Some (2) Often (3)
aces11f	K. Parental Separation or Divorce	N/A (0) Once (1) Some (2) Often (3)
Instructions	Please answer the following questions for the family in which you grew up. Severity Items	
aces1s	A. Emotional Abuse: Swearing, insults, threats	N/A (0) Mild (1) Moderate (2) Severe (3)
aces2s	B. Physical abuse: Slapping, hitting, throwing things	N/A (0) Mild (1) Moderate (2) Severe (3)
aces3s	C. Sexual abuse: Being touched or touching someone	N/A (0) Mild (1) Moderate (2) Severe (3)
aces4s	D. Emotional Neglect: Unloved, ignored, rejected	N/A (0) Mild (1) Moderate (2) Severe (3)

aces5s	E. Physical Neglect: Not properly clothed, not fed,	N/A (0) Mild (1) Moderate (2) Severe (3)
aces6s	F. Mother Was Treated Violently: She was pushed, bit	N/A (0) Mild (1) Moderate (2) Severe (3)
aces7s	G. Substance Use and Abuse: Alcohol Abuse, drug use, or Prescription abuse	N/A (0) Mild (1) Moderate (2) Severe (3)
aces8s	H. Household Mental Illness: Depression, Mental Illness	N/A (0) Mild (1) Moderate (2) Severe (3)
aces9s	I. Attempted Suicide or Suicide	N/A (0) Mild (1) Moderate (2) Severe (3)
aces10s	J. Incarcerated Household Member	N/A (0) Mild (1) Moderate (2) Severe (3)
aces11s	K. Parental Separation or Divorce	N/A (0) Mild (1) Moderate (2) Severe (3)

SPSS SYNTAX:
ACES

```
*Reliability for ACES frequency items.
reliability
/variables=aces1f aces2f aces3f aces4f aces5f aces6f aces7f aces8f aces9f aces10f aces11f
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

*Reliability for ACES severity items.
reliability
/variables=aces1s aces2s aces3s aces4s aces5s aces6s aces7s aces8s aces9s aces10s aces11s
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.
```

```
*ACES frequency items scale sum for self.
compute acesf_sum = sum(aces1f aces2f aces3f aces4f aces5f aces6f aces7f aces8f aces9f aces10f
aces11f).
execute.

*ACES severity items scale sum for partner.
compute acess_sum = sum(aces1s aces2s aces3s aces4s aces5s aces6s aces7s aces8s aces9s aces10s
aces11s).
execute.

**just in case you want the mean instead.
*ACES frequency items scale mean for self.
compute acesf_mean = mean(aces1f aces2f aces3f aces4f aces5f aces6f aces7f aces8f aces9f
aces10f aces11f).
execute.

*ACES severity items scale mean for a partner.
compute acess_mean = mean(aces1s aces2s aces3s aces4s aces5s aces6s aces7s aces8s aces9s
aces10s aces11s).
execute.
```

Conflict Tactics Scale

This is the violence subscale of the CTS for self and partner.
Description: The Violence Subscale of the CTS is designed to give clinicians an idea of the level of self-reported violence. The Violence Subscale of the CTS has demonstrated adequate to excellent reliability and validity.

Sub-Scales: This is a subscale of the Conflict Tactics Scales.

Scoring: To score the Violence Subscale of the CTS, total the numbers that have been marked. Higher scores indicate higher amounts of violence.

Items of Interest: Therapists are encouraged to pay particular attention to the items in the violence sub-scale that pertain to actual physical violence (3, 4, 5, & 6). If more severe violence items have higher scores therapists are required to discuss the case with a Faculty Supervisor. Follow-up is necessary to discern if a mandated report is required.

scts1	How often did YOU do the following during the past year? Threw something (but not at a family member) or smashed something	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
scts2	How often did YOU do the following during the past year? Threatened to hit or throw something at a family member	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4)

		11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
scts3	How often did YOU do the following during the past year? Threw something at family member	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
scts4	How often did YOU do the following during the past year? Pushed, grabbed, or shoved a family member	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
scts5	How often did YOU do the following during the past year? Hit (or tried to hit) a family member but not with anything hard	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
scts6	How often did YOU do the following during the past year? Hit (or tried to hit) a family member with something hard	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs1	How often did YOUR PARTNER do the following during the past year? Threw something (but not at a family member) or smashed something	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs2	How often did YOUR PARTNER do the following during the past year? Threatened to hit or throw something at a family member	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs3	How often did YOUR PARTNER do the following during the past year?	Never (0) Once (1) Twice (2)

	Threw something at family member	3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs4	How often did YOUR PARTNER do the following during the past year? Pushed, grabbed, or shoved a family member	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs5	How often did YOUR PARTNER do the following during the past year? Hit (or tried to hit) a family member but not with anything hard	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)
octs6	How often did YOUR PARTNER do the following during the past year? Hit (or tried to hit) a family member with something hard	Never (0) Once (1) Twice (2) 3-5 Times (3) 6-10 Times (4) 11-20 Times (5) More than 20 times (6) Happened but not in past year (7)

I (RG) HAVE USED RECODED VARIABLES BELOW—I DON'T THINK THAT HAPPENED BUT NOT IN THE PAST YEAR SHOULD BE 7, AND I RESCALED THINGS SO THAT IT'S BETWEEN NEVER AND ONCE. NEVER SHOULD YOU EVER RECODE INTO THE SAME VARIABLE!! SO, HERE'S WHAT I DID:
Recoded variables (with prefix r_)scale is as follows:
Never (0)
Once (2)
Twice (3)
3-5 Times (4)
6-10 Times (5)
11-20 Times (6)
More than 20 times (7)
Happened but not in past year (1)

SPSS SYNTAX:
Conflict Tactics Scale

```
*CTS recodes--here I am going to recode happened but not in the past year to be between never and once.
recode scts1 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts1.
recode scts2 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts2.
recode scts3 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts3.
recode scts4 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts4.
recode scts5 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts5.
recode scts6 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_scts6.
recode octs1 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs1.
recode octs2 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs2.
recode octs3 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs3.
recode octs4 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs4.
recode octs5 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs5.
recode octs6 (0=0) (1=2) (2=3) (3=4) (4=5) (5=6) (6=7) (7=1) into r_octs6.

*CTS reliabilities with recoded variables for self.
reliability
/variables=r_scts1 r_scts2 r_scts3 r_scts4 r_scts5 r_scts6
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

*CTS reliabilities with recoded variables for partner.
reliability
/variables=r_octs1 r_octs2 r_octs3 r_octs4 r_octs5 r_octs6
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

*CTS scale mean for self.
compute scts_mean = mean(r_scts1 r_scts2 r_scts3 r_scts4 r_scts5 r_scts6).
execute.

*CTS scale mean for partner.
compute octs_mean = mean(r_octs1 r_octs2 r_octs3 r_octs4 r_octs5 r_octs6).
execute.

**just in case you want the sum instead.
*CTS scale sum for self.
compute scts_sum = sum(r_scts1 r_scts2 r_scts3 r_scts4 r_scts5 r_scts6).
execute.

*CTS scale sum for partner.
compute octs_sum = sum(r_octs1 r_octs2 r_octs3 r_octs4 r_octs5 r_octs6). execute.
```

Couple Satisfaction Index

Couple Satisfaction. Couple satisfaction is measured using the 16-item version of the Couple Satisfaction Index (CSI; Funk & Rogge, 2007). This scale is used to assess the individual's satisfaction within their relationship; higher scores reflect greater satisfaction with the relationship.
Reference:
Funk, J. L. & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21*, 572-583.
Cui, M., Fincham, F.D., & Pasley, B.K. (2008). Young adult romantic relationships: The role of parents' marital problems and relationship efficacy. *Personality and Social Psychology Bulletin, 34*, 1226-1235.
Fincham, F.D., Cui, M., Braithwaite, S.R., & Pasley, K. (2008). Attitudes towards intimate partner violence in dating relationships. *Psychological Assessment, 20*, 260-269.

Variable Name	Question Text	Answer Options
csi1	Please indicate the degree of happiness, all things considered, of your relationship. Circle the best answer.	Extremely Unhappy (0) Fairly Unhappy (1) A Little Unhappy (2) Happy (3) Very Happy (4) Extremely Happy (5) Perfect (6)
csi2	How often do you think things between you and your partner are going well?	All the time (5) Most times (4) More than not (3) Occasionally (2) Rarely (1) Never (0)
csi3	Our relationship is strong	Not at all true (0) A little true (1) Somewhat true (2) Mostly true (3) Almost Completely True (4) Completely true (5)
csi4	My relationship with my partner makes me happy	Not at all true (0) A little true (1) Somewhat true (2) Mostly true (3) Almost Completely True (4) Completely true (5)
csi5	I have a warm and comfortable relationship with my partner	Not at all true (0) A little true (1) Somewhat true (2) Mostly true (3)

		Almost Completely true (4) Completely true (5)
csi6	I really feel like part of a team with my partner?	Not at all (0) A little (1) Somewhat (2) Mostly (3) Almost completely True (4) Completely (5)
csi7	How rewarding is your relationship with your partner?	Not at all (0) A little (1) Somewhat (2) Mostly (3) Almost Completely (4) Completely (5)
csi8	How well does your partner meet your needs?	Not at all (0) A little (1) Somewhat (2) Mostly (3) Almost Completely (4) Completely (5)
csi9	To what extent has your relationship met your original expectations?	Not at all (0) A little (1) Somewhat (2) Mostly (3) Almost completely (4) Completely (5)
csi10	In general, how satisfied are you with your relationship?	Not at all (0) A little (1) Somewhat (2) Mostly (3) Almost completely (4) Completely (5)
csi11	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings. Interesting to boring	Interesting (5) (4) (3) (2) (1) Boring (0)
csi12	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings. Bad to good	Bad (0) (1) (2) (3) (4) good (5)
csi13	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings.	Full (5) (4) (3)

	Full to empty	(2) (1) empty (0)
csi14	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings. Sturdy to fragile	sturdy (5) (4) (3) (2) (1) fragile (0)
csi15	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings. Discouraging to hopeful	discouraging (0) (1) (2) (3) (4) hopeful (5)
csi16	Select the answer that best describes *how you feel about your relationship*. Focus on your first impressions and immediate feelings. Enjoyable to miserable	enjoyable (5) (4) (3) (2) (1) miserable (0)

SPSS SYNTAX:

```
reliability
/variables=csi1 csi2 csi3 csi4 csi5 csi6 csi7 csi8 csi9 csi10 csi11 csi12 csi13 csi14 csi15 csi16
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

*CSI scale sum.
compute csi_sum = sum(csi1 csi2 csi3 csi4 csi5 csi6 csi7 csi8 csi9 csi10 csi11 csi12 csi13 csi14
csi15 csi16).
execute.

*CSI scale mean.
compute csi_mean = mean(csi1 csi2 csi3 csi4 csi5 csi6 csi7 csi8 csi9 csi10 csi11 csi12 csi13 csi14
csi15 csi16).
execute.
```

Demographics (height and weight)

height	Would you be willing to report your: Height	Number in inches
weight	Would you be willing to report your: Weight	Number in pounds

ECR Short Form

Description: The ECR was created to measure attachment in adult relationships. The authors took all the known assessments that measure attachment and using factor analysis derived two sub-scales. Each of the items is rated on a seven-point scale. The Short Form is a 12-item scale used to measure adult attachment. It contains two subscales: anxiety (even items) and avoidance (odd items).

Sub-Scales: The ECR has the following subscales:

- □ Avoidance: This subscale assesses the avoidance of intimacy, discomfort with closeness, and self-reliance. Avoidance items are all odd-numbered items.

- □ Anxiety: This subscale assesses preoccupation, jealousy/fear of abandonment, and fear of rejection. Anxiety items are all even numbered items.

Scoring:
Anxiety = 2, 4, 6, 8 (reverse), 10, 12
Avoidance = 1 (reverse), 3, 5 (reverse), 7, 9 (reverse), 11

References:

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The Experiences in Close Relationship Scale (ECR)-short form: Reliability, validity, and factor structure. *Journal of Personality Assessment*, *88*, 187-204.

ecr1	It helps to turn to my romantic partner in times of need	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr2	I need a lot of reassurance that I am loved by my partner	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr3	I want to get close to my partner, but I keep pulling back.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr4	I find that my partner doesn't want to get as close as I would like.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5)

		(6) Agree Strongly (7)
ecr5	I turn to my partner for many things, including comfort and reassurance.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr6	My desire to be very close sometimes scares people away.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr7	I try to avoid getting too close to my partner.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr8	I do <u>not</u> worry about being abandoned.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr9	I usually discuss my problems and concerns with my partner.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr10	I get frustrated if romantic partners are not available when I need them.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)
ecr11	I am nervous when partners get too close to me.	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5)

		(6) Agree Strongly (7)
ecr12	I worry that romantic partner won't care about me as much as I care	Disagree Strongly (1) (2) (3) Neutral/Mixed (4) (5) (6) Agree Strongly (7)

SPSS SYNTAX:

```
***reverse code items.
recode ecr1 (1=7) (2=6) (3=5) (4=4) (5=3) (6=2) (7=1) into r_ecr1.
recode ecr5 (1=7) (2=6) (3=5) (4=4) (5=3) (6=2) (7=1) into r_ecr5.
recode ecr8 (1=7) (2=6) (3=5) (4=4) (5=3) (6=2) (7=1) into r_ecr8.
recode ecr9 (1=7) (2=6) (3=5) (4=4) (5=3) (6=2) (7=1) into r_ecr9.

***reliability of anxiety subscale.
reliability
/variables=ecr2 ecr4 ecr6 r_ecr8 ecr10 ecr12
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

***reliability of avoidance subscale.
reliability
/variables=r_ecr1 ecr3 r_ecr5 ecr7 r_ecr9 ecr11
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

*ecr scale mean for anxiety.
compute ecranx_mean = mean(ecr2 ecr4 ecr6 r_ecr8 ecr10 ecr12).
execute.

*ecr scale mean for avoidance.
compute ecravd_mean = mean(r_ecr1 ecr3 r_ecr5 ecr7 r_ecr9 ecr11).
execute.

**or if you want the sum instead.
*ecr scale sum for anxiety.
compute ecranx_sum = sum(ecr2 ecr4 ecr6 r_ecr8 ecr10 ecr12).
execute.

*ecr scale sum for avoidance.
compute ecravd_sum = sum(r_ecr1 ecr3 r_ecr5 ecr7 r_ecr9 ecr11).
execute.
```

GAD-7

The GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) is a 7-item scale used to measure symptoms of generalized anxiety disorder.

Citation:

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*, 1092-1097.

Instructions	The next section will focus on your individual symptoms related to depression and anxiety over the last 2 weeks. *Note: these instructions appear before the MDI on the couples' packet.*	N/A
gad1	Feeling nervous, anxious or on edge	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad2	Not being able to stop or control worrying	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad3	Worrying too much about different things	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad4	Trouble relaxing	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad5	Being so restless that it is hard to sit still	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad6	Becoming easily annoyed or irritable	Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
gad7	Feeling afraid as if something awful might happen	Not at all (0) Several days (1)

		More than half the days (2) Nearly every day (3)
gad8	How difficult have these problems made it for you to do	Not difficult (0) Somewhat (1) Very (2) Extremely (3)

Syntax for reliability:

```
***reliability for total gad-7 scale.
reliability
/variables=gad1 gad2 gad3 gad4 gad5 gad6 gad7 gad8
/scale ('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.
*gad7 scale mean for first 7 items.
compute gad7_mean = mean (gad1 gad2 gad3 gad4 gad5 gad6 gad7).
execute.

**or if you want the sum instead.
*gad7 scale sum for first 7 items.
compute gad7_sum = sum (gad1 gad2 gad3 gad4 gad5 gad6 gad7).
execute.
```

Relationship Hopelessness Scale

The Relationship Hopelessness Scale is derived by Scott Ketring from the adolescent hopelessness scale. It is adapted from the Hopelessness Scale for Children-Revised, to identify hopelessness within a relationship (HSC-R; Kazdin, Fereench, Unis, Esveldt-Dawson, & Sherick, 1983). This scale is used to assess the hopelessness within a relationship; higher scores reflect increased hopelessness.

hope1	All I see ahead of me are bad experiences within this relationship	Strongly Disagree (1) Disagree (2) Agree (3) Strongly Agree (4)
hope2	There's no use in really trying to get my needs met within this relationship	Strongly Disagree (1) Disagree (2) Agree (3) Strongly Agree (4)
hope3	No matter how hard I try I can't make things better for myself within this relationship	Strongly Disagree (1) Disagree (2) Agree (3) Strongly Agree (4)
hope4	I haven't been able to turn this relationship around, nor do I believe that it will ever happen	Strongly Disagree (1) Disagree (2)

		Agree (3) Strongly Agree (4)
hope5	My desires are never really considered within this relationship	Strongly Disagree (1) Disagree (2) Agree (3) Strongly Agree (4)
hope6	I am about to give up because I don't expect this relationship to change	Strongly Disagree (1) Disagree (2) Agree (3) Strongly Agree (4)

Gottman IAI

The Ineffective Arguing Inventory (IAI) is a self-report measure that assesses a dysfunctional style of couple conflict resolution. Partners in heterosexual couples, gay/lesbian, and nonparent/parent heterosexual couples showed moderate overlap in their individual appraisals of the extent to which their relationship involved a pattern of ineffective arguing. Items conformed to a one-factor structure, and the single composite score derived from these items was internally consistent and stable over a 1-year period. Relationship dynamics are similar for gay/lesbian and heterosexual couples. The IAI score correlated negatively with relationship satisfaction, negative change in relationships satisfaction, and is associated with relationship dissolution.

iai1	By the end of an argument, each of us has been given a fair hearing	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai2	When we begin to fight or argue, I think, "Here we go again."	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai3	Overall, I'd say we're pretty good at solving our problems.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai4	Our arguments are left hanging and unresolved	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai5	We go for days without settling our differences.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

iai6	Our arguments seem to end in frustrating stalemates	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai7	We need to improve the way we settle our differences	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
iai8	Overall, our arguments are brief and quickly forgotten	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

Inventory of Parent and Peer Attachment-R IPPA-R

Miller Power Scales (MPS). The measure was designed to measure marital power by having each partner answer items according to their perception of their partner's level of power. The scale includes 15 questions. The higher the score for the individual questions, the more partners perceived the other as exerting power within the relationship; the item mean for each partner was used as their respective measure of partner marital power. The literature shows that the Cronbach's Alpha for this study is .92.

Marital Power Scales

Miller Power Scales (MPS). The measure was designed to measure marital power by having each partner answer items according to their perception of their partner's level of power. The scale includes 15 questions. The higher the score for the individual questions, the more partners perceived the other as exerting power within the relationship; the item mean for each partner was used as their respective measure of partner marital power. The literature shows that the Cronbach's Alpha for this study is .92.

pow1	My partner tends to discount my opinion	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow2	My partner does not listen to me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow3	When I want to talk about a problem in our relationship, my partner often refuses to talk with me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4)

		Strongly Agree (5)
pow4	My partner tends to dominate our conversations	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow5	When we do not agree on an issue, my partner gives me the cold shoulder	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow6	I feel free to express my opinion about issues in our relationship	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow7	My partner makes decisions that affect our family without talking to me first	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow8	My partner and I talk about problems until we both agree on a solution	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow9	I feel like my partner tries to control me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow10	When it comes to money, my partner's opinion usually wins out	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow11	When it comes to children, my partner's opinion usually wins out	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow12	It often seems my partner can get away with things in our relationship that I can never get away with	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow13	I have no choice but to do what my partner wants	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
pow14	My partner has more influence in our relationship than I do	Strongly Disagree (1) Disagree (2) Undecided (3)

		Agree (4) Strongly Agree (5)
pow15	When disagreements arise in our relationship, my partner's opinion usually wins out.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

MDI-Depression

The Major Depression Inventory (MDI; Olsen, Jensen, Noerholm, Martiny, & Bech, 2003) is a 10-item scale assessing clinical symptoms of major depression. Scores of 20 to 24 reflect mild depression, scores of 24 to 29 reflect moderate depression, and scores of 30 or more reflect severe depression. When scoring the MDI, take the max of 8a and b and 10 a and b for a total of 10 items.

Citation:

Olsen, L. R., Jensen, D. V., Noerholm, V., Martiny, K., & Bech, P. (2003). The internal and external validity of the Major Depression Inventory in measuring the severity of depressive states. *Psychological Medicine*, *33*, 351-356.

Variable Name	Item	Answer Options
mdi1	Have you felt low in spirits or sad?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi2	Have you lost interest in your daily activities?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi3	Have you felt lacking in energy and strength?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi4	Have you felt less self- confident?	All the time (5)

		Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi5	Have you had a bad conscience or feelings of guilt?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi6	Have you felt that life wasn't worth living?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi7	Have you had difficulty in concentrating, e.g. when reading the newspaper or watching TV?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi8a	(A) Have you felt very restless	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi8b	(B) Have you felt subdued or slowed down?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi9	Have you had trouble sleeping at night?	All the time (5) Most times (4)

		More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi10a	(A) Have you suffered from reduced appetite?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)
mdi10b	(B) Have you suffered from increased appetite?	All the time (5) Most times (4) More than half the time (3) Less than half the time (2) Sometimes (1) At no time (0)

***computing mdi8 and mdi10 based on max values
compute mdi8=max(mdi8a, mdi8b).
compute mdi10=max(mdi10a, mdi10b).
execute.

Syntax for reliability (this is for all items in the scale):

reliability
/variables=mdi1 mdi2 mdi3 mdi4 mdi5 mdi6 mdi7 mdi8 mdi9 mdi10
/scale('ALL VARIABLES') ALL
/model=alpha
/statistics=descriptive scale
/summary=total.

MFT COR Sexual Satisfaction Items

Female Sexual Function Index (FSFI). The FSFI is a frequently used 19 item self-report scale (Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, & D'Agostino 2000), with a 3 item subscale focusing on satisfaction. This measure was designed to measure sexual function for women, but the 3 item subscale is not gendered specific. The Cronbach's Alpha for this measure to be .82 (Rosen, et. al., 2000). For AU MFT sample it was .91. Levels of FSFI are discussed as low and high sexual satisfaction.

Rosen, C. Brown, J. Heiman, S. Leiblum, C. Meston, R. Shabsigh, D. Ferguson, R. D'Agostino, R. (2000). The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex &Marital Therapy*, *26*(2), 191-208.

sex1	With the amount of emotional closeness during sexual activity between you and your partner?	Very Dissatisfied (1) Moderately Dissatisfied (2) Equally Satisfied/Dissatisfied (3) Moderately Satisfied (4) Very Satisfied (5)
sex2	With your sexual relationship with your partner?	Very Dissatisfied (1) Moderately Dissatisfied (2) Equally Satisfied/Dissatisfied (3) Moderately Satisfied (4) Very Satisfied (5)
sex3	How satisfied have you been with your overall sexual life	Very Dissatisfied (1) Moderately Dissatisfied (2) Equally Satisfied/Dissatisfied (3) Moderately Satisfied (4) Very Satisfied (5)

MOS - 6

The Medical Outcomes Study (MOS), was revised. The new form, the MOS Sleep Scale–Revised (MOS Sleep–R), differs from the original in that it has five response options. This change was made based on findings from SF-36® Health Survey translation studies (Keller, Ware, Gandek et al., 1998), that this response choice was not consistently ordered in relation to other adjacent response options ("most of the time" and "some of the time"). Eliminating this response option simplified the format of the form with little or no loss of information.

The reliability and validity of the MOS Sleep Scale have been evaluated in a number of disease areas, including neuropathic pain, restless leg syndrome, overactive bladder and rheumatoid arthritis. It has also been evaluated in the U.S. general population. Starting in 2010, the MOS Sleep Scale is available with patient and aggregate reports and a single standardized scoring engine. Updated U.S. norms are also available using 2009 survey results. Intended for adults 18 years of age and older, the forms are available in a fixed form mode of administration, with a standard four-week recall period.

Instructions	How often during the past 4 weeks did you	
mos1	Get enough sleep to feel rested upon waking in the morning?	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)
mos2	Awaken short breath or with a headache?	All of the time (1) Most of the time (2)

		Some of the time (3) A little of the time (4) None of the time (5)
mos3	Have trouble falling asleep?	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)
mos4	Awaken during your sleep time and have trouble falling asleep?	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)
mos5	Have trouble staying awake during the day?	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)
mos6	Get the amount of sleep you needed?	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)

Perceived Stress Scale (PSS)

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. Items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. The scale also includes a number of direct queries about current levels of experienced stress. The PSS was designed for use in community samples with at least a junior high school education. The items are easy to

understand, and the response alternatives are simple to grasp. Moreover, the questions are of a general nature and hence are relatively free of content specific to any subpopulation group. The questions in the PSS ask about feelings and thoughts during the last month. In each case, respondents are asked how often they felt a certain way.

Higher PSS scores were associated with (for example): • failure to quit smoking • failure among people with diabetes to control blood sugar levels • greater vulnerability to stressful life-event-elicited depressive symptoms • more colds

Cohen et al. (1988) show correlations with PSS and: Stress Measures, SelfReported Health and Health Services Measures, Health Behavior Measures, Smoking Status, Help-Seeking Behavior

stres1	How often have you been upset because of something that happened unexpectedly?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres2	How often have you felt that you were unable to control the important things in your life?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres3	How often have you felt nervous and “stressed”?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres4	How often have you felt confident about your ability to handle your personal problems?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres5	How often have you felt that things were going your way?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres6	How often have you found that you could not cope with all the things that you had to do?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres7	How often have you been able to control irritations in your life?	Never (0)

		Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres8	How often have you felt that you were on top of things?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres9	How often have you been angered because of things that were outside of your control?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)
stres10	How often have you felt difficulties were piling up so high that you could not overcome them?	Never (0) Almost Never (1) Sometimes (2) Fairly Often (3) Very Often (4)

Scoring: PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 & 4 = 0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items. A short 4 item scale can be made from questions 2, 4, 5 and 10 of the PSS 10 item scale.

```
***compute average and reliability for 10-item Percived Stress Scale (Cohen).
compute pss_avg= mean(stres1, stres2, stres3,stres4,stres5,stres6,stres7,stres8,stres9,stres10).
execute.

reliability
/variables= stres1, stres2, stres3,stres4,stres5,stres6,stres7,stres8,stres9,stres10
/scale (alpha)=all
/model=alpha
/summary=total.
execute.
```

R-URICA

The R-URICA is comprised of three subscales: action (items 1, 2, 8, and 11), seeking (items 3, 4, 5, and 7), and ambivalence (items 6, 9, 10, and 12).

urica1	I am doing something about the problems that have been bothering me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4)

		Strongly Agree (5)
urica2	I am really working hard to change	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica3	I wish I had more ideas on how to solve the problem	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica4	I have started working on my problems, but I would like help	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica5	Maybe this place will be able to help me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica6	I may be part of the problems, but I don't really think I am	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica7	I hope that someone here will have some good advice for me	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica8	Anyone can talk about changing; I'm actually doing something about it	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica9	All this talk about psychology is boring. Why can't people just forget about	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

urica10	I have worries but so does the next guy. Why spend time thinking about them?	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica11	I am actively working on my problem	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
urica12	I would rather cope with my faults than try to change them	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

Sex Subscale of the Trauma Symptom Checklist 40

The TSC-40 is a 40-item self-report measure of symptomatic distress in adults arising from childhood or adult traumatic experiences. It measures aspects of posttraumatic stress as well as other symptoms found in some traumatized individuals. The TSC-40 has six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbances. We exclusively use the Sexual Problems Subscale.

sex4	How often have you experienced the following symptoms over the last two months? Sexual problems	Never (0) (1) (2) Often (3)
sex5	How often have you experienced the following symptoms over the last two months? Low sex drive	Never (0) (1) (2) Often (3)
sex6	How often have you experienced the following symptoms over the last two months? Sexual over-activity	Never (0) (1) (2) Often (3)
sex7	How often have you experienced the following symptoms over the last two months? Not feeling satisfied with your sex life	Never (0) (1) (2) Often (3)
sex8	How often have you experienced the following symptoms over the last two months? Having sex that you didn't enjoy	Never (0) (1) (2) Often (3)
sex9	How often have you experienced the following symptoms over the last two months?	Never (0) (1) (2)

	Bad thoughts or feelings during sex	Often (3)
sex10	How often have you experienced the following symptoms over the last two months? Being Confused about your sexual feelings	Never (0) (1) (2) Often (3)
sex11	How often have you experienced the following symptoms over the last two months? Sexual feelings when you shouldn't have them	Never (0) (1) (2) Often (3)

SF12

The SF-12v2™ Health Survey is a 12-item subset of the SF-36v2™ that measures the same eight domains of health. It is a brief, reliable measure of overall health status. It is useful in large population health surveys and has been used extensively as a screening tool.

The test-retest reliability of the PCS-12 summary measures was 0.890 in the US and 0.864 in the UK. Coefficients of 0.760 in US and 0.774 in the UK were observed for the MCS-12. Changes in scores between test and retest averaged less than 1 point for the 2 summary measures in both samples, and 85.3% scored at the 2nd administration within the 95% confidence interval of the scores at the first administration for both PCS-12 and MCS-12.

Ware J Jr, Kosinski M, Keller SD. A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. Med Care 1996; 34:220-33.

Gandek B, Ware JE, Aaronson NK, et al. Cross-validation of item selection and scoring for the SF-12 Health Survey in nine countries: results from the IQOLA Project. International Quality of Life Assessment. Journal of Clinical Epidemiology, 1998; 51:1171-8.

sf1	In general, would you say your health is	Excellent (5) Very good (4) Good (3) Fair (2) Poor (1)
Instructions 2	The following questions are about activities you might do on a typical day. Does your health now limit you in these activities? If so, how much? Circle the best answer.	N/A
sf2a	Moderate activities (e.g. moving a table, vacuuming, or golf)	Yes, limited a lot (2) Yes, limited a little (1) No, not at all (0)
sf2b	Climbing several flights of stairs	Yes, limited a lot (2) Yes, limited a little (1) No, not at all (0)
Instructions 3	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health (such as feeling depressed or anxious)?	N/A
sf3a	Accomplished less than you would like	Yes (1) No (0)
sf3b	Were limited in the kind of work or other activities	Yes (1) No (0)

Instructions 4	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	N/A
sf4a	Accomplished less than you would like	Yes (1) No (0)
sf4b	Did work or other activities less carefully than usual	Yes (1) No (0)
sf5	During the past 4 weeks, how much did pain interfere with your normal work (including both housework and work outside the home)? Circle the best answer.	Not at all (0) A little bit (1) Moderately (2) Quite a bit (3) Extremely (4)
Instructions 6	These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks	N/A
sf6a	Have you felt calm and peaceful?	All of the time (1) Most of the time (2) A good bit of the time (3) Some of the time (4) A little of the time (5) None of the time (6)
sf6b	Did you have a lot of energy?	All of the time (1) Most of the time (2) A good bit of the time (3) Some of the time (4) A little of the time (5) None of the time (6)
sf6c	Have you felt downhearted and blue? (needs to be reverse coded)	All of the time (1) Most of the time (2) A good bit of the time (3) Some of the time (4) A little of the time (5) None of the time (6)
sf7	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? Circle the best answer.	All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)

SF10 health Survey for Children

The SF-10™ Health Survey for Children is a parent-completed survey that contains 10 questions adapted from the Child Health Questionnaire (CHQ).

The SF-10™ provides coverage across a wide range of domains and is scored to produce physical and psychosocial health summary measures. The survey provides a quick and efficient means to measure health status in cases where CHQ domain scores are not necessary.

Due to its brevity, the SF-10™ can be easily integrated and administered within a broader assessment and is particularly applicable to large-scale child population surveys. This survey is intended for children between the ages of 5 and 18.

Citations

Saris-Baglama, R. N., DeRosa, M. A., Raczek, A. E., Bjorner, J. B., & Ware, J. E. Development, validation, and norming of the SF-10 for Children Health Survey [Abstract]. Quality of Life Research, 2006;15(S1), A-145

Saris-Baglama, R.N., DeRosa, M.A., Raczek, A.E., & Ware, J.E. (2006, November). Preliminary validation of the SF-10 for Children among those with and without disabilities. Poster presented at the annual meeting of the American Public Health Association, Boston, MA

Saris-Baglama, R. N.,DeRosa, M. A., Raczek, A. E., Bjorner, J. B.,Turner-Bowker, D. M., & Ware, J. E. (2007).The SF-10™ Health Survey for Children: A user's guide. Lincoln, RI: QualityMetric Incorporated.

Hopelessness Scale for Children-Revised, (Bolland, 2001)

Description: The Brief Hopelessness Scale is used to measure the amount of hopelessness in an adolescent's life. The Scale has demonstrated good reliability and validity. Hopelessness Scale for Children-Revised is measured using the 6-item version of the (HSC-R; Kazdin, Fereench, Unis, Esveldt-Dawson, & Sherick, 1983; Bolland, McCallum, Lian, Bailey, & Rowan, 2001). This scale is used to assess the child's level of hopelessness in life; higher scores reflect increased hopelessness.

Scoring: To score the Hopelessness Scale for Children-Revised, simply total the numbers that have been marked.

Items of Interest: The authors use the score of 4.0 as a cut-off score. For males, a score of 4.0 or greater is strongly correlated with alcohol and drug consumption, violent behaviors, trying to get someone pregnant, and delinquency. For females, a score of 4.0 or greater is mild to correlate with similar behaviors moderately. Since higher scores are an indicator of possible violence, delinquency, and sexually risky behavior, clients with higher scores should be brought to the attentions of your Faculty Supervisor.

Citation:

Kazdin, A. E., French, N. H., Unis, A. S., Esveldt-Dawson, K., & Sherick, R. B. (1983). Hopelessness, depression, and suicidal intent among psychiatrically disturbed inpatient children. Journal of consulting and clinical psychology, 51(4), 504.

Kazdin, A. E., Rodgers, A., & Colbus, D. (1986). The Hopelessness Scale for Children: Psychometric characteristics and concurrent validity. *Journal of consulting and clinical psychology*, *54*(2), 241.

Bolland, J. M., McCallum, D. M., Lian, B., Bailey, C. J., & Rowan, P. (2001). Hopelessness and violence among inner-city youths. *Maternal and Child Health Journal*, *5*(4), 237-244.

Alverson, J., Robinson, C., Bolland, J., Tarter, J., Thoma, S., & Tomek, S. (2014). A model of hopelessness, belongingness, engagement, and academic achievement. Dissertation Abstract International.

Please read the following statements and place an (A) in the blank if you Agree with the statement and a (D) if you Disagree with the statement:

Hope1	All I see ahead of me are bad things, not good things.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
Hope2	There's no use in really trying to get something I want because I probably won't get it.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
Hope3	I might as well give up because I can't make things better for myself.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
Hope4	I don't have good luck now, and there's no reason to think I will when I get older.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
Hope5	I never get what I want, so it's dumb to want anything.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)
Hope6	I don't expect to live a very long life.	Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

IPA (Inventory of Parent Attachment)

Description: The Inventory of Parent Attachment is designed to assess the parental attachment level as determined by the adolescent. The sub-scales focus on trust, communication, and alienation. The measure has been shown to discriminate between delinquent and non-delinquent adolescents. Greenberg and Armsden have given permission to adjust the measure so that the questions can be directed from the parents towards the children. Additional information concerning the parental rating of their child's trust, communication, and alienation needs to be compiled before information can be provided to the therapist.

Scoring:

Trust: Measures the amount of trust and caring that the adolescent experiences from the parents. Sub-scale items include 1, 2, (3), 4, (9), 12, 13, 20, 21, 22. (What do the parentheses mean?? Reverse scoring?)

Communication: Seeks to assess the level of communication that the adolescent perceives between themselves and the parents. Items in this sub-scale include 5, (6), 7, (14), 15, 16, 19, 24, and 25.

Alienation: Measures the adolescent's perception of the level of connection and acceptance the parent exhibits. Items in this sub-scale include 8, 10, 11, 17, 18, and 23.

Items of Interest: The IPA is related to well-being, self-esteem, the locus of control, and life satisfaction. Lower scores would suggest difficulty in relating interpersonally. Adolescents that rate the parent low on levels of communication, trust, and alienation have a higher risk of delinquency.

This questionnaire asks about your relationship with your parents. Please read the directions carefully. The following statements ask about you feelings about your Mother and Father. Please read each statement and circle ONE number that tells how true the statement is for you and your mother and ONE number that tells how true the statement is for you and your father. Use the following key:
1 = Almost Never or Never True, 2 = Not Very Often True, 3 = Sometimes True, 4 = Often True, 5 = Always True

		MOTHER					FATHER				
1.	My mother/father respect(s) my feelings.	1	2	3	4	5	1	2	3	4	5
2.	I feel my mother/father does a good job as my mother/father.	1	2	3	4	5	1	2	3	4	5
3.	I wish I had a different mother/father.	1	2	3	4	5	1	2	3	4	5
4.	My mother/father accept(s) me as I am.	1	2	3	4	5	1	2	3	4	5
5.	I like to get my mother's/father's point of view on things I am concerned about.	1	2	3	4	5	1	2	3	4	5
6.	I feel it's no use letting my feelings show around my mother/father.	1	2	3	4	5	1	2	3	4	5
7.	My mother/father can tell when I'm upset about something.	1	2	3	4	5	1	2	3	4	5
8.	Talking over my problems with my mother/father makes me feel ashamed or foolish.	1	2	3	4	5	1	2	3	4	5
9.	My mother/father expects too much from me.	1	2	3	4	5	1	2	3	4	5
10.	I get upset easily around my mother/father.	1	2	3	4	5	1	2	3	4	5
11.	I get upset a lot more than my mother/father knows about.	1	2	3	4	5	1	2	3	4	5
12.	When we discuss things, my mother/father cares about my point of view.	1	2	3	4	5	1	2	3	4	5
13.	My mother/father trusts my judgment.	1	2	3	4	5	1	2	3	4	5
14.	My mother/father has her/his own problems, so I don't bother him/her with mine.	1	2	3	4	5	1	2	3	4	5
15.	My mother/father helps me to understand myself better.	1	2	3	4	5	1	2	3	4	5
16.	I tell my mother/father about my problems and troubles.	1	2	3	4	5	1	2	3	4	5
17.	I feel angry with my mother/father.	1	2	3	4	5	1	2	3	4	5
18.	I don't get much attention from my mother/father.	1	2	3	4	5	1	2	3	4	5
19.	I talk to my mother/father about my difficulties.	1	2	3	4	5	1	2	3	4	5
20.	My mother/father understand(s) me.	1	2	3	4	5	1	2	3	4	5
21.	When I am angry about something, my mother/father tries to be understanding.	1	2	3	4	5	1	2	3	4	5
22.	I trust my mother/father.	1	2	3	4	5	1	2	3	4	5
23.	My mother/father doesn't understand what I am going through these days.	1	2	3	4	5	1	2	3	4	5
24.	I can count on my mother/father when I need to get something off my chest.	1	2	3	4	5	1	2	3	4	5
25.	If my mother/father knows something is bothering me, she/he asks me about it.	1	2	3	4	5	1	2	3	4	5

Ohio Youth Problem, Functioning: Parent Rating (Pinsof & Catherall, 1986)

Description:

The ***Ohio Scales*** are instruments developed to measure outcomes for youth ages 5 to 18 who receive mental health services. The Short Forms of the ***Ohio Scales*** consist of 2 domains: the 20-item *Functioning Scale,* and the 20-item *Problem Severity Scale*.

Target Population: Children and adolescents ages 5 to 18 years with severe emotional and behavioral problems

Scoring Information: Scoring tools and guidelines are available on the website. The reporter rates each item on a six-point scale, from zero "not at all" to five "all the time" in the last 30 days. Scoring is the sum of all items on the scale.

Training Requirements for Intended Users: Minimal clinical training for agency workers, caregiver and youth are self-reported. Training video and other materials are available for download on the website.

Scoring: The functioning scale total is calculated in the same manner used on the problem severity scale. Each of the 20 items is rated on its 5-point scale. The rating for each item is circled. The columns for each frequency are coded respectively from 0 (extreme troubles) to 4 (doing very well). Each column's score can then easily be added at the bottom of the page. The sum of the five columns then becomes the individual's score on the functioning scale. No items are reverse scored.

As can be seen from the scoring method, a high score on the problem severity scale is considered to be more problematic (more frequent problems), while a low score on the functioning scale is deemed to be more impairment. The method of scoring is thus congruent with what one would intuitively expect given the content of each scale. The short form and original Ohio Scales differ on this scale only in the wording of the items.

Scale Information:
https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvaGlvc2NhbGVzfGd4OjM3YzNhOWU4MjVjYzBjYTU

Citations:

Ash, S. E. & Weis, R. (2009). Recovery among youths referred to outpatient psychotherapy: reliable change, clinical significance, and predictors of outcome. *Child and Adolescent Social Work Journal, 26,* 399-413.

Bickman, L., Smith, C. M., Lambert, E. W. & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. *Journal of Child and Family Studies, 12,* 135–156.

Dierker, L.C., Solomon, T., Johnson, P., Smith, S. & Farrell, A. (2004). Serving Children and Families Characteristics of Urban and Nonurban Youth Enrolled in a Statewide System-of-Care Initiative. *Journal of Emotional and Behavioral Disorders,12*, 236

Gemmil, C. & Thomlinson, R. P. (2007). *An Evaluative Study of the Impact of School-Based Mental Health Services on Student Behavior, Psychosocial Functioning, and other Risk Factors.* 20th Annual Conference Proceedings – A System of Care for Children's Mental Health: Expanding the Research Base, 193-195.

Questionnaire on Self-Regulation (Novak, Scott, Clayton, Richard, 2011)

Description:

This 13 item questionnaire is used to assess children's ability to regulate negative emotions and disruptive behavior, and to set and attain goals.

Scoring:

Score items 6, 7, 9 using the following scale:

Never True = 1
Sometimes True = 2
Mostly True = 3
Always True = 4

Reverse score items 1, 2, 3, 4, 5, 8, 10, 11, 12, 13:

Never True = 4
Sometimes True = 3
Mostly True = 2
Always True =1

Items 1, 2, 3, 4, and 5 represent the child's ability to regulate his/her emotions.

Items 6, 7, and 8 represent the child's goal-setting ability.

Items 9, 10, 11, 12, and 13 represent the child's ability to regulate behavior.

Higher scores represent stronger ability to regulate.

Citation:

Novak, Scott P., & Clayton, Richard R. (2001). The Influence of School Environment and SelfRegulation on Transitions Between Stages of Cigarette Smoking: A Multilevel Analysis. Health Psychology, 20(3), 196-207.

SCORE-15 Index of Family Functioning and Change (Jewell, Carr, Stratton, Lask, Eisler, 2013)

Description:

SCORE is a self-report outcome measure designed to be sensitive to the kinds of changes in family relationships that systemic family and couples therapists see as indications of useful therapeutic change. It is intended to be serviceable in everyday practice; short, acceptable to clients and usable across the full range of our work - the entire range of presenting problems, the clientele, and the formats of work: including individual, couple, family and multi-family groups. It is free to use.

SCORE-15 can be used as an overall measure of family functioning but will also generate 'sub-scale' scores from the 5 items on each of three dimensions:
- Strengths and adaptability
- Overwhelmed by difficulties
- Disrupted communication

Web Site Information: http://www.aft.org.uk/view/score.html?tzcheck=1

Scoring Excel template is on the web page, or you can find the download on Z-Drive - SPSS folder

Therapy Alliance Scales (Pinsof & Catherall, 1986)

Description: The Therapy Alliance Scales come in three versions—individual, couple, and family. The TAS measures how well the individual, couple or family and therapist were able to work together on client goals, the client's perceptions of the therapist's competence and pacing, and the amount of caring and trustworthiness between the therapist and the client. Reliability of the total scale and subscales ranges from adequate to excellent.

It is important to reassure clients that information provided on this form is confidential and that therapists will not see any of the responses.

Information on the subscales and scoring is available upon request.

These statements refer to your thoughts about your therapist/therapy right NOW. We are interested in your FIRST impressions. (individual, couple, and family alliance scales).

		Completely Agree			*Neutral*			*Completely Disagree*
1.	Some of the people who are important to me would not be pleased with what I am doing in this therapy	1	2	3	4	5	6	7
2.	The therapist does not understand me	1	2	3	4	5	6	7
3.	Some of the people who are important to me would not agree with the therapist about the goals of this therapy	1	2	3	4	5	6	7
4.	The therapist and I are not in agreement about the goals for this therapy	1	2	3	4	5	6	7
5.	Some of the people who are important to me and I do not feel the same way about what I want to get out of this therapy	1	2	3	4	5	6	7
6.	The people who are important to me would understand my goals in this therapy	1	2	3	4	5	6	7
7.	Some of the people who are important to me would not be accepting of my involvement in this therapy	1	2	3	4	5	6	7
8.	I do not care about the therapist as a person	1	2	3	4	5	6	7

9. I do not feel accepted by the therapist	1	2	3	4	5	6	7
10. Some of the people who are important to me would not trust that this therapy is good for my relationship with them	1	2	3	4	5	6	7
11. The people who are important to me would approve of the way my therapy is being conducted	1	2	3	4	5	6	7
12. The people who are important to me would feel accepted by the therapist	1	2	3	4	5	6	7
13. The therapist does not agree with the goals I have for my important relationships	1	2	3	4	5	6	7
14. The therapist does not appreciate how important some of my relationships are to me	1	2	3	4	5	6	7
15. The therapist is helping me with my important relationships	1	2	3	4	5	6	7
16. I am satisfied with this therapy	1	2	3	4	5	6	7

	Completely						*Completely*
	Disagree----------Neutral----------Agree						
1. The therapist cares about me as a person	1	2	3	4	5	6	7
2. The therapist understands my goals in this therapy	1	2	3	4	5	6	7
3. The therapist and I are in agreement about the way the therapy is being conducted	1	2	3	4	5	6	7
4. The therapist does not understand the relationship between my partner and me	1	2	3	4	5	6	7
5. The therapist cares about the relationship between my partner and me	1	2	3	4	5	6	7
6. The therapist does not understand the goals that my partner and I have for ourselves as a couple or co-parents in this therapy	1	2	3	4	5	6	7
7. My partner feels accepted by the therapist	1	2	3	4	5	6	7
8. My partner and the therapist agree about the way the therapy is being conducted	1	2	3	4	5	6	7
9. The therapist understands my partner's goals for this therapy	1	2	3	4	5	6	7
10. My partner and I do not accept each other in this therapy	1	2	3	4	5	6	7
11. My partner and I are in agreement about our goals for this therapy	1	2	3	4	5	6	7
12. My partner and I are not pleased with the things that each of us does in this therapy..	1	2	3	4	5	6	7
13. I am satisfied with this therapy	1	2	3	4	5	6	7

	Completely						*Completely*
	Disagree----------Neutral----------Agree						
1. The therapist does not understand me	1	2	3	4	5	6	7
2. The therapist understands my goals in this therapy	1	2	3	4	5	6	7
3. I trust the therapist	1	2	3	4	5	6	7
4. The therapist does not understand my family's goals for this therapy	1	2	3	4	5	6	7
5. The therapist lacks the skills and ability to help my family	1	2	3	4	5	6	7
6. The therapist cares about my family	1	2	3	4	5	6	7
7. The therapist has the skills and ability to help all the other members of my family	1	2	3	4	5	6	7
8. The therapist understands the goals that all the other members of my family have for this therapy	1	2	3	4	5	6	7
9. The therapist does not care personally about some of the other members of my family	1	2	3	4	5	6	7
10. Some of the other members of my family and I do not feel the same way about what we want to get out of this therapy	1	2	3	4	5	6	7
11. Some of the other members of my family and I are not pleased with the things that each of us is doing in this therapy	1	2	3	4	5	6	7
12. Some of the other members of my family and I do not feel safe with each other in this therapy	1	2	3	4	5	6	7
13. I am satisfied with this therapy	1	2	3	4	5	6	7

Assessment Schedule

1. Intake Assessments
2. Follow-up Assessments at Sessions 4, 8, 12, 20.
3. Follow-up Assessments provided at termination
4. Clients invited for free six-month follow-up refresher session

Again, there are four different assessment packets. Assessment packets are in the file cabinet in the clinic office. For each case use a fourth session assessment packet that is titled the same as the intake packet (for example if at intake the clients completed an Individual Adult in Committed Relationship then after the fourth session the Individual Adult in Committed Relationship packet should be used). Therapists need to take considerable care in providing the therapist ID and the client code on each assessment packet.

At the session before one requiring a follow-up assessment (i.e., 3rd, etc.), therapists need to remind clients of the extra10-20 minutes needed to complete the packets. If necessary, therapists should plan to end their session early to facilitate the completion of the packets. All fourth session and subsequent assessments must be placed in the box by clients upon completion.

Six Month Follow-Up Session

The six-month follow-up session is a free check-up session. This session is designed to see how the clients have progressed since the end of therapy and make sure the changes they made in therapy have continued. Following this session, therapists are required to complete a Session Summary.

At the conclusion of the six-month follow-up session, clients complete the six-month follow-up assessments. These assessments are the same as the final session assessments, but the Attachment Scales (IPA & PAI), and the Conflict Tactics Scale (CTS) have been added. The instructions on the Conflict Tactics Scale that clients complete and the six-month follow-up session are different from the instructions at the beginning of therapy. Make sure that clients are informed that the IPA, PAI, and the CTS are answered on events occurring *since the termination of therapy*.

Assessment Scoring Procedures

After the first session, questionnaires need to be scored before the next session. If undergraduate interns are working in the MFT Center, they will help with scoring. However, the responsibility for scoring resides with the therapist. The scores from the questionnaires can then be used in treatment planning and setting therapeutic goals. Eventually, we will use Scoring Summary Sheets to present the scores.

Appendix F

Ethical Standards and Standards of Conduct

ALABAMA BOARD OF EXAMINERS IN MARRIAGE AND FAMILY THERAPY
ADMINISTRATIVE CODE

CHAPTER 536-X-6
GROUNDS FOR DISCIPLINE AND ETHICAL STANDARDS

The Board may deny, revoke, or suspend a license granted pursuant to the Marriage and Family Therapy Act on any of the following grounds:

11. Conviction of a crime which the Board determines to be of nature as to render the person convicted unfit to practice marriage and family therapy. The Board shall compile, maintain, and publish a list of the crimes.
12. Violation of ethical standards of nature as to render the person found by the Board to be unfit to practice marriage and family therapy. The Board shall publish and maintain the ethical standards. Either as an alternative to or as an additional disciplinary action, the Board may levy an administrative penalty of up to five hundred dollars ($500) for an ethical violation.
13. Fraud or misrepresentation in obtaining a license.
14. Other just and sufficient cause which renders a person unfit to practice marriage and family therapy, such as, but not limited to the following:
    a) Violations of rules, regulations, and standards set forth by the Board.
    b) Violations of the ethical standards for marriage and family therapists.
    c) Professional incompetence.
    d) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice that is harmful or detrimental to the public. Proof of actual injury need not be established.
    e) Habitual intoxication or addiction to drugs.
    f) Conviction of a felony related to the profession or occupation of the licensee or the conviction of any felony that would affect the licensee's ability to practice within the profession. A copy of the record of conviction or plea of guilty shall be conclusive evidence.
    g) Fraud in representations of overall therapy skill or ability.
    h) Use of untruthful or improbable statements in advertisements.
    i) Willful or repeated violations of the provisions of the Marriage and Family Therapy Licensure Act and the Rules and Regulations of the Alabama Board of Examiners in Marriage and Family Therapy.
    j) Personal disqualifications:
        1) Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
        2) Involuntary commitment for treatment of mental illness, drug addiction or alcoholism.
    k) Holding oneself out as a licensee when the license has expired, been suspended or revoked or no license has been granted.
    l) Revocation, suspension, or other disciplinary action taken by a mental health licensing authority of any state, territory, or country; or failure by the licensee to report in writing to the Board a revocation, suspension, or other disciplinary action taken by a mental health licensing authority of any state, territory, or country.
    m) Negligence by the licensee in the practice of the profession, which is a failure to exercise due care including negligent delegation to or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or

conditions which impair the ability to safely and skillfully practice the profession.

n) Prohibited acts consisting of the following:
   1) Permitting another person to use the license for any purpose.
   2) Practice outside the scope of the license.
   3) Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away, or administering controlled substances.
   4) Verbally or physically abusing clients.
   5) Any sexual intimidation or sexual relationship between a licensee and a client.

o) Unethical business practices, consisting of any of the following:
   1) False or misleading advertising.
   2) Betrayal of professional confidence.
   3) Falsifying client's records.

p) Failure to report to the Board a change of name or address within 60 days after it occurs.

q) Failure to comply with a subpoena issued by the Board, or to otherwise fail to cooperate with an investigation conducted by the Board.

CHAPTER 536-X-7
STANDARDS OF CONDUCT FOR MARRIAGE AND FAMILY THERAPISTS

(1) *Responsibility to clients*. Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance and make reasonable efforts to ensure that their services are used appropriately.

(a) Marriage and family therapists do not discriminate against or refuse professional service to anyone on the basis of race, gender, religion, national origin, or sexual orientation.

(b) Marriage and family therapists are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgment is not impaired, and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with clients. Sexual intimacy with clients is prohibited. Sexual intimacy with former clients is prohibited for two years following the termination of therapy.

(c) Marriage and family therapists do not use their professional relationships with clients to further their interests.

(d) Marriage and family therapists respect the right of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise a client that a decision on marriage status is the responsibility of the client.

(e) Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

(f) Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

(g) Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

(h) Marriage and family therapists obtain written, informed consent from clients before videotaping, audio recording, or permitting third-party observation.

(2) *Confidentiality*. Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard confidences of each individual client.

(a) Marriage and family therapists may not disclose client confidences, and the confidential relations and communications between licensed marriage and family therapists and clients are placed upon the same basis as those provided by law between attorney and client, and nothing in these rules and regulations or the Marriage and Family Therapy Licensure Act shall be construed to require any such privileged communication to be disclosed, except in the following circumstances:

i. As mandated by law;
ii. To prevent a clear and immediate danger to a person or persons;
iii. Where the therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy, in which case client confidences may be disclosed only in the course of that action;
iv. Where the client is a defendant in a criminal proceeding, and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses in his or her behalf or both;
v. If there is a waiver previously obtained in writing, and then such information may be revealed only in accordance with the terms of the waiver. In circumstances where more than one person in a family receives therapy conjointly, each family member who is legally competent to execute a waiver must agree to the waiver required by this subparagraph. Without such a waiver from each family member legally competent to execute a waiver, a therapist cannot disclose information received from any family member.
vi. Where there is a duty to warn under the limited circumstances outlined in Section 23 of the Marriage and Family Therapy Licensure Act.
vii. If both parties to a marriage have obtained marriage and family therapy by a licensed marriage and family therapist, the therapist shall not be competent to testify in an alimony or divorce action concerning information acquired in the course of the therapeutic relationship. This section shall not apply to custody actions.

(b) Marriage and family therapists use client or clinical materials in teaching, writing, and public presentations only if a written waiver has been obtained, or when appropriate steps have been taken to protect client identity and confidentiality.

(c) Marriage and family therapists store, for no less than seven years, and dispose of client records in ways that maintain confidentiality.

(d) Records of the therapy relationship, including interview notes, test data correspondence, tape recordings, electronic data storage, and other documents are to be considered professional information for use in therapy, and they should not be considered a part of the records of the institution or agency in which the therapist is employed unless specified by state statute or regulation. Revelation to others of therapy material must occur only upon the expressed consent of the client.

(3) *Professional competence and integrity.* Marriage and family therapists maintain high standards of professional competence and integrity.

(a) Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

(b) Marriage and family therapists, as teachers, supervisors, and researchers, are dedicated to upholding high standards of scholarship and presenting accurate information.
(c) Marriage and family therapists remain abreast of new developments in family therapy knowledge and practice through educational activities.
(d) Marriage and family therapists do not engage in sexual or other harassment or exploitation of clients, students, trainees, supervisees, employees, colleagues, research subjects, or actual or potential witnesses or complainants in investigations and ethical proceedings.
(e) Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competence.
(f) Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.
(g) Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

(4) *Responsibility to students, employees, and supervisees.* Marriage and family therapists do not exploit the trust and dependency of students, employees, and supervisees.

(a) Marriage and family therapists are aware of their influential position with respect to students, employees, and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid dual relationships that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgment is not impaired, and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with students, employees, or supervisees; or provision of therapy to students, employees, or supervisees. Sexual intimacy with students or supervisees is prohibited.
(b) Marriage and family therapists do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.
(c) Marriage and family therapists do not disclose supervisee confidences except:
    1. As mandated by law,
    2. To prevent a clear and immediate danger to a person or persons;
    3. Where the therapist is a defendant in a civil, criminal, or disciplinary action arising from the supervision (in which case supervisee confidences may be disclosed only in the course of that action);
    4. In educational or training settings where there are multiple supervisors, and then only to other professional colleagues who share responsibility for the training of the supervisee; or
    5. If there is a waiver previously obtained in writing, and then such information may be revealed only in accordance with the terms of the waiver.

(5) *Responsibilities to research participants.* Researchers respect the dignity and protect the welfare of participants in research and are aware of federal and state laws and regulations and professional standards governing the conduct of research.

(a) Researchers are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, researchers seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

(b) Researchers requesting participants' involvement in research inform them of all aspects of the research that might reasonably be expected to influence willingness to participate. Researchers are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, have impairments which limit understanding or communication, or when participants are children.

(c) Researchers respect participants' freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when researchers or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid dual relationships with research participants that could impair professional judgment or increase the risk of exploitation.

(d) Information obtained about a research participant during an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

(6) *Responsibility to the profession.* Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities which advance the goals of the profession.

(a) Marriage and family therapists remain accountable to the standards of the profession when acting as members or employees of organizations.

(b) Marriage and family therapists attempt to address any suspected violation of standards with the party in question prior to reporting such suspected violation to the Board.

(c) Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

(d) Marriage and family therapists who are the authors of books or other materials that are published or distributed cite persons to whom credit for original ideas is due.

(e) Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

(7) *Financial arrangements.* Marriage and Family Therapists make financial arrangements with clients, third-party payers, and supervisees that are reasonably understandable and conform to accepted professional practices.

(a) Marriage and Family Therapists do not offer or accept payment for referrals.

(b) Marriage and Family Therapists do not charge excessive fees for services

(c) Marriage, and Family Therapists disclose their fees to clients and supervisees at the beginning of services.

(d) Marriage and Family Therapists represent facts truthfully to clients, third party payers, and supervisees regarding services rendered.

(e) Marriage and Family Therapy Interns do not direct bill for services provided; such services may be billed through the agency or LMFT employing or providing a placement for the MFT Intern.

(f) Marriage and Family Therapy Associates may direct bill for services rendered.

(8) *Advertising.* Marriage and Family Therapists engage in appropriate informational activities, including those that enable lay persons to choose professional services on an informed basis.

(a) Marriage and Family Therapists accurately represent their competence, education, training, and experience relevant to their practice of marriage and family therapy.

(b) Marriage and Family Therapists do not use a name which could mislead the public

concerning the identity, responsibility, source, and status of those practicing under that name and do not hold themselves out as being partners or associates of a firm if they are not.

(c) Marriage and Family Therapists do not use any professional identification (such as business card, office sign, letterhead, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive. A statement is false, fraudulent, misleading, or deceptive if it:
   1. contains a material misrepresentation of fact;
   2. fails to state any material fact necessary to make the statement, in light of all circumstances, not misleading; or
   3. is intended to or is likely to create an unjustified expectation.

(d) Marriage and Family Therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

(e) Marriage and Family Therapists make certain that the qualifications of persons under their employment are represented in a manner that is not false, misleading, or deceptive.

(f) Marriage and Family Therapists may represent themselves as specializing within a limited area of marriage and family therapy, but only if they have the education and supervised experience in settings which meet recognized professional standards to practice in that specialty area. Professional association designations may only be represented by persons who have been qualified by the respective association, and may only be represented as permitted by that professional association.

AAMFT Code of Ethics

Effective January 1, 2015

Preamble

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective January 1, 2015.

Honoring Public Trust

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee.

Commitment to Service, Advocacy, and Public Participation

Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Marriage and family therapists embody these aspirations by participating in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the character of the field, and to the well-being of clients and their communities.

Seeking Consultation
The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Ethical Decision-Making
Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and take reasonable steps to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

Binding Expectations
The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories; all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

Resolving Complaints
The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

Aspirational Core Values
The following core values speak to the membership of AAMFT as a professional association, yet they also inform all the varieties of practice and service in which marriage and family therapists engage. These core values are aspirational in nature and are distinct from ethical standards. These values are intended to provide an aspirational framework within which marriage and family therapists may pursue the highest goals of the practice.
The core values of AAMFT embody:

1. Acceptance, appreciation, and the inclusion of a diverse membership.
2. Distinctiveness and excellence in the training of marriage and family therapists and those desiring to advance their skills, knowledge, and expertise in systemic and relational therapies.
3. Responsiveness and excellence in service to members.
4. Diversity, equity and excellence in clinical practice, research, education, and administration.

5. Integrity evidenced by a high threshold of ethical and honest behavior within Association governance and by members.
6. Innovation and the advancement of knowledge of systemic and relational therapies.

Ethical Standards

Ethical standards, by contrast, are rules of practice upon which the marriage and family therapist is obliged and judged. The introductory paragraph to each standard in the AAMFT Code of Ethics is an aspirational/explanatory orientation to the enforceable standards that follow.

STANDARD I
RESPONSIBILITY TO CLIENTS

Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system.

1.1 Non-Discrimination.

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

1.2 Informed Consent.

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented.

1.3 Multiple Relationships.

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

1.4 Sexual Intimacy with Current Clients and Others.

Sexual intimacy with current clients or with known members of the client's family system is prohibited.

1.5 Sexual Intimacy with Former Clients and Others.

Sexual intimacy with former clients or with known members of the client's family system is prohibited.

1.6 Reports of Unethical Conduct.

Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 Abuse of the Therapeutic Relationship.

Marriage and family therapists do not abuse their power in therapeutic relationships.

1.8 Client Autonomy in Decision Making.
Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Relationship Beneficial to Client.
Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Referrals.
Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help.

1.11 Non-Abandonment.
Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.

1.12 Written Consent to Record.
Marriage and family therapists obtain written informed consent from clients before recording any images or audio or permitting third-party observation.

1.13 Relationships with Third Parties.
Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

STANDARD II
CONFIDENTIALITY
Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Disclosing Limits of Confidentiality.
Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Written Authorization to Release Client Information.
Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations unless prohibited by law. When providing couple, family or group treatment, the therapist dos not disclose information outside the treatment context without written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

2.3 Client Access to Records.
Marriage and family therapists provide clients with reasonable access to records concerning the clients. When providing couple, family, or group treatment, the therapist does not provide access to records without written authorization from each individual competent to execute a waiver. Marriage and family therapists

limit client's access to their records only in exceptional circumstances when they are concerned, based on compelling evidence that such access could cause serious harm to the client. The client's request and the rationale for withholding some or all of the record should be documented in the client's file. Marriage and family therapists take steps to protect the confidentiality of other individuals identified in client records.

2.4 Confidentiality in Non-Clinical Activities.
Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Standard 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.5 Protection of Records.
Marriage and family therapists store, safeguard and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.6 Preparation for Practice Changes.
In preparation for moving a practice, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

2.7 Confidentiality in Consultations.
Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

STANDARD III

PROFESSIONAL COMPETENCE AND INTEGRITY
Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency.
Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.

3.2 Knowledge of Regulatory Standards.
Marriage and family therapists pursue appropriate consultation and training to ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards.

3.3 Seek Assistance.
Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment.

3.4 Conflicts of Interest.
Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Maintenance of Records.
Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

3.6 Development of New Skills.
While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, and/or supervised experience.

3.7 Harassment.
Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.8 Exploitation.
Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Gifts.
Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship.

3.10 Scope of Competence.
Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.11 Public Statements.
Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.12 Professional Misconduct.
Marriage and family therapists may be in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

STANDARD IV
RESPONSIBILITY TO STUDENTS AND SUPERVISEES
Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Exploitation.
Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Therapy with Students or Supervisees.
Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Sexual Intimacy with Students or Supervisees.

Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee.

4.4 Oversight of Supervisee Competence.

Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, the level of experience, and competence.

4.5 Oversight of Supervisee Professionalism.

Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Existing Relationship with Students or Supervisees

Marriage and family therapists are aware of their influential positions with respect to supervisees, and they avoid exploiting the trust and dependency of such persons. Supervisors, therefore, make every effort to avoid conditions and multiple relationships with supervisees that could impair professional judgment or increase the risk of exploitation. Examples of such relationships include, but are not limited to, business or close personal relationships with supervisees or the supervisee's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, supervisors document the appropriate precautions taken.

4.7 Confidentiality with Supervisees.

Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for the training of the supervisee. Verbal authorization will not be sufficient except in emergency situations unless prohibited by law.

4.8 Payment for Supervision.

Marriage and family therapists providing clinical supervision shall not enter into financial arrangements with supervisees through deceptive or exploitative practices, nor shall marriage and family therapists providing clinical supervision exert undue influence over supervisees when establishing supervision fees. Marriage and family therapists shall also not engage in other exploitative practices of supervisees.

STANDARD V

RESEARCH AND PUBLICATION

Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.

5.1 Institutional Approval.

When institutional approval is required, marriage and family therapists submit accurate information about their research proposals and obtain appropriate approval prior to conducting the research.

5. 2 Protection of Research Participants.

Marriage and family therapists are responsible for making careful examinations of ethical acceptability in planning research. To the extent that participation in research may compromise services to research participants, marriage and family therapists seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5. 3 Informed Consent to Research.

Marriage and family therapists inform participants about the purpose of the research, expected length, and research procedures. They also inform participants of the aspects of the research that might reasonably be

expected to influence willingness to participate such as potential risks, discomforts, or adverse effects. Marriage and family therapists are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services or have impairments which limit understanding and/or communication, or when participants are children. Marriage and family therapists inform participants about any potential research benefits, the limits of confidentiality, and whom to contact concerning questions about the research and their rights as research participants.

5.4 Right to Decline or Withdraw Participation.

Marriage and family therapists respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation. When offering inducements for research participation, marriage and family therapists make reasonable efforts to avoid offering inappropriate or excessive inducements when such inducements are likely to coerce participation.

5.5 Confidentiality of Research Data.

Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

5.6 Publication.

Marriage and family therapists do not fabricate research results. Marriage and family therapists disclose potential conflicts of interest and take authorship credit only for work they have performed or to which they have contributed. Publication credits accurately reflect the relative contributions of the individual involved.

5.7 Authorship of Student Work.

Marriage and family therapists do not accept or require authorship credit for publication based on student's research unless the marriage and family therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on student research should be determined in accordance with principles of fairness and justice.

5.8 Plagiarism.

Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

5.9 Accuracy in Publication.

Marriage and family therapists who are authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the published materials are accurate and factual.

STANDARD VI

TECHNOLOGY-ASSISTED PROFESSIONAL SERVICES

Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically-assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.

6.1 Technology Assisted Services.

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

6.2 Consent to Treat or Supervise.

Clients and supervisees, whether contracting for services as individuals, dyads, families, or groups, must be made aware of the risks and responsibilities associated with technology-assisted services. Therapists are to advise clients and supervisees in writing of these risks, and of both the therapist's and clients'/supervisees' responsibilities for minimizing such risks.

6.3 Confidentiality and Professional Responsibilities.

It is the therapist's or supervisor's responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

6.4 Technology and Documentation.

Therapists and supervisors are to ensure that all documentation containing identifying or otherwise sensitive information which is electronically stored and/or transferred is done using technology that adheres to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

6.5 Location of Services and Practice.

Therapists and supervisors follow all applicable laws regarding the location of practice and services and do not use technologically-assisted means for practicing outside of their allowed jurisdictions.

6.6 Training and Use of Current Technology.

Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services, and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees.

STANDARD VII

PROFESSIONAL EVALUATIONS

Marriage and family therapists aspire to the highest of standards in providing testimony in various contexts within the legal system.

7.1 Performance of Forensic Services.

Marriage and family therapists may perform forensic services which may include interviews, consultations, evaluations, reports, and assessments both formal and informal, in keeping with applicable laws and competencies.

7.2 Testimony in Legal Proceedings

Marriage and family therapists who provide expert or fact witness testimony in legal proceedings avoid misleading judgments, base conclusions, and opinions on appropriate data, and avoid inaccuracies insofar as possible. When offering testimony, as marriage and family therapy experts, they shall strive to be accurate, objective, fair, and independent.

7.3 Competence.

Marriage and family therapists demonstrate competence via education and experience in providing testimony in legal systems.

7.4 Informed Consent.

Marriage and family therapists provide written notice and make reasonable efforts to obtain written consents of persons who are the subject(s) of evaluations and inform clients about the evaluation process, use of information and recommendations, financial arrangements, and the role of the therapist within the legal system.

7.5 Avoiding Conflicts.

Clear distinctions are made between therapy and evaluations. Marriage and family therapists avoid conflict in roles in legal proceedings wherever possible and disclose potential conflicts. As therapy begins, marriage and family therapists clarify roles and the extent of confidentiality when legal systems are involved.

7.6 Avoiding Dual Roles.

Marriage and family therapists avoid providing therapy to clients for whom the therapist has provided a forensic evaluation and avoid providing evaluations for those who are clients unless otherwise mandated by legal systems.

7.7 Separation of Custody Evaluation from Therapy.

Marriage and family therapists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist obtains appropriate consents to release information.

7.8 Professional Opinions.

Marriage and family therapists who provide forensic evaluations avoid offering professional opinions about persons they have not directly interviewed. Marriage and family therapists declare the limits of their competencies and information.

7.9 Changes in Service.

Clients are informed if changes in the role of the provision of services of marriage and family therapy occur and/or are mandated by a legal system.

7.10 Familiarity with Rules.

Marriage and family therapists who provide forensic evaluations are familiar with judicial and/or administrative rules prescribing their roles.

STANDARD VIII
FINANCIAL ARRANGEMENTS

Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

8.1 Financial Integrity.

Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals. Fee-for-service arrangements are not prohibited.

8.2 Disclosure of Financial Policies.

Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

8.3 Notice of Payment Recovery Procedures.

Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

8.4 Truthful Representation of Services.

Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

8.5 Bartering.

Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted, and (d) a clear written contract is established.

8.6 Withholding Records for Non-Payment.

Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

STANDARD IX

ADVERTISING

Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

9.1 Accurate Professional Representation.

Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law.

9.2 Promotional Materials.

Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law.

9.3 Professional Affiliations.

Marriage and family therapists do not hold themselves out as being partners or associates of a firm if they are not.

9.4 Professional Identification.

Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, the Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

9.5 Educational Credentials.

Marriage and family therapists claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields.

9.6 Employee or Supervisee Qualifications.

Marriage and family therapists make certain that the qualifications of their employees and supervisees are represented in a manner that is true, accurate, and in accordance with applicable law.

9.7 Specialization.

Marriage and family therapists represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm.

9.8 Correction of Misinformation.

Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

This Code is published by:
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Appendix G

Affidavit of Compliance

I,_____having fully read the Auburn University Marriage and Family Therapy Program Handbook (MFT Program Handbook) and Auburn University Marriage and Family Therapy Center Handbook ([MFT Center Handbook] Reference to both, MFT Handbooks), understand that it is my responsibility to meet all academic and clinical requirements of the MFT program and to comply with all policies and procedures set forth in the MFT Handbooks.

I understand that, as a clinical graduate student in the Auburn University MFT (AU MFT) program, I will learn and abide by, both the Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT) and the Standards of Conduct of Marriage and Family Therapists set forth by the Alabama Board of Examiners in Marriage and Family Therapy (ABEMFT). In the case of any contrary standards, I will follow the higher standard. Both ethical codes are included in the MFT Handbooks. _____ (INITIALS)

I acknowledge having already read and signed the Auburn University Marriage and Family Therapy Center Confidentiality Agreement. _ _ (INITIALS)

Furthermore, I understand that, before I begin observing, and later working, with clients at the AU MFT Center, I must review, learn and begin following all policies and procedures of the MFT Center, contained in the MFT Center Handbook._____ (INITIALS)

Should I believe I have an academic grievance during my tenure as a student in the MFT program, I am aware that I should consult and follow the AU Student Academic Grievance Policy found at: https://sites.auburn.edu/admin/universitypolicies/Policies/StudentAcademicGrievancePolicy.pdf

By signing this document, I am signifying that I will abide by the terms of this affidavit of compliance.

_____

Signature of Student Date

_____

Signature of Witness Date