ABFT Dissemination and Implementation:

Starter Packet

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ABFT Dissemination and Implementation

This document outlines information about the dissemination and implementation of ABFT. For additional information about how ABFT can be effectively implemented in your agency contact Suzanne Levy, Ph.D., at the ABFT International Training Institute, at 267-270-2245 or info@abftinternational.com

Agency Readiness

Implementation and sustainability of a manualized, empirically supported treatment requires a high level of commitment and systems change on the part of an agency or treatment program. Therefore, agency readiness is of critical concern.

ABFT works well in communities in which both external and intra agency stakeholders (e.g., insurance companies, referring agencies, therapists, etc.) and possible funders are interested in promoting adolescent mental health via the family. Agencies need to identify the key partners, stakeholders, and possible champions of implementing ABFT. ABFT staff are available to help agencies identify relevant stakeholders and conduct presentations to stakeholders in order to increase buy-in.

Several initial phone and or face to face planning meetings are recommended between the ABFT training staff and the agency. Before the initial meeting, agencies will be asked to provide a description of the following (see appendix for the Agency Description – ABFT Implementation form):

a. Current programs, including types of clients seen
b. Referral process and sources
c. Family involvement (e.g., is family involved in treatment or just intake)
d. Staff profiles (e.g., degrees and training of staff)
e. Staff turnover rates
f. Funding sources and patient mix for current programs (e.g., private insurance, Medicaid, etc.)
g. Projected funding sources to fund ABFT training
h. Possible Stakeholder's
i. Previous experience with manually based treatments

In the first meetings, we will review this material with appropriate agency staff to get a better understanding of their current programs, staffing patterns, and commitment or experience with manualized and family based treatment. Previous family treatment training is not a requirement, but does determine the level of staff and agency cultural readiness for this intervention model. For instance, we look to see if families are engaged from the initial contact, how they are invited to the intake process and what expectation of parental participation is expected. We will talk with the agencies about their commitment to doing family therapy at their clinic. We also ask agencies to assess if they have therapists on staff that meet the desired staff characteristics (see below).

Agencies need to assess support within their agency for implementing ABFT, both at the administrative and direct care levels. We encourage agencies to consider all aspects of the program that will be affected if ABFT is implemented. All employees (at all levels of programming) need to have an understanding of the changes that will need to occur if ABFT is used in their agency. At the administrative level, decisions will need to be made regarding therapist productivity expectations while therapists are being trained, whether a specialty clinic can be developed within the agency for depressed or suicidal adolescents, how intake procedures will be adapted to ensure proper assessment and referral, and how follow-up assessments will be conducted. Intake clinicians will need to understand and accept that the intake process may change in order to identify proper cases for ABFT therapists. Therapists need to understand the time and commitment required to learn ABFT (see below for details), implement ABFT, and assist in assessing outcome. We talk with agencies about each of these issues (see Agency Readiness Issues Outline - ABFT Implementation).

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Funding
We are concerned about sustainability. There is a cost of training, credentialing, and ongoing supervision. Agencies need to identify funding sources that could be used to support training in ABFT.

Possible funding sources include:
- Medicaid and private insurance reimbursement at an increased payment rate for use of an empirically supported treatment.
- Federal grants
- State grants
- Foundation grants
- Training grants
- State and local youth system resources

We assist agencies in working with possible funding sources.

Required Resources
Another aspect that needs to be explored prior to implementation is the feasibility of ABFT in an agency. ABFT requires a sufficient level of resources to support and sustain quality treatment and outcomes. How cases are identified, referred, and assessed in such a program needs thoughtful attention. How staff will be selected, trained, and retained are also of interest to us. Each of these issues is addressed below.

Service Provider Organizations
ABFT is a well developed, manualized and tested family therapy model that provides specific goals and strategies that keep therapy focused on repairing core family processes. It has mostly been used as a brief (12 to 16 weeks) outpatient treatment with a high compliance and success rate. Home visits are done as clinically needed. The model is not constrained by the delivery context. ABFT could easily be a home visit model used by Mobile Therapists (BHRS) and or Family Based MHS teams. We also think it could be applied in inpatient units and day treatment programs where intensive family therapy could be done in two to three weeks.

Agencies interested in Level II and III Training (certification) need to have therapy session videotaping capabilities.

Case Identification
ABFT is empirically supported with depressed and or suicidal adolescents, even when these youth are struggling with a history of trauma or self-identify as LGBTGIA+. ABFT implementation works best if applied within a specialty treatment track focused on depressed and or suicidal adolescents; however, this is not required.

In general, patients referred for ABFT should meet the following criteria:
- Typically adolescents are ages 12-19. This work has also been done with young adults (early to mid 20's) when family work is relevant.
- Adolescents either live with caregiver or caregiver (e.g., parent, grandparent, etc.) lives close enough to attend weekly therapy sessions.
- Adolescent has significant depression symptoms or suicidal ideation.
- The severity of depression or suicide ideation needs to be manageable in the setting of the agency (i.e., inpatient, outpatient, home-based, etc.).

We have found that ABFT does not work well for adolescents with:
- Borderline intellectual functioning or mental retardation

- Autism Spectrum Disorders (with the exception of those who are high functioning)
- Active Psychosis

We also do not recommend ABFT for abused adolescents who are currently living with the perpetrator and immediate needs of safety and reporting are involved. Once this crisis phase is over, ABFT may be appropriate. We also find that adolescents with severe drug abuse or dependency and or severe conduct disorder may need other forms of treatment before ABFT is appropriate.

Agencies need to assess whether they have a sufficient number of clients meeting the above criteria to make training in ABFT worthwhile. Developing referrals sources from emergency rooms (hospital diversion) or inpatient units (aftercare) are recommended.

Case Assessment
Quality programs both systematically identify appropriate patients for treatment, as well as track patient success overtime. We recommend that agencies gather baseline, weekly and post treatment outcome data from families participating in ABFT. Doing so improves clinical monitoring, helps focus the therapist on clinical outcomes and provides ongoing demonstration of the program's clinical effectiveness to the community and payers. We recommend a brief assessment of depression and suicide ideation before ever session. If that is not feasible, then we recommend assessment at intake, 4, 8, 12 and 16 weeks.

Agencies have many options for how to collect and analyze data once it is collected. These options will be discussed with the ABFT staff before program implementation. Our strong preference however is the use of our own Web-based, Behavioral Health Screen (BHS).

The BHS is a 100% web-based, self-report, comprehensive solution for assessment of the 13 major domains in behavioral and mental health issues recommended or required by the American Academy of Pediatrics, American Psychiatric Association, and The Joint Commission. This screen provides a broad based baseline assessment and then can be used as a weekly outcomes assessment tracking tool. The BHS can be used as a patient data enter screen and then the program automatically scores and generates a report and aggregates the data for client and program report writing (see Diamond et al, 2010). The BHS has strong psychometric support and has been validated for youth through young adults, 12 to 24 years old. The BHS was developed through collaboration between Baltimore-based Medical Decision Logic, Inc. ("mdlogix"), a leading provider of health informatics solutions and services, and clinical investigators at the University of Pennsylvania and the Children's Hospital of Philadelphia ("CHOP").

The BHS is designed for an adolescent and young adult patient population. It takes up to 10 minutes to complete. The flexible web tool and platform allows for site-specific additional assessment items.

Key domains assessed are:

- Medicals
- School/Work
- Family
- Bullying
- Nutrition and Eating
- Psychosis
- Depression
- Anxiety
- Substance Use
- Violence
- Trauma
- Suicide
- Sexuality

The BHS is Health Insurance Portability and Accountability Act (HIPAA) compliant. Items on the BHS are scored instantly and a report is generated containing 4 categories: critical items, scales, risk behaviors, and

patient strengths. The system generated report provides scores for the key psychiatric scales. These scores and cut –offs are based on a large valid sample. The BHS results have the capacity to be integrated in electronic medical records (EMR). We have created a Video User's manual which details basic software set-up, how to register a patient, print the report, and troubleshooting strategies.

Based on BHS scoring, patients that meet criteria for moderate or severe depression or indicated clinical risk on the suicide scales would be one indication of appropriateness for treatment with ABFT.. Once patients screen in on this measure, they are further screened using the Suicidal Ideation Questionnaire (SIQ-JR; Reynolds, 1988). A score of 31 on the SIQ-Jr indicates an appropriate case for ABFT.

Alternative Recommended Battery

For those agencies who do not wish to use the BHS, we have a battery of recommended measures including measures on depressive symptoms, suicidal ideation, trauma, relationship closeness, client satisfaction, and therapeutic alliance. At the very least, we require that agencies track patient depression and suicidal ideation. We recommend using the Beck Depression Inventory-II (BDI; Beck, et al., 1996) and Suicidal Ideation Questionnaire (SIQ-JR; Reynolds, 1988). Arrangements will have to be made to have this data entered weekly and available for reports and charting.

If agencies decide to use these individual measures, a score of 16 on the BDI and or a score of 31 on the SIQ-Jr may indicate an appropriate case for ABFT.

Other considerations

We are also willing to work with agencies who have their own battery of assessment tools.

Staff Selection

For certification, we require that at least two therapists at an agency, along with a clinical supervisor, participate in the training. Therapists need to have at least a master's degree in social work, clinical, mental health, or counseling psychology, or couples and family therapy. In addition, therapists must be predominantly clinicians (not administrators) to ensure they have sufficient clinical time to treat clients. Supervisors are required to have a Ph.D. or be an advanced MSW or other master's level therapist and have definitive experience in family therapy. We ask that supervisors participate in the clinical credentialing process to assure long term sustainability of the model at each agency and maintain fidelity of treatment after training. However, if supervisors are unable to see clients and therefore complete the credentialing process, we are willing to negotiate this with the agency.

If an agency is not looking to get their staff certified, then we do not require a certain number of therapists or a supervisor participate.

Staff Characteristics

The beginning of sustainability of a treatment at an agency is choosing the right people to be trained. We work with the agencies to educate them on what makes an ideal therapist for ABFT.

Clinical staff will demonstrate knowledge of, and at least some experience in, the basic skills of family therapy. Therapists need to be open to new ideas, welcoming the opportunity to try new clinical methods and comfortable with using emotions in therapy, manually based treatments, and supervision.

When agencies are pursuing ABFT certification, we recommend agencies advertise the training to their staff and therapists nominate themselves for consideration. We then ask agencies to identify and only consider therapists from those nominated who fit the criteria listed above. Next, we may request to meet the therapists being considered for training by the agency before decisions are made. We would interview the therapists to

assess their readiness to be trained in ABFT. Before the interview, therapists are asked to complete some questionnaires; the ABFT Empirically Based Treatment Questionnaire, as well as the Theoretical Orientation Self-Test (see attached; Coleman, D., 2000). After reviewing the questionnaires and interviewing the therapists, we may make recommendations to the agency regarding who should be trained for certification. Agencies have the right not to take the ABFT staff recommendations.

Training

Certification

The certification process for ABFT typically can be completed in 18 months to two years, but can take longer if therapists desire. The certification process consists of didactic work, video consultation with individual feedback, and group consultation.

Readings

Therapists are required to read the entire treatment manual titled, "Attachment-Based Family Therapy for Depressed Adolescents" which was published by the American Psychological Association (Diamond, Diamond & Levy, 2014). It is recommended that therapists read the manual prior to attending the 3-day introductory workshop, but is not required.

Workshops

Therapists must attend a 3-day or Two-Part introductory workshop. On Day 1/Part One, lecture and videotape are used to provide a complete overview of the theoretical principles and clinical strategies of ABFT. Days 2 and 3/Part Two builds on Day 1/Part One, with the use of case discussion, tape review, and role-play to deepen participants' understanding of the approach. Throughout Days 2 and 3/Part Two, therapists are also taught how to use the ABFT adherence checklists.

Therapists must also attend an advanced 3-day workshop approximately 6 months after the introductory workshop. This workshop, will help advance therapist's ABFT skills. Participants discuss person of the therapist issues as they relate to ABFT and learn about the use of emotion-deepening skills in the context of ABFT. During the advanced training, a certified ABFT trainer provides supervision via role-play. In preparation for the training, we ask therapists to think about their biggest challenges in utilizing ABFT with families in Tasks 1-5.

Supervision

Starting after the initial workshop, trainees attend fortnightly, 60 minute group supervision phone calls for one year (22 sessions). Trainees are expected to discuss their current cases in which they are applying ABFT using the ABFT Case Presentation Outline. Therapists are required to send a short case write-up on cases when they present using the ABFT Case Write-up Outline. In addition, they are expected to present video clips of their work. At least one ABFT Certified Supervisor attends these calls and provides supervision for the cases.

Video Review

After attending the Advanced Workshop, trainees begin submitting therapy video recordings of complete ABFT sessions for review by certified supervisors. Trainees submit one to two videos a month, for a minimum of 10 tapes. These tapes should be of recent sessions so that therapists can demonstrate their use of feedback from the group supervision sessions. The ABFT supervisor will inform the therapist of which tasks or portions of a task to submit. When submitting tapes, therapists must submit a case write-up (template provided). Therapists must also provide self-feedback on their tapes with suggestions for how to improve portions of their tape that are not consistent with ABFT. Therapists are also expected to rate their own tapes which they submit using the adherence measures. ABFT Certified Supervisors review the tapes and provide in-depth written feedback, as well as 20 minutes of phone consultation (as needed) regarding the tape. In addition to the in-depth feedback,

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supervisors rate the tapes using our adherence measures. Completing all 10 tapes does not guarantee that someone is certified. A therapist may need to submit additional tapes (at additional cost) if they have yet to sufficiently develop certain skills. However, we have found that with the level of feedback we provide, most therapists are ready for certification review after 10 tapes.

Therapists that have been certified may refer to themselves as ABFT certified therapists. Certification does not expire. ABFT certified therapists and therapist in training can choose to have their contact information listed on the ABFT International Training Institute website.

ADDITIONAL TRAINING/SUPPORT

Mechanism for ongoing Supervision/Support

If therapists desire supervision beyond their initial contract, they may pay for ongoing supervision.

TIME COMMITMENT

Below is a breakdown of the hours that each therapist would be expected to invest in order to obtain certification.

Total hours are 85 if partaking in 60-minute group consultation. This includes 24 hours for the introductory workshop, 24 hours for the advanced workshop, 22 hours for 22 60-minute group consultation, and 15 hours for self-review of the 10 tapes sent to supervisor (estimated time to review is 90 minutes).

Training Flexibility

We have established criteria we believe will lead to the most effective training and the highest fidelity of model delivery. Fidelity to the model is of utmost importance if the therapists are to achieve the desired outcomes. However, we understand that agency resources and culture may require modifications of these procedures to fit the needs of the delivery context. We want to maintain high standards, but we are open to negotiations on how to best work with a given agency. Likewise, we have financial requirements needed to carry out this level of training, but again, we consider the needs of a given agency on a case-by-case basis.

For instance, we offer a training opportunity that involves the 3 –day Introductory workshop only. Organizations can hire us to conduct the initial workshop from 1-3 days or the initial workshop (3 days) and a follow-up advanced level workshop (1-3 days).

We now have a Level II Trained ABFT Therapist Status. In order to achieve the status of a Level II Trained ABFT Therapist, therapists must complete the following activities:

- Participate in 22 supervision sessions.
- Present at least 4 cases during supervision utilizing the case write-up or case conceptualization form. Case presentations do not have to be from the same case.
- Show at least 2 video excerpts of cases during the course of supervision.
- Complete the ABFT Level II Exam and receive at least an 80%.

Sustainability

Therapist retention is crucial to sustainability of a model. In order to retain therapist, we attempt to build a community among those therapists that are trained. We have a website (www.abftinternational.com) and Facebook page (www.facebook.com/Attachment.Based.Family.Therapy) where we announce trainings open to the public, new ABFT presentations and new ABFT articles. We also have a Facebook ABFT group which is private. Only therapists who have been through the training may join the group. Therapists may ask questions and discuss their experiences of implementing ABFT with the group. Finally, we host quarterly calls with all certified therapists to discuss relevant ABFT issues and experiences.

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We can also train certified ABFT therapists to become ABFT supervisors and Trainers within your organization. Please contact Suzanne Levy for more information (info@abftinternational.com).

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I. Is this model based in outpatient clinic settings, or community-based (BHRS)?

ABFT is a well-developed, manualized and tested family therapy model that provides specific goals and strategies that keep therapy focused on repairing core family processes. It has mostly been used as a brief (12 to 16 weeks) outpatient treatment with a high compliance and success rate. Home visits are done as clinically needed. The model is not constrained by the delivery context. ABFT has been used as a home visit model by Mobile Therapists (BHRS) and or Family Based MHS teams. We have worked with therapists who have used this in inpatient settings where intensive family therapy could be done in two to three weeks as well as day treatment, partial programs and residential treatment facilities. ABFT is also used via Telehealth. While the model is designed to be brief, it can also be extended over a longer period of time when necessary.

II. Inclusionary/Exclusionary criteria?

ABFT has been researched with 12-29 year olds. The model has been developed to target family and individual processes relevant for adolescents and young adults with internalizing disorders (e.g. depression, suicide, trauma, anxiety, etc). It has also been used where family conflict is the presenting problem. It is not the frontline treatment for adolescent with borderline intellectual functioning, active psychosis, ADHD or other externalizing problems. However, the guiding principle of ABFT could be applied when working with any family.

III. Is this model currently covered through MA, or is supported through grant funds?

Yes, this outpatient service would be covered (coded) as an outpatient MH procedure much like Family Therapy. We have helped agencies advocate for reimbursement for family therapy without the patient present. There is currently no special reimbursement rate associated with ABFT. We are working toward that goal.

The staff training, supervision, certification, adherence monitoring will be rate setting factors for consideration. Should the provider elect to participate in outcome monitoring and related research activity this too may be a cost/benefit factor.

IV. How are other counties billing for this model?

Billing is as an outpatient unit of service. ABFT could be a candidate for a case rate based on projected average range of sessions. Therapists bill for "family therapy" when meeting with the caregivers and youth and youth alone. Therapists bill for "family therapy without the patient" when meeting with only caregivers.

X. Has ABFT been reviewed by any independent panels?

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ABFT is listed on SPRC's Best Practice Registry
https://bpr.sprc.org/program/attachment-based-family-therapy/

ABFT is rated as a program with effective outcomes for suicidal thoughts and behaviors as well as depression and depressive symptoms in SAMHSA's National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov).

ABFT is also listed on the Promising Practices Network as a "Proven" treatment. (www.promisingpractices.net).

ABFT has been listed in the CDC's Preventing Suicide: A Technical Package of Policy, Programs and Practices as a recommended treatment for people at risk of suicide. (https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf)

ABFT is listed on the CEBC California Evidenced-Based Clearinghouse for Child Welfare (CEBC) has rated ABFT as a program with "Promising Research Evidence" for adolescent depression
(https://www.cebc4cw.org/program/attachment-based-family-therapy/)

ABFT has been listed as having moderate evidence in SAMHSA's guide for Treatment of Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth
(https://store.samhsa.gov/product/Treatment-for-Suicidal-Ideation-Self-harm-and-Suicide-Attempts-Among-Youth/PEP20-06-01-002)

XI. Where can I get more information on ABFT?

Free ABFT Webinars:
https://www.youtube.com/watch?v=KcwHznzq-S4

Free Podcast:
http://socialworkpodcast.blogspot.com/2015/03/ABFT.html

Review of Research on ABFT
https://onlinelibrary.wiley.com/doi/abs/10.1111/famp.12241
Australian and New Zealand Journal of Family Therapy Special Issue – Attachment-Based Family Therapy: Adaptation and Dissemination
(a series of case study articles and dissemination articles)
https://onlinelibrary.wiley.com/toc/14678438/37/2

Please visit our website as well: www.abftinternational.com

Agency Description – ABFT Implementation

Agency Name:	**Contact:**
Agency Address:	**Phone:**

Briefly describe the current treatment programs at your agency (e.g., level of care, staffing, patient profile, etc). Be more detailed about the child serving systems but we do want to understand the over all agency.

Please describe your current referral sources:

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Describe the current level of family involvement in the treatment program (e.g., only involved in intake, etc). Also give some sense of the staff's general approach to families. We know agencies want to be family centered, but do you feel that actually plays out in the agency.
Please provide the professional profile of your staff (e.g., degrees and training of staff).
Please describe your staff turnover rate. What reasons attribute to this?

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Please describe your current funding sources (e.g., private insurance, Medicaid, etc.).
Please describe how you anticipate funding the training and incorporation of ABFT in your agency.
The implementation of ABFT works best when a broad group of Stakeholders are involved (providers, insurance companies, agency directors, emergency room, psychiatric hospital, etc.). Please list possible Stakeholder's and what investment they would have in bringing ABFT to your agency.
What is your agency's previous experience with importing empirically supported manually based treatments?

Agency Readiness Issues Outline - ABFT Implementation

Administrative Level Concerns

1. Therapist productivity expectations
2. Development of a specialty clinic for depressed or suicidal adolescents
3. Adaptation of intake procedures
4. Follow-up assessments
5. Responsibility of cases (ABFT trainers are consultants).
6. Dedicated therapists and supervisor

Intake clinicians concerns

1. Possible change in intake process
2. Assessing for depression and suicide

Therapist concerns

1. Time and commitment required to learn ABFT
2. Self-evaluation
3. Assist in assessing outcome

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ABFT Empirically Based Treatment Therapist Questionnaire

Please answer the questions below to the best of your ability. Please attach additional pages if you require additional space.

Prior use of a manual.
1. Have you ever used a manual? Is so, which one? What were the pros and cons?
2. If you have previously used a manual, did you feel like your creativity was restricted?
3. If you have previously used a manual, did it improve your work in any way?
4. If you have previously used a manual, were there times when you felt you needed to go outside the manual? If so, why ?

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Views on brief treatment.
5. Do you think brief treatment can be helpful?
6. How does using a brief treatment affect the patient?
7. How does using a brief treatment affect the therapist?
Current Practices
8. Currently, on average, what percent of time to you just see the child alone in a given case?

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9. What is the added value of seeing the parents along with the child?

10. If you do work with a family, what are your general goals?

11. How would you describe your current theoretical orientation?

12. To what degree do you mostly use the approach you noted in #11 or are you more eclectic?

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13. If you take an eclectic approach how do you decide what technique to use with which patient or at which time in treatment?
14. To what extent is your approach behavioral and problem solving focused?
15. To what extent is your approach emotion and process focused?
New practices
16. How open are you to learning new skills?

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17. Do you think you accept supervision well or do you resent when people tell you what to do? Explain.
18. What is your experience with live and video-tape supervision?

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THEORETICAL EVALUATION
SELF TEST (TEST)

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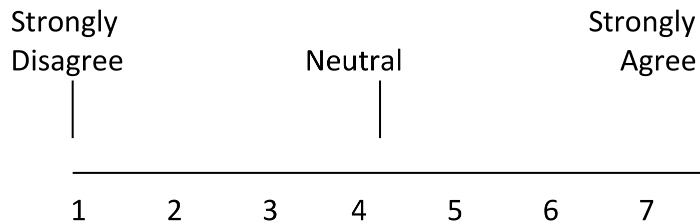
Theoretical Evaluation Self-Test

CIRCLE the number which best reflects your agreement or disagreement with each item.



Statement	**Rating**
1. One central therapeutic factor is the symbolic recreation of a nurturing caretaker relationship with the therapist.	1 2 3 4 5 6 7
2. The therapist should educate the client about the relationship of patterns of cognition and many mental health problems.	1 2 3 4 5 6 7
3. The therapist's unconditional positive regard for the client is a crucial therapeutic factor.	1 2 3 4 5 6 7
4. It is important for therapists to see clients together with their families	1 2 3 4 5 6 7
5. The therapeutic alliance is important primarily to provide a foundation for collaborative case management.	1 2 3 4 5 6 7
6. Human behavior is shaped by patterns of reinforcements and punishments in the environment.	1 2 3 4 5 6 7
7. Change occurs in therapy because of the therapist's empathic, non-judgmental, positive attitude towards the client.	1 2 3 4 5 6 7
8. Psychoeducation about the benefits and side effects of medications is an important part of treatment.	1 2 3 4 5 6 7
9. Dreams discussed in therapy can uncover significant unconscious wishes, conflicts and feelings.	1 2 3 4 5 6 7
10. Most psychotherapy theories are distractions from the central task of solving the client's problems.	1 2 3 4 5 6 7
11. Advocacy with other providers on behalf of clients is a central role of the therapist.	1 2 3 4 5 6 7
12. It is important for the therapist to respond to clients with spontaneous, genuine affect.	1 2 3 4 5 6 7

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13. Primary emphasis should be placed on the client's interactions with his or her family.	1 2 3 4 5 6 7
14. The role of the therapist is to advise and guide the client.	1 2 3 4 5 6 7
15. Client's problems are often caused by negative patterns of thinking.	1 2 3 4 5 6 7
16. Psychological problems vary with the culture of the client.	1 2 3 4 5 6 7
17. Many mental health problems are effectively treated with medication.	1 2 3 4 5 6 7
18. The therapist should be active, directive and goal-oriented.	1 2 3 4 5 6 7
19. Client's problems are often contributed to by social problems and gaps in the social service system.	1 2 3 4 5 6 7
20. It is important to attend to what the client is projecting onto the therapist.	1 2 3 4 5 6 7
21. The therapist should teach clients techniques to address problem areas.	1 2 3 4 5 6 7
22. When one person in a family is experiencing problems, it is usually the expression of family communication and relationship problems.	1 2 3 4 5 6 7
23. Many clients can benefit from psychiatric medication.	1 2 3 4 5 6 7
24. It is important to assess not only the person seeking services, but his or her environment as well.	1 2 3 4 5 6 7
25. Change occurs in therapy through restoring healthy family structures.	1 2 3 4 5 6 7
26. It is essential for therapists to be aware of the values and worldview of their own culture and how they might affect clients.	1 2 3 4 5 6 7
27. Change occurs in therapy because of the client's insight into characteristic ways of relating with others set in early childhood.	1 2 3 4 5 6 7
28. It is helpful to ask questions to lead the client to realize their mistakes or misperceptions.	1 2 3 4 5 6 7
29. There is evidence that most mental health problems have biological causes.	1 2 3 4 5 6 7
30. Denial, repression, intellectualization and other defense mechanisms are important to understanding psychology.	1 2 3 4 5 6 7

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Fold this column, transfer your response, and sum.	COLUMN1 To compare scales, Divide each sum by # of items.	COLUMN2 Compare your summed scale score to the responses of 130 subjects.
PSYCHO-DYNAMIC		
1_________		
9_________		
20________		
27________		Mean (sd)
30________		
Sum ______	/5 = _______	26.2 (5.2)
BIOLOGICAL		
8_________		
17________		
23________		
29________		
Sum_______	/4 = _______	14.6 (4.0)
FAMILY		
4_________		
13________		
22________		
25________		
Sum ______	/4 = _______	18.2 (4.0)
ECOSYSTEMS		
16________		
19________		
24________		
26________		
Sum ______	/4 = _______	24.2 (2.6)
COGNITIVE		
2_________		
6_________		
15________		
21________		
28________		
Sum_______	/5 = _______	25 (4.5)
PRAGMATIC		
5__________		
10_________		
11_________		
14_________		
18_________		
Sum_______	/5 = _______	20.1 (5.7)
HUMANISTIC		
3_________		
7_________		
12________		
Sum______	/3 = _______	10.4 (2.4)

INTERPRETING YOUR SCORE: The subscales you used to add up your scores (psychodynamic, biological, etc) are derived from a factor analysis of the responses of 130 subjects. See below for sample information (footnote 1).

Column 1 allows you to standardize your subscale scores by dividing the subscale sum by the number of items in that scale. With these 1 item equivalents you can examine which orientations you tend to score more highly on, and which are lower. If you chose to not make the calculation, notice which subscales have 5,4, and 3 items and you can make comparisons within these groups. Some participants have found it helpful to refer back to their responses to individual items to see if there are parts of a theory they tend to agree with more or less.

Column 2 provides the means and standard deviations of the sample of 130 community clinicians. Since these are from one selectively drawn sample, they provide a reference point but are not Anorms@. (These are means of the summed scale scores, not standardized to the 1 item level).

To aid you in interpretation the mean +/- 1 standard deviation would include 68% of the sample, and +/- 2 standard deviations would include 95% of the sample. One caution is that the reliability of the scales is adequate to discriminate group differences, but not individual differences. These scores should be used to stimulate reflection, but not as precise measurements of individual theoretical orientation.

[1] Sample Information: (n=130) Fifty-six (43%) of the subjects were MSW students, and 74 (57%) were practicing clinicians. Ninety-three (72%) were social work associated (students and practitioners) and 37 (28%) were from the other mental health professions. The average age of subjects was 35 (sd=13.7). The average practice experience of practitioners was 13.8 years (sd=11.2).

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