2024

Auburn University Marriage and Family Therapy Center Handbook

DEPARTMENT OF HUMAN DEVELOPMENT AND FAMILY SCIENCES, AUBURN UNIVERSITY, MARRIAGE AND FAMILY THERAPY CENTER AT ARTF BUILDING #1, 202 SPIDLE HALL, AUBURN, ALABAMA 36849-5604

THE RELEASE OF A NEW EDITION OF THE HANDBOOK WILL OCCUR WHEN SIGNIFICANT CHANGES IN POLICIES OR PROCEDUES ARE INSTITUTED

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MFT Clinical Requirements and Definitions

COAMFTE

Commission on Accreditation for Marriage and Family Therapy Education.

Observation Hours

As part of the HDFS 7601 lab, students are required to observe and code therapist behaviors across 35 therapy hours. This requirement is an essential element required to be able to produce practice–based evidence of your therapeutic competence. This requirement must be completed for students to be eligible to begin seeing clients during their second semester. The requirement serves several purposes. First, students learn from watching other therapists' work. Second, students gain exposure to various therapist styles and theoretical approaches. Third, students learn to observe rather than "watch" therapy. By observing and coding, therapists-in-training gain an appreciation for various therapeutic behaviors.

Completing observation hours occurs in three ways: (1) by watching live cases at the MFT Center or (2) by watching recorded sessions. The recorded sessions allow the therapist to stop the tape and process the session. (3) There are also master therapist tapes in the library. Appendix C lists some of the available videotapes. Students can observe up to five hours of the master therapist videotapes. We recommend that the student follow at least one live case for 5-6 sessions, beginning with the first session.

The students are responsible for arranging with the therapist to observe therapy. By interacting with the second-year students before, during, and after the therapy session, the observations become meaningful experiences. Therapy observance requires the same level of confidentiality as therapy.

Students will record their observation hours using the TGCSQ form. They are required to view the session with another cohort member and complete the TGCSQ form together, coming to a consensus on what behaviors were seen. Students will reach at least an 80% consensus in their ratings on the form before turning them in. The deadline(s) for completing the observation hours and accompanying TGCSQ forms will be listed in the HDFS 7601 syllabus.

500 Direct Client Contact Hours

You are required to complete 500 direct client contact hours, with half being relational (250 hours with two or more clients in the therapy room), to graduate from the Auburn MFT program. No student has ever delayed graduation because they lacked the 500 hours. However, a few students have pushed the deadline out to August of their final semester to complete hours. The programmatic experience of the last three Program Directors (PDs) spans 40 years. The shared wisdom from the Program Directors is that at the end of the fourth semester (second fall semester), the student should be close to 200 hours. At the end of the fifth semester, a student should have around 350 hours. While some students have accumulated fewer hours and completed the program on time, they experienced more significant stress throughout the process.

The student is responsible for seeking the PD and discussing their clinical progress during the internship. The PD evaluates the monthly clinical hours and is typically aware of any disconcerting numbers. If a student accrues fewer clinical hours, the PD and Internship Supervisor will meet with the student to establish a plan. If there continues to be a concern, the PD will write a formal letter with requested benchmarks suggested to improve the accrual of clinical hours. The student can meet with the clinical faculty to discuss options for increasing hours. The typical option is to increase clinical hours at the MFT internship or the AU MFT Center.

Students must remember that they are required to complete the required 500 therapy hours. If they do not, they will delay graduation, pay tuition for additional semesters (in-state or out-of-state because the tuition waiver ends at two years), and lose assistantship for the placement.

Half of the 500 direct client contact hours must be relational (two or more clients in the therapy room). COAMFTE defines direct client contact as face-to-face (therapist and client) therapeutic intervention occurring in person synchronously, either physically in the exact location or mediated by technology. Also, therapy services delivered through interactive team modalities may provide direct client contact for specific team members who have in-person interaction with the client/system during the session. Therapy team members who engage in the therapeutic process only behind the mirror may not count the experience as direct client contact. Activities such as telephone contact (other than calls of extended duration), case planning, observing therapy, record keeping, travel, administrative activities, consultation with community members or professionals, or supervision are not considered direct client contact. A maximum of 100 hours teaming behind the mirror that includes direct contact with the clients during live therapy sessions may count toward the 500 hours.

To obtain the 500 hours within two years, students carry a caseload sufficient to obtain a minimum of 10 client contact hours per week. Cancellations and no-shows by clients are frequent; therefore, the student should aim to schedule a total of 17-20 sessions per week between all placements. Typically, students will easily surpass the required 500-hour clinical requirement. However, the student will continue seeing clients until the completion of the program.

Individual: The session is counted as "individual" when meeting with one person.

Relational: Relational Hours are a category of direct clinical contact hours in which a clinician delivers therapeutic services to two or more individuals who share an ongoing relationship beyond that which occurs in the therapeutic experience itself. Examples include family, intimate couple subsystems, and enduring friendship/community support subsystems.

- Relational hours may also be counted with relational subsystems, including a person whose only available means to participate in the in-person therapeutic meeting is telephonic or electronic (e.g., incarcerated, deployed, or out-of-town subsystem members).
- Group therapy can be counted as relational hours if those in the group therapy have a relationship outside of (above and beyond) the group itself. Conversely, group therapy sessions of otherwise non-related individuals are not considered as relational hours but as individual direct client contact.

100 Supervision Hours

Concurrent with the required 500 hours of direct client contact, students must obtain at least 100 hours of supervision from approved supervisors. This supervision will consist of both individual/dyadic and group. A minimum of 50 individual or dyadic supervision hours is required. Students must receive at least 1 hour of individual supervision each week they see clients and a minimum of 1 hour of supervision for every 5 hours of therapy conducted. Obtaining the 1:5 ratio of supervision to direct client contact occurs through participation in group case consultation, live supervision (primarily on clinic nights), and individual supervision with their on-campus supervisor. Additionally, if the internship supervisor is an AAMFT Approved Supervisor or Supervisor Candidate, the supervision received at the site also counts toward the program supervision requirement. Furthermore, at least 50 hours of supervision must utilize raw data, which is defined as live supervision or recordings of

sessions.

Supervisors: All supervisors for MFT students are required to be AAMFT and/or ABEMFT certified supervisors or AAMFT and/or ABEMFT supervisor candidates. An AAMFT approved supervisor is "An individual who has satisfied all of the academic, clinical requirements, and supervisory training requirements set by the AAMFT to be designated an AAMFT Approved Supervisor" (COAMFTE Accreditation Standards Version 12.5). An ABEMFT is "A Licensed Marriage and Family Therapist who has met [Alabama Board of Examiners in Marriage and Family Therapists] Board requirements to provide MFT Supervision" (ABEMFT Rule 536-X-3-.01).

Definitions of Supervision Hours

Individual Supervision: This type of supervision occurs in the presence of an AU MFT program clinical supervisor and with one to two supervisees.

Group Supervision: This supervision occurs with a program clinical supervisor and a group of six (6) or fewer student supervisees.

Types of Program Clinical Supervision

Case Consultation: This is counted when your case or another student's case is reviewed and supervised without using observable data (video, audiotape, or live supervision).

Observable Data

- **Video:** This is counted when you or another student is supervised, and a video of the case is presented. In both individual and group supervision, all students in the group can count this as observable data.
- **Audio:** This is counted when you are supervised individually or in a group, and an audiotape of the case is presented. All students present during supervision count the experience as observable data.
- **Live**: Live supervision is counted when you conduct therapy in the presence of your supervisor or view a live case with your supervisor. The one or two therapists conducting the session and those therapists viewing the session count it as live supervision.

Supervision Interruptions

Supervisors are expected to provide supervisory support during planned and unplanned interruptions to supervision. Students must receive supervision from a designated supervisor when seeing clients when the University is closed (i.e., Spring Break, Winter Break, etc.). During interruptions and breaks, the supervisor responsible for the semester will continue the supervision. The fall internship supervisor will supervise the winter break; the spring supervisor will supervise the spring break. The summer supervisor will supervise the first-year students transitioning to receive the client load from second-year therapists.

MFT Center Policies and Procedures

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

how the Center functions.

MFT Center Operations

The Auburn MFT Clinic is open to provide therapeutic services to the community. It is open Monday through Thursday from 8 am until 8 pm and Fridays until 5 pm. The clinic is open for services on the same days Auburn University is open, not based on the Auburn University academic calendar. The clinic will adhere to the University's protocol in regard to emergency situations requiring closing.

MFT students provide therapeutic services for the MFT Center and market to receive clients for the Center. Each therapist is required to attend their clinic night and participate actively in therapy from 4 pm until 8 pm. Clinic nights will be based on the cohort year in the program, and other cohorts should only schedule clients on these nights if there is prior approval from the Program Director/Clinical Administrator.

Second-year therapists play a significant role in the operation of the MFT Center. They are required to block out nine (9) additional hours of therapy services outside of clinic night. This is crucial for staffing the Center and ensuring we can provide the necessary services to fund the basic functioning of the Center and support student growth.

Students provide the Clinical Administrator with their classes, internships, and assistantships schedule. When providing the outline, the therapist provides substantive information about each block of time. The MFT Center will honor the class schedule and internship/assistantship schedule. The Office Administrator and Clinic Administrator will list clinical hour responsibilities for therapists throughout the week. Students then have their MFT Center schedule and are required to be present to receive clients on those days and times at the MFT Center. Students cannot cancel sessions for clients without the Program Director or Clinical Administrator's permission. The PD/CA will need a doctor's notification if the student is sick.

Due to the clinic being open in the evening, faculty and staff may or may not be present. Therefore, students must have at least one other student physically present with them in the building while delivering therapy. Both students are allowed to see clients simultaneously. Students cannot see clients when no other student or center staff is in the office.

Client Contact

Students are required to make and maintain contact with their clients. The Office Administrator, if available, will schedule the intake session when assigning clients. However, if they cannot schedule, it is the responsibility of the student to call and schedule with their clients (see Appendix C). Emailing from the center email is only acceptable for scheduling if unable to contact the clients via phone call in the first three (3) attempts. Students are responsible for communicating any cancelled or rescheduled sessions via phone calls with their clients. Students should also monitor the clinic email for any contact made by the client. See Appendix C for further information on scheduling and case management.

Students are only permitted to use their personal cell phones for scheduling purposes. Conducting sessions via direct cell phone call is prohibited. Students must change the voicemail greeting of their cell phone to the required AU MFT Center clinical intern voicemail greeting (see Appendix C). Texting with clients is not permitted.

TAFTS

In response to the COVID-19 pandemic, the Marriage and Family Therapy Center (AU MFT Center) transitioned to a modified operations model. Best practice recommendations from state, federal, and university authorities have informed the development of these policies and procedures.

The AU MFT Center will offer technology-assisted family therapy services (TAFTS) post-pandemic to all clients in the state of Alabama (at the time-of-service delivery). TAFTS will be used for individual, couple, and family therapy, as well as clinical supervision. These services will be provided in the form of teletherapy and tele-supervision via ZOOM, as secure, HIPAA-compliant videoconferencing platform, with telephone meetings as a back-up in emergencies. (See AU MFT Teletherapy Guidelines Handbook).

Marriage and Family Therapists 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 (https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx) and the ABEMFT Standards of Ethical Conduct, (https://mft.alabama.gov/PDF/2020/RulesRegs.pdf) found in Appendix F. 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.

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. You are expected to join AAMFT as a student member to be covered under the liability insurance.

MFT Clinical and Supervision Monthly Report Form

Once students begin doing therapy, they must complete an MFT Clinical Hours Report Form at the end of each month (Appendix A). 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 completed by the third day of each month.

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

Definitions of terms:

SITE SUPERVISOR: The supervisor at each location who the student directly reports to regarding the clients seen at each location. The supervisor at MFT Center is the AAMFT approved supervisor or AAMFT approved supervisor candidate teaching the practicum course. The faculty supervisor will be in communication with the PD and/or Clinic Administrator and each site supervisor to assess student's clinical practice.

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

TEAM THERAPY HOURS: The hours 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 Reporting Form

Name:_____ Month/Year:

Cases Assigned at MFT Center for the Month:

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

Client ID#	Category	Date Assigned	Date Called	Intake Date	Session #

		Client Contact Hours					**Supervision Hours**					
Site Name	**Modality**	**Ind.**	**Couple** (relation)	**Family** (relation)	**Relational** add cpl + fam 250hrs	**Total Client Hrs** 500 hrs	**Case Report**	**Live** raw data	**Video** raw data	**Audio** Raw data	**Direct Obs** add (aud+ vid+ live) 50 hrs	**Total Hrs Supervision** 100 hrs
MFT Center	**IND**											
	GRP											
	TEAM											
Site Supervisor Signature: _____ **Date:** _____												
	IND											
	GRP											
	TEAM											
Site Supervisor Signature: _____ **Date:** _____												
	IND											
	GRP											
	TEAM											
Site Supervisor Signature: _____ **Date:** _____												
Cumulative Totals add hrs earned all sites						Aa						bb

Student Signature: _____ Date: _____

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 one session in progress, the following applies:
    a. The primary therapists receive 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 over 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 supervision 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 on-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 hours 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 4-9:00 p.m., the supervisor assists students in calculating the appropriate amount and kind of supervision. There is also a case reporting time before seeing clients (this has traditionally been from 3-4:00 p.m. on Thursdays).

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. In addition, a written report will be made containing all 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

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

Auburn leases Suite 202 of the Auburn Research and Technology Foundation (ARTF) Building #1 for the AU Marriage & Family Therapy Program’s use. Since you will frequently be using the center on

evenings or weekends, students will need to obtain swipe access to the ARTF Building, Suite 202, and Room 285. Students will need to e-mail their names and banner numbers to the Office Administrator who will contact the ARTF Building Director to obtain access. A community key ring, large enough to prevent it from being accidentally carried off, is located inside the Center and contains keys for the four (4) therapy rooms, the observation room, the MFT conference room, and the two MFT labs. 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. Ketring 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 ensure that the building is secure. All office doors, including the conference room, computer labs, and observation room, need to be locked. We must make sure that no one can access anything inside while conducting therapy.

Being responsible also means making sure that filing cabinets are locked, equipment is locked away, and inside doors closed and locked. It is your responsibility to make sure that everything is secured before leaving.

Client Hard Files

Client case files are stored in two locations. Active client files through January 2020 are stored in a locked filing cabinet, behind closed doors in ARTF, Room 285. The door locked and card swipe access.

The filing cabinet is locked at all times unless a therapist or clinic staff member is in the room. Active client flies after June 2020 are stored in the MFT Titanium Schedule software. 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 filing cabinets in Room 285. 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.

Titanium

Titanium is the online clinic software that MFT students, faculty, and staff will utilize to maintain client files, records, billing, supervision, and client forms. The Titanium software is only accessible through approved MFT computers with access granted by Walter Tolbert, the HDFS IT specialist. Remote access to Titanium is available but must be approved by the MFT supervisor.

Valt

Valt is the online video and audio software the MFT clinic uses to record all therapy sessions completed in the Auburn MFT Clinic. Access to the software is only accessible through approved MFT computers, with access granted by Walter Tolbert, the HDFS IT specialist. Outside of the AU MFT clinic, client video or audio recordings are strictly prohibited.

Equipment

The digital audio, Chrome Books, and video equipment are to remain behind locked doors and turned off/plugged in when not in use. 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. Additionally, two iPads are to be used at approved MFT clinical internship locations. When used off campus, the student is responsible for the care and safe keeping of the iPad. These are strictly for recording video and audio of sessions held at the off-campus locations.

Case Summary

A template for the Session Summary Form is stored on the MFT Titanium program. This form should be completed on the computer and then sent to the correct supervisor to review and sign. There is no need to save the case note on a hard drive.

Phone

To make calls locally press 9 + the 7- digit number. Personal calls allowed with phone number 844-4482, in the MFT student lab. 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.

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.

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

Students are only permitted to use their personal cell phones for scheduling purposes. Conducting sessions via direct cell phone call is prohibited. Students must change the voicemail greeting of their cell phone to the required AU MFT Center clinical intern voicemail greeting (see Appendix ???). Texting with clients is not permitted. Some students have created google voice numbers to contact clients for scheduling purposes. **Remember that client contact information is strictly confidential.**

Email

The AU MFT center has a single shared email address for communication between clients and students. Emails should strictly be used for scheduling, providing links for assessments, or linking to telehealth sessions. All email content should maintain client confidentiality. See below for additional information.

Dress Code

Your work at the MFT Center represents a professional position, and your attire needs to reflect that position. For all students, clothing that reveals cleavage, chest, back, stomach or underwear is not appropriate for a place of business. Clothing should not be wrinkled, torn, dirty, or frayed. All seams must be finished. Clothing that has words, terms, or pictures that may be offensive to clients will require faculty review. Dress, kilt, and skirt length should be past the knees and allow you to sit comfortably in public. Mini-skirts, shorts, sundresses, beach dresses, t-shirts, and spaghetti-strap shirts or dresses are not allowed. Remember that some are allergic to the chemicals in perfumes and makeup, so wear these substances with restraint. Clothing and piercings should not be distracting to clients. The

dress code is in effect when interacting with clients or representing the Center or the MFT Program.

Room Use

You must schedule all therapy sessions in the calendar on the Titanium program. If you do not, you may find yourself with no place to conduct therapy. Likewise, if you do not have clients properly scheduled in the calendar you could unexpectedly receive new clients by office staff. Additionally, calendared entries are part of our internal auditing for fee collection. Those who do not list clients are potentially creating an audit and ethics violation. 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 use the equipment.

Smoke, Substance, Firearm and Alcohol- Free Facility

Smoking, vaping, alcohol, firearms, or drug use are not permitted in the MFT Center

Directions and Parking

The following are directions to the MFT Center.

Address:
570 Duvall Dr., Building #1
Office #
Auburn, Alabama 36849

There is parking in the East and West lots of this building. No car tag is required.

Severe Weather Action Plan and Policy

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 second floor of the ARTF Building #1 should immediately take shelter on the first floor.

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 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 a windowless location on the first floor 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 a safe location. 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 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 inform emergency crews or to direct proper personnel to any damage of 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 immediately.

Emergency Phone Numbers

911 – Police

334-749-8161 – Emergency Operations Center

Case Management- Policy, Files, and Forms

Confidentiality

To maintain client confidentiality, the two rooms housing computers storing video will be locked at all times. All physical client files and all sources of client data are stored in the locked file cabinets in the locked equipment room 285, or on the secure hard drive. All client files created after June 2020 will be securely stored in the MFT Titanium software. You must fully log out of any clinic computers once done using the Titanium software.

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 receives a call requesting MFT Center services completes the appropriate referral form.
2. Inform the caller about the MFT Center services and training component, the therapists and supervisors, the sliding scale fee, the first session fee, and any potential delays in scheduling.
3. The person taking the call will then inform the client of the scheduling procedure. Information will be input into the appropriate Bubbles Excel as well as the Titanium program. A therapist will be assigned to the client case, as their case load will allow or need. The therapist will call the client to schedule the appointment(s).
4. The therapist will send the client the link, via email, to the intake assessment (initial paperwork) and informed consent to treat, prior to the first appointment. Clients who are unable to complete the forms prior to the appointment will be asked to do so during their scheduled session time.
5. We are not allowed to send client data through email. While a link can be sent, client information is protected legally. Clients can fax, mail, or bring the informed consent to the MFT Center before treatment occurs. Remember that you cannot treat clients unless you have their informed consent.
6. For every new appointment, a client file should be prepared using the appropriate procedures noted below.

Good Faith Estimate

Links to Good Faith Estimate
Z Drive

Full Packet Z:\Forms and Paperwork to Print\Forms\Good Faith Estimates\AU MFT Center Good Faith Estimate 2022 Packet.docx

Posting Z:\Forms and Paperwork to Print\Forms\Good Faith Estimates\AU MFT Center Good Faith Estimate 2022 Post.docx

Frist Session Z:\Forms and Paperwork to Print\Forms\Good Faith Estimates\AU MFT Center Good Faith Estimate 2022 First Session.docx

Subsequent Session Z:\Forms and Paperwork to Print\Forms\Good Faith Estimates\AU MFT Center Good Faith Estimate 2022 Subsequent Sessions.docx

Box Drive:

Full Packet https://auburn.box.com/s/zsnoaqxghczpdmevbdhuxl9fmw7blias

Posting https://auburn.box.com/s/f0d2s3elgjfc6wvcterq7hyaxu1d7jc2

Frist Session https://auburn.box.com/s/3pqbxaomjlzlgkn1codujis34ex1lh2o

Subsequent Session https://auburn.box.com/s/5y7f9bepupgpf46wabx4zw1hb7wrga6t

Samples:
Posting:

AUBURN UNIVERSITY (Taxpayer ID: 63-6000724)
MARRIAGE & FAMILY THERAPY CENTER
Glanton House, 312 Quad Drive, Auburn, Alabama 36849-5604 (or **via telehealth**)
Telephone: (334) 844-4478 | Fax: (334) 844-1924 | www.mftcenter.auburn.edu

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost.

Under the law, health care organizations need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care organization gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care organization, and any other organization you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises** or call 1-800-985-3059.

First Session:

AUBURN UNIVERSITY (Taxpayer ID: 63-6000724)

MARRIAGE & FAMILY THERAPY CENTER

Glanton House, 312 Quad Drive, Auburn, Alabama 36849-5604 (or **via telehealth**)
Telephone: (334) 844-4478 | Fax: (334) 844-1924 | www.mftcenter.auburn.edu

Client Name: **Date of Birth:**

Communication Preference: ☐ Electronic ☐ Mail

The following is a detailed list of expected charges.

Date of Service	Type of Service/Code	Quantity	Expected Cost
	Diagnostic Interview 90791	1	$
Total Expected Charges			$

Clients who no-show, cancel or reschedule with less than 24 hours of appointment will be billed the full session rate. These actions increase cost and length of treatment.

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer

This Good Faith Estimate shows the cost of services reasonably expected for your health care needs for a service. The estimate is based on information known when the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Federal law allows you to dispute (appeal) the bill if this happens. This Good Faith Estimate is not a contract and does not require you to obtain services from the AU MFT Center.

You may contact the AU MFT Center to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

Non-disclosure of relationship, addiction, or mental health problems and diagnoses impacts the length and subsequent cost of treatment. Likewise, not following the treatment homework and guidelines can impact the length and cost of treatment.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date of the original bill. There is a $25.00 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will only pay the price of this Good Faith Estimate. If the agency disagrees with you and agrees with the AU MFT Center, you must pay the higher amount. Initiation of a client-provider dispute resolution process will not adversely affect the quality of health care services furnished to you by the AU MFT Center.

Go to www.cms.gov/nosurprises for a form or more information, or call 1-800-985-3059.

Please keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Signature of Client: _____ **Date:** _____

Subsequent Sessions

AUBURN UNIVERSITY (Taxpayer ID: 63-6000724)

MARRIAGE & FAMILY THERAPY CENTER

Glanton House, 312 Quad Drive, Auburn, Alabama 36849-5604 (or **via telehealth**)
Telephone: (334) 844-4478 | Fax: (334) 844-1924 | www.mftcenter.auburn.edu

Client Name: **Date of Birth:**

Communication Preference: ☐ Electronic ☐ Mail

The following is a detailed list of expected charges.

Range of Service Dates	Type of Service	Each Costs	Quantity	Expected Cost
to	N/A			$
to	N/A			$
Total Expected Charges				$

Clients who no-show, cancel or reschedule with less than 24 hours of appointment will be billed the full session rate. These actions increase cost and length of treatment. **Client Initials:** _____

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer

This Good Faith Estimate shows the cost of services reasonably expected for your health care needs for a service. The estimate is based on information known when the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Federal law allows you to dispute (appeal) the bill if this happens. This Good Faith Estimate is not a contract and does not require you to obtain services from the AU MFT Center.

You may contact the AU MFT Center to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

Non-disclosure of relationship, addiction, or mental health problems and diagnoses impacts the length and subsequent cost of treatment. Likewise, not following the treatment homework and guidelines can impact the length and cost of treatment.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date of the original bill. There is a $25.00 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will only pay the price of this Good Faith Estimate. If the agency disagrees with you and agrees with the AU MFT Center, you must pay the higher amount. Initiation of a client-provider dispute resolution process will not adversely affect the quality of health care services furnished to you by the AU MFT Center.

Go to www.cms.gov/nosurprises for a form or more information, or call 1-800-985-3059.

Please keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Signature of Client: _____ **Date:** _____

Preparation of Client Files

Admin Duties:

The MFT Admin will maintain the record of client calls, new client assignments, and the creation of new client files in the MFT Titanium program.

The MFT Admin will work to audit and ensure that all client files contain the proper paperwork in correspondence with the correct session.

Maintain the Client Codes in Bubbles. The first new client in January of each year will have the code of Year01001, e.g., in 2022 the number is 202201001, and the second client in January would be 202201002. The first client in February would have 202202###, with ### dependent on what the last new client number was in January.

Necessary Paperwork Filed:

1. Informed Consent for Treatment
2. Assessments
3. Intersession Reports
4. Case Notes
5. Treatment plans
6. Release of Information
7. TAFTS consent (If conducting teletherapy session)
8. Consent to treat a minor (if client is underage)
9. Invoices

Fee Policy and Schedule

The MFT Center collects fees because of budgetary or administrative needs, and the conviction that learning how to arrange fee agreements, 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. The clinic has a set fee of $60.00. However, clients can opt for a sliding fee across the first twenty sessions if they provide proof of income (e.g., tax forms, salary stubs for two pay periods). Agreeing to fees at the outset of therapy is a foundation for a working alliance. The professional roles of the clients and therapist have begun to take form. Not arranging fees with clients during the training program impedes the transition to the professional world. The fee reduction is available for the first 20 sessions. After the 20th session the fee will automatically increase to $60.00 for subsequent sessions. Research is clear that most therapy does not demonstrate client improvements past the 20th session. Clients can either pay the higher amount or take a 120-day (approximately 4 months) break from the center before returning to be eligible for the reduced rate again.

To be eligible to receive a reduced rate the client must meet the following criteria: 1) Agree to a weekly schedule of therapy, 2) Not have more than two no-show/cancelled appointments, and 3) Complete all assessments in a timely manner.

Therapists 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. Client fees can be decreased below the minimum rate ($20.00) but can only be decreased below the rate four

sessions at a time. Supervisor approval is required for the fee reduction below the minimum rate. A letter is written to the client specifying the number of reduced sessions, the expectations for therapy, and the amount. In addition, the client will maintain a strict assessment schedule during the reduced rate with no missing assessment data and will attend weekly. The therapist will track the outcomes regularly to demonstrate progress. The client will not receive a reduce fee past the 20th session without agreement by the Program Director. 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).

Fee Collection Policies and Procedures

1. Fees are charged according to the approved fee schedule. When a client calls for the initial appointment, they are informed that the center's fee is $60 for the initial session and $60 thereafter. Inform the client that they 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, if the client brings the necessary paperwork (tax return, W2 forms). Payment is accepted online or through cash, checks, or credit cards. Checks must be made payable to Auburn University. The clinic does 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, the next order of business will be to determine 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 or her rationale (e.g., extensive medical bills, funeral costs, debt consolidation). The therapist may present the client's rationale to his or her supervisor for a fee reduction. **No client fee 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 beginning of each session. **Client files will be audited to verify that the therapists collect invoices.** Write the client a receipt and schedule the next session in Titanium. A receipt is completed for all fee payment types whether or not the client desires one. **Do not** remove the pink receipt copies; these remain in the receipt book. Place the yellow copy of the receipt in the client payment envelope as part of step 5.a. If you make a mistake on a receipt, **do not throw it away.** Write "VOID" on the receipt and leave all three copies (white, pink, yellow) in the receipt book. Please ensure that the cardboard page is placed behind each receipt page to avoid the ruining of other receipts as writing transfers through carbon paper.

5. Record all appointments in Titanium. The schedule is a key component to maintaining the accounting records and monthly auditing process for the clinic.

    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 will both need to sign their names on the sealed envelope. Envelopes should have written on the outside, the therapist's number, the client's ID number, fee amount paid, and form of payment. Once this

information is written and the envelope is sealed, place envelope in the collection box behind the reception desk. **Do not leave monies out or unattended at any time.**

6. A client can only fail to pay for one session on a case. If the client fails to pay for a session, the therapist will require the client to pay for two sessions at the **beginning** of the following session. If the client arrives without payment, a second time, a good faith plan for resuming regular fee payments, according to the fee agreement, must be made in writing in order to meet again. If a satisfactory written plan is not agreeable to the client, the therapist and supervisor will discuss referring the client elsewhere. Clients who do not show up for a session and do not call to cancel at least 24 hours in advance will be charged the full session fee. Therapists may, one time, choose to forgive the no-show fee for an unusual circumstance.

7. The MFT office Administrator is responsible for removing the fees and receipts on a regular basis of at least once a week, or more frequently, when the clinic is busy. The AU MFT Center utilizes Auburn University compliant auditing procedures. The office Administrator will check the receipts against the client files in Titanium to ascertain the status of all scheduled appointments to ensure the accuracy of the appointment schedule. Any financial discrepancies on daily records are the responsibility of the therapist.

8. The MFT office Administrator will audit the account of every open case once each month. Each therapist will resolve all their cases in which the audit determines account discrepancies. When a client has not made payments in accordance with his or 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 resides with the therapist and the supervisor. Contact clients who leave an unpaid balance in writing with a copy of the letter uploaded to their file in Titanium.

9. If a check is returned, the therapist will make a phone call to the client informing them of the discrepancy. The returned check should be scanned and uploaded into the client's file in Titanium. Checks can be post-dated to avoid returns (these should be annotated on the payment envelope if applicable). Clients may need to file a new income evaluation or be considered for a lower fee.

First Session Assessment Fee

An additional $20.00 is assessed as a first-session fee but is capped so that the total amount paid for any visit does not surpass $60.00.

Fee Schedule per Session

* Revised 02/2022 * * * * * * * * * * * * * * * * * *

INCOME RANGE FOR SESSIONS (A $20 administrative fee is added to the first session and capped at $60.00)

# Fam	Under $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	$65,000 69,999	$70,000 74,999	$75,000 79,999	$80,000 More
1	$25	$30	$35	$40	$45	$50	$50	$55	$55	$60	$60	$60	$60	$60	$60
2	$20	$25	$25	$30	$35	$40	$45	$50	$50	$55	$55	$60	$60	$60	$60
3	$20	$20	$25	$25	$30	$35	$35	$40	$40	$45	$50	$55	$55	$60	$60
4	$20	$20	$20	$25	$30	$30	$35	$35	$40	$40	$45	$50	$55	$55	$60
5	$20	$20	$20	$20	$25	$25	$30	$35	$40	$40	$45	$50	$50	$55	$60
6+	$20	$20	$20	$20	$20	$25	$30	$35	$35	$40	$45	$45	$50	$55	$60

**** The fee for individual clients who are students with an active student ID is $30 per session, except for a student who can demonstrate proof of federal student aid. <u>The student fee is not calculated for students receiving couple or family therapy and their partner is not a student.</u> Students referred from Safe Harbor will receive six free sessions and pay the standard student fee for subsequent 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 $60 (unless client brings proof of income to qualify for a reduced rate).

Following a phone referral:

1. Determine the client code number from the client database called Bubbles. The file is password protected and located on the shared drive. This number is used as the client file number in Titanium.

2. Put the client's demographics and file number into the Bubbles file and create a new file in Titanium.

3. Select an appropriate therapist to assign the client to and inform the therapist of his or her new client via email. Please be aware that no identifying information can be sent through email. Client file numbers are used in lieu of personal information when communicating with therapists.

I. Process for Receiving Clients Equitably
A) Discuss availability with clients & their therapist's preference (Clients can request a therapist, especially if the therapist actively recruits the client)
B) First assignments go to those who need hours for completion of their degree (we have favored those with the fewest hours to help them graduate)
C) The therapist with the lowest MFT Center caseload would be the next priority (Therapists who have low census at the Center would be selected – so if I only had a caseload of two clients then I would receive priority).
D) If no matching is available, the new client is assigned to another therapy as long as they don't have a full caseload.

Assignment of Clients from Phone Referrals

1. The office Administrator will maintain record of each therapist's client load. New clients will be scheduled based on the client load attendance hours, not on the number of cases. It is the therapist's responsibility to keep accurate records of client appointments and case closures to ensure caseloads are accurate in assigning new clients.

2. Upon receiving a referral, call the client to schedule the first appointment, unless the office administrator has already scheduled the client. If the client does not answer the first call, try at least 3 more times, within the week, to schedule. Please make call notes in Titanium each time contact is attempted or made with a client detailing the nature of the call or attempted call. Please be sure to schedule appointment in Titanium.

3. Be on time for your clients (15 minutes before session). For example, the therapist needs to arrive at the Center by noon if the client is scheduled to arrive at 12:15 p. m. Clients should complete paperwork prior to their appointment online. It is the responsibility of the therapist to not only send the correct paperwork to their client prior to their scheduled appointment but to ensure it has been completed and filed in Titanium. If you have issues filing paperwork, please see the Office Administrator for assistance.

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.

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 allow the client to review each section of the informed consent and sign it. After the **12th 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 them with the paperwork.

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 or on the Shared Drive. 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.
- The information obtained from the assessments has a two-fold purpose, which are to help the specific clients track progress, and secondly, 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
In-person therapy and TAFTS consent

Informed Consent Including Technology-Assisted Family Therapy Services (TAFTS)

Initialing each page and specific sections, along with signing this document, provides consent to each aspect of the clinical service described in this informed consent document.

Welcome to the Auburn University Marriage and Family Therapy Center (MFT Center). We serve couples, families, and individuals throughout East Alabama. Services are provided by graduate students receiving training in marriage and family therapy. All are professionals-in-training and are under the direct supervision of the clinical faculty in the Marriage and Family Therapy Program. The clinical faculty are Approved Supervisors of the American Association for Marriage and Family Therapy (AAMFT).

The MFT Center altered operations to accommodate client needs during COVID-19, to continue serving your mental and relational health needs throughout this process. For this purpose, we provide both in-person and Technology-Assisted Family Therapy Services (TAFTS) to promote services that maintain client and therapist health and safety. Operating procedures and protocols connected with therapy services are located at: https://www.mftcenter.auburn.edu/

Because our primary functions are to train clinicians in their chosen specialty, we require permission to audio and video record interviews and to observe the treatment sessions either live or recorded. The use of observation, taping, and supervision is crucial to your treatment and allows for instruction and supervisory input, ensuring the highest quality services possible. Please discuss any questions about this practice with your therapists. Signing your name at the end of this Informed Consent means that you have entirely read, understand, and have inquired as necessary, about all aspects of the consent.

TAFTS is therapy delivered through electronic communications and used for individual, couple, family therapy, and clinical supervision. There are some barriers to TAFTS compared to sitting with a therapist in the same room, and it could be less appropriate for some populations. Some limitations can be addressed and are minor depending on the quality of sound and video, the level of care needed by the client(s), and the comfort level in using teleconferencing platforms.

Zoom – The Digital Platform for TAFTS: The AU MFT Program uses Zoom Teleconferencing (Zoom) to conduct all TAFTS. Zoom is a secure application for video conferencing that works across mobile devices and desktops. Before your TAFTS sessions, you will receive an individualized Zoom link and meeting ID number through email, which will enable download and installation. Additionally, you will need access to a webcam, microphone, and a private room to participate. A supervisor may join the session to supervise the therapist-in-training.

Titanium – Electronic Medical Records (EMR): The AU MFT Program uses Titanium Schedule, an electronic medical records (EMR) system, to schedule clients and store treatment notes and assessments. You will be emailed a link to complete assessments protected by encryption.

Email: Email is required for TAFTS because we will need to coordinate scheduling, sending web links, surveys, and other materials related to services. The AU MFT Program uses Outlook 365 email. These messages are not encrypted and are thus NOT CONFIDENTIAL. Please note that email is not a platform used by therapists or staff at the AU MFT Center to answer questions or conduct therapy sessions. If you are uncomfortable with the unsecured email communication for scheduling TAFTS, we can establish an alternate communication method.

By initialing below, you consent to communicate with you via email according to the limits described.

____ 1. I consent to have AU MFT Center, and my therapist communicates with me via email.

My email address is (possibly multiple): _____

Cell Phone: Contacting therapists through their phones is a temporary policy shift to facilitate TAFTS for technological disruption and scheduling. Once Auburn University emergency response to COVID-19 is completed, therapists will no longer communicate with clients by cell phones but will return to contact through the MFT Center number (**334-844-4478**). Therapists will not store client numbers nor communicate via text. Therapists' phones are password-protected, but we cannot guarantee there will be a breach of confidentiality. If a therapist has not returned a phone call within 24 hours, please contact the MFT Center number.

PATIENTS RIGHTS

Confidentiality: To protect client confidentiality, we adhere to the following procedures:

1. Written, telephone, or verbal inquiries about clients will not be acknowledged without your consent. Signed consent is required to release information about you is shared with anyone outside the Center. Even then, we may advise you to withhold information if we feel it is in your best interest.
2. All records, tapes, or other identifying materials are kept confidential.

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

1.
2. 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 clear and imminent danger to you or others, by court order, if you plan to commit a violent crime, 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.
3. The therapist-in-training will testify in any court proceeding if ordered by the judge.

Clinical Change and Research: The primary purpose of assessing clients is to help clinicians make informed treatment decisions. Assessments are completed throughout therapy to track client progress and therapist effectiveness. You can access the forms on the AU MFT web page. The secondary purpose of the assessments is to publish about treatment. We track biographical data, clinical assessments, and coding of therapist behaviors to assess effectiveness. All identifying client information is removed to ensure confidentiality, and only aggregated client data is evaluated. Initialing and signing the document provides approval to use assessment information for research, which will not be conducted without Auburn University IRB approval.

Expected Benefits and Possible Risks of TAFTS: When Auburn University's on-site services are temporarily shut down based on COVID outbreak, or therapist or client illness, TAFTS is an option to continue providing client care. TAFTS enables individuals to receive treatment at their home or office. TAFTS is similar to in-person therapy in addressing client needs, developing a professional relationship, and treating mental illness.

There are potential risks associated with TAFTS. They include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., low resolution of images and weak broadband) to allow for appropriate treatment.
- Delays in treatment could occur due to deficiencies or failures of equipment.
- Security protocols could fail. However, data encryption makes this risk highly unlikely.
- A client chooses a non-private location in which to participate in the TAFTS session.

If TAFTS are unacceptable or do not meet your therapy needs, you can postpone services, or we can provide you with referrals for other clinicians in the area.

Additional Points for Client Understanding:

1. I understand that TAFTS is temporarily offered at the AU MFT Program to continue services during the COVID-19 outbreak.

2. I understand that TAFTS is voluntary and that I can choose not to participate.

3. **If I experience an emergency during a TAFT session, my therapist will call emergency services and my emergency contacts.**

4. My therapist explained to me how TAFTS will be used. I understand that TAFT sessions will not be precisely as in-person sessions, as I will not be in the same room as my therapist.

5. I understand my therapist or myself can discontinue the TAFT sessions for technological difficulties or personal discomfort with the service format.

6. I understand that I may experience benefits from the use of therapy, but that no results can be guaranteed or assured.

7. If I am experiencing an emergency, I will call 911 or proceed to the nearest hospital emergency room.

8. I understand that both my therapist and I will exchange phone information at the beginning of the session so that contact can occur if the TAFTS connection drops.

9. **I know that I will be asked to create a safety plan with my therapist for emergencies.**

10. I acknowledge that TAFTS cannot occur if I am outside the state of Alabama.

11. It is my responsibility to ensure that I participate in all TAFT sessions in a secure location

12. Those who have not signed the Informed Consent are not allowed to be present in therapy.

13. Because the therapeutic services are a professional relationship, neither interns nor staff at the AU MFT Center give or receive gifts from clients.

PAYMENT AGREEMENT

I understand that payment is expected before the therapist-in-training renders services. **By initialing items #1-12, you indicate that you have read, understand, and agree to the following:**

____ 1. The AU MFT Center payment for therapy services will be **$60.00 per 50-minute hour**. Any time spent in treatment beyond the clinical hour will be billed accordingly.

____ 2. Engaging therapists-in-training in verbal (including phone contact), written (including reports, court reports, or letters), or face-to-face meetings, will be billed $60.00 per 50-minute hour.

____ 3. Any client who pays with a check that does not have sufficient funds (i.e., bounced check) will be billed a $25.00 additional fee. The form of payment might also be changed.

____ 4. The AU MFT Center **strictly provides a fee for service practice. We do not bill insurance.**

____ 5. All clients will be billed for the full $60.00 rate for a session if (1) they do not call to cancel within 24 hours of your scheduled appointment (334) 844-4478; or (2) they no-show an appointment.

____ 6. Your therapist will wait on Zoom for **15 minutes** before leaving the therapy session. If you are late, then you must contact the therapist to let them know you are late. If you do not make it within 15 minutes, you will be charged a late fee.

____ 7. You agree that you will be billed for late cancellations and non-attendance.

You may petition to receive a reduced payment obligation. To qualify, you accept that the payment reduction is a service that can be revoked if abused, and you agree to the following:

____ 8. If a client cancels or reschedules appointments on three different occasions within two months, the reduced fee will be voided (exceptions include hospitalization or tragedies).

____ 9. To be eligible for reduced fees, clients are required to attend weekly.

____ 10. The reduced fee is guaranteed for 20 sessions. Following 20 sessions, the fee reduction is eliminated, and the client pays the flat rate of $60.00.

____ 11. All clients will be billed for the $60.00 session rate if (1) you no-show; or (2) you do not call (334) 844-4478 to cancel within 24 hours of your scheduled appointment start time.

____ 12. The AU MFT Center intern therapists and faculty do not perform court-related evaluations for child custody, nor do we testify in hearings involving child custody issues. Also, we do not appear voluntarily at any court or administrative hearing.

____ 13. If you, or your attorney, choose to subpoena an MFT Center therapist or other personnel for court testimony, including depositions or administrative hearings, you will be charged $100 per hour for any MFT Center personnel preparation time and $500 per 4-hour block of time our personnel spend being "on-call" to testify, traveling to and from the court, waiting to appear, and testifying. These charges will apply even if MFT Center personnel are excused from testifying. The minimum charge will be for 4 hours, and subsequent time will be billed in 4-hour blocks. By signing this agreement, you agree to pay these charges, and pay the attorney's fees and costs of collection incurred.

SAFETY PLAN

Please identify the names and phone numbers of three emergency contact people, as well as the contact information for your local emergency services provider. **These individuals/entities can be contacted in the event of an emergency or crisis.**

Emergency Contact People

1) Name: _____ Phone #: _____

2) Name: _____ Phone #: _____

3) Name: _____ Phone #: _____

Local Emergency Services Provider: (e.g., hospital)

Organization Name: _____

Organization Phone #: _____

Organization Address: _____

Police: _____ Paramedics: _____

Additional Resources

If you are not in immediate danger but would like someone to speak with, you can access the following resources. Both are free, confidential, and open 24 hours a day, seven days a week.

Resource: National Suicide Prevention Lifeline Phone #: 1-800-273-8255

Resource: Crisis Text Line Contact Info: Text HOME to 741741

CONSENT TO CLINICAL SERVICES

By initialing items #1-13, you indicate that you understand and agree to the following:

____ 1. I understand that the AU MFT Center services will be supervised by core faculty and program supervisors, including case consultation by audio/video recording or direct observation and review of treatment notes.

____ 2. I understand the confidentiality policies of the AU MFT Center and agree to them.

____ 3. I understand my rights/responsibilities as an AU MFT Center client and agree to them.

____ 4. I understand the fee agreement and agree to all client payment responsibilities.

____ 5. I understand that assessments are part of the treatment process and agree to answer the assessments honestly and thoroughly.

____ 6. I am willing to allow client assessments to be used for research purposes, as outlined in the agreement above, and as conditioned by the Auburn University IRB.

____ 7. I understand that the therapists' sharing of the cell phone will end after COVID-19.

____ 8. I understand and agree that if there is an emergency during one of my sessions, my therapist has permission to contact my emergency contacts and emergency services.

____ 9. I understand that my therapist will verify my location before the start of TAFTS.

____ 10. I affirm that I have provided the MFT Center with a working telephone number to reach me if the TAFTS connection fails during my session.

____ 11. I affirm that the MFT Center has provided me with a contact number to reach my therapist-in-training should the TAFTS connection fail during my session. If this occurs, I will call the number provided if my therapist/the MFT Center does not call me back within five minutes.

____ 12. I understand and agree that my sessions will be carried out in-person at the MFT Center or via the HIPAA compliant Zoom videoconferencing program.

____ 13. I affirm that I have been offered a copy of this consent form.

I have read and understand the information provided above, have, and all my questions have been answered to my satisfaction. I hereby give my informed consent for clinical services.

Signature of Client(s) *(or person authorized to sign for the client)*:

Client	Client
Client	Client

If Authorized Signer, relationship to client: _____

Signature of Witness(es) *(reserved for therapists)*:

Witness #1	Date	Witness #2	Date

Consent to Treat a Minor

Auburn University,
Alabama 36849-
5604 College of
Human Science

Department of Human
4478
Marriage & Family Therapy Center
4515

Telephone: (334) 844-

FAX: (334) 844-

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

Release of Information

Auburn University

Auburn University, Alabama 36849-5604
College of Human Science

Department of Human Development &
Family Studies Marriage and Family Therapy Center
ARTF Bld. #1, 570 Duvall Drive

Telephone: (334) 844-4478
FAX: (334) 844-1924
Email: aumft@auburn.edu

Authorization for Release of Confidential Information

Client Name(s):_____ Birth Date:_____

Client Name(s):_____ Birth Date:_____

I hereby authorize AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CENTER and the agency or individual listed below, or their representatives, to mutually release, disclose, and/or exchange the following information and/or reports:

___ Treatment Progress
___ Billing Codes and Diagnosis
___ Medical History/Diagnosis
___ Social History/Intake Summary
___ Medications and Compliance
___ Other-Specify: _____

___ Treatment Plans
___ Treatment Notes
___ Testing/Test Results
___ Referral/Recommendations

___ Case Notes
___ Treatment Coordination
___ Description of behavioral psychological and medical condition

___ I (we) also authorize each of the persons and entities listed below, or their representatives, to mutually release and exchange copies of all files and documents which contain confidential information.

In furtherance of this authorization, I do hereby waive any privilege and right of confidentiality relating to any disclosure hereby authorized. I (we) understand that this authorization will remain in effect until I (we) cancel it by written notice to AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CENTER, which shall identify each person or entity for whom this authorization is withdrawn and cancelled.

A photocopy of this authorization, shall be accepted as granting the same authority as a signed original

Name/Entity:	Address: Phone #:	Client's Initials
Name/Entity:	Address Phone #:	Client's Initials

Signatures

Client Signature:	Date:	Client Signature:	Date:
Name of parent or guardian (if client is under 18)	Date:	Name of parent or guardian (if client is under 18)	Date:
Witness:	Date:	Witness:	Date:

IN-PERSON SESSION PROTOCOL

- No new parties (i.e., clients that are not already on the existing file) may participate or join sessions without supervisor approval.
- Sessions should last no longer than 50-minutes unless a client is in crisis, or you have received permission from your supervisor for an extended session length.
- Students are only permitted to use their personal cell phones for scheduling purposes. Conducting sessions via direct cell phone call is prohibited. Students must change the voicemail greeting of their cell phone to the required AU MFT Center clinical intern voicemail greeting (see Appendix ???). Texting with clients is not permitted.
- Students must maintain a detailed contact log for all clients in Titanium. All communications (e.g., phone, email, text message, Zoom, etc.) should be documented in a comprehensive log of all contact with your clients.
- Students are required to abide by the AU MFT Center dress code during all in-person sessions.
- The following phone numbers should be provided/confirmed with all clients.
    - AU MFT Center main line for general questions: (334) 844-4478.
    - Voicemail number for clients to reach you: your own cell phone number (for scheduling purposes only).
    - Emergency contact numbers Resource: 911, National Suicide Prevention Lifeline (1-800-273-8255), Crisis Text Line (Text HOME to 741741).

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, complete the client safety plan. The suicide assessment procedures can be found under EMERGENCIES. Remember that a suicide contract is not sufficient in securing a client agreement to not self-harm.

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 are in violation of ethical conduct if their client files - including case notes, treatment plans, 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 Office Administrator will notify the Program Director, Clinical Administrator, current supervisor and each therapist individually, either in person or by a note in his/her mailbox or email, 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 to the Program Director, Clinical Administrator, and 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 either the case note form or treatment plan (depending on session number) in Titanium. The form is to be completed within 48 hours of the session, signed by the therapist, and sent to the Supervisor.

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 client is not seen within 21 days (other than agreed upon circumstances), 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 in Titanium.

9. The therapist is to complete the Case Closure note 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 should be notified of the case closure to audit.

Appendix D

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 the clients with the crisis line number as required. (Crisis Center - 821-8600)
3) Inform their clients to proceed to the nearest hospital emergency room in the case of emergency.

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

Procedures for Adult Suicide 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,
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.

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

3) 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.

4) 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.

5) 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.

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

7) 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.

8) 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.

9) 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?

10) 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 individuals are not available.

11) 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.

12) 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.

13) 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 should contact the EAMHC for a consultation and contact the police department for a welfare check

and/or a home visit. (Auburn Police 334-821-3000).

14) 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 Hotline Number - 334-821-8600**

Procedure 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. apoplectic

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:
        i. -Withdrawal from family and friends
        ii. -Drop in school achievement or school refusal
        iii. -Excessive sleeping (or reversal of normal sleep-wake pattern)

iv. -Withdrawal from sports or other school activities in which the child/youth has been engaged
v. -Running away from home
vi. -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.

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.

d. 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.

e. 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 assessing), 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 arrange 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), 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 Hotline Number 334-821-8600

Auburn University Safety Plan

1. Please identify the names and phone numbers of three emergency contacts people, as well as the contact information for your local emergency services provider. These individuals/entities can be contacted in the event of an emergency or crisis.

Emergency Contact People:

1) Name: _____ Phone #: _____
2) Name: _____ Phone #: _____
3) Name: _____ Phone #: _____

Local Emergency Services Provider: (e.g., hospital)
Organization Name: _____
Organization Phone #: _____
Organization Address: _____
Police: _____ Paramedics: _____

Additional Resources:
If you are not in immediate danger, but would like someone to speak with, you can access the following resources. Both are free, confidential, and open 24 hours a day, 7 days a week.

Resource: National Suicide Prevention Lifeline Phone #: 1-800-273-8255
Resource: Crisis Text Line Contact Info: Text HOME to 741741

_____ _____
Client Date Client Date

_____ _____
Client Date Client Date

(or person authorized to sign for client): _____

Authorized signer, relationship to client: _____

_____
Witness Date

NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

1. In the past few weeks, have you wished you were dead? Yes ☐ No ☐
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** Yes ☐ No ☐
3. **In the past week, have you been having thoughts about killing yourself?** Yes ☐ No ☐
4. Have you ever tried to kill yourself? Yes ☐ No ☐

If yes, how?

_____

_____

_____

When? _____

_____

If the client answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** Yes ☐ No ☐

If yes, please describe: _____

Next steps:

- If client answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If client answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**

○ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)

- **Client requires a STAT safety/full mental health evaluation.**

Client cannot leave until evaluated for safety.

- Keep client in sight. Remove all dangerous objects from room. Alert Faculty Supervisor for client's care.

○ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)

- **Client requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Client cannot leave until evaluated for safety.**
- Alert Faculty Supervisor responsible for patient's care.

Provide resources to all patients

- *24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454*
- 24/7 Crisis Text Line: Text "HELLO" to 741741

Case Closure Policies

Case Closures (Planned or Unplanned) and Therapy Breaks

The Case Closure Form in Titanium is to be completed following the closure of a case or if an extended therapy break is planned (extended is more than three weeks). 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 Office Administrator 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.

Cancellations/Reschedules

When a client calls to reschedule an appointment, the rescheduled appointment must be updated in Titanium. 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 No Show in Titanium. It is the responsibility of the therapist to follow up with the client to try to reschedule the appointment. Make note of all attempted and completed calls in the client file of Titanium. If the client is unable to be reached, close the case, and inform the Office Administrator. The Office Administrator will remove the client information from Titanium and update the Bubbles spreadsheet, removing any identifiable information.

No-Show Established Client

At the time of the no-show, the therapist is to update the appointment in Titanium to No Show 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 or follow-up, the therapist can open the appointment time.

Note: The admin workstation is not a secure area when not attended by staff. A note may be left on the Office Administrator's desk to indicate that confidential material

Session summaries and case closures for review by the supervisor are to be sent to the Supervisor through Titanium. Once the form is signed, it will be locked and filed into the client file in Titanium. Forms cannot be altered once locked and signed unless unlocked by a system administrator.

Sample Letter

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

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

October 21, 2022

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.

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) Program Director must approve the project. To gain approval students must meet with the Program Director to discuss their proposed project. One week before attending the meeting a 1-2 page outline or synopsis of the proposed project should be emailed. Upon Director 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).

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 Program Director must approve the 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 VIDEO 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.

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.
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 complete paperwork prior to their initial session.

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 Schedule

1. Intake Assessments
2. Follow-up Assessments at Sessions 4, 8, 12, 20, 30, 40 50.
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, in Titanium, and on the Shared Drive. 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 extra 10-20 minutes needed to complete the packets. If necessary, therapists should plan to end their session early to facilitate the completion of the packets.

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.

Assessment Forms

There are 8 different sets of assessments (Individual Intake, Individual Follow-up, Couple Intake, Couple Follow-up, Parent Intake, Parent Follow-Up, Adolescent Intake, Adolescent Follow-up). The Intakes are taken before the first session and Follow-ups are taken every 28 days. There are also Intersession Report (Individual, Couple, Family) assessments. These are taken every 7 days, before and after sessions.

Below is a list of the various assessments.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
	Demographics	Basic information	I, C, P, A	Intake only	N/A	Clinical judgment
MOS 6 (6 items)	Medical Outcome Study Sleep Scale	Sleep	I, C, P, A	Intake, every 28 days	6-30	Higher scores indicate more sleep problems.
GAD 7 (7 items)	Generalized Anxiety Disorder-7	Anxiety	I, C, P, A	Intake, every 28 days	0 – 21	Higher scores indicate more anxiety. The following ranges have been suggested: 0-4 minimal anxiety 5-9 mild anxiety 10-14 moderate anxiety 15-21 severe anxiety **RCI on the GAD-7 was 3.87**

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
PHQ-9 (9 items)	Patient Health Questionnaire	Depression Scale	I, C, P, A	Intake, every 28 days	0-27	**Interpretation of Total Score** Total Score Depression Severity 1-4 Minimal depression 5-9 Mild depression 10-14 Moderate depression 15-19 Moderately severe depression 20-27 Severe depression In participants with major depressive disorder (Titov et al., 2015), the RCI on the PHQ-9 was 5.15. In participants with mixed anxiety/depression (Terides et al., 2018; Titov et al., 2013), the RCI on the GAD-7 was 3.87 and the PHQ-9 was 5.83.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms. Major depressive disorder (MDD) is suggested if: • Of the nine items, five or more are checked as at least 'more than half the days' • Either item 1 or 2 is checked as at least 'more than half the days' Other depressive syndrome is suggested if: • Of the 9 items, between 2 to 4 are checked as at least 'more than half the days' • Either item 1 or 2 is checked as at least 'more than half the days' Depression should not be diagnosed or excluded solely based on a PHQ-9 score. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression.1 Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire and other relevant information from the patient.						
TSC-40 (8 items)	Trauma Symptom Checklist—Sexual Problems subscale	Sexual Problems	I, C, P, A	Intake, every 28 days	0-24	Higher scores indicate more sexual problems and more dissociation. No ranges or cutoffs have been suggested.
CSI-16 (16 items)	Couple Satisfaction Index	Relationship Satisfaction	I, C	Intake, every 28 days	0 – 80	Higher scores indicate better couple satisfaction. Scores lower than 51.5 are considered clinically distressed. RCI = 9.4
IAI (8 item)	Ineffective Arguing Inventory	Patterns of arguing	I, C	Intake, every 28 days	8-40	A higher score indicates increased dissatisfaction with the style of arguing within the relationship. No ranges or cutoffs have been suggested.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
According to Kurdek (1994) the IAI is based on the conceptual position that 'ineffective arguing' is a global, unidimensional, couple interactional pattern. Signs of this pattern include fighting over repetitive issues, knowing how an argument is going to end even before it is over, ending the argument without resolving the issue at hand, and ending the argument with neither partner feeling that they have been given a fair hearing.						
HS (6 items)	Hopelessness Scale	Amount of hopelessness	I, C	Intake, every 28 days	0-6	Higher scores indicate more ineffective arguing. No ranges or cutoffs have been suggested. It ranges from 0 to 36 points.
PSS (10 items)	Perceived Stress Scale	Amount of stress	I, C, P, A	Intake, every 28 days	0-40	PSS-10; Cohen, Kamarch, & Mermelstein,1983) is a popular tool for measuring psychological stress.
Individual scores on the PSS can range from 0 to 40, with higher scores indicating higher perceived. stress. Scores ranging from 0-13 would be considered low stress. Scores ranging from 14-26 would be considered moderate stress, and 27-40 would be considered high perceived stress. 1. Subscales: Perceived helplessness (items 1, 2, 3, 6, 9, 10) – measuring an individual's feelings of a lack of control over their circumstances, emotions, or reactions. 2. Lack of self-efficacy (items 4, 5, 7, 8) – measuring an individual's perceived inability to handle problems. https://novopsych.com.au/assessments/well-being/perceived-stress-scale-pss-0/#:~:text=Scoring%20and%20Interpretation,Janicki%2DDeverts%2C%202012).						
CTS-V (6 items)	Conflict Tactics Scale-Violence subscale	Level of violence	C, P, A	Intake, every 28 days	0-42	Higher scores indicate more violence. No ranges or cutoffs have been suggested.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
CQ (14 items)	Co-parenting Questionnaire	Collaboration between parents. Cooperation, Triangulation and Conflict subscale.	P	Intake, every 28 days	Coop=5-25 Train=4-20 Conf=5-25 Total=14-70	Higher scores indicate better co-parenting. No ranges or cutoffs have been suggested.
FAD-GFS (12 items)	Family Assessment Device-General Functioning subscale	Overall family functioning	P, A	Intake, every 28 days	1-4	Lower scores indicate better family functioning.
SS (3 items)	Sexual Satisfaction	Sexual satisfaction	I, C, P, A	Intake, every 28 days	1-5 5 – 15 points	Clinical Judgment
PC (2 items)	Perceived Criticism	Amount of criticism in relationships	I, C, P, A	Intake, every 28 days	1-10 for each question	Scores => 4 on question 1 have an 81% rate of relapse. Scores => 5 on question one have a 91% rate of relapse.
POS (9 items)	Marital Power	Amount of power used in decision making	C, F, P, A	Intake, every 28 days	6-30	Higher scores indicate that one partner in the relationship uses more power.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
HCU (4 items)	Health Care Utilization	How many times people visit the doctor or hospital	I, C, P, A	Intake, every 28 days	Count of how many times clients have seen a doctor or stayed in the hospital	Higher numbers indicate more doctor visits or more overnight stays in the hospital.
R-IPA (22 items)	Revised Inventory of Parental Attachment	Parent-adolescent attachment.	P	Intake, every 28 days	Trust/avoidance= 16-80 Comm.=6-30 Total score=22-110	Higher scores indicate better parent-adolescent attachment.
IPPA (30 items)	Inventory of Parent & Peer Attachment	Adolescent-parent attachment	A	Intake, every 28 days	Trust=15-75 Alienation=12-60 Total Score=30-150	Higher scores indicate better adolescent-parent attachment.
IR (10 items)	Intersession Report	General functioning	I, C, P, A	Every 7 days	N/A	Clinical Judgment
Ohio Youth		Adolescent Outcome	Parent Adolescent Agency	Every 28 days	Problem 20 0-5	Higher scores indicate worse problem behaviors. Scores higher than the cut-offs of 20 and 30 points designate behavior problems one and two standard deviations higher than the community sample. RCI = 10 points

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
Ohio Youth		Adolescent Functioning	Parent Adolescent Agency	Every 28 days	Function 20 0-4	Higher scores indicate better functioning. Scores lower than the cut-offs of 52 and 42 points designates behaviors problems one and two standard deviations lower than the community sample. Scores lower than the cut-offs could be reasonably assumed to have clinically meaningful impairment in functioning. RCI = 12 points
Alliance (13 items)	Therapy Alliance	Relationship between therapist and clients	I, C, P, A	Every 7 days	I=16-112 C=13-91 F=13-91 A=13-91	Higher scores indicate better relationship
SRS (4 items)	Session Rating Scale	Relationship between therapist and clients	I, C, P, A	Every 7 days	0-40 39-40 Excellent 37-38 Very Good 36 Good 34-35 OK <=33 Poor Cutoff is 36	The SRS is a rating of the therapeutic relationship. It measures the therapist's collaboration and effectiveness in meeting the client's needs.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
ORS (4 items)	Outcome Rating Scale	Client Well-Being	I, C, P, A	Every 7 days	0-40 ORS the RCI = 5 points Cutoff 25 Adults Cutoff 28 Adol	The ORS measures the client's perspective of change or improvement in relation to personal, interpersonal, social, and overall well-being.
PRIOR SCALES						
R-URICA (14 items)	Revised University of Rhode Island Change Assessment-Action, Seeking Assistance, & Ambivalence subscales	Process of Change	I, C, P, A	Intake, every 28 days	Action=8-40 Seek=4-20 Ambiv=4-20 Total=16-20	Higher scores indicate more action, seeking assistance, or ambivalence. No ranges or cutoff scores are available.
SF-12 (12 items)	SF-12 Health Survey	Physical and Mental Health	I, C, P, A	Intake, every 28 days	Mean=50 SD=10	Scores higher than 50 indicate better than average health, lower indicate lower average health.
ECR-S (12)	Experiences in Close Relationships – Short Form	Attachment—Anxiety & Avoidance subscales	C	Intake, every 28 days	6-42 for each subscale	Higher scores indicate more attachment related anxiety or attachment related avoidance. No ranges or cutoff scores are available.

Assessment	**Official Name**	**What it measures**	**Who completes measure****	**When completed**	**Range of Scores**	**Interpretation**
MDI (10 items)	Major Depression Inventory	Depression	I, C, P, A	Intake, every 28 days	0 – 50	Higher scores indicate more depression. The following ranges have been suggested: 20-24 mild depression 25-29 moderate depression 30-50 severe depression

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

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

Dube, S., Anda, R., Felitti, V., Chapman, D., Williamson, D., & Giles, W. (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., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., & Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. Amer Journal of Prev Med, 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: Uninvolved, 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	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 Health	N/A (0), Once (1), Some (2) Often (3)
Aces9f	I. Attempted Suicide or	N/A (0), Once (1), Some (2)

	Suicidal	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	
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: Pushed, Bit	N/A (0), Mild (1), Moderate (2), Severe (3)
Aces7s	G. Substance Use and Abuse: Alcohol abuse, drug use, or prescription use	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 Scale Tactic

Description: The Violence Subscale of the CTS is designed to give clinicians an idea of the level of self/partner 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 discuss the case with a Faculty Supervisor regarding the type and intensity of services 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 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)
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 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)
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? Threaten 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? Threw 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)
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) recoded variables so that “happened but not in the past year so that it is scored between never and once this year.

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.

Is measured using the 16-item version of the Couple Satisfaction Index (CSI; Funk & Rogge, 2007). The scale is used to assess the individual's relationship satisfaction. 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' martial 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 True (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 True (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 True (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 True (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 impression and immediate feelings. Good to bad	Good (5) (4) (3) (2) (1) Bad (0)
Csi13	Select the answer that best describes *how you feel about*	Full (5) (4)

	your relationship. Focus on your first impressions and immediate feelings Full to empty	(3) (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. Hopeful to discouraging	Hopeful (5) (4) (3) (2) (1) Discouraging (0)
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 of 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.

Reference:

Wei, M., Russell, D., Mallinckrodt, B., & Vogel, D. (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 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 not 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 my romantic partner won't care about me as much as I care about them.	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.

Reference:
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.*	
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 frustration 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 doesn't 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 me	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 that 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.

Reference:

Olsen, L., Jensen, D., 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 or watching T.V?	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.

Reference:

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 having 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, Self Reported 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 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 Perceived 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 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.

How often have you experienced the following symptoms over the <u>last two months?</u>

Sex4	Sexual Problems	Never (0) (1) (2) Often (3)
Sex5	<u>Low sex drive</u>	Never (0), (1), (2), Often (3)
Sex6	Sexual over-activity	Never (0), (1), (2), Often (3)
Sex7	Not feeling satisfied with your sex life	Never (0), (1), (2), Often (3)
Sex8	Having sex that you didn't enjoy	Never (0), (1), (2), Often (3)
Sex9	Bad thoughts/feelings during sex	Never (0), (1), (2), Often (3)
Sex10	Being confused about your sexual feelings	Never (0), (1), (2), Often (3)
Sex11	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.

Reference:

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 <u>your health now limit you</u> in these activities? If so, how much? Circle the best answer	N/A
Sf2a	<u>Moderate activities</u> Moving a table, vacuuming, or golf	Yes, limited a lot (2) Yes, limited a little (1) No, not at all (0)
Sf2b	Climbing <u>several</u> flights of stairs	Yes, limited a lot (2) Yes, limited a little (1) No, not at all (0)
INSTRUCTIONS 3	During the <u>past 4 weeks,</u> have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u> (such as feeling depressed or anxious?)	N/A
Sf3a	Accomplished less than you would like	Yes (1), No (0)
Sf3b	Were limited in the <u>work</u> or other activities	Yes (1), No (0)
INSTRUCTIONS 4	During the <u>past 4 weeks,</u> have you had any of the following problems with your work or other regular daily activities <u>as a result of your emotional problems</u> (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 carefully than usual	Yes (1), No (0)
Sf5	During the past <u>4 weeks,</u> how much did <u>pain</u> interfere	Not at all (0)

	with your normal work? (including both housework and work outside the home)? Circle the best answer.	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) Some of the time (3) A little of the time (4) None of the time (5)
Sf6b	Did you have a lot of energy?	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)
Sf6c	Have you felt downhearted and blue? (need to be reversed coded)	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)
Sf7	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities? (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.

References:
Saris-Baglama, R., DeRosa, M., Raczek, A., Bjorner, J., & Ware, J. 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., DeRosa, M., Raczek, A., & Ware, J. (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., DeRosa, M., Raczek, A., Bjorner, J., Turner-Bowker, D., & Ware, J. (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 adolescent hopelessness. The Scale has good reliability and validity, with the revised scale uses the 6-item version of the (HSC-R; Kazdin, Fereench, Unis, Esveldt-Dawson, & Sherick, 1983; Bolland, McCallum, Lian, Bailey, & Rowan, 2001). The scale is used to assess the child's life hopelessness. Higher scores reflect increased hopelessness

Scoring: To score the Hopelessness Scale for Children-Revised, 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 moderately correlated with similar behaviors. 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.

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

Kazdin, A., 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., McCallum, D., Lian, B., Bailey, C., & 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.

Instructions	Please read the following statements and circle the best answer	Strongly Disagree (1) Disagree (2) Undecided (3)

		Agree (4) Strongly Agree (5)
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.

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 your 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, 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

References:

Ash, S. & 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.

References:

Novak, Scott P., & Clayton, Richard R. (2001). The Influence of School Environment and Self Regulation 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.

Instructions: **These statements refer to your thoughts about your therapy/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 thetherapist 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 Disagree			*Neutral*			*Completely 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 Disagree			*Neutral*			*Completely 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 ofmy 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

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:

10. 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.
11. 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.
12. Fraud or misrepresentation in obtaining a license.
13. Other just and sufficient cause which renders a person unfit to practice marriage and family therapy, such as, but not limited to the follow:
    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 to be established.
    e. Habitual intoxication or addiction to drugs.
    f. Conviction of a felony related to the profession or occupation of the licensee of 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 guilt shall be conclusive evidence.
    g. Fraud in representation of overall therapy skill or ability.
    h. Use of untruthful or improbably 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 or 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 or 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 of 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 judgement or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgement is not impaired, and not 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 benefitting 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 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 the action
iv. Where the client is a defendant in 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 received 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 waiter, a therapists 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 statue or regulation. Revelation to others of therapy materials 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 judgement.
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 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 judgement or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgement 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. 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:
    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 supervision (in which case supervisee confidences may be disclosed only in the course of that action;
    iv. 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
    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.

(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 or 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 payments 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 laypersons 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:
    i. Contains a material misrepresentation of fact;
    ii. Fails to state any material fact necessary to make the statement, in light of all circumstances, not misleading; or

iii. 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 in 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 does 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. These 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:
American Association for Marriage and Family Therapy
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808 - Fax: (703) 838-9805 www aamft.org

Appendix G
Additional TAFTS Training

To fulfill the State of Alabama's continuing education requirements for the practice of teletherapy, Dr. Ketring will make a total of 15 hours of training available to all students, staff, and supervisors in the AU MFT Program. Note: Students are required to complete all 15 hours of teletherapy training before providing TAFTS to their current clients.

Alabama Board of Examiners in Marriage and Family Therapy Administrative Code:

536-X-8-.09. Technology-Assisted Training/Education Requirements of Profession.

(6) In order for a Licensed MFT Intern to practice teletherapy, the Intern must be actively supervised for one (1) hour for every five (5) face-to-face clinical hours, by an AAMFT Approved Supervisor or Supervisor Candidate, or by an ABEMFT Approved Supervisor or Supervisor Candidate trained in teletherapy while the therapist is practicing teletherapy and has not completed the 500 hours of supervised therapy required for an LMFT intern.

(7) In order for a Licensed MFT Associate to practice teletherapy, the LMFT Associate must have completed a minimum of 15 supervision hours training. This requirement is met for LMFT's who completed the 15 supervision training hours as an LMFT Intern and receive continuous supervision by a supervisor trained in teletherapy and telesupervision.

(8) In order for a Licensed MFT to practice teletherapy, the licensee must have completed a minimum of 15 hours initial training.

(9) In order for an AAMFT Approved Supervisor, AAMFT Supervisor Candidate, ABEMFT Approved Supervisor, or ABEMFT Supervisor Candidate to be considered trained to provide telesupervision or telesupervision training, the Supervisor must have nine (9) continuing education hours or a one (1) credit course (15 classroom hours) in teletherapy dealing with supervision conducted via electronic communication (e.g., encryption of data, HIPAA compliant connections, telesupervision therapy and practice, telephone and video conferencing, legal/ethical issues, handling online emergencies, and best practices and informed consent).

Documentation of Completion for Additional TAFTS Training Modules:

Dr. Scott Ketring will keep a copy of certificates completed for AU MFT Program records.

Appendix H
Clinical Intern Cell Phone Voicemail Greeting

AU MFT Center Clinical Intern Cell Phone Voicemail Greeting

Tips for Recording a Professional Voicemail Greeting:

- **Speak clearly and slowly.**

Remember, some of your clients may have accessibility issues that can make listening to voicemails very challenging. Make sure that you do not mumble, speak too fast, or speak too slow when recording your voicemail greeting. You should speak slowly and clearly enough that listeners can easily write down the phone numbers you are providing. Remember, the way you communicate with people through your greeting sends a message about how you communicate with people in person. Put your best foot forward!

- **Speak in a professional, yet welcoming tone.**

Make sure that the volume and tone of your voice is professional, yet welcoming. Think about the type of voicemail greeting you expect from your doctor's office. How does the person's voice, tone, pacing, etc. influence your perception of your doctor's office and the professionalism and/or competence of their staff? Keep this in mind when recording your greeting.

- **Smile while recording your voicemail greeting.**

It sounds silly but smiling while recording your greeting will put some enthusiasm in your voice. Callers will pick up on it and feel more comfortable when leaving you a message. Research shows that smiling affects how we speak, and listeners are not only able to identify that people are smiling, but also the intent of the smile based on voice intonation alone. Remember, clients make inferences about you as a therapist and the AU MFT Center overall when listening to your voicemail greeting. If you want your greeting to leave a positive impression, smile when you record it!

- **Use the required voicemail greeting script.**

To meet ethical and legal standards, clinical interns must use the required voicemail greeting script in its entirety with no alterations. Spend time reading and re-reading the script to get comfortable with it before recording.

- **Rehearse your greeting several times.**

Practice saying the voicemail greeting several times. Plan your pauses and select natural places to take a breath. Even though you are using a script, try to make sure that you do not sound robotic and rehearsed. When listening to your voicemail greeting, callers should not feel like they are listening to an impersonal recording – keep it conversational.

- **Do a few practice recordings.**

Using a recording app on your phone, computer, or other device, record yourself saying the greeting. Listen to and analyze your voicemail greeting. Are you happy with it? Is it slow enough that your grandparent could understand what you are saying? Does it sound robotic or like you are reading from a script? Do you inflect your voice the same way you do when speaking in conversation or are you monotoned? Rehearse your greeting a few times before you press record. Plan your pauses and select natural places to take a breath.

- **Record your voicemail greeting in a quite space.**

When you are ready to record, remove all background noise. Ambient noise on your recording could be sending the wrong message to your callers. The sound of traffic, pets, kids, etc. in the background of your greeting detracts from your professional image. When you record your voicemail greeting, choose a quiet spot free from interruption, so your message is the only thing callers hear. It is also good to avoid large, cavernous spaces where sound reverberates.

- **Change how you hold your phone while recording your voicemail greeting.**

If you are recording directly into your phone, do not hold it to your ear like you are talking to someone. This can produce a muffled tone. Hold the phone out in front of you a few inches from your mouth for the clearest recording. This may require some trial and error to figure out what produces the best sound on your specific device, so playback your greeting and make necessary adjustments when you re-record.

- **Be patient with yourself.**

Recording a professional voicemail can be tricky. It is okay if you have to do a few recordings to get it just right. Eventually it will sound precisely how you'd like.

Required Clinical Intern Cell Phone Voicemail Greeting Script:

Hello. You've reached the voicemail of [first and last name], MFT intern at the Auburn University Marriage and Family Therapy Center. I am currently unable to take your call, so please leave a voicemail stating your name, phone number, a detailed message, and whether it is okay to leave a voicemail on your answering machine when returning your call. Our front office hours are Monday through Friday from 8 a.m. to 5 p.m. I will return your call as soon as possible. If this is an emergency, please hang up and dial 911 or go to your local emergency room. If you are not in immediate danger, but would like someone to speak with, you can reach the National Suicide Prevention Lifeline by calling 1-800-273-8255 or the Crisis Text Line by texting HOME to 741741. Both services are free, confidential, and open 24 hours a day, 7 days a week. For questions about scheduling and clinic policies, you can also contact the AU MFT Center directly by calling (334) 844-4478. Thank you for your call and have a great day.

Appendix I
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] and the [Teletherapy Handbook], all together referred to as the MFT Handbooks. I 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