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A Message from the President

Happy New Year 2020!
Just saying that conjures a sense of vision. My hope is that this year—indeed, this decade—is one of vision, foresight, and generativity. I’m staring down the road of my second year as president—and thinking beyond. I’m reflecting on the thematic aims and hopes I expressed last year for my term of service in this leadership role.

I will aim to provide a picture of the road ahead for the coming year and beyond. I hope you will share in the sense of excitement we feel and join us as we meet the dynamic future that is ever evolving in AAMFT and beyond. The board is committed to three major initiatives to be launched this year: 1) The Approved Supervisor Inclusivity Task Force; 2) a renewed Bylaws amendment to open and simplify the member categories, and; 3) a comprehensive strategic plan review. I’m personally excited about each of these initiatives because they speak to the heart of my hopes and themes for greater diversity, inclusivity and equity in AAMFT. We plan to redouble our focus on those themes, and the elimination of unwarranted barriers to access and a felt sense of belonging in AAMFT.

Before I proceed, however, I want to acknowledge some felt tension I have in writing this column. I want to make it personal and to be open and transparent as the person of the president. At the same time, my role compels a responsibility to highlight the 30,000-foot level view of AAMFT and association management in general. On the personal level, I can talk all day about the things I am excited about, and eager for the board to actively engage members about the future of AAMFT. Since the governance orientation last month, I have been more keenly aware that at an organizational level, members sometimes don’t know (or sometimes forget) all the things that are interconnected in AAMFT, and exactly how they fit together (and sometimes don’t) for achieving our purpose and mission.

In my last FTM column (September/October 2019), I tried to unpack some of the board work and thinking around the actions supporting the bylaw amendments. And you may have noticed the new governance series we launched recently in the AAMFT eNews. We are aiming to provide clearer context for the processes the board engages in around their deliberations and actions. In the bi-weekly eNews, you can see how specific policies and governance practices guide the board’s processes and lead us to more thoughtful and deliberate strategic actions. You can clearly see the work that goes into vetting any board actions.

This brings me to the board vision for 2020. One of those major initiatives is the recent appointment of the Approved Supervisor Inclusivity Task Force (ASITF). This international group of seasoned approved supervisors (AS) and trainers will closely examine our current AS standards for any unintended barriers that may pose unreasonable constraints to achieving that prized AS designation. Upon the completion of their work and report, the ASITF will offer recommendations for the board to consider that could enhance inclusivity, access and equity, and increase the number of highly qualified approved supervisors.

The second major initiative is related to our bylaws. If AAMFT is to survive and strategically compete in the professional association world, we simply need to change our membership categories. The board is vigorously committed to the member category change and will engage in a greater outreach effort to our members and stakeholders to help them see how the overall organizational viability and viability is on the line. The unintended barriers to AAMFT membership with our current member category scheme are undeniable and unsustainable. Opening our doors to simplify access to membership in AAMFT is in alignment with our overarching purpose of AAMFT: To advance the profession and practice of systemic therapy.

Let me pause to ask: how else might we advance the profession in the face of an evolving and accelerating trend of retiring members? How do we advance the profession when more and more stakeholders tell us that they wish to join; and though they were trained in another discipline they identify as a marriage and family therapist. I think that to simply do ‘more of the same’ in the face of such trends is irresponsible from a board position, and unimaginative from any angle. In my view, the voiced fear of ‘selling out’ the MFT licentiates was alarmist and distracting from the reality that we do not own the practice of systemic family therapy. We continue our strong and abiding stance of advocacy. In fact, we continue to rack up more cumulative state and provincial advocacy wins with the Family TEAM than ever before. AAMFT will always fight to protect the independent licensed Marriage and Family Therapist.

Anyone who knows me knows that I am incredibly proud of my LMFT (so much so that I maintain my MFT license in 4 states). I fully embrace the uniqueness of that license. I am also incredibly proud of my rigorous MFT training at Purdue, as I am about the stellar graduates of our COAMFTE-accredited programs. But remember, our roots as an organization have been proudly interdisciplinary and we have held passionately to the concept of equifinality. We must recognize that there exists a multiplicity of ways for one to earn their systemic family therapy stripes. Thus, I still believe that we can be a big tent again—only more vibrant in our diversity, more inclusive in our access, and more collaborative in our equity of belonging in AAMFT.
The board sees a key driver in our effort to become a more inclusive organization directly relates to our membership categories. There were concerns voiced among different segments of the association who worried the 2019 bylaws amendment might alter the DNA of our association. I believe that concern was not founded on the facts which the Board viewed as mission critical. Another concern we heard in the last vote was regarding the composition of elected officers and the assurance of deeply committed systemic leaders in AAMFT.

This past December, the board acted to direct staff to craft new language for another bylaw amendment this summer, which will again seek to open and simplify the member categories, and to clarify this issue regarding committed systemic leadership of AAMFT. We aim to strengthen our assurance for the members to that end. The board is committed to member outreach and communication and to fully address any other voiced concerns. And we will ask the nearly 60 percent of voting members who supported the change to please help your member peers see the vital importance of this vote for change. The board strongly believes that opening and simplifying the member categories will reflect a clearer equity of access and lift unintended barriers to international members, systemic oriented professionals trained in other disciplines, and students who will become eligible to vote.

This leads me to the third major undertaking in 2020, and arguably the most exhilarating for the board and me. After the upcoming March meeting, we will be launching a comprehensive strategic plan review. I want to highlight that this is BIG! It will be the first major substantive review of the plan since 2013. Yes, we have made minor tweaks and adjustments in our biennial review years (2015 and 2017, respectively). And in July 2018, after careful consideration and discussion with an association consultant, the board voted to defer a substantive review of the strategic plan until 2020. Well, that time is now, and I hope that everyone who wants to become engaged and offer their input to that process will join one of the many prospective virtual town hall meetings.

The first task of this initiative will be the appointment of a strategic plan steering committee to identify the architecture for the process and priorities in developing the new plan. The board vision is that this process will involve all levels of governance and stakeholders—members, network leaders, commissioners. The aim of the steering committee will be to develop policy-informed processes for AAMFT to be continuously thinking and planning strategically and generatively. You can look for more details about the planning process and opportunities for member engagement after the March 2020 board meeting.

Finally, it occurs to me that AAMFT is many things to many members. Like growing up in a large family, each member has their perspective and sense that their needs are unique from the others. Oh sure, we share a common bond of systemic thought, but our social locations and the intersectionality of each one of us lead us to different experiences of (and the community of) AAMFT. Our experiences of belonging and attachment and affiliation vary. The board, its task forces and committees, and staff have worked diligently this past year to attend to our D & I policy to remove unintended barriers and to open up space for greater diversity, inclusion and equity. It is a work in progress, but it is intentional work that is ongoing. We want to invite your voice in that process. Thank you.

TIMOTHY F. DWYER, PHD
NOTEWORTHY

data note
Teen Views on Social Media

Among those teens who said social media has a mostly positive impact on people their own age (31%), main reasons provided are:

- 4% Learning new things
- 5% Getting support from others
- 7% Self expression
- 9% Keeps you entertained/upbeat
- 15% Meeting others with same interests
- 6% Other

Among those teens who said social media has a mostly negative impact on people their own age (24%), main reasons provided are:

- 12% Other
- 3% Drama, in general
- 4% Causes mental health issues
- 12% Peer pressure
- 14% Causes distractions/addiction
- 23% Bullying/rumor spreading
- 17% Harms relationships/lack of in-person contact
- 15% Unrealistic views of others’ lives

45% of teens saw neither positive nor negative effect.

Pew Research Center, Teens and Their Experiences on Social Media, November 2018.
therapy talk

Hal Runkel, LMFT, author of Scream Free Parenting, believes parenting has changed in recent decades as a result of the 24/7 news cycle, the internet and the ability to check children’s grades, school attendance and whereabouts at any moment. Runkel says, “If we think our number one job is to protect our child, then anxiety is going to drive the boat. We will want to know before they make a mistake or get into trouble.” Instead, we need to redefine our number one job as preparing children to live as independent adults. As Runkel notes, “The more we protect them, the less we prepare them. Think: I am supposed to protect them in the service of preparing them, not vice versa.”

REMEmBERING
Karen Wampler
Karen Smith Wampler, PhD, AAMFT Clinical Fellow, died on January 2, 2020, in Sydney, Australia, while traveling with her husband and granddaughter, Dominique Maderal. She is survived by her husband, Richard, their two children, Leah and Nathan, five grandchildren, and seven great-grandchildren. I wanted to take this opportunity to offer a tribute to her life as an academic, researcher, mentor and friend, and leader in our field through four decades, while highlighting her accomplishments and legacy.

Life overview
Karen was born in Kalamazoo, Michigan, the eldest of four siblings with three younger brothers. Her family moved several times in Michigan and Indiana for her father’s career. Her undergraduate (Indiana University) and master’s (University of Pennsylvania) degrees were in sociology, with a particular focus on family sociology. She went on to research positions, including at the Kinsey Institute and the Franklin Institute Research Laboratory. While caring for her young children, Leah and Nathan, she continued her research work in Kansas and Indiana. In 1975, she returned to graduate school in one of the first MFT doctoral classes at Purdue University. Upon completing her PhD in MFT in 1979, she spent the rest of her career in academia (University of Georgia [1979-1989], Texas Tech University [1989-2007], and Michigan State University [2007-2013]), teaching and training students while also doing research in MFT and serving as an administrator.

Professional contributions
... to research. Karen left her mark on our field in terms of research. Karen published over 60 peer reviewed journal articles and 12 book chapters, and was responsible for hundreds of videos, editorials, reviews, and professional presentations. Her work advanced understanding of interactional processes as well as the process of change in therapy, but also included her thinking about our profession and practice.

Karen is best known for her work in attachment-related dynamics, especially her translation of attachment theory into observable behaviors. Karen’s understanding of attachment theory and its relevance for our field was unmatched. When I entered my PhD program, I thought I had a pretty good understanding of attachment theory.
However, it did not take very many conversations with Karen to realize how much I did not know. I cherish those conversations, not only because they taught me information that I still use in my research, but they helped me get to know Karen, her incredible mind, her capacity to integrate information from many fields, and her excitement about attachment theory and research.

...to programs and departments. Karen had unmatched administrative skills. She developed and directed the accredited MFT program at the University of Georgia, also overseeing a cooperative specialty certificate with the School of Social Work and the Department of Counseling. In 1989, she moved to Texas Tech University, where she served as the MFT program director and eventually as the chair of the newly created department of Applied and Professional Studies. One of her unique contributions in this role was the development of an undergraduate major in Community and Family Addiction Services. Her final academic role was as chair of the Human Development and Family Studies Department at Michigan State University.

Karen had an innate sense of fairness and was not afraid to address challenging situations. I greatly admire her courage and ability to have hard conversations where people left feeling supported and hopeful rather than defeated. She was also an incredible problem solver, finding ways to succeed even when she was confronted with difficult administrative challenges.

...to training and mentoring. Karen's scholarship also contributed important knowledge regarding training in our field. She addressed topics such as the researcher-clinician gap, as well as addressing the training models in our field. She emphasized what made us unique as a field while also recognizing training elements within other fields that we could emulate. Her conversations about training served to bring new awareness and move the field forward.

Although Karen's scholarship seldom addressed the mentoring process per se, her example in this area was great. She supervised 27 doctoral dissertations and 7 master's theses, and served as a participating committee member on many dissertations and theses. Her students have achieved success in academic and/or therapy careers. Karen was my model for what a mentor should be. She was extremely busy as a department chair while I worked towards my PhD. Yet she always made time. I can only hope to one day be the mentor that she was to me.

...editorial skills. I always loved to have Karen read and edit my papers. She had such a way of thinking about our field that was both broad and deep. Karen used her clarity of thought and vision for the field as the editor-in-chief of the Journal of Marital and Family Therapy (JMFT) from 2001 through 2005. During her tenure as editor, she facilitated many important conversations within the field while also advancing the scope and reach of the journal.

More recently, she served as the editor-in-chief of The Handbook of Systemic Family Therapy, a four-volume work now in final preparation by Wiley for publication in 2020. I remember talking with her when she was deciding whether to undertake the project. She had a lofty vision of what the handbook could become and what it could do for the field. I never doubted for one second that AAMFT had chosen the right person to spearhead the publication process with Wiley and work productively with so many diverse contributing authors. Karen had such a talent for thinking about things and breaking complex ideas up into straightforward and manageable pieces.

The handbook grew into four volumes, consisting of 106 chapters and more than 2,700 pages written by 292 authors and co-authors. I was amazed at the amount of work she put in—she put her whole heart and soul into this project. As an associate editor, I saw the in-depth process that went in to choosing the content, organizing it, selecting and inviting authors, reviewing the chapters, etc. Karen was intimately involved in every part of the process. She read every chapter, sometimes two and three times. I honestly do not know how she did it. Her husband, Richard, said she thought of the handbook as her magnum opus. It truly represents her legacy and a gift that she given our field.

Personal contributions
Karen’s contributions to systemic family therapy were outstanding. Her vision and clarity of thought left our field better off than she found it. Yet, as monumental as her professional contributions were, I am confident that her loss will be more keenly felt at the personal level. As a self-proclaimed introvert, she never sought the spotlight (although her brilliance often thrust her into it). As a result, she often preferred one-on-one interactions. It was in these individual interactions that Karen truly shone, in large part because she was authentic and attuned to the other person.

Personally, I am saddened by the passing of an incredible mentor and friend. It goes without saying that I was not ready to lose Karen (none of us were) and her incredible support and strength in my life. For as connected as she was to my professional life—following it and giving much needed perspective and advice—she was just as connected to my personal life. She knew each of my children by name and regularly asked how they were doing. She always made sure to ask about my wife, Ruth, and made sure to send her regards. I will miss those conversations.

Call it her attachment training or simply who she was, but Karen had a unique ability to make every single person with whom she interacted feel special—like the most important person in the world. I remember always feeling that with her and thinking how lucky I was. Then, I would see her at social functions off to the side with a different person and overhear her talking as sincerely and thoughtfully to them. She just had the knack to connect with people.

For the past couple of years, I have wanted to give Karen a plaque that said: “People may forget what you say and do, but they will NEVER forget how you make them feel.” To me, that represents Karen Wampler’s life and what she means to me and so many of us. Henry Wadsworth Longfellow wrote, “Lives of great men [and women] all remind us we can make our lives sublime, and departing, leave behind us footprints on the sands of time.” What incredible footprints Karen has left for all of us to walk in. Thank you, Karen.

Ryan Seedall, PhD
Marriage and Family Therapy Program
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SCREENING SCREEN TIME

Evidence-Informed Guidelines for Parenting in the Digital Age

Diane R. Gehart, PhD
Those are texts from my nine-year-old that I see on my phone between sessions. He’s wanting “time” on his iPad because none of his games or YouTube app are visible. I have locked down all third-party apps except for the half-hour I give him after he has done his homework and chores. Like most parents today, I have had a steep learning curve when it comes to managing my children’s relationship with screens. It often feels like I am lost in a foreign wilderness without a map.

In my clinical practice, texting, social media, screen time, or gaming is identified as an issue for virtually all children, adolescents, and families with whom I work. I have learned to assess for screen time issues along with the old clinical standards, such as mood, academic performance, behavioral issues, sleep, and eating. However, I used to rely on less-than-professional resources about screen time, such as my online newsfeeds, webs searches, and my own life experience. So, when I had a chance to go on sabbatical at my university, I immediately knew how I wanted to update my knowledge: screen time for families.
How screen time impacts children and adolescents

Research on screen time actually began in the 1970s with concerns related to children watching television (e.g., Anderson, Levin, & Puzgles Lorch, 1977). Over the past 20 years, there has been an increasing amount of research on video games, especially related to the newly recognized Gaming Disorder, by the World Health Organization (2018), and Internet Gaming Disorder appears in the DSM-5 (American Psychiatric Association, 2013) as a condition for further study. Youth having extensive access to the internet, social media, and digital devices is a relatively new phenomenon of the past decade, and thus there is less research on the impact of today’s screen use than one would hope. However, after decades of not funding a large-scale study on this topic, the U.S. National Institutes of Health (2019) is currently conducting an investigation related to youth health that includes screen time, but it will take another decade or more before we have long-term results. Most parents will be done raising their kids before we have a solid understanding of how today’s technology affects growing brains and bodies. Therefore, therapists and parents will have to work with the information we have available now, which is sufficient to make relatively specific and informed decisions in most areas. The existing evidence base addresses how screen time affects youth sleep, weight, aggression, attention, mental health, and neurological development.

Sleep

One of the strongest correlations between media use and youth behavior is related to sleep: the more children and teens have access to screens, the less they sleep. Sleep is critical for growing brains and for learning, and is an important part of consolidating memories, which is essential for academic success (Knell, Durand, Kohl, Wu, & Pettee Gabriel, 2019). However, only 63% of 15-year-olds in 2012 reported getting more than seven hours of sleep per night (Twenge, Krizan, & Hisler, 2017). Decreases in adolescent sleep have been directly associated with the increase in screen time and social media. For example, those with access to a portable device at night had a 79% chance of getting less than nine hours per night for adolescents, or 10 hours for children (Carter, Rees, Hale, Bhattacharjee, & Paradkar, 2016). The research also emphasizes that screen time an hour before bed is particularly detrimental because the screen's blue light inhibits the production of melatonin, interfering with the body’s natural circadian rhythms and making it more difficult for children (and adults) to fall asleep (Bradford, 2016).

Weight management and obesity

The second-best established concern related to screen time is childhood obesity and weight management (Robinson et al., 2017). This research began with the study of television viewing and has continued with today’s mobile devices. However, the exact reason screen time use is correlated with obesity is unknown because the seemingly obvious “lack of exercise” hypothesis is not consistently supported by the evidence. Not all children who spend more time on screens actually get less exercise. Nonetheless, researchers have found that reducing screen time in adolescence has a significant impact on obesity in young adulthood (Boone, Gordon-Larsen, Adair, & Popkin, 2007). In their 2016 policy statement on media and youth, the American Academy of Pediatrics emphasized the importance of ensuring children and adolescents have at least one hour of moderate-intensity exercise in their schedule before allowing screen time to reduce the chances of obesity and weight-related issues.

Aggression and desensitization to violence

A topic of significant public debate, screen time, particularly violent video games and media, have been associated with increased aggression and decreased sensitivity to violence and the suffering of others. Studies from the 1960s established that children who watch violence are more likely to act violently (Kamenetz, 2018). Several studies have found that playing violent video games reduces activity in the prefrontal cortex and a person’s ability to regulate one’s mood and behavior; these effects are measurable not only immediately after playing, but also weeks later (Hummer, Kronenberger, Wang, & Mathews, 2019). Similarly, researchers have found that playing character-based, risk-glorying video games increased delinquent behaviors in all areas measured, including alcohol use, smoking, aggression, and risky behavior (Hull, Brunelle, Prescott, & Sargent, 2014). However, experts are also quick to point out that violent games and media cannot and do not explain serious acts of violence, such as school shootings.
which are correlated much more significantly with mental illness, dysfunctional family dynamics, and economic insecurity (Kamenetz, 2018). Furthermore, evidence indicates that certain children seem to be more vulnerable to the negative outcomes than others, although the moderating factors are not yet clearly identified. On a more hopeful note, Harrington and O’Connell (2016) found that playing prosocial video games results in increased prosocial behavior, such as empathy, sharing, and positive emotion.

**Attention problems**

Few dispute the claim that screen time affects children’s (and adult’s) attention spans. Both television viewing and video game playing have been found to decrease children’s, adolescents’, and young adults’ attention spans, so the impact extends far beyond the early years (Swing, Gentile, Anderson, & Walsh, 2010). Two different issues relate to attention and screen time: a) amount of time on screen and, b) speed of images on screen (Kamenetz, 2018). While the first is relatively obvious, the second is less so and more critical for younger children in particular. The faster images shift on screen, the more the stress response is triggered, with younger children having a more noticeable response. Thus, a video game such as solitaire that moves at a speed determined by the player has a very different effect on the nervous system than one such as Tetris or Bejeweled where the tempo of falling puzzle pieces is entirely controlled by the game itself. The more time spent watching fast moving images, the more the stress response is triggered and the more difficult it can be to pay attention to slower, normally paced activities, such as reading or playing a board game.

**Depression, anxiety, and narcissism**

The National Institute of Mental Health reports that the lifetime prevalence of any mental disorder for adolescents 13-17 is 49.5% with the three most common disorders being attention deficit disorder (ADD), anxiety, and depression (Merikangas et al., 2010). Both social media and long video game sessions are correlated with higher rates of adolescent depression and anxiety (Kamenetz, 2018), and factors such as frequency of posting selfies, number of followers, and time spent on social media has been correlated with narcissism (McCain & Campbell, 2018). Although screen time is not causal of these disorders, increased screen time can be a sign that a child is struggling with one of these or another mental health disorder and intervening on the amount and type of screen time may help reduce symptoms.

**Brain changes and academic performance**

The U.S. National Institutes of Health (2019) is in the process of conducting a large-scale study examining, among other things, the long-term effects of screen time. The study is following over 11,000 children at 21 sites across the United States. Their initial data had some significant findings related to screen time and brain development:

- MRI scans found significant differences between the brains of some children (sample included 9-10 year olds) who reported over 7 hours per day of total screen time.
- Children who reported more than 2 hours per day of screen time had lower scores on language and reasoning tests.

These findings are particularly concerning since the average 5-7 year old has 4.5 hours per day and the average 8-12 year old has 6 hours per day.

**Parenting recommendations by age**

Parenting around screen time is a complex issue, and therapists need to factor in numerous dynamics, such as family configuration, child temperament, parenting style, cultural and gender norms, and mental health issues. The following recommendations offer therapists a place to begin conceptualizing how best to begin dialogues and explore possibilities with families related to
Setting healthy limits and creating healthy attitudes towards screen time in these early years sets a solid foundation for effectively managing it themselves in adolescence and adulthood.

these issues. Ultimately, the goal is to help children develop a healthy relationship with screens, the internet, and their virtual social worlds, which parents do through mentoring, conversation, and role modeling. The recommendations below are based on those from the American Academy of Pediatrics (AAP, 2016), combined with the emerging research findings described previously, and provide an initial framework for ongoing family dialogue about these multifaceted issues.

**Infants and toddlers: 0-24 months**
Although there are apps and videos targeting this age range, experts agree that no amount of screen time is recommended for children in the first two years with the exception of video chatting to connect with relatives (AAP, 2016). Researchers found that infants and toddlers who viewed media prior to 18 months had significant and measurable drops in language development (Zimmerman & Christakis, 2005). At age 18-24 months, parents can introduce high-quality (i.e., educational) shows that the parents sit down and watch with the child.

**Preschoolers: 2-5 years old**
The AAP (2016) recommends a clear time limit for preschool-aged children: no more than one hour of total screen time (television, tablets, computers, and smartphones combined). The AAP recommends strongly that parents watch or play with the child to help the child understand and engage with the media. Co-viewing and co-playing enable parents to coach children on how to engage digital media in healthy ways and offer opportunities to strengthen the parent-child bond (Sanders, Parent, Forehand, & Breslend, 2016).

**Elementary school aged children: Ages 6-12**
At this age, parents need to monitor, manage, and observe the impact of screen time on each child and adjust as needed, but with an overall attitude of developing a lifetime of healthy digital habits. Setting healthy limits and creating healthy attitudes towards screen time in these early years sets a solid foundation for effectively managing it themselves in adolescence and adulthood. The easiest system for managing time is to use not only the built-in parental controls in virtually all digital devices, but also employ third-party parenting control apps that allow parents to schedule and control screen time remotely (however, note that you will receive texts like the ones at the beginning of this article regularly). As noted previously, screen time should never come before a minimum of an hour of daily exercise and a full night’s sleep (10-11 hours at this age). Smart phones and social media are not advised at this age, and parents should carefully research the ratings and content of apps and games before purchase. Ideally, parents play with their children to better understand how a particular game or show may be affecting them. Finally, parents should regularly have discussions and conversations about screen time and media with children throughout these years to help them develop good habits and attitudes.

**Middle and high school aged youth: Ages 12-18**
Parents need to change their management strategies in middle and high school because the focus quickly shifts to online safety—use built-in parental controls that provide a baseline of filtering inappropriate content and location tracking, a third-party app that allows parents to monitor online activities, including contacts, internet search terms, websites visited, time in each app, texting patterns, etc. Such apps typically allow adolescents to use an allowance of time as they choose throughout the day to develop self-monitoring skills, which differs from apps that require parents to set predetermined periods of time for younger children. Because the National Sleep Foundation (2019) estimates that less than 15% of teens typically get the recommended 9-10 hours of sleep per night, parents are strongly encouraged to collect all digital devices (or use an app...
to disallow use) one hour before a reasonable bedtime in addition to ensuring an hour of exercise per day.

During these years, perhaps the most difficult decisions parents have to make are related to allowing social media and violent games/media; the pros and cons of allowing such media must be considered for each individual child. Similarly, parents have the challenging task of addressing a wide variety of digital sexual issues, including internet pornography, sexting (texting sexually explicit photos and videos), online sexual predators, and sex trafficking. In addition to ongoing family discussions about these difficult topics, third-party parental control apps offer the most effective option for identifying these issues before they get out of hand. During adolescence, parents also need to monitor for mood and anxiety issues, which are often exacerbated with both increased screen time and specific types of content. Lastly, perhaps the most important task is to role model and openly discuss the many challenges and dilemmas of screen time, the internet, and living in our digital age. These frank conversations set the foundation for a healthy relationship with media for a lifetime, which is the ultimate goal.

Closing reflections

Marriage and family therapists are in a unique position to help families with children of all ages effectively navigate the many challenges of parenting in the digital age. Although we do not have simple and clear answers to all concerns, we have sufficient research to offer specific and meaningful guidance to parents who typically struggle with knowing how to effectively parent in this new frontier.

**REFERENCES**


THE SOCIAL MEDIA
BATTLE GROUND

Katharine Larson, MA
A parent recently sat with me during a session, and she talked with me about how she is coping, and accepting, that things have changed since she was young. She stated to me, “When I was a kid in the 70s, my summers were spent almost every day outdoors until the streetlights came on. That was our curfew; otherwise my parents didn’t really want to see us in the house except for lunch and the occasional bathroom break. If we lingered too long in the house during these times, I could see my mother’s eyebrows start to wrinkle and the sighs would become longer and more exasperated. My sister and I bolted out as we heard, “Alright all of you, get outside already.” We were wonderfully exhausted by bedtime and I would reflect on our adventures from earlier in the day. We both agreed that young people today are not getting as much in-person interaction with their peers as we did in our childhood.
For the past four or five years of my almost 20 years of practice, I have observed new, challenging behaviors with preteens and teens, and parent/child conflict, all related to social media and excessive screen time.

When I met separately with her son, we discussed his mother’s concerns about his need to be on social media so frequently. “I kinda want to be on social media with all my friends, but it’s mostly drama and there are things that aren’t true on there, I know that. But it’s also fun to see what my friends are doing. Sometimes I have to walk away from my phone and do some gaming with friends online because it drives me crazy.” He stated that he visits social media sites after school, before he does his homework, for about an hour or so, then his mother will come in his room and remind him to get off his phone or gaming system and start his homework.

His mother had initially brought him in to address his anxiety and depression, which she stated worsened when he started middle school. His mother reported that this was when she decided to allow him to have social media, with monitoring and efforts to restrict access to inappropriate websites. She expressed concerns that approximately three months after being on social media, he began to present as more irritable, withdrawn, and with decreased ability to concentrate on his homework. I had decided to have them meet with me together so that they could express their feelings to each other. I felt it was particularly important for my client to share with his mother that being on social media can be stressful for him, as well.

It might be tempting for parents to go to extremes and either restrict access to social media altogether, or overly accommodate their worries and stressors by inadvertently helping them avoid problem-solving. Leah Shafer (2018) of the Harvard Graduate School of Education states, “Teenagers report feeling all kinds of positive and negative emotions when describing the same social media experiences—posting selfies, Snapchatting, browsing videos—but the majority rate their overall experiences as positive (para. 3). She adds, “Understanding these nuances can help families better grasp their teens’ up-and-down experiences in the digital world (para. 4). She further explains, “Just cutting teens off from social media entirely may not be the best solution, since that will likely cut them off from positive experiences as well” (para. 17).

When talking with my colleagues who work with parents and teens dealing with social media habits and concerns, they share that they are often validating their concerns or guiding and supporting parents’ efforts to set and maintain healthy limits the use of social media. While most parents will express appreciation for the support, I have found that despite efforts they make to follow through with some suggestions, parents will often report to me that they feel in competition with social media. They express with frustration that they can’t get their child out of his or her room, and conflict will escalate when they feel they must go to extremes to get their child’s attention away from social media. Most parents tell me that at one point they ended up shutting off the internet altogether for an hour or more. “This can lead to World War III,” one parent told me.

I often assess parents’ knowledge of their child’s use of social media, and how they balance being watchful but not intrusive. I encourage parents to talk with their child/teen about social media use—what to look out for, and when to alert parents if they are concerned—prior to allowing them access to a social media site.

I encourage parents to talk with their child/teen about social media use—what to look out for, and when to alert parents if they are concerned—prior to allowing them access to a social media site.
that is concerning or alarming, without the fear of being shut out of social media, unless the parent perceives a safety risk.

Emily Weinstein (Weinstein & Selman, 2014), who studies teens and their social media habits, identified six digital stressors teens encounter. Type 1 stressors reflect the migration of common forms of relational hostility onto the online space and echo discussions of harassment, drama, and bullying:
• mean and harassing personal attacks
• public shaming and humiliation
• impersonation

Type 2 stressors stem from adolescents’ use of digital technologies in the context of their attempts to form and maintain intimacy or close connections with others. They include:
• feeling smothered
• feeling pressure to comply with requests for access
• breaking and entering into digital accounts and devices

These are great platforms for parent/child dialogue when discussing parents’ concerns around their teen’s social media habits. The role of the practitioner-as-facilitator of dialogue between parent and child when discussing power and control over social media is crucial. Allowing for validation of parent's concerns, and acknowledgement of the risks emotionally for teens while recognizing some of the positives, should all be included in the discussion. Therapists can support all involved in managing social media, with the goal of helping the parent coexist with their child’s social media instead of feeling the need to compete with it.

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Divorce, Remarriage, and Blended Families
Checklists for Therapists
There is a strong correlation between marriage and family therapy and significant improvements experienced by clients with regard to their management of family discord, marital relationship conflict, parent-child struggles, and overall systemic distress (Tao & Randall, 2017). In addition, the specialized education, professional training, and therapeutic interventions employed by marriage and family therapists (MFTs) have reliably resulted in significant increases in inter-relational coping skills with commensurate re-establishment of homeostasis within the family system (Tao & Randall, 2017). Thus, MFTs are uniquely qualified to efficaciously treat the entire family system, as opposed to an individualized approach. In the event clients determine there is a need for systemic change, MFTs are particularly equipped to help them achieve a successful life transition.
Surviving divorce
The Centers for Disease Control and Prevention (2019) reported that as of 2018, 6.5 of every 1,000 people in the United States get married, which equates to 2,132,853 marriages annually. They also reported that as of 2018, 2.9 out of every 1,000 marriages in the U.S. ends in divorce, which equates to 782,000 divorces annually. Raley, Sweeney, and Wondra (2015) broke the numbers down by ethnicity and reported 40% of White women, 45% of Hispanic women, and 55% of Black women become divorced annually. Empirical research has shown men, women, and children experience the effects of divorce somewhat differently. Nevertheless, it is a substantial adjustment for all parties. Research consensus indicates men commonly experience divorce as follows (Baum, 2004; Beal, 1989):

• Least likely to initiate the divorce
• More likely to be the non-custodial parent
• Experience challenges maintaining contact with their children when non-custodial
• Often experience a sudden loss of social support
• Develop feelings of aloneness, guilt, self-blame, and anger
• Frequent lack of structure in day-to-day life
• Grieve the lack of daily contact with their children
• Often engage in sexual promiscuity/rebound relationships as means of re-establishing the support they had from their spouse
• Begin spending longer hours at work
• Decline in physical health due to unhealthy behaviors, such as drinking, increased intake of junk foods/fast food, and lack of adequate sleep

Men commonly experience a sudden loss of social support

It is supportive to normalize these reactions, which allows the client to perceive a greater sense of control. In addition, clients may find the following coping strategies helpful for a successful transition (Baum, 2004; Beal, 1989):

• Seek counsel from a member of the clergy
• Join a divorced spouse/parent support group
• Engage in regular physical activity
• Find new healthful activities or hobbies that bring pleasure
• Be open to cooperative parenting
• Get in touch with their feelings and find a trusted source with whom to express them
• Attend joint counseling sessions with their child
• Refocus attention on the future instead of the past

Leopold (2018) reported women commonly encounter divorce as follows:

• Most likely to be the custodial parent
• Commonly feel stress due to reduced financial resources
• Have an increased need for child care
• Experience feelings of intense grief, blame, and loss
• Tend to feel an increased desire for social support
• Often have a decrease in self-esteem due to self-blame

Clients should be informed these feelings and experiences are completely normal and occur as part of the adjustment process. Some coping strategies clients may find helpful are (Leopold, 2018):

• Provide an opportunity for the children to participate in therapeutic services
• Attend parent-child therapy sessions
• Seek counsel from a member of the clergy
• Join a divorced spouse/parent support group
• Gather a circle of trusted supportive friends and family
• Avoid spending a lot of time with people who focus on the negative aspects of the separation (e.g., placing blame, stoking negative feelings)
• Make time to participate in self-nurturing activities (e.g., spa days, meditation)
• Be open to cooperative parenting
• Refocus attention on the future instead of the past
• Honor their emotions and allow emotions to come forward

According to Kelly (2003), most children do not experience long-term adjustment problems following parental divorce except under the following circumstances:

• blindsided because the parents did not take the time to sit down and explain the divorce and what it
means
• Absence of the non-custodial parent for extended periods of time
• Exposure to intense parental conflict or abuse before or after the divorce
• Emotional and/or physical unavailability of the custodial parent (e.g., increased time with sitters due to additional hours at work, parent emotionally withdrawn)
• Moving away from friends and classmates due to parental financial insufficiencies or required sale of the family home
• Negative statements by one parent about the other parent in front of or directly to the children

Nevertheless, children are very resilient, and even if they have been exposed to one or more of these circumstances, there are strategies that can help (Kelly, 2003):
• Implementation of regular visitation by the non-abusive non-custodial parent
• Deliberate effort by parents to avoid negative parental interactions in front of the children
• Seek services for the child from an MFT
• Engagement in open parent-child discussions with permitted expression of child’s feelings without judgment but with empathy and understanding

• Validation by parent and therapist of child’s feelings of grief and anger with assurances the child bears no responsibility for the dissolution of the marriage
• Establish an amicable or at least cooperative consistent co-parenting relationship

Co-parenting after divorce
Co-parenting after divorce can be difficult, uncomfortable, or undesirable. Some strategies for co-parenting success (Ferraro, Malespin, Oehme, Bruker, & Opel, 2016; Serani, 2012):
• Presentation of united front and open communication between parents to eliminate the possibility of the child pitting one parent against the other or forcing the child to choose sides due to messaging inconsistencies
• Avoid the temptation to present as the “good” or “fun” parent
• Agree on parental rules and enforce them equally and consistently
• Prohibition by both parents against child speaking negatively about either parent
• Set an example for civil discourse with complimentary, or at least non-critical, mutual parental behavior
• Discuss with the child what co-parenting will look like and what it means (e.g., child is still loved, separate households)

• Participate in co-parenting training class
• Make welfare of the child a primary focus

Remarriage
In their latest statistics, the Centers for Disease Control and Prevention (2002) reported 54% of White women, 44% of Hispanic women, and 32% of Black women were expected to remarry following divorce. They also reported the overall rate of remarriage has been on the decline since the 1950s, which suggests these numbers are now likely even lower. Many people who have been divorced typically have emotional baggage from their previous marriage. This is certainly not unusual, nor unexpected. In order to have a successful subsequent marriage, it is important to maintain baggage awareness and develop adaptive behavior management skills. Some strategies for a successful subsequent marriage include (McCarthy & Ginsburg, 2007):
• Choose new spouse based on his or her own merits irrespective of what has happened in the past
• Do not compare current spouse to former spouse, neither internally nor verbally
• Avoid active participation in disputes with former spouse to avoid energy drainage from the new marriage which can lead to relationship instability
• Heed past relationship lessons
• Avoid living in the past
• Be honest; work through residual struggles from former relationships together; do not keep secrets
• Seek professional help from MFT for obsessive preoccupation with the former spouse
• Resolve most issues (emotional, financial, and circumstantial) from the prior marriage before entering into a new marriage

Discuss with the child what co-parenting will look like and what it means
Blended families
Remarriage is a challenge, and often, there are children involved from previous marriages or relationships, which present an additional challenge; thus, creating what is known as a blended family. According to Pew Research Center (2015), 22% of children in the U.S. are living within a blended family. The following are some frequently identified challenges associated with blended families (McCarthy & Ginsburg, 2007; Pace, Shafer, Jensen, & Larson, 2015):

• Biological parent disagreement on the role and authority of the new spouse or partner with regard to their interaction with the children
• Unclear boundaries regarding biological vs. step-parent parenting roles
• Child resistance to the acceptance of the step-parent as an authority figure with alternative acceptance of the step-parent as solely an adult figure
• Differing views amongst spouses regarding parental roles and responsibilities

• Family strife, confusion, and feelings of resentment amongst both immediate and extended family members

These issues can be resolved but it will take persistence, patience, and commitment. Recommendations for blended family success are (McCarthy & Ginsburg, 2007; Pace et al., 2015):

• Negotiate and establish roles with clear boundaries
• Include participating biological parents in the negotiations
• Communicate feelings honestly and openly
• Utilize an empathic approach to understanding opposing viewpoints
• Maintain open lines of communication
• Seek MFT services to attain family unity and achieve stability

Divorce, remarriage, and blending of families can generate painful, confusing, and challenging experiences. Based on the reported statistics, the expertise of MFTs is needed more than ever to help couples, children, and families who are struggling with systemic changes. Clients should be encouraged to utilize empathy and flexibility when navigating these transitions in order to effectuate a peacable adaptive life change. Furthermore, although systemic adjustments are made collectively, it is important clients remember they evolve at an individual pace. Accordingly, with the right tools and resources, successful new beginnings can be achieved and sustained.

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Supporting Clients Facing INFERTILITY
Infertility—a word we usually don’t hear until we are actively trying to get pregnant.

Infertility is defined as the inability to get pregnant or remain pregnant after one year of unprotected sex, or six months if the woman is above the age of 35 years (Center for Disease Control and Prevention, 2019). I remember when I was taught about the “birds and the bees” in middle school and it sounded like anyone could get pregnant at any time. Now, as an adult, I realize this is not the case. In fact, 1 in 8 couples in the U.S. has some form of infertility and the rates of infertility are rising (U.S. Department of Health & Human Services, 2019). There are many hypotheses about why this is happening. Couples are waiting to have children later in life, life has become more stressful, and our food isn’t as nutritious as it used to be. Plus, there are things like cancer treatments, accidents, genetic mutations, and other physiological explanations for infertility.

Linda Meier Abdelsayed, MA
The following will shed some light on infertility and how to support clients who are undergoing fertility treatments.

**Step 1 - Get informed**

The infertility world is a world of its own, with its own language. Knowing how to speak about infertility is the first thing that any clinician needs to do in order to be a source of support. In the infertility world, we speak about “spontaneous pregnancies” rather than “natural pregnancies.” It is important to be mindful of this terminology because all pregnancies are natural (no fetus has been carried to term in a lab yet). Further, it is important to recognize this differentiation of terminology because it also comes across as judgmental and punitive when you ask “So, this wasn’t a natural pregnancy?”

Another important term is ART. ART stands for “assisted reproductive technology” and refers to any medical intervention for infertility. Medical interventions can vary from medical treatments such as Clomid (the most commonly used oral hormone), to IUI (intrauterine insemination), to IVF (in-vitro fertilization). While most of us have heard of IVF at this point, it only accounts for about three percent of infertility services in the U.S. (The American Society for Reproductive Medicine, 2017). Success rates are defined as the live birth of a baby and vary from couple to couple, but once a woman is diagnosed with infertility, the overall likelihood for a live birth is about 50 percent (Stacey, 2019).

It is important to understand the statistics. Most couples who start the infertility journey believe that infertility is female-based. Afterall, we are the ones who frequently take years of hormonal (or physical) birth control, we are the ones who carry the fetus, and in general, we tend to blame ourselves when things “go wrong.” So, it is common for a couple to believe the infertility issue is only in the female. However, the statistics for infertility offer the following insights (The American Society for Reproductive Medicine, 2017):

- Infertility affects men and women equally
- 25% of couples with infertility have more than one factor that contributes to their infertility
- In approximately 40% of couples with infertility, the primary cause is male-factor

**Step 2 - Understand the emotions**

Expect that someone dealing with infertility is going to present with an array of emotions, including grief, fear, shame, hope, and a feeling of unfairness.

Grief hits when a couple starts to realize that their ideas of how to make a baby are altered. Many of us dream of making love and forming a baby together. It is an intimate process that is private. So, when that image gets taken away and replaced with doctor visits, invasions of privacy (emotionally and physically), and oftentimes with many strangers in the room involved in the process, it is important to allow for grief to occur. Having an infertility diagnosis is a bit like having something die. The image of what you thought getting pregnant would look like has died. So, it is important to give clients the opportunity to grieve this loss in therapy.

Fear is another powerful emotion that hits most couples with infertility. Some of the most common sources of fear include:

- Fear about fertility treatments not working
- Fear of not knowing what the treatments will do to your body long term
- Fear of having to make decisions about your fertility treatments immediately because “your biological clock is ticking”
- Fear of having to take time off work
- Fear of the financial strain of fertility treatments
- Fear of what others will think if they find out what you’re going through
- Fear of the relationship not being able to withstand the treatments

A lot of decisions related to fertility treatments are fear based. Process this fear in sessions with clients and acknowledge that a lot of their fears are based in reality. Afterall, any one of these could come true.

A feeling of life being unfair usually also surfaces with infertility. Infertility oftentimes feels like a punishment. Clients might say “I don’t deserve this” or “I’m a good person—why is this happening to me?” There is an underlying schema in most of us that bad things happen to bad people. And infertility is a bad thing, so how can it happen to a good person? Additionally, clients can do everything right with their fertility treatments, follow each of the doctor’s recommendations, and it still might not work. Validating and acknowledging these feelings of unfairness are vital for people undergoing fertility treatments.

Oftentimes, there is shame associated with infertility. There is this notion of “my body can’t do something that it’s supposed to be able to do.” Shame is usually stronger in male factor infertility than in female factor infertility. A lot of men are taught that part of “being a man” is being able to conceive children spontaneously. So, low sperm count or sperm with low motility is something that many men view as shameful or as making them “less of a man.” Shame also creates feelings of isolation because people
who are ashamed of something are often less likely to talk about it for fear of drawing negative attention to it.

Finally, the last feeling that is the quiet force supporting fertility treatments is hope. Clients who are still in the treatment stage of infertility still have hope. Hope that the treatments will work, and hope that they will have a biological child. The hope is usually strongest right at the beginning of a new treatment attempt and will continue to grow until right after an implantation attempt or timed sex. Emotional self-preservation kicks in and clients are filled with doubt as they await their first pregnancy test because they don’t want to get too excited and then be disappointed by a negative result. Hope is the emotion that therapists need to carry throughout their work with clients with infertility. Clients will have waves of hope and it is vital for us to be the holders of that hope and the reminders of it.

Step 3 – Best clinical interventions
With the foundation of terminology and some of the emotions involved in treating clients with infertility, it’s time to turn to the clinical interventions. What helps clients with infertility cope with their diagnosis and make educated decisions about their fertility treatments?

Validation. Validating, empathizing, and reflecting clients’ thoughts and feelings about infertility is one of the best treatment approaches. People going through infertility treatments are going through them alone. So, therapy needs to be a safe space. A space where they can talk about these negative emotions and feel heard. Validation allows for this to happen. It allows for clients to feel heard, understood, and supported. It is important to avoid giving suggestions while validating. Questions like “Well, have you tried xyz?” or “How are you taking your medication?” are not only inappropriate but can be perceived as judgmental. Your job is to support the client in processing and coping with this journey.

Emotional safety. Creating emotional safety is another strong clinical intervention to use. Most couples undergoing fertility treatments will report that they do not feel emotionally heard or safe with their doctors. They trust that their doctors know how to help them with conception (and keep them pregnant) but these doctors don’t really stop to ask “How are you feeling?” Fertility clinics look just like other doctor’s offices and don’t really give off feelings of love and comfort. So, it’s important for you to create emotional safety in your treatment approach. Sessions with you are when clients can speak about how they feel about their decisions and their fertility treatments. In these sessions, couples can speak about their fears of what the fertility treatments will cost them or cost their marriage. They can also process what they can do to make the process more loving and caring, such as giving each other a kiss when the embryo is transferred into the uterus during IVF or holding hands during IUI. Creating emotional safety will also allow you to support your client in creating meaning of what is happening to their bodies and support them in changing the narrative of their infertility journey.

Systemic application of Cognitive-behavioral therapy (CBT). Finally, the staple of all evidence-based therapy is to incorporate some CBT into your treatment approach. Teaching clients relaxation skills such as deep breathing and positive imagery for them to use while undergoing fertility treatments can help with reducing anxiety in the room and increasing physical comfort. A lot of fertility treatments (i.e., IUI, IVF) involve dilating the cervix. This can be painful and made even more painful if the woman is not relaxed. Therefore, practicing relaxation skills in these moments helps reduce pain. Additionally, cognitive strategies such as thought records and positive mantras can help in creating positive meaning throughout a client’s infertility journey, as well as giving clients ways of remaining positive and hopeful.

Infertility is a life altering diagnosis for many couples. As such, it is important to be educated on the diagnosis and provide treatment that will help clients process and cope with it. For more detailed training on this topic, information is available at the American Society for Reproductive Medicine.

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References


Respect—Is this the Key Ingredient in the Recipe for Successful Family Relationships?

There are times in the life cycle of a family during which there may be a lack of respect for other family members by some of the individuals within the family. While this does not necessarily indicate an inherent pathological problem or pattern in the family system, the reality is that this presents a challenge many parents face while attempting to raise their children.

The skill level of the parent(s) often determines the extent of respect inherent in the family system. Therefore, the onus to provide respect for others falls upon the parents. If there is discord in the family, it is the duty of the parents to make an effort to correct this. If the parents allow or continue to tolerate disrespect, there will likely be further problems in the future.
Another factor impacting lack of respect shown by children to parents is related to the child’s level of development. Some of the “terrible two” behaviors that parents are exposed to may be natural and even appropriate when taking this early stage of development into consideration. Nevertheless, no matter the age of the child, parents must recognize that their child’s brain is in the process of attaining further growth, maturity, and development.
Pioneering psychologist Jean Piaget (1969) proposed four stages of cognitive development. His insights, hypotheses, and theories regarding the stages of child development continue to be relevant and pertinent regarding this subject.

**Stage 1: birth to 2 years** – Sensory motor stage. The child’s communications are limited to having their basic needs provided to them by their parents, expressed with crying and what may appear to be excessive expressions of emotion. The child is simply reacting to the environment and relying on the primal brain (the hindbrain and medulla) in order to survive.

**Stage 2: 2 to 7 years** – Preoperational stage. The child is slowly making the transition from relying solely on the hindbrain to using the prefrontal cortex, which provides greater emotional regulation.

**Stage 3: 7 to 11 years** – Concrete operational stage. The child’s brain progresses further from the primal hindbrain to the frontal portion of the brain which is responsible for increasing the ability of the child to attain higher levels of decision making (executive functioning).

**Stage 4: adolescence to adulthood** – The child progresses to a more formal operational stage. Logic and the understanding of abstract concepts begin to take hold. The brain moves from seeing the world as black and white to understanding that there are many gray areas regarding perceptions of life.

With this in mind, therapists can educate parents about the types of behaviors to expect of their child based on their level of development and facilitate reducing the sometimes extreme responses parents display when they perceive misbehaviors or possibly rebellious behaviors.

Emerson Eggerichs (2013) makes the following point: “It is important for parents to not automatically assume disrespect. You may have had to give your child a ‘time-out.’ But do not assume that your child has been disrespectful. Always remember, irresponsible is not the same as disrespectful” (para. 12).

Understanding developmental levels in children is just one important step in providing for children’s needs during their growth.

There are a number of ways in which parents may lose the respect of their child and therefore reduce their credibility as a family leader. One of the more important aspects of creating stability in the family home environment is based on the ability of the parents to remain calm while dealing with their children (Sytsma, 2018). The emotional reactions that parents sometimes display frequently get in the way of establishing a leadership role. Systemic therapists recognize that emotional reactions in any type of relationship interfere with effective communication. A breakdown in communication as a result of emotional reactions by parents often results in parents not receiving the behaviors desired from the child. It is important for parents to consider the impact of some of the things they may be saying to their child that could inhibit progress.

Hilton-Anderson and Booth (2019) suggest the following statements, often used by parents in the heat of the moment, are ineffective and should never be used:

- “Why don’t you listen? What’s wrong with you?” The parent has just told the child there is something wrong with him or her.
- “With you asking for so much, I don’t know how I can pay the bills.” The child is not responsible for paying the bills.
- “You’ll never change.” This type of statement does not give a person much hope.
- “Leave me alone. I’m busy. Go find something else to do.” The brain of a young child interprets this as “I’m not interested in you.”
- “Why do keep bugging me? You’re starting to make me mad.” The child is seeking someone to fulfill emotional needs. Not only has the child been rejected, the parent is angry at him or her.
- “Stop being lazy and get your chores done like I told you to.” Being told you are lazy is not a good motivator.
- “Why do I have to tell you over and over?” Anger often accompanies this statement. A parent may feel this is a means to increase responsibility

The emotional reactions that parents sometimes display frequently get in the way of establishing a leadership role.
The authoritative method of parenting appears to produce the best results in terms of raising a child who will thrive in an adult world. Authoritative parenting is a multi-faceted approach that “covers all the bases” in terms of a parenting method that provides the nurturing experiences most beneficial to children.

and accountability in the child, but the only effect this has is to send a message to the child that he or she “just doesn’t get it.” This may provide further proof to the child he or she is inept and stupid. But kids are not stupid. If they hear this statement frequently, they will often discard this as something akin to listening to a broken record. It is so repetitive that it loses any effect the parent may have intended.

It is no secret that children are adept at getting their way by “bugging” their parents. Persistence is their most effective weapon. If the child continues in this manner, the parents will sometimes lose patience. As a result, the parents may end up reducing themselves to an emotional level equivalent to that of the child’s. The quality of communication between the parent and child will often take a serious downturn. It is important for a parent to remain calm to establish credibility.

Parents who remain involved in their child’s lives are less likely to experience frustration during their child-rearing efforts. Based on my own experiences as a practitioner, as well as the research I have done, the authoritative method of parenting appears to produce the best results in terms of raising a child who will thrive in an adult world. Authoritative parenting is a multi-faceted approach that “covers all the bases” in terms of a parenting method that provides the nurturing experiences most beneficial to children.

Klein and Ballantine (2012) explain the theory and methodology behind this successful form of parenting, citing that authoritative parents are demanding and responsive; controlling but not restrictive. This child-centered pattern includes high parental involvement, interest and participation in the child’s life, open communication, trust and acceptance, encouragement of psychological autonomy, and awareness of where children are, with whom, and what they are doing. The authors make a distinction between authoritative parents and authoritarian parents. They describe an authoritarian parent as being someone who shows little trust toward their children, and their way of engagement is strictly adult-centered. These parents often fear losing control, and they discourage open communication. Their desire and propensity for providing meaningful communication with their children is often limited.

Steinberg, Elman, and Mounts (1989) conclude that:

• Authoritative parenting facilitates academic success.
• Each component of authoritativeness studied makes an individual contribution to achievement. The positive impact of authoritative parenting on achievement is mediated at least in part through the effects of authoritativeness on the development of a healthy sense of autonomy, and more specifically, a healthy psychological orientation toward work.
• Adolescents who describe their parents as treating them warmly, democratically, and firmly are more likely than their peers to develop positive attitudes toward, and beliefs about, their achievement, and as a consequence they are more likely to do better in school.

Parenting via an authoritative parenting style also has the potential of changing parenting patterns which could potentially affect future generations. This method not only teaches, but also encourages respectful behaviors among family members.
It is important to recognize that parenting styles may vary from being lenient to being strict. In any event, extreme parental responses to their child’s behaviors often provide a recipe for unfortunate outcomes. Rebellion on the part of a child is often the result of strictness or laxness in regards to the parenting approach.

It is apparent that the extent and degree of parental involvement is one of the key factors in terms of raising an emotionally healthy and competent child.

Ronald Richardson (1984) notes that each of us needs closeness (togetherness) on one hand, and distance (separateness) on the other. We need affiliation, support, security, love, independence, autonomy, freedom, and self-direction. These apparently opposite needs stay with us throughout life, changing in their intensity depending on the environment and our stage in life.

Parental involvement may be the best means to show children that parents not only care about them, but they respect them as well. This in turn will often result in the child gaining greater respect for the parent. Although a child may not be able to express this, he or she may think, “You are taking care of me. You have helped me feel better about myself. Thank you. I love you.” It is important to establish respect between parent and child at an early age. By the time a child reaches middle or high school age, it may become more difficult to correct behaviors of a child who is presenting with more pronounced issues. Further, Smith and Stern (1997) note that children who have grown up in homes characterized by parents lacking parenting skills will more likely be delinquent.

Stixrud and Johnson (2019) note that some parents believe they must be in control of their children’s lives as a result of false assumptions. They state the following examples: 1) there is a narrow path to success, 2) it is critical to do well in school if you want to do well in life, 3) pushing more will lead children to become more accomplished, 4) the world is dangerous so we must protect children. Many parents will take issue with these false assumptions. What is important to recognize is that most children are more resilient and adaptable than many parents acknowledge. Common sense tells us that we learn the most from our mistakes. Allowing children to learn from mistakes gives them greater insight to make better choices.

I am reminded of a family incident in which my granddaughters announced they wished to go outside and play. It was rainy and rather cold. As they rushed to the door, their grandmother told them they should put on their jackets. My daughter-in-law is a very savvy parent. She stopped her mother and told her “let them find out for themselves.” It wasn’t long before my granddaughters fled back inside the house to dress for the weather.

Stixrud and Johnson (2019) suggest children will thrive better if they are given the freedom to become better decision-makers. The role of the parent therefore shifts from one of being a controlling leader to becoming an advising leader. Offering choices as opposed to giving commands is one of the first steps in this process. Making time for open discussions can alleviate feelings of anxiety on the part of the child. It is also important to validate feelings. This takes the form of telling children that their feelings are normal. Validation also comes from parents telling their children that they have confidence in them to make good decisions.

Parents can fare better by allowing themselves to go with the flow of life. Decisions based on fear usually result in fighting the current. Parents should model self-acceptance and tell their kids what they are doing to accomplish this, as well as teach their children to accomplish this themselves by giving them the tools to become more self-directed, which should lead to greater levels of self-acceptance and self-confidence.

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Parental involvement may be the best means to show children that parents not only care about them, but they respect them as well. This in turn will often result in the child gaining greater respect for the parent.

References
The Ethics of Teaching Ethics

A few years ago, I was asked to teach an ethics course to satisfy Washington State requirements for MFT license renewal. The state requires six hours of ethics for each renewal period. While I had always prided myself on practicing ethically, I had never even contemplated that I knew enough to teach ethics. Somehow, I was persuaded to embark on this endeavor. Then, the real terror set in. What did I really know about ethics?

What was the best way to teach something so abstract as ethics when every situation is different? How could I come up with enough interesting things to talk about that would last six hours? Would people sign up? Would they fall asleep? Self-doubt began to seep in. Why had I been crazy enough to think I knew enough to do this?

Having committed to a date, time and place, there was no backing out. So, I began to research how to lead an ethics presentation that would be worthwhile. I asked myself what I would want if I were taking an ethics refresher class. The answer was quite clear. I would want it to be case based and relevant to the practice of marriage and family therapy. I would want it to be interactive, so I could learn from others, as well as the instructor. I would want it to relate back to AAMFT’s Code of Ethics (2015). So, okay, having identified the parameters that I thought would be important, where would I find the help that I needed to satisfy the requirements that I would want if I were taking this class? The answer began with a trip to AAMFT’s website. I was fortunate enough to discover some case material (not actual cases) on the website and these were exactly what I needed. They were interesting dilemmas with relevancy and related back to the Code of Ethics.

Now I had to arrive at a format for using these cases. Being an interactive learner, I wanted to deliver these in such a way that everyone could be involved in sorting through the ethical issues raised, as well as sharing their thinking about how they processed the cases. Small groups came to mind as the way to involve all. But, keeping everyone in small groups for six hours did not seem like a good idea. I needed to come up with a way to move participants in and out of the small groups and back to the larger group to share their work.

Thinking back to successful workshops I had experienced, I arrived at a format I thought would work. We needed a framework upon which to base all the cases. The AAMFT Code of Ethics would be it! So I decided to present the Code as a starting point, highlighting the areas that most often precipitated complaints.

I had this information from having served as chair of the Department of Health Advisory Committee in Washington State where we advised the Department of Health on MFT issues embedded in cases sent to them. Next, I decided to present one of the cases via the complaint letter sent to AAMFT. Breaking into small groups, I asked everyone to evaluate the complaint and see where the Code might be relevant and what, if any, charges they would issue. Returning to the larger group, I asked for responses to the assigned task. Then, I sent them back to their respective groups armed with the made-up response from the Ethics Committee, denoting their charges and the response from the member who had been charged. Now, the small groups had to struggle with the two differing sides to this complaint. I asked them to discuss what they would do if they had to make a decision on the complaint. We then returned to the larger group to hear their responses and thinking. Much to my delight, there was great interaction and a very lively discussion with support both for and against the therapist involved.
In teaching ethics, it is important for learners to struggle to arrive at their decisions using the tools that are available to them, such as the AAMFT Code of Ethics.

As systemic therapists, it is important to see the whole system, not just a part of it. Presenting ethical dilemmas requires us to see them in a whole, systemic way. As in therapy, we want clients to arrive at their own solutions, and in teaching ethics, it is important for learners to struggle to arrive at their decisions using the tools that are available to them, such as the AAMFT Code of Ethics. Therapy requires interaction and involvement of the participants, and so does a good ethics workshop. Last, but certainly not least, there needs to be growth in therapy for both the clients and the therapist, and the same holds true in teaching ethics. There needs to be learning and growth for both the learners and the instructor.

In keeping with that last point, I welcome feedback on this so I can keep learning and improving my teaching of this important and vital subject.

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References
Four Metaphors Useful in Couple Therapy

Maladaptive couple processes are a core feature of couples in distress and are among the best predictors of marital decline (Gottman, Coan, Carrera, & Swanson, 1998; Lebow, Chambers, Christensen, & Johnson, 2012). The likelihood of therapeutic success is maximized when the therapist and the couple focus on this pathological dance, in which the emotional music generally matters more than the words.

The noted couple therapist and researcher Susan Johnson put it this way: “The novice therapist has to learn not to get lost in the pragmatic issues and the content of interactions, but to focus instead on the process of interaction, and how inner experience evolves in that interaction” (2008, p. 129). Virtually all experienced couple therapists agree (Nielsen, 2017a). According to this view, much couple behavior is an emergent property of individual interactions, where what emerges is more than the sum of the individual contributions.

Over many years working with couples (Nielsen, 2016, 2017a, 2017b, 2019a), I’ve found that certain metaphors are effective and memorable in clarifying and normalizing the experience of couple distress. By likening events in therapy to other, more familiar, experiences, I am able to build an alliance in a setting that otherwise might seem distressingly foreign and threatening.

**Metaphor: Lessons**
Early in therapy, I often compare conjoint couple sessions to taking lessons in music, sports or dance. I say, “If you are learning piano, tennis, or ballroom dancing, it’s not sufficient for you to tell your teacher or coach what you do. He or she has to see you do it, in order to help you improve.” For this reason, having couples talk to each other while I observe and try to help is the starting point for repairing and strengthening their relationships. I refer to this as Couple Therapy 1.0.

After couples are talking to each other, the next crucial step is to focus on their maladaptive dance. All schools of couple therapy do this, though in different ways. The key is not to get bogged down in weekly discussions of “the problem du jour.” In most cases, problem solving will have to wait until the process improves.

While this focus makes logical sense to most clients, many have trouble with the idea that a “system” has “emergent properties” (here, destructive and amplifying ones) that can’t be blamed entirely on one person. The following metaphors can help clients grasp the systemic nature of their problems.

**Metaphor: Chemical reactions**
To explain how both partners usually contribute to their problems and to reduce mutual blaming, I compare the partners to two harmless, colorless reagents in separate beakers that, when mixed, become drastically altered: perhaps becoming explosively hot, ice cold, or foul smelling. One of the reagents might think, “I was just fine before: not hot, cold, or smelly. This sudden change, in which I don’t even recognize myself, must be due to that other damn chemical!” This metaphor powerfully illustrates how group process is not reducible to individual behavior and is experience-near for individuals who are feeling blamelessly victimized by their partners.

**Metaphor: Hungry diners and unresponsive waiters**
Escalation commonly consists of one or both partners speaking increasingly loudly, impatiently, and aggressively,
Some metaphors are especially useful for explaining and highlighting certain psychological phenomena that are otherwise difficult to understand.

perhaps while nagging, guilt-tripping, or swearing. These ineffective attempts to influence a partner tend to occur and intensify when the partner appears unresponsive. Therapists can normalize these counterproductive behaviors by explaining them in systemic terms. One metaphor I frequently use is of a hungry person calling for an unresponsive waiter. At first, the diner waits respectfully. Then he tries to signal non-verbally. Then he calls out in a calm voice. Finally, he resorts to yelling. Often, it is more accurate to characterize both partners as hungry diners, even though one may superficially appear to be an unresponsive waiter.

Metaphor: Firefighters battling forest fires
Just as escalating pursuit can seem appropriate in some situations, so can flight. Withdrawal becomes more comprehensible and acceptable if one remembers that firefighters facing a raging forest fire must sometimes retreat temporarily. Helping clients share their reasons for retreating frequently deepens the treatment.

As discussed by Summers (2013):
“The linguists Lakoff and Johnson (2003) have argued convincingly that metaphor is not just a figure of speech used primarily by poets and fiction writers, but a way of thinking built into our conceptual system. Metaphor is ‘understanding and experiencing one kind of thing in terms of another’ (p. 5). While we do not notice it, metaphor saturates our language . . . ‘time is money,’ . . . ‘I am feeling down,’ ‘she is overflowing with joy,’ ‘I am drained,’ ‘she is a knockout’ . . . To use Lakoff and Johnson’s most discussed illustration: ‘Argument is war’ shows that we think of argument the way we think of war: trying to gain ground, defending our position, seeing the other’s position as indefensible, [etc.]. . . [W]e do not simply register experience, but routinely think of our immediate experience in terms of other events and experiences.” (p. 69)

Summers’ metaphor of “argument as war” could sadly be applied to many couples seeking our help in therapy. My metaphor of couple therapy as resembling “lessons” is much more hopeful. More generally, following Lakoff and Johnson, we can appreciate that metaphors are not just figures of speech; they saturate our speech and our thinking. And some metaphors are especially useful for explaining and highlighting certain psychological phenomena that are otherwise difficult to understand. The metaphors discussed in this piece attempt to bring to life concepts that most of us find challenging, all related to how human experience is frequently co-created, non-linear, and emergent, rather than simply the direct result of one person acting on another. Of course, this insight is no news to this audience and was central to the family therapy movement (e.g., Minuchin, 1974). However, since intimate partners routinely misidentify their problems as coming from a recalcitrant or malevolent “other,” the metaphors discussed here are especially useful for the therapist who is addressing co-created, circular causation. By showing that “it takes two to tango” (another metaphor), these images—blameless, inert chemical reagents; hungry diners and unresponsive waiters; retreating firefighters—can help therapists point to the couple’s interpersonal process as the problem, in what Michael White (2007) termed an “externalizing conversation.”

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References
A first of its kind resource for clinicians, researchers, educators, graduate students, and policymakers, this authoritative four-volume Handbook is a ground-breaking reference work on both the profession and the practice of systemic family therapy. The Handbook integrates the scholarly literature on systemic interventions focused on children, couples, and families into a single resource. Volume I includes critical information on the theoretical, practice, research, and policy foundations of the profession of systemic family therapy and its roles in an integrated health care system. Topics in Volume 2 (children and adolescents), Volume 3 (couples), and Volume 4 (family over the lifespan) reflect established and emerging interventions for the core difficulties in relationships that impact the mental and physical health of individuals, couples, and families. Contributors provide a balanced, integrative, and forward-looking analysis of the research, theory and interventions related to their topic illustrated with clinical examples. Particular attention is paid to cultural and family diversity throughout the work.
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