Social responsibility
What is it, what role does it play for mental health practitioners, and how do we solve dilemmas?
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Personal stories
Clinicians with very unique backgrounds share what social responsibility means to them
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Diversity and outcomes-based education
Where does MFT training stand in cultural competence?
page 32
Twenty-five percent of this paper is post-consumer recycled material and preserves 17.49 trees, saves 7,429 gallons of wastewater flow, conserves 12,387,806 BTUs of energy, prevents 822 lbs of solid waste from being created, and prevents 1,618 lbs net of greenhouse gases.

**Social Responsibility: A Commitment to an Effective Decision Making Process**

What does it mean to be socially responsible? A case vignette is used to understand how dilemmas can be solved for socially responsible therapists, built on the construct of empathy, contextual understanding, and social responsibility, which together promote social justice. The author also examines the Social Empathy Model.

MaryAnna Domokos-Cheng Ham, EdD

**Encouraging Complexity: Defining Diversity Student Learning Outcomes in MFT Education**

While MFT programs generally embrace the importance of diversity education, a schema for organizing and clarifying a program’s diversity student learning outcomes has not yet emerged. This article offers one way to conceptualize diversity student learning outcomes and provides examples of learning activities implemented in two MFT masters level programs.

Linda L. Terry, EdD
LETTERS TO THE EDITOR
We encourage members’ feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

40 Individual Responsibility: Marriage and Family Therapy as A Way of Life
As MFTs, we give so much of our time, energy, knowledge, skills, and talents to assist our clients in life’s journey. We also engage in various professional development activities because of the duty we have to provide quality care to our clients. How does the duty or responsibility that we have inside the therapy room intersect with the responsibility we have as a citizen of the communities in which we reside?
DeAnna Harris-McKoy, PhD  Erica Wilkins, PhD

45 The Minority Fellowship Program at AAMFT: Pursuing Social Change
Meet two MFP Fellows who are working to create conditions that allow for meaningful and systemic change.

48 Responsible Social Responsibility
Sometimes those with good intentions can’t foresee the potential negative consequences of their advocacy. Socially responsible organizations act with restraint and humility, with the understanding that any action taken on social issues may have consequences far different than intended.
Scott Johnson, PhD

The editorial team thanks MaryAnna Domokos-Cheng Ham, EdD, for her expertise, guidance, and contributions to this issue.

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MFTs in the Media
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62 First Person: Soulful Gestures
Christina Neumeyer, MA

65 Perspectives: No Holds Barred: The Irony & Dignity of Couples Therapy
Blake Edwards, MS
Choosing to work from a systemic perspective certainly places a relational therapist in a position of sensitivity and consideration, even if superficial, to the dynamics of oppression, power, marginalization, and disenfranchisement.

Whether working in an impoverished urban area or an affluent suburb, private practice or community agency, behavioral healthcare organization or academia, we recognize the greater context and its impact on treatment. Recognition is shallow if action doesn’t follow. Of course, the challenge is determining what level of social responsibility we are willing to engage in within the context of work and residence.

Social empathy, responsibility, and contextual understanding are important for both individuals and systems.

As Domokos-Cheng Ham (page 14) points out, social responsibility is part of a recursive process helping to eventuate social justice. Social empathy, responsibility, and contextual understanding are important for both individuals and systems. Sheldon Jacobs (page 26) states,”…we have a responsibility to acknowledge a problem exists on a micro or macro level, and to be part of the solution some way, some how.” Within recursive relationships, individuals, programs, divisions, and AAMFT have social responsibilities.

AAMFT, the AAMFT Research and Education Foundation, and the accrediting agency of the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) have a history of striving for social responsibility.

The AAMFT Code of Ethics has been particularly sensitive to social responsibility, which has been present in every code from the beginning. Section 17 of the 1962 Code stated:

*It is desirable for the counselor to seek opportunities for community leadership and public education in matters relating to marriage and the family and to cooperate with others so engaged.*

In 1975, Section 1 included:

> ...a counselor provides professional service to anyone regardless of race, religion, sex, political affiliation, social or economic status, or choice of lifestyle. When a counselor cannot offer service for any reason, he or she will make a proper referral. Counselors are encouraged to devote a portion of their time to work for which there is little or no financial return.

In 1982, the Code introduced Section 8:

> Family therapists acknowledge a responsibility to participate in activities contributing to a better community in society, including devoting a portion of their professional activity to services for which there is little or no financial return.

Understanding that the Code is a passive effort toward social responsibility, AAMFT continued to make active strides in social responsibility via the strategic plan. Historically, the AAMFT Strategic Plan has included priorities and goals related to diversity and inclusion. Beginning in 1991, the AAMFT Strategic Plan included the following goals and subgoals:

- To increase the organizational strength of AAMFT
  - Double the number of AAMFT members in each membership category by year 2000.
  - Continue and expand member recruitment and retention program activities, including an emphasis on minority recruitment (also included in the goal related to Approved Supervisors).
- Increase racial, ethnic, and cultural diversity among AAMFT members and Approved Supervisors.

The core values of the 2002 strategic plan included:

- Embodying a culture of openness and inclusion
- Honoring diversity in clinical practice, research, education and administration

A specific goal listed in the 2002 plan included:

- Build confidence within the association that AAMFT
is an open and inclusive culture. The 2013 strategic plan includes the following two core values:

• Acceptance, appreciation, and inclusion of a diverse membership.
• Diversity, equity and excellence in clinical practice, research, education and administration.

Importantly, the strategic plan indicates, “AAMFT will revisit the Policy on Social Policies.” This policy creates accountability that AAMFT will not allow a lapse on being cognizant of its social responsibilities. Clearly, the strategic plan moved AAMFT from a passive position regarding social responsibility to a more active role.

Another example is the accrediting agency, COAMFTE, through its accreditation standards, strives to ensure that the next generation of marriage and family therapists are equipped to work with a diverse range of populations. In the recently completed version of the accreditation standards, COAMFTE devotes an entire area of the standards specifically to making sure that educational programs have a commitment to diversity and inclusion to ensure that students are able to serve diverse, marginalized, and/or underserved communities.

In 2003, the AAMFT Board of Directors took a big step in setting the course of social responsibility with its Couples Statement.

Couples Statement - Statement from AAMFT Board of Directors published in March/April 2003 Family Therapy Magazine

The recent publication of an article in the Journal of Marital and Family Therapy (JMFT) led to discussion among the AAMFT Board of Directors regarding the issue of treatments known as reparative or conversion therapy. We want to address our Association’s position on issues of sexual orientation, and our values related to individuals who may have a different sexual orientation than the majority. We recognize that our members hold divergent religious, political, and social views, yet are deeply concerned about the pain and potential damage that some may feel in response to the publication of this article.

In many ways, the Couples Statement was a part of our association’s story about social responsibility. As the personal stories throughout this issue suggest, each individual ultimately needs to make decisions involving social responsibility. Dustin Stucki (page 28) stated about his training, “I became fully aware that I had to be accountable for my decisions.” Making such decisions is not easy and choosing a path of social responsibility can very well be the most challenging path chosen.

While members can debate whether AAMFT pursued the right causes or went far enough in the pursuit, over time the results of these efforts have become apparent.

• In a 1998 all member survey, 93% of respondents indicated they were Caucasian, in 2010 the percentage was 83, and in a recent all member survey 81% of the respondents indicated they were white, non-Hispanic.
• Beginning in 2003 AAMFT pursued inclusion in the SAMHSA Minority Fellowship Program. Finally, in 2008...
AAMFT applied for and was granted funding from SAMHSA for the MFP. The results to date are that over 160 awards have been issued to doctoral students from 23 states across the country to further their research and service delivery efforts focused on underserved populations.

- AAMFT has made steady increases in the number of offerings at the annual conference that cover a broad range of social topics including diversity and LGBT concerns. In comparing AC14 to AC13 we see an 85% increase in the number of sessions and discussion groups being offered at this event. In 2004, AALANA joined the Queer Affirmative Caucus as one of our most highly attended open forum groups and both continue to bring open dialogue about these important issues to our event.

Social responsibility is certainly more than race composition of an association, standards, federal funds, and conference activities. Yet, as I review the strategic plan, the core value of “Embodying a culture of openness and inclusion” is one of which I am proud when I reflect upon AAMFT’s efforts towards it. AAMFT has provided, and will certainly continue to provide, platforms for members to collaborate, share, and network to advance socially responsible efforts. For AAMFT to be stronger and more socially responsible, whether a clinical population, treatment system, legislation, or human rights, members will need to challenge themselves to interact and utilize these platforms to create impactful change. Collectively, when we each choose social responsibility, the sum of the profession’s parts will be greater than the whole.

—Tracy Todd, PhD

References
A Remembrance of Braulio Montalvo  
(1934–2014)

I am in Albuquerque, New Mexico. I have just come back with my wife, Tana, Braulio’s widow, Margarita Montalvo, and their daughter, Maria, from visiting Braulio’s ashes in the mountains where they were scattered. On the beautiful mountain slopes, I said Kaddish, the Jewish prayer for the dead, for my devout Roman Catholic friend, Braulio. Desolate, as I walk towards the car, I pull this photograph that Margarita had given me a few hours earlier, out of my pocket. I look at the photo, Braulio Montalvo, middle-aged, handsome, strong-faced, probably taken in Argentina. I notice the graffiti next to Braulio’s shoulder: “Huevos,” a Spanish colloquial term for balls or courage. I wonder whether Braulio’s hosts in Buenos Aires thoughtfully selected the setting for this photo.

How fitting. Braulio was a role model for a generation of family therapists because of his brilliance, framed by his moral and intellectual courage.

H. Charles Fishman, MD
Braulio came to New York City in the early 1960s to study psychology at Colombia University. Fortunately for all, he began working with Salvador Minuchin and his colleagues at the Wiltwyck School for Boys, a residential school founded by Eleanor Roosevelt. Their sentinel work is memorialized in their book, *Families of the Slums* (Minuchin, Montalvo, Gurney, Rosman & Schumer, 1967). For one of the first times in psychiatry and psychology, efforts were directed not just to the troubled individuals, but also to the family as a whole.

I had often wondered how Sal, Braulio, and their colleagues came to break with the orthodoxy of the time and involve families. When I asked Sal recently, he told me the following anecdote: “At Wiltwyck, I had a very smart secretary who said to me, ‘You know, this boy was here two years ago and you wrote exactly the same thing about him now as you did then.’” Sal said this made them realize that they needed to look further and examine the families of these children.

Braulio and his colleagues were guided by pragmatism. Even though Sal was, by then, a well-trained psychoanalyst, they made sure that common sense trumped theoretical orthodoxy. Involving families must have seemed an act of heresy in the rarified psychoanalytic world of the day, where double doors protected each patient encounter. This new approach was unthinkable. Particularly for Braulio, who at the time was a young man and had to break from the teachers in his conservative Ivy League master’s program.

Following Wiltwyck, Braulio went with Sal and Jay Haley to the Philadelphia Child Guidance Clinic where they all worked closely together. Of note were the legendary Mount Airy carpools, riding to work together and developing theories for this new field. Along with Sal and Braulio, Jay had been challenging no less august an institution as the Holy Bible in his book, *The Power Tactics of Jesus Christ and Other Essays* (Haley, 1969).

Once in Philadelphia, they wasted no time in taking on the establishment. Jay Haley and Braulio started a family therapy training program in the inner city (Institute of Family Therapy; IFT program). Challenging the academic gatekeepers, they determined that the better prerequisite to being an excellent family therapist was not academic credentials, but having rich family and life experiences. They feared that an excess of academic training around treating the individual would actually interfere with learning family systems theory; it would entail too much to “unlearn.” Thus, they recruited non-credentialed people from the community and trained them to be family therapists. History has proven that Braulio and Jay were prescient; some of the finest family therapists at the Philadelphia Child Guidance Clinic were from this program.

In these training programs, family therapists eagerly embraced videotape technology. Breaking from the secrecy of the psychoanalysts’ inner sanctums, they asked families permission to videotape sessions and for the trainees to observe. Video soon proved to be for family therapy what the microscope was to biology. A whole new world of analysis opened up. Braulio came to be the master at analyzing and describing these fertile family interactional patterns. His micro-dissection of interactions highlighted that the processes were not random but held significant meaning and were recursively connected to the symptoms. The Master’s exquisite eye for understanding and explicating the family “dance” became legendary for all of those who came across his work.

Included in Braulio’s lasting legacies are his invaluable classic teaching tapes. One such tape, *Family with a Little Fire* (1973), finds a seven-year-old girl, one of four children to a single mother in the inner city, who had set fire to her mother’s mattress. Braulio gently enters the system and masterfully works with the process, restructuring the family. One psychological interpretation might well be that the girl set the fire because she was angry with her mother. Speculation aside, Braulio sees the emotional distance between them. The mother was highly critical of her daughter and Braulio introduced enactments to foster closeness between the mother and daughter. At one point in the session, Braulio noted that the girl was reading quietly. Braulio challenged this idea and asked for the child to read out loud. A 20-minute precious segment ensues where the increasingly competent, tearful youngster read almost fluently to her mother, much to the mother’s surprise. This was groundbreaking, innovative therapy in 1973. It introduced to this young field, a “therapy of experience,” where the therapist helps the family in the session find new and more functional interactional patterns.

Bolstered and documented by countless video analyses, Braulio understood the veracity of the Batesonian concept of “mind in context”: the self as multi-faceted and changeable as it responds to
fluid contexts. Most importantly, for him, the systemic family therapy paradigm, to use a phrase popular today, was a “disruptive technology,” disconnected from earlier paradigms. It could not be reduced into another, earlier paradigm. T. S. Kuhn (1962), in his sentinel book, The Structure of Scientific Revolutions, documented that over the course of scientific history, successful paradigms functioned discontinuously from earlier ones.

Braulio owned a purity of vision understanding the centrality of contemporary context. We analyzed countless tapes together over the years with wide-ranging problems from divorce to anorexia to post traumatic stress disorder. Braulio was razor-sharp at detecting the contextual “smoking gun” that would unlock the clinical roadblock. Once successfully addressed, symptoms resolved.

My dear friend was much loved for his brilliance, generosity, loyalty, kindness and his social commitment. Of the people I’ve spoken to after his death, especially the old Philadelphia Child Guidance crowd, it became clear that Braulio provided unique contributions to all of our lives over the years. I think this special gift was best said by Sal in his book, Families and Family Therapy: “Braulio, who I consider my most influential teacher, has the rare capacity of receiving an idea and giving it back enlarged” (Minuchin, 1974, p.11). He gave that gift to us all countless times.

Years ago, there was a movement advocating that clinicians study the ethnicity of their clients. I asked Braulio what he thought of this idea. He advocated that the clinician should employ the practice of “informed one down.” That is, tell the family they are the experts on their culture. They teach me about their culture and I’ll use my expertise about families and we’ll work together. Braulio Montalvo was a modest, gentle man. His interest was not in promoting himself, but helping people around him, his friends, family and his mentees to excel.

We need Braulio’s passion and perspective. A recent New York Times article reports, “about 15,000 American toddlers 2 or 3 years old, many on Medicaid, are being medicated for attention deficit hyperactivity disorder” (Dell’Antonia, 2014). This reflects an unwillingness or lack of capacity to address the social issues in their context. Similarly, Allan Frances, MD, one of the authors of the DSM-IV, has written a new book which condemns the acontextual DSM-V for creating an avalanche of new diagnoses, many of which conveniently have psychiatric medication claiming to mitigate them (Frances, 2014). Braulio’s incisive wisdom is necessary as an antidote to these “hair-brain” practices.

Braulio’s legacy would challenge clinicians and policy makers to look beyond symptoms and to seek understanding of the intricate Mobius strip connections between the individual and their most influential context—the family. Unfortunately, these concepts are still radical today in many circles.

Even in Braulio’s last weeks, when he was very ill, struggling for breath, he was irate about the plight of the poor in America. He fervently believed that what children and families needed was respect, the respect to acknowledge their struggles and their circumstances, not the tunnel vision of quick fixes. He believed clinicians needed the courage to buck “groupthink” as he did many years ago, and to address the dynamics and context in an individual’s and family’s life and create lasting change. We must deal with the messy realities of families. This brings to mind a joke that Braulio loved. Quoting Woody Allen, “I hate reality, but it’s still the best place to get a good steak.”

In the spirit of Braulio, I encourage you family therapists, so committed to rolling up your sleeves, to continue on this courageous path. Our clients and their families need you.

Who knows, you may even get a good steak along the way.

H. Charles Fishman, MD, is clinical professor of psychiatry at University of Hawaii, John A. Burns School of Medicine. He is an AAMFT Clinical Fellow. See more information at http://intensivestructuraltherapy.com.

References


“Braulio, who I consider my most influential teacher, has the rare capacity of receiving an idea and giving it back enlarged.” —Sal Minuchin
noteworthy

# Awareness Dates

## SEPTEMBER

**1-30**

**National Recovery Month**
Substance Abuse and Mental Health Services Administration SAMHSA
Info@samhsa.hhs.gov
www.recoverymonth.gov

**World Alzheimer’s Month**
Alzheimer’s Disease International
info@alz.co.uk
www.alz.co.uk/wam

**7-13**

**National Suicide Prevention Week**
American Association of Suicidology
info@suicidology.org
www.suicidology.org

**10**

**World Suicide Prevention Day**
International Association for Suicide Prevention
c/o National Centre for Suicide Research and Prevention
www.iasp.info/wspd/index.php

**18**

**National HIV/AIDS and Aging Awareness Day**
The AIDS Institute
MScavnicky@TheAIDSInstitute.org
www.NHAAAD.org

**27**

**RAINN Day**
Rape, Abuse & Incest National Network
(800) 656-HOPE (4673) National Sexual Assault Hotline
rainnday@rainn.org
www.rainn.org/rainnday

## OCTOBER

**1-31**

**Domestic Violence Awareness Month**
National Coalition Against Domestic Violence
mainoffice@ncadv.org
www.ncadv.org/takeaction/
DomesticViolenceAwarenessMonth.php

**National Bullying Prevention Month**
PACER Center, Inc.
bullying411@pacer.org
www.pacer.org/bullying/nbpm/

**6-10**

**Mental Illness Awareness Week**
National Alliance on Mental Illness
info@nami.org
www.nami.org

**9**

**National Depression Screening Day®**
Screening for Mental Health, Inc.
smhinfo@mentalhealthscreening.org
www.mentalhealthscreening.org/events/national-depression-screening-day.aspx

### Go Online

The AAMFT offers a variety of Therapy Topics for your clients. Visit [www.aamft.org/therapytopics.asp](http://www.aamft.org/therapytopics.asp) to view our full library of topics, including all those listed in the awareness dates.
Medicare MFT Coverage Included in House Democrats’ Omnibus Mental Health Bill

IN VIEW OF the recent shooting deaths in Isla Vista, California, of six people by a young man who was being treated for a mental health condition, Congress may look more closely at these mental health bills.

On May 6, Rep. Ron Barber (D-AZ) and four other House Democrats introduced the Strengthening Mental Health in Our Communities Act, HR 4574. Barber, a former aide to Rep. Gabrielle Giffords (D-AZ), was elected to her seat after a mass shooting by a man later diagnosed with paranoid schizophrenia, resulting in the deaths of six people and Giffords suffering major brain damage.

HR 4574 includes Medicare MFT coverage (Section 608) in a provision identical to the freestanding bipartisan House bill, HR 3662, by Reps. Chris Gibson (R-NY) and Mike Thompson (D-CA). HR 4574’s cosponsors include Reps. DeGette (D-CO), Matsui (D-CA), Napolitano (D-CA), and Tonko (D-NY).

Unfortunately, even before HR 4574 was introduced, it was criticized by psychologist Rep. Tim Murphy, PhD (R-PA), the chief sponsor of another omnibus mental health bill (HR 3717). Rep. Murphy’s bill does not include Medicare MFT coverage, and would eliminate programs run by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that are not specified by Congressionally-adopted statute.

This elimination would include SAMHSA’s Minority Fellowship Program (MFP), which currently funds 25 doctoral MFT students, as well as dozens of doctoral students in other behavioral professions. Rep. Murphy’s stated intent is to focus federal mental health and substance abuse funding on people with “severe mental illness” rather than less extreme disorders (background on HR 3717 was provided in the May/June Advocacy column).

Members wishing to support HR4574 and other Medicare MFT legislation may do so by visiting http://www.congressweb.com/aamft/5.
US House of Representatives Approves Recommendation for VA to Offer MFTs an Alternative to COAMFTE Degree Rule

AS REPORTED IN the previous FTM Advocacy column, 24 House Democrats led by Rep. Sam Farr (D-CA) urged the House Appropriations Military Construction and Veterans Affairs Subcommittee to direct the Department of Veterans Affairs (VA) to allow MFTs to be eligible for VA jobs if the MFT has graduated from a graduate school accredited by a Regional Accrediting Agency. Nearly all American graduate schools are accredited by such an Agency.

Department of Veterans Affairs (VA) Deputy Undersecretary for Health Robert Jesse, MD, addressed a May mental health conference in which AAMFT staff participated.

VA annually treats 1.4 million veterans with behavioral issues, and employs 24,000 behavioral staff. It now requires MFTs to hold a degree from a program accredited by the Commission for the Accreditation of Marriage and Family Therapy Education (COAMFTE). This rule bars about half of all licensed MFTs. Although MFTs became eligible for VA employment in 2006, only about 100 MFTs are employed in VA’s behavioral workforce of 24,000.

On April 30, the full House of Representatives approved a bill (HR 4486) with an official accompanying Report (H Rpt 113-416) that “encourages” VA to provide an alternative to a COAMFTE degree for MFT employment. On May 22, the Senate Appropriations Committee approved its version of this bill with an official accompanying Report (S Rpt 113-174) that directs VA to expand efforts to provide financial stipends to MFT clinical interns. The Senate and House versions of this bill had not been reconciled at deadline, but these official reports legally indicate Congress’s direction in the matter of VA’s use of MFTs.

In addition to working for this change, AAMFT staff continue to press VA to provide financial stipends to MFT clinical interns, as VA does for all psychology and most social work interns (for background on that issue, see http://www.congressweb.com/aamft/7).

Also in May, the 2.4-million-member American Legion and several Republican and Democratic Members of Congress called for the resignation of VA Secretary Eric Shinseki due to continued reports of avoidable deaths and other adverse clinical outcomes at VA healthcare facilities. At a May 15 Senate VA Committee hearing on these allegations, Senators noted confirmed mental health treatment problems at VA’s Atlanta and Miami facilities, and Congresspeople and VA staffers have made similar mental health allegations at VA’s St. Louis; Chicago; El Paso; Charleston, West Virginia; and Walla Walla, Washington units.

All of VA’s hundreds of healthcare facilities are now being investigated. On May 16, VA’s Undersecretary for Health, Robert Petzel, MD, resigned, while on May 30, VA Secretary Eric Shinseki also resigned.

Urge your Congressmen to cosponsor S. 1155/HR 3499, federal VA stipends for MFT interns, at www.congressweb.com/aamft/7
Health Reform Insurance Exchanges Have Mixed Success

AT THE END of March—the deadline for most uninsured people to obtain health insurance or pay a fine on their 2014 federal income tax returns—about 8 million had enrolled in Exchange plan coverage. Although the 8 million figure is impressive, it is unclear how many had actually paid premiums, and how many had been forced into Exchange plans after their prior coverage was cancelled due to it not conforming to new rules in the Affordable Care Act (ACA, also called ObamaCare).

In addition, several State-run Exchanges had major problems. Oregon’s $248 million state-exchange website was so flawed that it was unable to enroll even one person online. The FBI is investigating possible malfeasance, while Oregon will convert to the federal exchange system. Maryland’s website also had major flaws, leading it to adopt software used in Connecticut.

And Massachusetts and Hawaii, which enacted rules for universal coverage before the federal law, found that their existing websites were often incompatible with ACA rules. Massachusetts had to enroll 160,000 exchange-eligible people into Medicaid coverage at a state cost of $10 million per month. Exchanges in Vermont and the District of Columbia are under-funded, prompting both jurisdictions to tax all health insurance plans to subsidize their exchanges.

The proportion of uninsured people who signed up for exchange plans varies widely, being highest in states controlled by Democrats, who have championed the new law. Meanwhile, many healthcare providers face exclusion from “narrow” exchange provider networks, and low pay rates even when they are included.

Providers’ experience with exchange plans thus is similar to Medicaid, which now covers about 4 million more people, mainly in the 26 states that chose to expand it to people with higher incomes. But despite providers’ problems, it is clear that millions of people now have better coverage for behavioral disorders than before the ACA took effect.

Based on early pharmaceutical claims, exchange enrollees’ rate of clinical depression is higher than for the general population. And in response to reports that tobacco-cessation services are being inconsistently covered by exchange plans, the Obama administration issued a clarification on May 2.

A majority of Americans continue to oppose ACA, although many wish it improved rather than repealed entirely. This law has become a major issue for November’s Congressional elections, in which Republicans are expected to keep their House majority and probably win a Senate majority as well.

AAMFT’s Political Action Committee Contributes to Congressional Candidates

During the first half of 2014, AAMFT’s Political Action Committee (PAC) contributed to Sens. Begich (D-AK) and Merkley (D-OR), and to Reps. Barber (D-AZ), DeLauro (D-CT), Gibson (R-NY) and Tonko (D-NY) at events where AAMFT staff spoke personally to these Members of Congress about MFT issues. Total contributions for this period were $7,500.
US House, Senate Pass Bills with AAMFT-endorsed Military Mental Health Screening Provisions

ON MAY 22, the House of Representatives passed the Fiscal 2015 National Defense Authorization Act, HR 4435, which includes an AAMFT-endorsed provision (HR 4305) requiring the Defense Department to screen military recruits for mental health issues. Studies have shown that as many as one in five military recruits have pre-existing mental health issues.

The US Senate has included a similar AAMFT-endorsed provision (S 2300) by Sens. Donnelly (D-IN) and Wicker (R-MS) as part of its version of this Defense bill. As of this writing, the Senate and House versions of this bill had not been reconciled.

AAMFT files comments to the federal government concerning provider nondiscrimination law

ON JUNE 10, AAMFT filed comments with the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) concerning the interpretation of a law that requires insurers not to discriminate against MFTs and other providers with respect to participation in a health plan.

Included in the Affordable Care Act, the provider nondiscrimination law, Section 2706(a) of the Public Health Service Act, which went into effect on January 1, 2014, prohibits group health plans and insurance companies from discriminating with respect plan participation or coverage against “any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” This provision does not require plans to contract with any health care provider willing to abide by the health plan’s terms and conditions for participation. This law also does not prevent the establishment of “varying reimbursement rates based on quality or performance measures.”

In April 2013, the Departments issued a Frequently Asked Question (FAQ) regarding the provider nondiscrimination law. However, this FAQ is flawed because it would seem to allow plans and issuers to limit patient choice contrary to the law and congressional intent. For example, the FAQ states that insurers are not required to accept all types of providers into a provider network, which appears to be contrary to the language in the law.

In March 2014, the Departments asked for public comments regarding all aspects of the interpretation of the provider nondiscrimination law. AAMFT’s comments focused on the proper interpretation of this law and the major problems with the FAQ. AAMFT’s letter requests that the Departments revise the FAQ so that it will specifically require all plans and issuers to recognize all categories of licensed health providers who are acting within the scope of their license under state law, and to prohibit plans from covering a service when offered by one type of provider licensed to provide that service while denying coverage when the same service is provided by another type of licensed provider who can provide that same service.

AAMFT is a member of the Coalition for Patients’ Rights (CPR), a coalition of over 35 professional associations that represent non-physician healthcare professionals. The CPR also provided written comments to the Departments. AAMFT and many other organizations signed on to this letter. AAMFT will continue working on efforts to ensure that the federal government issues a revised FAQ that reflects the law.
Division Advocacy

Since the start of the year, divisions have been actively engaged in state legislative advocacy initiatives. Below are recent developments in some states concerning MFT division advocacy for 2014.

**ALASKA:** The Alaska division was successful in its efforts to pass legislation that extends the sunset date of the MFT licensure board from 2014 to 2018. This bill was signed into law by Governor Sean Parnell on June 18. Congratulations to the Alaska division on this accomplishment.

**CONNECTICUT:** Ban on reparative therapy for minors and enactment of legislation to assist MFT trainees.

**GEORGIA:** In June, two bills were signed into law that will benefit MFTs in Connecticut. One new law requires the state Medicaid plan to reimburse LMFTs and other mental health professionals in private practice who treat individuals 21 and over. This significant change will now allow adult enrollees in Medicaid to access the services of MFTs in private practice. The other new law will allow out-of-state MFT applicants for licensure who have been licensed in other states for three years to meet the supervised experience requirements for MFT licensure in Connecticut. Previously, out-of-state applicants needed five years of work experience in order to meet the MFT supervised experience requirements. Congratulations to the Connecticut division on these two accomplishments.

**LOUISIANA:** The Louisiana division accomplished two of its advocacy goals this year. The division was successful in its legislative efforts to add the term “diagnosis” to the MFT scope of practice. This legislation was signed into law by Governor Bobby Jindal on June 19. Another bill that was also signed into law in June will allow for the licensure of MFT associates. Congratulations to the division on these two legislative victories.

**OHIO:** The Ohio division successfully advocated for passage of legislation that would allow MFT students who are in an internship to be recognized as trainees. Having this trainee status will allow agencies to more easily bill for services provided by MFT interns. This legislation was signed into law by Governor John Kasich. Congratulations to the Ohio Division on this important legislative victory.

**SOUTH CAROLINA:** In South Carolina, legislation was enacted into law in June that creates a school safety task force. This task force will examine public school mental health staffing and the programs that fund school mental health services. The task force will issue its final report by the end of the year. The law includes one representative of the South Carolina division on this task force. Congratulations to the division on successfully advocating for a representative on this important task force.

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**Supreme Court Allows Ban on Reparative Therapy for Minors**

THE U.S. SUPREME COURT announced that it has declined to hear Pickup v Brown and Welch v Brown, the challenges to California’s ban on reparative therapy for minors. The decision means that the ban, which was signed into law by Governor Brown as Senate Bill 1172 in September 2012, will be allowed to take effect. Any mental health professional in California may have action taken against his or her license or registration if the professional engages in reparative therapy with anyone under the age of 18. The ban on reparative therapy for minors represents an important step forward in ensuring that licensed MFTs only provide safe and trustworthy services to the public.

AAMFT recognizes the hard work and efforts of Benjamin Caldwell, Angela Kahn, James Guay, the AAMFT-CA Legislative and Advocacy Committee, and many other dedicated advocates in California.
Social Responsibility:
Would I, a dedicated family therapist, consider myself to be a socially responsible person? “Of course,” I say without hesitation. Yet, if I stop to think about the meaning of socially responsible, I am more honest to myself. I recognize my uncertainty in believing that I am truly socially responsible. I sometimes wonder if we all have such moments of uncertainty, when we question our decisions. Particularly with the challenge of being socially responsible, I often find myself in the midst of a dilemma: To be socially responsible, should I carry out action A or should I carry out action B? If I want to be a socially responsible family therapist, my first task is to resolve this dilemma.

MaryAnna Domokos-Cheng Ham, EdD
The following vignette exemplifies how a family therapist I was supervising found herself immobilized by the choice she had to make if she were to be socially responsible to the family she was seeing. The discussion that follows introduces a framework that was useful in prying apart a complex dilemma confronting a family and their family therapist. This framework, called The Social Empathy Model (Segal, 2011), is built on the construct of empathy, contextual understanding, and social responsibility, which together promotes social justice. For the family therapist, Theresa, the dilemma described in the vignette had particular significance. She was concerned that in helping the family to resolve their dilemma, she might not be socially responsible in helping the family to unravel their painful decision.

**A dilemma for a family therapist**

Alan’s parents had met at a military installation in Japan after World War II. His father, John, was an American naval officer from a small affluent community outside Boston; his Japanese mother, Kyoko, although fluent in English, was thoroughly culturally Japanese by maintaining many Japanese traditions. For Kyoko, the most important was her continued and faithful following of Buddhism. The next 40 years for the couple and their children were filled with both happiness and some disappointments, but were without crisis. Then, when Kyoko was close to becoming 64 years old, she was diagnosed with a virulent and terminal cancer. John was devastated, and could not accept the possibility of his wife’s death. The children were also distraught, but as adult children, found they had responsibilities for their parent that they had not expected.

Alan, the oldest son, learned from talking with his mother at her hospital bedside, that she wanted to end her own life. Kyoko felt she could bear her own suffering, but more important than her own pain, she did not want her husband, John, to experience anguish and heartache from watching her suffer. When Alan told his father and siblings that Kyoko requested to initiate her own death, the dilemma for the family members seemed irreconcilable. The choices they had were both indefensible: either they were going to condone and assist in the death of Kyoko, beloved wife and cherished mother, or they were going to experience her suffering, and bear their own, by approving and continuing with the medical care she was currently receiving. At the first session, they presented their choices to Theresa, their family therapist. Although Theresa’s values were formed as a child by her parents’ devout faith in Catholicism, she had moved away from her parents’ beliefs and considered herself to be committed to humanity, not to a specific belief in God. In listening to the family’s situation, she experienced both personal and professional dilemmas, which began with the question of whether she could condone self-imposed death (Houser, Wilczenski, & Ham, 2006).

As Theresa’s agency supervisor for this case, I knew that she and I had to grapple with her own personal dilemma as it related to the family. Theresa’s concern was whether she would endorse Kyoko’s wish for intentionally ending her own life that was in direct conflict with her own childhood instruction about the value of life, or, would she accept Kyoko’s assisted suicide, which she could interpret as a behavior to enhance human autonomy and freedom of choice.

Theresa wanted to convey to the entire family that she was acting in a socially responsible way by choosing a compassionate process for resolving their dilemma. She was aware that like a true dilemma, no good solution existed. Theresa said she could easily support the point of view of Kyoko’s husband and children because it was hers as well. However, the decision resulting from this point of view would leave Kyoko to succumb to her disease in a way she did not want. On the other hand, Theresa could take on Kyoko’s point of view, which was to end her own life in order to protect her husband and children from the pain they would endure by watching her suffer. The explanation Kyoko gave was consistent with her cultural tradition and religious beliefs. Yet, to follow through with Kyoko’s wish would oppose the values of the other family members.

Theresa needed to broaden her understanding of the dilemmas. I asked her, “What issues presented in this dilemma are confusing to you? Did you need to define concepts or find a framework to help you understand the different positions the family...”
takes?” Theresa had already begun the conversation by emphatically saying, “I have a responsibility to the entire family. I must make the right decision for them!” And with that emphatic note, Theresa began the process of unpacking the dilemma by considering what she meant by “social responsibility” and how others defined the term.

**Social Responsibility**

*Social Responsibility is a theory informed by ethical belief systems, which proposes that individuals or organizations have an obligation to act to benefit society at large.*

Theresa needed to consider whether this definition would be relevant to the situation the family was experiencing. Immediately, she identified the importance of the differences in values professed in Catholicism and Buddhism. In both of these religions, the values are extensions of constructed ethical theories and are important influences on the way individual, families, and communities behave, develop attitudes, and make decisions about their lives. Theresa recognized that this definition of social responsibility would work if she could embrace both Kyoko’s and John’s personal embedded ethical belief systems and find their commonalities. She presumed that in both ethical belief systems, individuals would be obligated to act to benefit society at large.

Although the definition of social responsibility was acceptable, Theresa wanted a broad conceptual framework that would be more inclusive in addressing the complexity of the family’s dilemma. During our discussions about this family, we had an “aha” moment, almost at the same time. We both recalled the model of *Social Empathy*, recently proposed by Elizabeth Segal (2011). We were excited with the possibilities this model would offer.

**Social Empathy: A context for Social Responsibility**

The construct of empathy, both a trait and behavior, intends to convey accurately and sensitively to another person that you understand her or his experiences and feelings, as if you are “walking in the shoes” of the other person. *Individual empathy*, the act of “stepping into someone else’s shoes,” requires you to have a cognitive understanding of someone, as well as an emotional resonance with her or him. Social empathy, however, joins together a) individual empathy; b) sociocultural, economic, and historical contexts; and c) social responsibility. This unifying concept, social empathy, provides a framework for better understanding the experiences of different people, communities and cultures.

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The Social Empathy model
The social empathy model is an integration of empathy, contextual understanding, and social responsibility that promotes social justice. Empathy, with its commitment to relational awareness, is unified with contextual understanding, informed by knowledge and insights of historical, sociocultural, and economic contributions, promotes social responsibility while advancing social action and social justice (Segal, 2011). The figure below visually conveys how social empathy leads to social justice. A cautionary note: the figure as it is laid out on paper may appear to be a linear process. The social empathy model, however, is dimensional, thus fostering a fluid and recursive process.

Factors contributing to the Social Empathy model
Empathy. Empathy is a multifunctional construct that requires both cognitive processing and affective resonance. As a cognitive process, empathy provides us the ability to predict what someone may be feeling or thinking, and affective resonance assists us in responding by mirroring and sympathizing with the emotions of someone else. In addition, to be effective, empathy must be a communication process and needs to be demonstrated.

A parallel exists between types of altruism and levels of empathy (de Waal, 2008). In the first stage of directed altruism, we experience altruistic impulses or spontaneous responses to the emotions of another. This experience is similar to emotional contagion, the most common denominator of all empathic processes, where one person is affected by the emotional state of another. The second stage of altruism is learned from positive interactions we have as either the person in pain or the person offering caring. Cognitive empathy requires a learning process as well. To have sympathetic concern for another person, we need to discover and understand the cause of the other person’s emotions. The third stage of altruism, intentional altruism, and the most effective demonstration of caring, is based on the prediction. The person recognizing the pain or need of another person must also “guess” or predict what would be helpful to the other person. This two-fold process is often referred to as the “true
empathy.” Empathic perspective-taking emphasizes our ability to adopt the point of view of another person in order to understand her or his pain or need.

**Contextual Understanding.** The discussion of contextual understanding begins with noting the importance of empathic perspective-taking. To provide care to people different from ourselves, we often find individual empathy alone is insufficient. Instead, we find our caring acts are more successful when we delve into the context of the person’s pain. All the components contributing to the entire context contribute to the mosaic of a person’s life. We find how easily we can make assumptions regarding just about anything if we don’t have accurate information. We also suspect that empathic perspective-taking is easier when someone looks like you and has a similar life experience (Stürmer, Snyder, & Omoto, 2005). Hence, we must suspend the beliefs and expectations we have about another person, and instead become curious about her or his world.

**Social Responsibility.** In this model we can see how social responsibility extends beyond responsibility to an individual or the family unit. The social empathy model invites us to broaden our perspective and consider multiple opportunities for acting responsibly, not only to include a person but also all the domains encompassing her or him: community, nation, society and culture. We build upon our contextual understanding to acquire an accurate empathic perspective about the conditions, needs, and emotions of others. With learned skills of accurate empathic perspective-taking, we are more likely to feel an obligation to be socially responsible and to respond directly to perceived needs of others.

To act in a socially responsible manner requires from us conscious decision making. In turn, our conscious decisions lead to empathic action. Praxis—the performance or application of skill as opposed to theory—becomes the basis of social change. Embedded in praxis is a reflection of the world order that demands an understanding of the fullest meaning of social power, inequity, and oppression. We find social responsibility as the conduit to take action, to grapple with social and personal dilemmas, and promote social justice (Freire, 2000).

**Taking action to resolve Theresa’s dilemma: Implementing the Social Empathy model**

To resolve a dilemma is to choose between choices, none of which is correct, a condition posed by any dilemma. Theresa and I were both fully aware of this. Moreover, Theresa was adamant: her purpose in talking with the family about their choices for Kyoko had to be socially responsible. Perhaps following the process of the social empathy model might be useful, we agreed. The model helped Theresa to frame questions we needed to ask family members and directed discussions with them.

**Empathy:** The prevailing issue that Kyoko, John and their children had to face was Kyoko’s impending death. Her terminal condition evoked emotional contagion in family members. Although they all expressed sympathetic concern for Kyoko, Theresa noted that family members could not reconcile Kyoko’s solution to her pain. John and their children had a different emotional response to her suffering than she did. Theresa observed how the divergent emotional response to dying and death created conflict within the family. She wanted to understand these differences more clearly, and chose to ask each family member the following questions (this is only a sample of what she asked the family): Who, among the family, is suffering the most? How do you know when suffering is too much to endure? Whose suffering is of most concern for you? What is your own experience with suffering?

For family members to be fully empathic with Kyoko’s suffering, as well as the pain of each other, they needed to enlist their skill in empathic perspective-taking. Their skillfulness in adopting the other person’s point of view is dependent on the cognitive ability of a person to construct plausible hypotheses about the emotional state of another person. Theresa asked each family member hypothesis testing questions: To Kyoko: “If you were in John’s ‘shoes,’ would it be more difficult to lose me or to watch me suffer?” To John: “What do you imagine Kyoko is feeling as she becomes aware that she will be losing you and the children?”

**Contextual Understanding:** Theresa was aware how social and cultural influences affect biracial and bicultural couples’ relationships, like the coupleship of Kyoko and John. Kyoko and John brought the values, lifestyles, and belief systems from individual sociocultural contexts to their relationship. With Kyoko’s impending death, they were retreating to pervasive values from their culture-of-origin. Moreover, Theresa’s own beliefs clouded her complete acceptance of Kyoko’s values. From a stance of curiosity, family members and
Theresa would have many questions to ask about each other’s beliefs about dying. From listening to each other’s answers, each person would have the opportunity to learn about the context subsuming each answer. Theresa offered the family to consider these questions of curiosity: To Kyoko: “I would very much like to know what Buddhist teachings tell about death and the process of dying.” “From your experiences growing up in Japan, how are you to behave when someone is dying? How do you express your grief?” To John: “What beliefs did your family-of-origin rely upon while a family member is dying?” “What traditions or ceremonies did they have after a family member died?” For Theresa to ask herself: “Can you think of any values, beliefs, and traditions in the Catholic faith involving death that could be similar to the Buddhist teachings?” “What aspects of your Catholic beliefs about death and dying would you like to retain in your life?”

Social Responsibility: Therese knew that with social responsibility comes action. At the end of our lengthy review of the social empathy model and discussion of the relevance of the model to the family’s dilemma, Theresa agreed she was ready to move forward with a family meeting. In our discussion, we reviewed the steps for resolving ethical dilemmas:

- Become sensitive to the concept of “dilemma.”
- Reason and talk about the issues presented in the dilemma.
- Develop moral responsibility for your own position in the dilemma.
- Reflect about the multiple perspective and positions the dilemma presents.
- Develop strength to take action.

“We’ve done this,” Theresa said. “We’ve gone through all these steps. Now all I can do is to have the family go through the same process we did.” “Yes,” I said, “to show respect to every member of the family, you need to give them the opportunity to go through this same process you did.”

My last words to Theresa were, “You will be socially responsible to this family by accompanying them through this difficult journey to resolve their dilemma. Through this decision making process, they will work toward understanding the truths of each other, as well as their own response to new information. Most importantly, you will know when you have been socially responsible by observing the family create spaces large enough to embrace the values, beliefs, and perspectives of each other.”

MaryAnna Domokos-Cheng Ham, EdD, is currently a professor emerita at the University of Massachusetts Boston. During her 20 years there she founded, developed, and directed its Family Therapy Program. Ham has been president of the Massachusetts Division of AAMFT and in December 2013 completed her position as an AAMFT board member. Her scholarship has been informed by her experiences as a biracial person and as a provider of family, couple, and individual therapy to diverse populations. In 2012, the American Psychological Association’s Division 43, Society of Family Psychology, awarded Ham the Carolyn Attneave Diversity award in acknowledgement of her special contributions to the promotion of diversity in family psychology.

References
Social responsibility means different things to different people. At its core, we can probably agree social responsibility means positively impacting the broader society and culture in which we all live and work. But maybe a better way to illustrate social responsibility is to have some therapists from unique backgrounds and experiences demonstrate how they enact social responsibility in their own lives.
Jason J. Platt: Looking Beyond Nationalism

My brother is in prison and is facing the death penalty. His crimes are significant and he has hurt many people.

I have complicated feelings and I do not yet have clarity about what outcome is just. When I was a child, my mother was partially paralyzed in a car accident and thus unable to have additional biological children. My parents eventually decided to add to our family through international adoption. After a few years, they had adopted seven children from five different national backgrounds. It was not initially evident how much my adopted siblings’ prior histories and the varied social, political and economic infrastructures of their respective national origins influenced their development. All of my adopted siblings had experienced significant traumas that were linked to geopolitics, poverty, hunger and war. My brother, who is in prison, was born and spent the first years of his life during the very violent Salvadoran Civil War. Among many horrific and ugly experiences, he witnessed his father dragged out of the house and killed.

I was raised in a small conservative, middle class, white Mormon community in Utah. Our neighborhood was made up primarily of an embracing network of fellow Mormons who we would see each Sunday at church, during evening strolls or at neighborhood barbeques. Though social problems existed in many communities in the United States, it’s safe to say that many protective factors existed and that it was a fairly sheltered community. It was not a particularly diverse community, though. In thinking about my school experiences, I believe there were only two or three Catholics, maybe three Latinos, not a single black person and only the occasional foreign exchange student. When the adoptions happened, in large part, our family became the representative diversity for the local community.

When our worlds met, there were explosive cultural clashes that ironically often remained shrouded in invisibility. We did not see or understand how much an impact nationality had as an influencing variable. One of the most memorable examples for me was when we gave my siblings anti-parasitic medicine. Soon, wide-ranging types of parasites began to come out of every orifice, like a scene from a horror movie. They were collected in dishes scattered around on countertops so that they could be taken to show to the doctors. In the midst of this, I went into our living room and sat down and began to hyperventilate. I was about eight years old and had never seen anything like that before. My brother from Colombia, amused by my reaction, mocked me by holding his scrawny finger to his mouth imitating a parasite. His experience in life had been immeasurably different from my own. At this point, my view of how the world was constructed began to crumble (Platt, 2014).

The experience of witnessing the parasite exodus was only an initial awakening to complexity and differences that exist in the world. We did not have conversations about or awareness that two in three people on the planet lack access to clean water. We did not know that 22,000 children die each day due to hunger and poverty (Shah, 2013). We were just a family dealing with strange decontextualized behaviors like the kids hoarding food. We were not connecting the challenges our family faced with realities such as the recruitment of child soldiers, human trafficking, genocides, or the extensive historical and sociocultural variables of different nations. We were, each of us, living out the stories of our respective national cultures. The explanation offered by Mair (1988) resonates with me as he explained, “We inhabit the great stories of our culture. We live through stories. We are lived by the stories of our race and place. It is this enveloping and constituting function of stories that is especially important to sense more fully” (p.127). I believe we were particularly influenced by the cultural tendency of people in the United States to be unaware of the influence of U.S. values on what we see and do not see (Platt & Laszloffy, 2013).

We were not alone in our myopic views of the world. Multiple and varied mental health providers worked with our family. I could be wrong, but I do not believe any of the clinicians had the slightest idea about the national realities from which my siblings had arrived. I doubt that consideration of and knowledge about international populations was a required component of their training. Thus, they likely drew on models, theories and interventions that were also developed far from the influencing realities of my siblings’ nations of origin. In the years since, I fear that limited progress has been made. While there is increasing lip service about the need to internationalize education, the fact that U.S. education is violently racing toward increased standardization is concerning. Standardization is a significant problem because embedded within what gets standardized (and also exported) is a U.S. limited perspective (Platt & Natrajan-Tyagi, in press). Moreover, standardization has a bad track record with links to the eugenics movement in the United States, Nazi Germany, the
sterilization of millions of people throughout the world, and many other human rights violations (Lake, 2013). The U.S. obsession with standardization creates significant barriers toward developing mental health approaches for a pluralistic and international society. The unintended nationalism that can be transferred in this process has real life ramifications for the clinicians we train and the clinical populations we serve. Educator Paulo Freire (2007) perhaps articulated this danger most clearly when he stated:

*Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world* (p. 34).

It is clear to me that my atypical family background has influenced my professional values and career path. For example, there are three things I believe to be true: 1) It is meaningful that the conceptualization of mental health, clinical models and most interventions primarily developed within wealthy communities are thus best suited for the wealthy elite; 2) The vast majority of the world lives in poverty; and 3) We have an ethical imperative and social responsibility to internationalize our conceptualization of mental health and to find better ways to meet the needs of the poor.

Social responsibility to me is about being accountable for doing my part to benefit society. In my role as a mental health educator, I feel it would be socially irresponsible to see the harm caused by nationalism within the field of family therapy and do nothing. I also think this drive for me is connected to realizing the long list of privileges I have that are not shared by my siblings and others I love. While I feel there is so much more to be done, I have made several initial efforts to try and be accountable in my work. I have now lived in Mexico City for 10 years. To me, Mexico is a culture of creativity, and while I still work for a U.S. institution, this context has allowed me a little more freedom to incorporate a global perspective. I am the director of a master’s in International Counseling Psychology program. I added international to keep that a focus of the program and curriculum. I also developed a certificate in Latin American Family Therapy that is designed to provide clinicians with knowledge of critical issues in Latin America that have an influence on Latin American clients. I make a concerted effort to ensure that Latin American originating theories of mental health are taught. A component of the certificate program is a five-week Spanish language class and cultural immersion program here in Mexico. In addition to my work in Mexico, I am a co-leader of the India Cultural Immersion program with Dr. Raji Natrajan-Tyagi and the Cambodia intercultural exchange in family therapy with Dr. John K. Miller.

A common benefit among these programs is that they help make visible to participants the fact that the U.S. has a culture and values that shape how mental health practices are conceptualized. I also think that participants gain an increased awareness of the world beyond the borders of the U.S., including about healing and change practices. I have struggled about the ethics of being part of the
process of basically taking away a degree of innocence. For example, there is a loss of innocence as we see the bones and teeth still lying in the dirt in the killing fields of Cambodia or while connecting with children in the gypsy community in India who are living a landfill. Ethically though, I think clinicians gaining an understanding of global realities is the higher good, and that therapists do not have a right to the comfort of an innocence if it is resulting in clinical blinds spots.

My brother made his own choices. I do not blame the path his life has taken on the mental health workers’ lack of an international perspective. Still, had they had an understanding about El Salvador and the war, I do believe they would have been better positioned to intervene. Better yet, would be if the clinicians would have had access to all the healing and change practices that exist in the world rather than just those from a few privileged nations. In the age of globalization, it is now time that we expand our view beyond our own borders. There is a real cost for individuals, families and society when our effectiveness as clinicians is limited by nationalism, and therefore we have a moral duty to recognize it and move beyond it.

**Jason J. Platt, PhD,** is an associate professor and the program director of the Masters in International Counseling Psychology program at Alliant International University’s Mexico City Campus. He is an AAMFT Clinical Member and an Approved Supervisor. He is the founder of the CSPP Spanish Language, Class and Cultural Immersion program and the Certificate in Latin American Family Therapy. His research interests include international clinical competencies, liberation psychology, indigenous healing, alternative educational and training modalities, and critical pedagogy.

**References**


Platt and Laszloffy are recognized for their piece, “Critical Patriotism: Incorporating Nationality into MFT Education and Training.”


Wittenborn, Dolbin-MacNab, and Keiley are recognized for “Dyadic Research in Marriage and Family Therapy: Methodological Considerations.”


In February of each year, the editor of the Journal of Marital and Family Therapy will examine the articles published in JMFT the previous year and identify approximately 4-5 articles to be considered for the “JMFT Best Article of the Year” award. These articles will be forwarded to the Editorial Council for their evaluation and the ratings will determine the winner.
Social responsibility has many layers that ultimately stems from our ethical obligations to society at large. Systems such as family, culture, and society greatly influence our views on how we approach social responsibility. This article will share my personal experiences and examine my views on social responsibility.

Growing up as a Black male in the inner city brought a lot of challenges. Some of which were brought on by my own shortcomings. By the 3rd grade, I was diagnosed with a learning disability. Coupled with my difficulty to learn, my peers knew something was amiss so they ridiculed me a lot. I often felt inferior and quite frankly never good enough, and in order to mask my learning deficits, I started getting into trouble. I was that student who was usually referred to as the “class clown,” which to my own amazement, everyone in school wanted to be my friend, or at least wanted to partake in the comedy hour.

There was also a strong gang presence in my neighborhood and joining a gang was usually what marginalized kids like me did. Most of the gang members I knew either came from broken families or they were indoctrinated based on family ties. I came from a good family, but I did have two older cousins I looked up to who were notorious gang members. However, what I think was even more profound was the fact that my father was absent throughout my childhood. There is something to be said about the void a father leaves on a son, which is evident in the research. And to add injury to insult, my father has six children with six different women.

What was most difficult for me was that my father was involved in my other siblings’ lives. The question I often asked myself was, Why not me? Talk about feeling unloved, and not worthy. This very issue is something I never learned how to deal with.

My relationship with my father has improved substantially over the years, but despite our improved relationship, I still feel as though there was some kind of role reversal. I was the one who took the initiative to get to know him. I initiated our visits and just about all of our conversations. What I have come to find out is that he never accepted the challenges of being a man. It took me having my own family before I could even realize this. I was able to marry the woman of my dreams and my wife gave birth to our first-born child a little over a year ago. When I look at my son, I could never imagine not being a constant presence in his life. My son is the most precious thing in the world to me, and for him to never know me, just devastates me when I think of my experiences with my own father. Can I ever forgive my father is the question I often get asked by friends.
and family. Because I have a forgiving heart, I was able to forgive him, but it had to happen on my own terms. My father showed me enough for me to realize that he loves me. But, forgetting that he wasn’t there is something that would never happen because the pain remains too deep.

Because of the pain I experienced, my life was off track for a significant part of my childhood. Becoming a part of a street gang became easy to do because my “homies” were accepting of me no matter what my shortcomings. Interestingly, the challenges I faced were less complex than the unanswered questions that came about as a result of being a product of an environment filled with so many social ills. There were two issues I could not quite understand. First, why do so many “Black men” not rise to the occasion to be present in the lives of their children and families? It’s frustrating to see the number of Black youth who grow up fatherless. How can this cycle be stopped? One of the issues I see is that a lot of successful “Black men” from the inner cities across America have the inclination to turn their backs on their communities. It’s almost as if they are immune to the problem because they perceive themselves as no longer being part of that problem.

The second issue I could not understand was why so many Black males in my community would go to prison or jail, and as soon as they were released, they would go right back in a matter of months and sometimes weeks. I used to think to myself that incarceration must not be all that bad for them to keep going back. Then I would turn on the television and see how the “Black male” was portrayed as a criminal. I then started making the connections based in large part to my own personal experiences. The looks of disgust I would receive from police officers when I was simply minding my own business was alarming. What was interesting to me was that every time I wasn’t doing anything wrong, the police seemed to be around waiting for me to make the wrong move. Though I was able to reconstitute my life and make some positive changes, I was pulled over by the police on three separate occasions for no apparent reason. After each contact with police, I was either asked if I had drugs or guns, none of which I had ever possessed. There is no worse feeling than being accused of doing something wrong, especially when you have not. It may be easy to say, “Well, you didn’t do anything, so you have nothing to worry about.” On the contrary, there is a sense of insecurity that tends to resonate just by being a “Black male” at the mercy of law enforcement. It is something you can’t really explain unless you have been racially profiled before. Imagine being in high school and the female student sitting next to you is unable to locate her purse and she accuses you of stealing it because you are within close reach of where she sits. She proceeds to tell the teacher who then questions you. The principal is called into the classroom. At this point you are frustrated not only because you are being wrongly accused, but because you fear you will be reprimanded for something you did not do. Now, it’s about the fear of the unknown that overwhelms you. Then the student quickly apologizes after realizing she left the purse in her locker.

Do you think that fear and anger subside? No, there is a residual effect; the emotions never going away. And I think that is why you have so many men of color with an array of mixed emotions towards systems of control such as the judicial and prison systems. It is not by accident that there is a disproportionate amount of Black men in our prison systems. There is a reason for that, and it appears this matter is not being addressed on the appropriate level. As long as Black males continue to be marginalized, you will have gangs, drugs, crime and the high incarceration rates.

Professionally, I have tried to address some of the aforementioned issues looking at the lens of first order and second order change. In order to move towards permanent change, we have to focus on second order change, which requires us looking at the system as a whole. I work with youth in the juvenile justice system. My department has established committees that I have participated in that target the high number of minority youth in the system. Within some of these committees, I have been able to connect with community leaders, providers and citizens to collaborate on ideas to address the issue at hand. In order to make systemic change, you have to work with all the parts. But, these changes will not happen overnight. As MFTs, we have a responsibility to acknowledge a problem exists on a micro or macro level, and to be a part of the solution some way, somehow. But, there really aren’t any classes in graduate programs that examine social responsibility and also, there is minimal credence given to social responsibility in trainings and conferences. What me must do as mental health professionals is examine our own ethical responsibilities and determine how we can influence social change based on our own beliefs. For me, it was my own journey that provided me with the perspective that I needed in order to understand where I can influence change. I hope you do the same.

Sheldon A. Jacobs, PsyD, MFT, is a Child and Family Intervention Specialist with Department of Juvenile Justice Services Agency, Clark County, NV, and a core faculty member with the University of Phoenix. He is an AAMFT Clinical Fellow.
When I received my undergraduate degree in psychology at Brigham Young University, I felt uncertain about a plan for the future. I felt obligated to attend graduate school to make a viable career out of my BA degree. Even though there were numerous programs close to home, I was drawn to the family therapy program at the University of Massachusetts in Boston and liked its multicultural focus.

Even in the initial interview, the Boston Family Therapy program (FTP) began to expand my view of life and encouraged me to consider how I could be a socially responsible professional once I graduated. I was prepared to talk about my resume, research experience, and transcript. Instead, the director asked me to think of a metaphor to describe my interest in becoming a family therapist and to consider how the FTP could help me achieve my goals. This question took me completely by surprise. I had to stop for a moment and think about that question before I answered. This was the first of many times when the Boston Family Therapy program would make me stop and think.

I learned in my undergraduate experience, and through a Mormon Church mission in Puerto Rico, that the world was my campus where I could learn and help people throughout the world. This mission experience had broadened my perceptions of how others lived their lives. But the challenge of the FTP was to recognize that my ethical and social responsibility was to develop empathy and understanding of others, as well as to fulfill a civic duty. My social responsibility was to find a balance between duty and empathy, understanding, and respect.

The program challenged me to open my eyes to see, and my heart to understand, what families from varying cultures, different belief systems, and with dissimilar values from my own, needed in order to feel understood. I began to recognize more fully the needs of other people and society at large. I truly began to be able to take what I had learned as life experience and use it to benefit society. To fulfill the internship requirement for the FTP, I worked in a clinic that provided family therapy and counseling to youth. I spent the first couple of months observing and being individually supervised during actual therapy sessions with families. Then, much to my surprise, I was encouraged to pursue my own therapeutic approach. This was the first time in my life that I was empowered as an “expert” to influence the lives of others.
I became fully aware that I had to be accountable for my decisions. The family therapy program had taught me to recognize and embrace my own values. I could see that my values, together with additional perspectives, provided by experiences with other students and professors, and through the content of course readings, influenced my stance toward working with families. I found that the influence of a therapist on a family was enormous. I was amazed to see how much power I had to improve the lives of others so they had a better place. With this taste of how my actions could benefit a family, I wanted to share what I had experienced with the entire world, so after I graduated from the family therapy program, my wife and I decided to join the Peace Corps. We felt this decision was our way of expressing social responsibility. In our assigned country of Costa Rica, we were able to use our education, resources, and experience to be a positive influence in parts of the world without the opportunities we had been given. While there, we helped build a high school in our small village, taught classes in English, computer, and even formed and led AA groups.

After we returned, I began working as a family and child therapist in California. In my practice, I was greatly impacted by the devastation that divorce and custody disputes had on families. I noticed how some attorneys, in their behaviors toward the family, would purposefully, or in ignorance, replicate the trauma of divorce on the families they saw. I recognized that often divorce cannot, and in many cases, should not be avoided. Thus, I concluded that the most socially responsible approach with divorcing couples and their children would be to help minimize the traumatic effects of divorce on the entire family.

With my convictions, I began attending law school in the evenings while I worked during the day. I recently graduated and passed the bar exam, and have started my own family law firm. My intention is to provide empathic, ethical, and socially responsible representation for families going through divorce and dealing with custody disputes.

The metaphor I thought of during the interview for admission to the UMass Family Therapy program was that I was like an acorn. I had potential, but I felt that to succeed, I needed something beyond what I already knew. I felt the Family Therapy program could provide the water, sun, and nutrients to help me grow. The program not only enabled me to grow, but the knowledge and experience I gained continue to guide my growth as a socially responsible person and professional.

Since that initial interview, I now stop and think how the actions I take can best influence society for the better.

**Dustin B. Stucki, MEd, JD,** practices family law in California. He is also a registered MFT intern. He completed an MEd from the Family Therapy program at the University of Massachusetts in Boston, and a JD from the University of the Pacific, McGeorge School of Law. He recently formed the Stucki Law Firm to provide passionate representation with compassion for families in conflict. Stucki resides in Sacramento, CA.
I am a 2005 graduate of the family therapy program at the University of Massachusetts, Boston (UMB). I moved to the United States from Turkey with my husband and two-year-old son. My motivation was to enter a family therapy program to gain the necessary knowledge and experience, and then take what I had learned back to Turkey so I could help families in my country of origin. I come from a clinical psychology background with a psychodynamic orientation. After earning my masters in Turkey, I worked with children at a private agency where I conducted testing and play therapy, and met with the parents once every few weeks to provide psychoeducation. I remember sometimes having the fantasy of adopting the children and fixing all their problems by being a good parental figure. However, after a while, I felt something was missing in the picture. I would diagnose the child, decide what treatment would be best for him or her, and then tell the parents what they were doing wrong so they could change their behaviors. I remember how the parents reacted to some of the suggestions I made when I was a young therapist. After a while, I started to think, I need to learn how to form an alliance with these parents who were feeling hurt and helpless.

The family therapy program at UMB changed my whole world view. Now, when I look back, I am not only a different therapist, but I am a whole new person. For me, the clients’ parents are not the damaging figures in their child’s life, but they are a part of a family system which sometimes has a hard time adapting to situational factors. I see the whole family struggling with the dominant discourses in their culture and need someone to show them the possibility of alternative stories.

In an ethics course, I remember how I was challenged by my professor’s comment on abusive parents: “We are not that far from being an abusive parent ourselves.” In this program, I was invited to question my own biases. Being a Turkish woman, Sunni (although not practicing), well educated, higher socio-economic status and abled person, I belong to the majority group in Turkey. However, I never had a chance to see how these characteristics would affect the way I help others who do not belong to my group. In the psychology programs in Turkey, we did not discuss diversity. The diagnoses or the personality structure was what mattered for treating clients, not the culture. In the admission interview at UMB, I was asked, “How do you think your culture will affect the way you do therapy with clients?” After hearing that question, I started to acknowledge that there is a relationship between the two—culture and personality structure.

During my time at UMB, culture and diversity issues were in every part of the education: the curriculum, the professors’ discourses and the relationships they established with the students, and the internship. However, I never felt that I was pushed to see things that I was not ready to see. In the first class, we were asked what our names meant in our native language. We had a chance to talk about our family stories and rituals. I was given a chance to talk about my culture of origin. These experiences encouraged me to have a voice, which provided a secure base for me to look at my privileges and entitlements. I became aware of how my values are closely related to my privileges and how this can play a role in the therapy room. I believe this reflexivity is the first requirement to be a socially responsible therapist. My internship was at a non-profit agency where I was a home-based family therapist. Visiting the homes of diverse clients taught me how to work with families who were thought to be minorities in this society. I struggled in
the beginning of the internship. To the clients I was a white person (with an accent) but ironically, my passport indicated I was an alien. To them, I was a professional, but in the neighborhood I lived in, I experienced discrimination as a Turkish person. I felt the urge to make them feel that I was on their side. I wanted them to know I had a genuine interest in them and their stories. By learning from their stories, I could build an alliance with them.

Before I graduated from UMB, I knew I wanted to get a PhD in MFT. I wanted to further my knowledge by doing research, and I wanted to teach family therapy in Turkey in order to expand the profession in the country so more families could receive services. My professors encouraged me in my pursuit, so I applied and became the first cohort at Antioch University New England PhD program. There, I was also encouraged to have my voice heard. This time, my voice came through my first publication, which was about my experience being an immigrant therapist (Akyil, 2011). My curiosity in cultural matters that was planted at UMB continued in my PhD dissertation, which was on intergenerational transmission of values in families and social change in Turkey. In this qualitative study, I wanted to become aware of the experiences parents had in balancing traditional and new ways of being in their families, and to understand how this process of balancing value affected their relationships.

Now, I am back in Turkey. I am one of the cofounders of the couple and family therapy association whose mission is to promote the marriage and family therapy profession in Turkey, to set the standards of care and to reach families all over Turkey. I am also the coordinator of the couple and family therapy track in the clinical psychology masters program at Istanbul Bilgi University. Being an educator is a wonderful way to create a culture of collaboration, justice and responsibility. By providing a supportive atmosphere and by appreciating each student’s uniqueness, I am able to give them the space to be self reflexive, question their biases and enhance their tolerance for different points of view. In class, we talk about theoretical models as social constructions and underline each family’s unique needs. I am very eager to expand alternative views of problems that families encounter so that the students can look beyond the labels and dominant discourses, which at times can be restricting.

As part of an academic institution, I hope to be able to influence the larger systems in my country. One of the biggest challenges in Turkey’s mental health system is that psychotherapy is not covered by insurance. For the poor, there are only state hospitals where clients wait in long lines to be seen for 10 minutes. The graduate programs and academicians have a social responsibility to initiate projects and non-profit organizations where family therapy can be available for the disadvantaged populations. Some of our students will be doing workshops with children who have immigrated from Syria, and some of them will be working for the foster parenting system, which is newly established. Recently, I have been planning to start a home-based family therapy internship program for our second year students.

In closing, I want to say that I am grateful for every aspect of the seven-year family therapy journey in the U.S. Seeing society’s injustices and more importantly, coming up with alternative ways to cope with them, opened up new ways for me to see how I can contribute to the marriage and family therapy profession in Turkey. To have learned family therapy in an individualistic society, the U.S., and then returning to a collectivistic culture, Turkey, to practice and teach family therapy, is an experience about which I still need to think. I hope in the future to do research about the effects this phenomenon has on marriage and family training for international students.

Yudum Akyil, PhD, is a full time professor at Istanbul Bilgi University. She is the coordinator of the marriage and family therapy masters program. Akyil is also the cofounder and board member of CATED (Couple and Family Therapy Association). She designed a family therapy board game for Turkish consumers and has a private practice. Her research and clinical interests are directed toward value transmission in families, the effects of technology on relationships, family play therapy, and integration of attachment and narrative therapies.

References
I became fully aware during my experience of over 10 years as a bilingual Spanish-speaking guidance counselor working for the New York City Department of Education that the mental health needs of adolescents in schools were increasing and becoming more complex. Currently, this is still the case. Students are faced with severe pressures coming from outside the school, such as poverty, violence, trauma, and disrupted families, yet they are also required to meet academic requirements set by school administrators who, in turn, must comply with state and national standards. These students must confront the incongruity of conforming to academic and school pressures while coping with the stresses of their lives outside of school.

School-based family counselors have a unique position in schools. Their training in systemic perspectives enables them to understand the range of experiences students face within the school, in their families and in the community.

The success and well-being of students in school can be profoundly affected by the conflicting stressors in every venue. School-based family counselors are left with the demanding task of tackling and defusing the emotional consequences of contradictory goals.

The American School Counselor Association (ASCA, 2003) advocacy competencies provide a helpful framework to increase a systems theory emphasis, as well as to encourage school-based family counselors to have an advocacy perspective. This perspective lays the groundwork for family counselors to be socially responsive to students and their families and includes the need for multicultural social justice advocacy (MSJA).

The terminology of social justice advocacy (SJA) and multicultural social justice advocacy may be new to school-based family counselors, but the ideas are not new. From the inception of school counseling, numerous authors and researchers have pointed out that advocacy is a cornerstone of school counseling (Ratts, Toporek, & Lewis, 2010). In particular, SJA is “the action taken by a counseling professional to facilitate the removal of external and institutional barriers to clients’ well-being” (Toporek & Liu, 2001). Of importance, this view of advocacy requires empowering the individual, examining contextual factors, and working towards changing the environment. MSJA addresses the contextual factors (social, political, economical and cultural) within systems that impact individuals’ and families’ development, and thus shifts the focus away from individuals and families to a systems perspective. For school-based family counselors, MSJA emphasizes that counselors’ involvement extends beyond the needs of individuals and their parents and includes socially responsible advocacy on behalf of individuals and families so they can be empowered to overcome external barriers, such as discrimination and oppression (Toporek, Lewis, & Ratts, 2010). By following the guidelines of SJA and MSJA, school-based family counselors find themselves in a position where they can be socially responsible as they advocate for individual students and their families.

School-based family counselors regularly advocate together with, and for, students and their families. This advocacy is on a microlevel. MSJA, however, advocates on a macrolevel, which includes reaching out and involving institutions or groups outside the immediate school environment (such as community organizations, school districts, school boards and...
School-based family counselors who interact with these organizations must advocate on the macrolevel in order to be socially responsible to institutions both in the community and public arena. MSJA is an integral part of the daily work of conscientious and socially responsible urban school-based family counselors, as it was for me to be an effective school-based family counselor in the South Bronx. Since the work of urban school-based family counselors is responding to the needs of diverse and underserved populations, they routinely find themselves connecting the challenges of individuals to larger systemic issues (Crethar, 2010).

The use of school-based family counselor advocacy is not the only means for individuals and their families to be empowered. The MSJA perspective includes assisting individuals and families to advocate on their own behalf as change agents. Participation of students and families to pursued organizations to leverage change on a macrolevel can help school-based family counselors feel less isolated and overwhelmed by their responsibilities. In fact, when they collaborate with others, they may find their own effectiveness within the school environment improves.

School-based family counselors address the myriad of student needs by working with, and advocating for, caretakers and parents, and extended community, and all those who come in contact with students. By adding an MSJA model to their existing knowledge and experience, and by increasing advocacy work with students and their families, school-based family counselors are in a position to be socially responsible to students, their families, schools, and communities.

Audrey Ham, PhD completed her doctorate at New York University while working in the New York City public schools as a school counselor. She completed her clinical internship in the New York public hospitals and post-doctoral training in a community health agency. She was part of the National Health Service Corps in Hawaii, a federal program for doctors serving underserved areas. Ham was an assistant professor in school counseling at California State University. Her most recent area of research focused on a group intervention for parents of children who bully using a narrative therapy theoretical orientation.

References


ENCOURAGING COMPLEXITY
DEFINING DIVERSITY STUDENT LEARNING OUTCOMES IN MFT EDUCATION:
LINDA L. TERRY, EdD
Diversity and outcomes-based education

Diversity education, commonly referred to as the cultural competence movement, has remained strongly philosophical and aspirational with little attention given to identifying achievable outcomes (Sue, 2006). While MFT programs generally embrace the importance of diversity education, they vary in the extent and depth of attention to diversity outcomes. COAMFTE accreditation standards, Version 11 (2007), moved toward an outcome-based education approach requiring that programs demonstrate a “respect and understanding for diversity” (p. 6) and identify diversity student learning, faculty and program outcomes. The recently published Version 12 (2014) advances this outcome focus giving greater specificity to the meaning of valuing diversity and the program content and processes that support achievement of student learning outcomes. However, a schema for organizing and clarifying a program’s diversity student learning outcomes has not emerged. This article offers one way to conceptualize diversity student learning outcomes (SLOs), provides examples of learning activities implemented in two MFT masters level programs for which the author was a faculty member, and suggests evaluation methods for measuring progress towards SLO achievement.

Complexity and diversity student learning outcomes

Cultural competence and cultural humility

Sue’s (2006) widely accepted definition of cultural competence calls for counselors to develop awareness, knowledge and skills to appreciate and recognize differences of cultural groups and work effectively in cross-cultural counseling relationships. Although the entry of this construct into mental health fields has positively impacted psychotherapy training, critics challenge that it has many different meanings, insufficiently specific descriptors, and is not grounded in theory (Sue, Zane, Nagayama Hall, & Berger, 2009).
The definition implies that competence has a finite endpoint achievable through knowable skills. This understanding leads to training in culture-specific content that leads to stereotyping.

Tervalon and Murray-Garcia (1998), addressing physician training, proposed the construct of cultural humility to replace cultural competence. Cultural humility requires a “lifelong commitment to self-evaluation and self-critique, to redressing power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (p. 123).” It is an ongoing and reflective process engaged with clients and ourselves. Diversity education should be a collaborative process that challenges and encourages readiness to be curious and wrong. However, this process-centered construct may move educators further away from being able to clarify and measure SLOs. Taking a both/and approach, that is, utilizing the constructs of cultural competency and cultural humility, conveys value for gaining knowledge about culture and cultural groups while remaining exploratory about each person’s unique experiences and meanings, and humble about what we think we know.

**Cultural identities and intersectionalities**
The cultural competence movement was founded on the assumption that diversity education is for white people about the “Other,” such as Latino, African-American, immigrant, or gay/lesbian groups. Recent voices noted that these categorizations of identity do not respect varied and nuanced intra- and inter-group differences. Individuals and families comprise multiple identities, such as gender, race, ethnicity, class, and religion. These identities intersect with social power positions and show as complex, shifting, unique social location experiences. The possible meanings of these diverse intersectionalities are infinite and best approximated through collaborative learning processes (Hernandez-Wolfe & McDowell, 2010). From a “both/and” perspective, a conceptual frame that includes both cultural identities and intersectionalities invites recognition of the complexity of identity processes while allowing for attention to particular and salient identities as needed.

**Schema of diversity student learning outcomes:**
Four diversity SLOs can guide the advancement of cultural competence and humility in MFT programs. Students are to demonstrate:

a) Cultural awareness and sensitivity in therapeutic and other professional relationships;

b) Clinical effectiveness in cross-cultural relationships;

c) Social responsibility practices in therapeutic relationships and other professional settings; and

d) Social justice practices in therapeutic relationships and other professional settings.

All four SLOs are currently pursued in MFT programs; however, programs distinguish themselves by their prioritization. Prioritization has implications for setting objectives, curriculum design, course content, and teaching/learning practices. To foster SLO achievement, the program needs to maintain diverse student and faculty bodies, as well as incorporate separate diversity courses and infuse diversity content and activities throughout the curriculum.

**Demonstrate cultural awareness and sensitivity in therapeutic and professional relationships**
Educators advance cultural awareness through the acquisition of knowledge about self and others. It is an intellectual process engaged through cognitive functioning. Cultural sensitivity is engaged through affective processes generated through multicultural experiential learning. Beliefs and attitudes are challenged by emotional and perceptual experiences that elicit recognition of the complexity of intersectionalities and variances in salient identities, vulnerabilities and resiliencies derived from cultural experiences, and the effects of meaningful connections and gaps in cross-cultural understanding. This outcome is central to developing effective cross-cultural therapeutic relationships (Hardy & Laszloffy, 1995).

Two colleagues and this author co-taught a required first semester course entitled *Cross-cultural Communication* that set the foundation for engagement with cultural awareness and sensitivity. The format was a two-week, all day experiential intensive. The student diversity composition was 75 percent students of color and gay/lesbian
identities and 25 percent white identities, usually with multiple representations of identities. Although two of the five core faculty identified as faculty of color, the three faculty members, two core and one adjunct, who taught the course, identified as white, with salient minority identities and dominant culture privilege.

The course included both structured and unstructured activities that generated experiences of differences in cultural histories, access to resources and opportunities, and injustice, as well as understandings and perceptions of behaviors, events, and environments.

Unstructured exercises brought forth microaggressions (Sue, Capodilupo, Torina, Bucceri, Holder, Nadal, & Eaquilin, 2007) that occurred within the group between faculty and student and between students and provided opportunity to understand and repair in the moment. For one activity, students collectively generated a list of cultural identities, such as race, gender, and geography. Individually, students drew a pie chart allocating pie slice sizes in relation to the saliency of identities. Students reported on their selected identities and the reasons for their importance rating. In addition to newly perceiving the complexities and differences of identity experience, students became aware of saliency patterns, such as the primacy of race for students of color and the frequent absence of race in white students’ pie charts. Responses of sensitivity to the social experience stories that shaped saliency were expressed through compassion, respect, and admiration. This sensitivity resulted in changed perceptions and feelings, and new cross-cultural connections.

Self-report, portfolio assessment, and observational measures provide valuable growth monitoring assessment.

Program self-reflection questions for clarifying diversity SLOs

1. How does your program define these concepts: Awareness/sensitivity, clinical effectiveness, social responsibility, social justice?
2. Do any/all of the four SLOs fit for your program?
3. How does your program prioritize these SLOs?
4. What objectives would support attainment of your prioritized SLOs?
5. How prepared are faculty, supervisors, off-site supervisors, and adjunct faculty to support attainment of the diversity SLOs and objectives?
6. How can your program support the professional growth of faculty and supervisors in relevant diversity education?
7. Does your program need to do to gain administrative support for your prioritized SLOs?
8. Do your program policies and procedures fit for your SLO priorities?
9. How can your program prepare incoming students for engaging in the content and process of diversity education?
10. Do your recruitment, admissions, retention, and evaluation processes and procedures fit for the SLO priorities?
11. What MFT models best fit for your SLO priorities?
12. Do the diversity SLOs fit for the composition and readiness of the student body?
13. Do the clinical experience sites support achievement of SLOs and objectives?
14. What forms of leadership and participation fits with your SLOs?
15. What areas of preparation require separate courses and/or course infusion?
16. What type of relationship with the larger communities best fits your SLOs?
17. What types of teaching-learning activities and assignments best fit your SLOs?
18. What types of community-based engagements beyond internship best fit your SLOs?
19. What types of research knowledge and experiences best fit your SLOs?
20. What types of assessment systems and measures best fit your SLOs outcomes?
tools. Students can write papers or journals about their own changes, the experiences that generated change, and the effects of these changes for their work with clients. It is important to include specific examples of changed perspectives, feelings, and behaviors.

**Demonstrated clinical effectiveness with cross-cultural therapeutic relationships**

Although data on treatment outcomes continue to be difficult to gather, there is evidence of positive impact of culturally responsive work (Betancourt, Green, & Carrillo, 2005; Sue et al., 2009; Szapocznik, Santisteban, Rio, Perez-Vidal, & Hervis, 1989). Since cultural competence and humility apply to therapist training, it is useful to consider clinical effectiveness both in terms of the implementation of clinical processes and treatment outcomes. For example, programs educate for and require demonstration of successful application of culture-centered assessment models or tools. Observation and self-report methods can demonstrate strengthened cross-cultural therapeutic relationships and the therapist’s increased complexity with culture-centered conceptualization.

For MFT group supervision, each student prepared and presented a guided cultural genogram to the group. Interns identified family culture-based patterns that might enhance and/or constrain the therapy process. A collaborative and affirming leadership approach supported students in being able to help each other with “blind spots” and develop multiple perspectives and actions to enhance the therapeutic relationship and meet treatment goals. This training-practice-supervision process is distinguished from the more frequent use of the cultural genogram in the classroom or clinical practice.

**Demonstrated social responsibility in therapeutic relationships and professional settings**

Social responsibility and social justice are often discussed as intersecting and mutually necessary (Brady-Amoon, Makhija, Dixit, & Datar, 2012; Pachamama Alliance, 2014). Nevertheless, they are distinct concepts and call upon distinct attitudes and behaviors. Social responsibility requires considering decisions for action in relation to the effects for individuals, social groups, and society as a whole. It is grounded in ethical theory and adheres to the moral values of fairness and beneficence in relation to society’s welfare.

The MFT program sponsored a family therapy in the schools project as an internship in an urban elementary school. Under the creative leadership and supervision of an adjunct faculty supervisor, MFT interns provided individual, group and family therapy with children who were showing with behavioral and academic difficulties in the school. Additional project components included parent support meetings, classroom observations, meetings with teachers and administration, supportive self-care activities for teachers, assistance with parent-teacher conferences, self-esteem building activities with children, and celebrations of children’s work. The project enacted a social responsibility stance that building family-school relationships through partnership rather than repairing children and families leads to increased understanding and appreciation between families and schools and children’s school achievement.

To document progress towards social responsibility, supervisor evaluation forms can include items that monitor social responsibility. An example might be something like, “the supervisee considers effects of therapist decisions for client welfare in cross-cultural therapy relationships.”

**Demonstrated social justice practices in therapeutic relationships and professional settings**

The relationship between diversity, cultural competence in therapy and social justice as a core SLO is evolving within the psychotherapy fields (Brady-Amoon, Makhija, Dixit, & Datar, 2012; Chung & Bemak, 2012; Thomas, 2002). Social justice advocates argue that culturally unfair and inequitable therapy treatment is at the heart of the need for cultural competence and humility education. Without a consciousness of how institutionalized oppression and misuse of power operate in society, the therapist is likely to overemphasize individual or relationship determination in the change process (Vera & Speight, 2003) and perpetuate the status quo. The therapist role requires advocacy for clients, building coalitions and collaborations that foster client success, and/or engaging with community groups around social change issues, apart from therapy.

The MFT program offered a special topics course in Families and Larger Systems. The course provided an opportunity to take a leadership role
in identifying a social justice issue and designing and implementing a social justice action plan, from the social location of therapist-in-training. One Native American student obtained approval to start a support group for adolescents on her reservation. A team of a white and a Filipina student obtained approval to conduct a workshop on cultural trauma within their internship site. The students presented their projects and learnings in class. The experience provided an opportunity to expand knowledge about the complexity of larger systems and how “to make a difference.”

Evaluating a social justice outcome is difficult since changes may be small, require long-term plans, and usually are not immediate. Student evaluation needs to be based on observation and report of steps of the process rather than the actual social change effected.

Conclusion
This article provides a schema for identifying diversity SLOs in MFT programs and offers a few examples from two programs’ evolving efforts to align course content and teaching/learning activities with diversity SLOs. These efforts reflect steps of the ongoing journey and raise additional questions for consideration:

- Do diversity SLOs and derived objectives need to change based on the diversity composition of the student group?
- How do programs benchmark the progress of students and faculty/supervisors in diversity education?
- How does SLO evaluation design address differences in satisfaction with diversity content and processes between students of color and white students?

Responses to these questions and others emerging from the complexity of cultural competence and humility education will bring forth additional schema for clarifying the four identified diversity SLOs and defining new ones.

Linda L. Terry, EdD, LMFT, is professor emeritus from the Marriage and Family Therapy Program, Department of Counseling and School Psychology, San Diego State University. Post-retirement from SDSU, she was part-time faculty at Central Connecticut State University, Department of Counselor Education and Family Therapy, and Clinic Coordinator for the CCSU-Klingberg Family Therapy Institute. She is a Clinical Fellow and Approved Supervisor of AAMFT. She is also past commissioner and commission chair of the Commission on Accreditation for Marriages and Family Therapy Education.

References


Additional Resources

Individual Responsibility: Marriage and Family Therapy as
A Way of Life

DeAnna Harris-McKoy, PhD
Erica Wilkins, PhD

As MFTs, we give so much of our time, energy, knowledge, skills, and talents to assist our clients in life’s journey. We also engage in various professional development activities because of the duty we have to provide quality care to our clients. How does the duty or responsibility that we have inside the therapy room intersect with the responsibility we have as a citizen of the communities in which we reside? Ken Hardy (2001) said, “I believe that as family therapists, we do have a mandate to do our small part to transform the human condition, especially as it maligns the lives of those we serve” (p.19). Being a family therapist is more than a professional title, but a way of life. Can we authentically serve the multifaceted needs of our clients, if we absolve ourselves of the ways in which our personal social location impacts theirs?
As systemic thinkers, MFTs understand how contexts and systems influence individuals. We attempt to alter the (family) system, making it more beneficial and functional for the family or individual. Ascribing to systemic theory should then result in MFTs not only taking professional responsibility but also in being personally invested in improving the lives of those living in the communities in which we serve. We also have a responsibility to attempt to alter the larger systems to make them more beneficial and functional for all. Using Bronfenbrenner’s (1986) Ecological model, we provide space for therapists to analyze their duty and responsibility at various levels and provide examples of how therapists can expand their responsibility beyond their clients to their communities and society at large.

**Self reflection in action—microsystem**

Individual social responsibility starts with therapists understanding the ways in which personal and sociohistorical factors intersect with therapeutic interventions. One vehicle through which to attend to individual social responsibility, prior to beginning therapy, is by engaging in person of the therapist training. Watson (1993) posits that a “…critical issue in the person of the therapist area is the inclusion of the therapist’s gender and culture as part of the dynamic interplay between the therapist and the client” (p. 24). Person of the therapist training helps therapists critically think about their social location. This is a vehicle through which therapists can understand the ways in which their microsystem—such as family, friends, and colleagues—are affected by these factors. Failure to consider the advantages and disadvantages associated with membership in multiple dominant groups could result in apathy about issues that do not directly influence our functioning. Inaction often coincides with apathy. Therefore, it is prudent to consider the power, privilege and oppression associated with our individualized social location. The unique aspects of our multifaceted social location enable us to advocate for equality and fairness. At this level we can ask our selves: 1) What areas of oppression or invisible privilege do I experience? 2) How does oppression or privilege influence my life? 3) When do I feel most connected to humanity? 4) What do I find deplorable about the current human condition? 5) What hinders me from acting when I see injustice occur?

One advocate for children in the foster care system uses the term uses the term “courageous conversations” to describe the ways that healthcare practitioners can voice concerns about injustice, inequality and discrimination. It seems likely that, after engaging in person of the therapist training, a therapist may begin to more vividly understand the ways that their clients’ lives are affected by power and oppression. They often begin to more vividly notice the presence of these dynamics.

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in a variety of settings, such as within the classroom or at their jobs. Identification gives way to action, when therapists then begin engaging in courageous conversations within which they overtly discuss the existence of power and privilege.

**Impacting change—mesosystem**

Considering the mesosystem, we can integrate our various professional and civic roles for the benefit of our communities. When contemplating making changes at this level, we can ask ourselves: 1) What are my various professional roles? 2) What are the systems in which I am member? 3) What are the needs of the community in which I work or live? 4) How can I facilitate the collaboration between these systems to benefit the local community? For instance, researchers and professors can collaborate with the communities to engage in research that is beneficial to the community. At a conference, a presenter discussed working with youth in Brazil, and noted that she did not want to be a hit-and-run researcher, so she stayed in the community for an extended time to assist the community in other efforts that were not necessarily beneficial to the research. While adding more time to the trip, it was a sense of responsibility for the surrounding community that led her to help. Dr. America Bracho, executive director at Latino Health Access, is another example of involving multiple systems in community research that decreases the barriers faced in that community.

A number of methods can be used to address social responsibility at the university level. These methods can dictate types of curricula, pedagogy, clinical services and the incorporation of students in administrative decision-making. It is not enough to simply have students learn about diversity in an isolated course. Instead, issues related to social justice and social location can be infused throughout most courses, as doing so can help students understand the ubiquitous nature of these dynamics and increase their level of individual responsibility. The pedagogy that is used in the classroom experience can also help students become comfortable having courageous conversations. Utilization of interactive pedagogy allows professors to facilitate courageous conversations among students. The ultimate goal would be to help these future therapists gain comfort, both personally and professionally, in addressing previously uncomfortable issues. Another way that MFT programs can encourage social responsibility is through clinics that provide free or lost cost therapy for surrounding communities. Lastly, programs that are committed to social responsibility can decide to incorporate students in the administrative decision-making process. Asking students to participate in faculty meetings aids in dampening hierarchy.

Clinicians who are invested in social responsibility can be purposeful about the creation of their caseload and their relationships with marginalized populations. Private practice clinicians can provide free or low-cost services for those with financial limitations, volunteer with local agencies that provide low-cost services, or take therapy to clients and provide in-home therapy where mental health services are scarce. Marginalized populations may not readily seek therapy out of fear that they may be further stigmatized by health professionals. Clinicians can aid these populations by entering their communities, and presenting themselves and their profession as trustworthy. How healing it would be for clinicians to go into communities and discuss the systemic creation of marginalization—who is advantaged and who is disadvantaged by it? One potential outcome might result in community members who view therapy as a resource within which they can address social responsibility and social issues that are often felt, but rarely explicitly addressed.

MFTs can also be thoughtful about the non-professional service that they provide to their communities. Authentic advocacy should necessitate a desire to work in the community in various capacities, even if they are unrelated to marriage and family therapy. Help is needed along a variety of indices such as, but not limited to: education, financial literacy, nutrition, and legal matters. As highly educated professionals, we can think of ways to leverage our privilege and/or professional network to assist in areas that may be completely unrelated to the provision of therapy. For instance, we volunteer.
for local AAMFT chapters or other community organizations. Both of the authors are invested in their local communities and are members of professional women’s organizations that provide transformational programs in communities. Considering the immediate environments in which you have frequent contact, ask yourself: 1) What and who in this environment/setting is important to me? 2) Who am I leaving out/excluding, and why? 3) Where are the barriers to fairness in this environment? 4) What can I do to decrease the barriers?

**Advocacy in complex structures—exosystem**

As systemic thinkers, we understand that the (exosystem) larger systems (educational, political, economic, etc.) directly and indirectly affect our clients, especially those underserved. It is an amorphous yet powerful force that impacts all of us. Because of the nebulous nature of the exosystem, it feels daunting to address it in a meaningful way. A strategy to use with clients is to speak truth to power. Clients often feel the ways in which entities such as government systems, political systems, or religious systems influence their lives. Despite feeling this impact, it is common for most people not to have language or frameworks to understand the direct connection between these systems and themselves. A therapist can help empower clients by illuminating the power of these systems while also highlighting clients’ individual responsibility and resilience.

Therapist can use their voice and power to help alleviate barriers created by these systems. How in good consciousness can we suggest to clients to obtain resources, employment, or support that does not exist in their community, without also attempting to bring those resources to those communities? MFTs, as individuals, can write letters or talk to governmental/local officials, contribute to the AAMFT PACs, vote in all elections, or participate in marches and protest. We can ask ourselves 1) What are the larger system barriers that my clients discuss? 2) Do I consider marginalized populations when I am politically active?

Many people become therapist because of this need to help others and serve. We, like our clients, do not live in a vacuum. Our environment directly and indirectly influences the operations of our daily lives. We, as individuals, have a responsibility to advocate for a better world for our clients, for our communities, for our families, and for ourselves. We may postpone any action because we do not know where to start, or we believe that our actions will not make a difference. In this article we have provided examples of how MFTs, as individuals, can become change agents at various levels. It is our hope that you use your voice and power to advocate for those in and outside of the therapy room.

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**DeAnna Harris-McKoy, PhD,** is a Pre-Clinical Fellow of AAMFT and an assistant professor at Texas A&M University Central Texas and a couple and family therapist in private practice. Harris-McKoy is also an Alumni of the Minority Fellowship Program (MFP). She was awarded a Fellowship from the MFP in 2007 and 2008.

**Erica Wilkins, PhD,** is committed to helping individuals, couples and families heal through the use of therapeutic practices that are tailored to meet the unique needs of every client. She is an assistant clinical professor at Drexel University who trains masters and doctoral level couple and family therapy students. Wilkins is the recipient of numerous awards and is a published author who has presented locally, nationally, and internationally. Wilkins is also an Alumni of the Minority Fellowship Program (MFP). She was awarded a Fellowship from the MFP in 2007 and 2008.

**References**


The Minority Fellowship Program (MFP), housed in AAMFT's Research & Education Foundation, has trained 89 doctoral Fellows from its inception in 2007 to the present. Our Fellows share a common vision of and demonstrated commitment to advancing the health and wellbeing of underserved minority populations through their research and service. Funded by SAMHSA, this program’s foci include substance abuse, mental health, and training in cultural sensitivity. Fellows are competitively selected by the MFP Advisory Committee from a vast number of applicants, based on their stated service and research interests, past activities, academic performance and recommendations from their mentors and academic advisors. Over the years, Fellows have specialized in numerous topics, such as substance abuse prevention and treatment, refining culturally sensitive approaches to therapy, intervention with at-risk youth, GLBTQ issues, and working with trauma. Underlying all of the above is the MFP’s commitment to social change. The following descriptions of the activities of an MFP alum and a current Fellow demostrate the impact of the MFP in encouraging change at multiple levels.
Carizma A. Chapman (MFP Award Years 2009, 2010 and 2011), social responsibility means collaborating with others in the creation of conditions that allow for meaningful and systemic change. To this end, Carizma strives to attend to the personal, relational, and structural realities that shape mental health.

Carizma plans to complete her studies in the summer of 2014, with dual doctorates in marital and family therapy (DMFT) and family studies (PhD), from Loma Linda University. Carizma is committed to increasing the availability and accessibility of culturally sensitive services needed by undeserved, minority, and substance abusing populations. In pursuing social change, Carizma can often be found cycling through a range of roles from administrator, researcher, program developer, instructor, and advocate, to clinician—always attending to issues of gender, race, power, and culture.

In her work, she addresses health disparities, promotes equality, and facilitates family and community development of healthy and sustainable lifestyles. Carizma’s professional focus and research interests include sexual and reproductive health/ethics, interdisciplinary team building and collaboration, community and organizational development and capacity building, minority mental health and health disparities, and biotechnology. Among the many activities she has been engaged in, Carizma completed community assessments in two coastal communities in Southern Honduras for her DMFT project.

Additionally, she maintains an interest in HIV-related concerns. She has been studying HIV+ provider decision-making for her dissertation. Carizma has also been working to understand the needs of HIV positive clients to improve their care. She has focused particularly on the health and treatment needs of African American and Latino women, men who have sex with men (MSM), and gay men. Her related activities include working as a program evaluator for the AIDS Project Los Angeles and Foothills AIDS Project (FAP) while also functioning as a mental health clinician and educator for (FAP).

Carizma has been writing and presenting on one of her more recent areas of interest, namely, “Preimplantation Genetic Diagnosing” (PGD). Reproductive technological advancements are continuously providing individuals and couples with increased family planning options, and are increasingly shaping the farthest reaches of human development. Carizma stresses the importance of intentionality in reproductive decision-making. In her work, she speaks to how the utilization of PGD for medical and nonmedical reasons necessitates conscious and deliberate decision-making to mitigate child harm, relational instability, and inequality, and punctuates the important role mental health clinicians and educators can have in helping individuals and couples make informed decisions.

Carizma’s work has been very much informed by the MFP program and her mentors at Loma Linda University and Appalachian State University, including Drs. Colwick Wilson, Douglas Huenergardt, Brian Distelberg, Curtis Fox, Karen Caldwell, Randall Walker, and Lolita Domingue. She credits the MFP and her mentors in increasing her awareness of social inequality, health disparities, substance abuse, and helping her to focus her creativity and deepen her passion for civic engagement. Carizma believes in the Latin phrase *fiat justitia ruat caelum*, which means: justice ought to be pursued regardless of the consequences. She hopes to continue to improve the health, quality of life, connectedness, consciousness, and intentionality of people she encounters, even if at the end of day the person who shifts is herself.

The MFP Fellows’ goals include serving diverse communities, producing scholarship related to substance abuse and mental health, and fostering a commitment to social justice.
Hernán Barenboim (MFP Award Year 2013) strongly believes that access to mental health is not a luxury, but a right. He quotes his mentor Dr. Ruben Parra-Cardona as saying that: “It is not about us, it is about them.” He credits the support and inspiration of mentors and other scholars in leading him to become more passionate than ever in meeting the needs of underrepresented populations, including but not limited to the largest minority in the United States, the Latino community.

As a PhD student at St. Louis University, Hernán is committed to delivering mental health services to immigrant families. A foreign national from Argentina, Hernán understands the difficulties and requirements of life as an immigrant. He is devoted to reducing alcoholism, drug abuse, youth delinquency, and domestic violence in immigrant families that may result from hardships faced in the acculturation process. He also emphasizes family unity as the building block for community growth.

Hernán received training in psychoanalysis during his master’s studies, with an emphasis on the theories of Jacques Lacan and Melanie Klein. Since relocating to the U.S., he expanded his theoretical background to include the study of cognitive family therapy, behavioral therapy, and dialectical behavioral therapy. Hernán has had a special interest in systemic-relational therapy since 2004, especially when working with Hispanic and bicultural families adapting to their new lives in the United States. This experience gave him a more refined focus on research regarding dysfunctional attachments in multicultural families. He believes that this area of research could help to increase the understanding of cultural adaptation, international adoptions, substance abuse, and parenting.

In the past year, Hernán has been actively committed to serving disadvantaged immigrant populations in the St. Louis area. A great number of these families have been affected by political persecution in their native land, as well as drug-related kidnapping and physical and psychological torture. Hernán identifies with the power of resilience since he experienced firsthand, as a child, the political persecution from the military government in Argentina in 1976. Hernán trusts in the influence and role of healthy families in building strong societies. His work is consciously tailored to affect not only individuals, but also the communities they represent. He believes in what he calls the “cultural web effect” with mental health agencies acting as the web, attracting those in extreme need, for the helping hands of family therapists.

Hernán is grateful for the learning experiences he has had during the past year as an MFP Fellow. The sheer amount of mentoring in academic research, grant writing, and professional development he has received has been unmatched in his entire career as a mental health provider. He is appreciative of the renowned scholars in the field of marriage and family therapy who have taken the time to teach him the paths to succeed not only as a therapist, scholar, and researcher, but also as an individual.

MFP Fellows work with Native populations, HIV prevention, same-sex couples, military families, and much more.

We are doing federally funded research, teaching at universities, and working in agencies or practice settings.
Back in the early 1990s, when I was a new faculty member in my university’s doctoral MFT program and had also just joined my state’s AAMFT division board, I attended a meeting of the university president’s advisory council. I was there to ask the council, made up of deans, provosts, and others responsible for day to day operations, to endorse a bill the division was supporting in the state legislature that would, for the first time, license MFTs in Virginia. I thought I had a pretty good case. The public needed protection from unqualified practitioners, and the university had the only two MFT training programs in the state. Surely it had a vested interest in protecting the public and in our graduates being able to practice as licensed professionals. Or so it seemed to me.
But not to the president’s council. “You mean,” they asked me, “that we train students for a profession that isn’t licensed?” Yes, I answered, which is why the university should endorse a licensure bill. But the president, always looking for ways to economize, turned the question around. “Maybe,” he said, glancing at his deans, “we need to ask if we need two programs that train people for a profession that isn’t even licensed in the first place.” My blood froze. That was not the direction I had thought they’d take. I wanted them to endorse MFT licensure; instead they were thinking about killing our MFT programs precisely because state licensure didn’t exist. “Perhaps,” someone said, taking pity on me, “we can table this discussion for another time.” I certainly didn’t disagree.

I did, however, sit through the rest of the meeting, still stunned at how close I had come to talking myself and my MFT colleagues out of our jobs, all while nominally trying to ask the university to do the socially responsible thing and endorse MFT licensure.

Licensure of course eventually passed, but my university never supported it. It did, however, decide at that meeting to support another proposal made by some undergraduates right after my own near disaster: a ban on the sale of foreign sweatshop clothing in university bookstores.

The foreign sweatshop clothing sale ban was of course an easy sell, even if licensure wasn’t. Images of poor people, many of them children, toiling in sweltering buildings in third world countries for what most of us would call pocket change evoke revulsion in many industrialized societies, and a desire to right what seems an obvious wrong.
My university, like hundreds of others, quickly took the pledge: no more profits from sweatshop labor. What, after all, could be worse than third world children and others working in a sweatshop, earning in a day what many Americans make in half an hour, and what easier way to protect them than to boycott clothing sales?

Unfortunately, what not only could be but was far worse than working in a sweatshop was working as a street hustler or prostitute or farmhand, which is what many former sweatshop workers became when sweatshop owners, forced out of business by American bans on their products, closed their doors. Tens of thousands of former sweatshop workers, many of them children, went from sitting at looms or sewing machines in sweltering, rickety buildings with no fire codes for long hours for five or ten dollars a day, to having unprotected sex with strangers for pennies an encounter, in sweltering, rickety buildings with no fire codes if they were lucky, or alleys or doorways or cars or trucks or deserted lots if they were not (Krugman, 2001). Child farm workers and others let go from garment-making exchanged the dangers of whirling sewing needles and electric shears for work in malarial fields under the open skies, up to their knees in muck, dodging snakes and insects, trying not to amputate a hand or leg with a sickle or machete for perhaps a tenth what they earned before—which in many cases was more than twice the local per capita income (Powell & Skarbek, 2005). Sweatshop workers in one of Nike’s shops went from walking to the factory the first few years, to riding on bikes bought with their earnings, and later on scooters, their lives clearly improved (Norberg, 2003). But for many, such progress out of poverty ended with the sweatshop boycotts.

In their fervor to be socially responsible, anti-sweatshop activists of then and now have failed to understand that there aren’t too many sweatshops overseas, but too few, as champions of the global underclass like Nobel Laureate Paul Krugman (2000) and journalist Nicholas Kristoff observe. Sweatshops have been a direct route out of the fields, out of commercial sex work, out of pan handling and drudgery, for hundreds of thousands of third world workers. Boycotts of sweatshop products, like the one my own university so righteously but carelessly adopted, have done real damage to the people they are meant to help. “The simplest way to help the poorest” third worlders, write Kristof and Sheryl WuDunn, “would be to buy more from sweatshops, not less” (2000). Many economists agree (Powell & Skarbek, 2005). Their statement echoes that of Candida Rosa Lopez, a Nicaraguan sweatshop worker, who told a Miami Herald journalist, “I wish more people would buy the clothes we make” (Osorio, 2001).

Certainly, calls for improved conditions in third world garment factories can be helpful. But refusing to buy foreign sweatshop goods in the name of defending the world’s poor clearly harms the people we are trying to aid.

Over two decades ago, several hundred AAMFT members had their own brush with the ironies of social responsibility, when, in the wake of President George Herbert Walker Bush’s 1990 nomination of David Souter to the Supreme Court, they urged the AAMFT Board to endorse the Court’s Roe v. Wade decision affirming women’s legal access to abortion, and called for a poll of our members to see if a majority, as they confidently expected, wanted AAMFT to take this official stance (Nichols, 1992). Souter, several civil rights groups claimed, would vote to overturn Roe and would be hostile to women and minorities. Yet when the poll was tallied, while most respondents identified as personally pro-choice, most members did not want an official AAMFT pro-choice statement (Reproductive Rights Survey, 1991; Nichols, 1992). The Board took no action, and the group that had lobbied it, nonplussed, called for a boycott of the upcoming Dallas conference. But even that gained little traction. Conference attendance went up, not down. Even more ironically, Souter, once confirmed, turned out to be one of the most liberal justices in recent times, repeatedly voting to support Roe and other milestones for women and marginalized groups. Socially responsible action, in short, is rarely simple and straightforward, a point we MFTs don’t always seem to grasp.

How then does an organization act socially responsibly in a complicated world? Here are a few suggestions. First, a socially responsible organization realizes its primary duty is to its organizational mission. For AAMFT that means the promotion of
philosophically are, whatever our actual
improve others' lives, most therapists
which, as people who believe we can
It is easy for liberal leaning persons—
contributions, conversely, rose
women's health. Planned Parenthood's
felt Komen was playing politics with
pointed out, many previous donors
raising dropped markedly and has yet
to return to former levels (Hiltzik,
2013). As various commentators
pointed out, many previous donors
felt Komen was playing politics with
women's health. Planned Parenthood's
contributions, conversely, rose
markedly.

It is easy for liberal leaning persons—
which, as people who believe we can
improve others' lives, most therapists
philosophically are, whatever our actual
politics—to see the Komen episode as
simple stupidity or bad governance. But
it is crucial to recognize that the Komen
board believed it was acting socially
responsibly, again underscoring that
intending to be socially responsible has
nothing to do with actually being it.
Too commonly, we forget this basic fact.

Second, socially responsible
organizations recognize the diversity
of views within their membership,
and do not needlessly create division.
This is especially important in
AAMFT, whose members include
social workers, clergy, psychologists,
psychiatrists, as well as solely trained
MFTs. We are Republicans
and Democrats, Jews, Christians,
Muslims, Buddhists, agnostics, atheists,
liberals, independents, anarchists and
conservatives, pacifists and members
of the military, scholars and clinicians,
attorneys, administrators, researchers
and practitioners, gays, straights and
transgendered, blacks and whites,
whites, reds and browns, able-bodied
and physically challenged. While as
a rule many of us share many basic
values, there are important areas where
we may disagree. Good organizations
don't act as if one size social policy-
making fits all.

One of the best outcomes from
the early 1990s controversy over
reproductive rights was enactment of
AAMFT's “Policy on Social Policy,”
which specified the limited conditions
under which our group could take
public positions on social issues
(Nichols, 1992). The policy itself
was developed by both politically
conservative and liberal Association
members, making clear that socially
responsible organizations value
cooperation, compromise, and
democratic decision making, rather
than conflict and decree—another
point easily lost in the swirl of feelings
that often motivates demands for
socially responsible initiatives.

Socially responsible organizations
also act, when they do, with restraint
and humility. Most often, they do not
act at all, out of the obvious reality
that of the hundreds of challenges
the world confronts, few of us really
know the ones we could or should
influence. They understand beforehand
that any action they may take on
social issues may backfire, or have
consequences far different than they
intend, as the Komen board learned to
its embarrassment and regret.

This truth can be especially hard for
family therapists, since we are by nature
rescuers, and for all our warnings
to clients to avoid black and white
thinking, we frequently see the world in
starkly black and white, victim versus
oppressor—and ourselves saviors—
terms. Gregory Bateson (1972) famously
divided the world into “Occident” and
“Orient,” with “Occidentals” prone
to “errors of epistemology,” as if
being born east of the Urals somehow
rendered one immune from human
folly, or west of them doomed us to
stupidity. Yet, as silly as it was—how
many different cultures make up the
so-called “Orient”—many accepted
Bateson’s view. The current fashion for
seeing “post-modern” therapy as “more
respectful” of clients than a “modernist”
approach, as if the scales of insensitivity

Socially responsible organizations recognize the diversity of views within their membership, and do not needlessly create division.
have only now fallen off our eyes, is another painfully obvious example of our underlying penchant for all-white versus all-black ideas.

Family therapists are further disadvantaged when it comes to behaving socially responsibly by our frequently ginormous egos, born of the conceit that a systemic lens lets us understand and even solve enduring mysteries. Thus Brad Keeney (1983) passionately wrote that a “cybernetic perspective,” if universally adopted, would “save the planet” from nuclear holocaust, as if thinking like MFTs would bring humanity world peace.

Socially responsible organizations also are aware that a penchant for taking social positions, however well meant, can easily become mere window dressing or even cynicism, a kind of “Keeping up with the Kardashians” PR, and that genuine socially responsible behavior requires more than changing policies or the names we call ourselves.

Finally, truly socially responsible organizations ask themselves, to whom are we primarily socially responsible? They recognize that all socially responsible behavior must first begin at home. They ask, are our employment or membership policies lawful? Are they fair? Are they inclusive? Do our decisions follow due process? Are they democratic? Do we seek out opposing viewpoints and treat them with respect? Do we dictate to our members or value compromise? How aligned are our positions with our sister organizations? With best practices and common law? How, in an organizational structure often dominated by college faculty, do we ensure that the voices of day to day clinical practitioners and administrators who make up the vast majority of our members, and who know the needs of the families and others we serve firsthand, are heard above the disproportionately loud minority of members—myself among them—whose home is academia? Who, in a socially just organization, we might ask, is looking out for them?

Scott Johnson, PhD, LMFT, directs the Virginia Tech Marriage and Family Therapy PhD Program, and was President of AAMFT in 2007 and 2008. He currently serves on the Virginia MFT licensing board, and was associate director of the Virginia Tech Office of Recovery and Support, working with the 32 families of the victims of the 2007 shootings there, from 2007-2010.

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A Proposed Framework for Considering Conscience-based Referrals

Benjamin E. Caldwell, PsyD

I wrote last year about the struggles mental health practitioners face in determining when the therapist’s morals and values might make it appropriate to refer a client to another therapist rather than offering treatment themselves (Caldwell, 2013). While the most common example in public debate about the issue has been gay or lesbian clients seeking services from a religious practitioner, other situations might impact non-religious therapists, such as a client who comes to therapy seeking to improve his relationship in spite of being married to another woman, who is not aware of the affair. Could you turn that client away simply because you find the goal of therapy morally distasteful?

As I noted then, the AAMFT Code of Ethics is not clear about the role of the therapist’s values relative to those of the client. As you may know, the Ethics Code Task Force has put forward a draft revision to the Code of Ethics that, if adopted, would take effect in 2015. That draft is currently in its public comment period. Subprinciples 1.1 (non-discrimination) and 3.4 (avoiding conflicts of interest that would impair clinical judgment) are unchanged in the current draft revision.

The Task Force did recommend changes to subprinciple 1.10 to include that “the method of referral must safeguard the welfare of the person” when a therapist is unable or unwilling to provide services, and also recommended the adoption of six aspirational “core values” to guide decision-making when therapists are seeking out the best course of action in a given situation, rather than one that is simply good enough. However, the current draft does not provide additional clarity about when therapists may appropriately refuse to provide services based on matters of conscience. In lieu of such clarity, there is room for a reasoned conversation about when the Code of Ethics might allow for conscience-based referrals and when it might not.

It should be noted that the following framework assumes the client (used broadly here, “client” may mean an individual, a couple, or a family) is pursuing a goal that therapists generally would consider an appropriate goal for psychotherapy. A client who seeks out your assistance with an issue outside of your scope of practice or otherwise inappropriate for psychotherapy would, of course, warrant turning them away.

“Class” here refers to all of those protected classes identified in the AAMFT Code of Ethics non-discrimination clause, which specifically requires that MFTs “provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status” (AAMFT, 2012, subprinciple 1.1; unchanged in current draft revision). In my thinking, it is likely that all of the following criteria would need to be met for a conscience-based referral to be appropriate.

- The therapist must be trained and willing to provide competent emergency services regardless of client class or behavior. Simply put, the needs of the client in a mental health emergency trump the therapist's values. A therapist cannot refuse treatment to a suicidal client simply because the client engages in a behavior with which the therapist is not morally comfortable.

- The behavioral issue prompting the referral must be directly and demonstrably tied to the goals of therapy. Even a therapist who doesn’t support premarital sex could not refuse treatment to a client who engaged in premarital sex unless the client was specifically seeking treatment in support of that sexual relationship.

- Alternate treatment options reflecting a comparable level of care must be readily available. The ethical decision-making process on a potential referral would appropriately be different for the lone therapist in a rural area (or, even in an urban area, one of few therapists speaking a particular minority language) as opposed to one therapist in a clinic of 20, where others can immediately step in to provide therapy. The phrase “comparable level of care” refers to the frequency, length, location, cost, language, and method of service delivery, as well as the qualifications of the service provider. The alternate treatment option also must be demonstrably more appropriate to the client’s needs than the therapist making the referral; for example, a
The therapist could not refuse treatment to LGBT clients and simply refer them to other non-LGBT-affirmative therapists.

• Class is not an acceptable reason for referral. A behavioral proxy for class is also not an acceptable reason for referral. The Code of Ethics is clear in opposing discrimination in both letter (subprinciple 1.1) and spirit (both the Preamble and the introduction to Principle I are relevant). For example, a therapist could not differentiate between “being Jewish” and “attending synagogue” in an effort to make refusals to treat Jewish clients acceptable. Similarly, a therapist could not differentiate between “being gay” and “engaging in a same-sex relationship” in an effort to make it acceptable to refuse treatment to gay and lesbian clients. Any behavior that members of a class generally identify as being part and parcel of that class status could reasonably be considered a behavioral proxy for class.

• The normal inclination should be away from making conscience-based referrals due to the damaging message they send and their potential to further societal oppression of marginalized groups. Conscience-based referrals should only be made: 1) in extraordinary circumstances; 2) when there is a clear, immediate, and demonstrable benefit to the client; 3) when this benefit clearly supersedes the individual and social costs created by such a referral; and 4) when the reasons for referral are appropriately documented.

• The ability to make conscience-based referrals for treatment does not mean that a therapist or therapy student may refuse any training deemed necessary or appropriate by one’s school, supervisor, licensing board, or other appropriate authority. The proposed Version 12 COAMFT Accreditation Standards would require all accredited programs to teach LGBTQ-affirmative practices. Students and programs would not, and should not, be free to simply opt out of this portion of their educational requirements.

Conscience-based referrals should be carefully and critically examined by teachers, supervisors, and licensing boards. Such conscience-based referrals should be rare, and must be well-justified and non-discriminatory in their application. To wit, a therapist could not systematically refuse treatment to Latino clients by finding a new behavior to be bothered by with each new Latino client who presents for therapy.

In my thinking, referring a client away based on the therapist’s morals or values may be considered appropriate if the above criteria are met. Of course, any such construction is bound to have exceptions, and any exercise such as this is likely to bring forward elements I had not considered. These criteria are, I hope, a useful starting point for conversation. Would it work in your practice or training site? I would appreciate your thoughts.

Benjamin E. Caldwell, PsyD, teaches in the Couple and Family Therapy Graduate Programs at Alliant International University in Los Angeles. His first book, Basics of California Law for LMFTs, LPCCs, and LCSWs, was published this year. He serves on the Board of the California Division. Caldwell is an AAMFT Clinical Fellow.

References

Go Online
Visit AAMFT’s Community to share your thoughts or experiences. This is a members-only forum and you will need your member ID and password to participate. www.aamft.org/conscienceclauses

This is a proposed framework for thinking about the acceptability of a conscience-based referral. It must be considered as a proposal, and nothing more; it is simply my own personal construction, based on my understanding and application of the AAMFT Code of Ethics. It is not an official position of AAMFT or its Ethics Committee, and cannot be considered a replacement for ethical or legal consultation. It is intended as an effort to spur conversation and to bring clarity to decision-making on conscience-based referrals within the current AAMFT Code of Ethics, and not in any way to override or contradict the Code. If you have questions about whether a conscience-based referral might be appropriate in a specific situation, AAMFT offers free ethical advisory opinions, which in my own experience are fast and very helpful.
Shifting the Status Quo:
Social Responsibility in the Supervisory Relationship

Linda Buck, MA

“As accepting oppressive social conditions diminishes human liberation” (Ratner, 2002).

As clinical supervisors, we are called as leaders and trainers in our field toward advocating for social responsibility, which is linked to the shifting of the status quo. We have responsibilities that go beyond the basics of safeguarding the client experience and ensuring quality clinical skills. It is our obligation, or social responsibility, to nurture an environment of “reflection and action upon [the supervisory relationship] in order to transform it” (Freire, 2000, p. 33).

Social responsibility is the willingness to reflect and act on issues of oppression and liberation in order to bring justice to people and communities that are marginalized, exploited and/or dominated. Most of this focus generally goes toward the client’s reality of unsupportive community and familial structures, socioeconomic difficulties, gender and sexualities, education, violence and multicultural concerns. However, how do these same issues correlate to the praxis of social responsibility within the supervisory relationship? The goal of this article is to provide both a reflective and thought-provoking dialog around the issues of oppression and liberation within the supervisory relationship.

Take a moment to reflect on the following three questions:

1) The power differential is inherent to a supervisory relationship. How does this power differential become activated in your supervisory relationships?

2) How do you react when a supervisee questions your knowledge and/or has knowledge that you do not possess?

3) We all work within systems and structures, even in private practice. What are some structural elements in these systems with which you disagree and would like to see changed?

These questions can elicit very complex reflections. There are no absolutes; rather, these questions help deconstruct the meaning of oppressive structures within the supervisory relationship and provide insight into how they support the status quo.

Liberatory relationships, such as a supervisory relationship, need to work at “humanizing social institutions, practices, conditions, and values” (Ratner, 2002). In fact, for a relationship to be liberatory, all parties need to be very aware of the potential for the oppressive practices found in exploitation, marginalization, powerlessness, cultural imperialism, and violence (Young, 1990). Each of these forms of oppression has the potential for entering into the supervisory relationship and need to be liberated.

This seems like a very tall order of business. Some of you reading may find it difficult to accept that you could be entrenched in oppressive practices. Even as I write this, I become more keenly aware of my own collusion with these practices. I like to equate it to the water in which a fish swims. The fish does not know it is swimming in water; it simply swims and breathes and has adapted to live in this element.

Since the Industrial Revolution, we have been swimming in the water of societal institutionalization. This means that we have lived as part of institutionalized practices and if we move too much beyond these societal norms, we are equated to being a fish-out-of-water, floundering until we find our way back into the fold. Dennis Fox explains that mainstream psychology trains practitioners to:

work too comfortably within government and corporate institutions...[and] within these institutions, bureaucratic and ideological demands for routinization, categorization, adaptation, pacification, and obfuscation dwarf individual concerns for values such as justice, equality, individuality, and caring...therapists presumably relatively free of institutional constraints, despite good intentions, too often reinforce oppression even when they think they are working to ameliorate its consequences (2003, p. 299).
If a supervisor is not aware of and accepts oppressive practices within the framework of the supervisory relationship, both supervisor and supervisee experience a diminishment in the full potential of their relationship. The status quo is reified. As clinical supervisors, perhaps the work we are called toward is liberating the status quo and developing new frameworks that break through the often-subtle dynamics that create such oppression.

In order to do this, it is important to have a foundational understanding of two terms: oppression and liberation. Oppression entails “asymmetric power relations characterized by domination, subordination, and resistance” (Prilleltensky & Gonick, 1996, p. 530) in which the dominating person, group or structure exercises power over the subordinated person or group. The subordinated group grows to understand themselves as dependent on the oppressive system or individual in authority. This dynamic can be easily played out in any relationship, including clinical supervision, where there is an inherent power differential.

There is much written about oppression; however, liberation is not so easily defined and is generally explained as a counterpoint to oppression. Carl Ratner (2009) states that liberation “begins with its opposite...oppression, which is why liberation is necessary” and it “must systematically overcome each of [oppression’s] specific details and its supportive cultural context.” Thus, liberation appears when the societal and interpersonal relationships no longer support structures that promote oppressive power differentials and exclusionary practices.

So, what does this look like in terms of a supervisory relationship? What are these structures that promote oppressive and exclusionary practices?

Most importantly, how do we, as supervisors, become aware of and shift our own practices so as not to collude with the status quo? In order to explore this, we will review the concept of self-determinism and marginalization.

**Self-determinism**

For any supervisee who is emerging as a capable and competent professional, self-determination and agency are critical. A liberatory supervisory relationship aims at developing a supervisee’s identity autonomous from the supervisor. The supervisor provides acceptance and support of the supervisee’s unique gifts and skills.

In contrast, oppressive practices may require the supervisee to align with a prescribed, inflexible system of identity. The supervisee forms his or her identity as a therapist at the expense of self authenticity and authority. In essence, the system demands the supervisee to become a reflection of the supervisor and anything outside of this supervisor’s ideal becomes unacceptable.

Thus, for the supervisee to experience a sense of agency, both the supervisor and the system need to possess “empathy with and understanding of the difficult struggles and self-analysis through which the supervisee must go” (Falender & Schafranske, 2004). I know I have successfully facilitated the supervisee in gaining a sense of determination and agency when she or he expresses a differing viewpoint for client care from the guidance I provide, and when the supervisee discusses his or her most vulnerable imperfections and insecurities. With this type of disclosure, the supervisee is holding his or her own authority and authenticity.

As a clinical supervisor, what attitude do you hold toward a supervisee whom is stylistically different? Does the program or system in which you work mandate an inflexible expression of therapeutic work? These are but two ways that self-determination can be impacted by the supervisory relationship. We all work within systems, and we need to become more aware of how these systems influence us as supervisors and how we collude
with them unknowingly so as to liberate ourselves and the supervisees.

Marginalization
Whereas self-determination primarily speaks to the interpersonal nature of supervision, this next dynamic, marginalization, moves toward the systemic nature of supervisory practices. Pre-licensed therapists are marginalized when they are placed outside the privileges of the profession. These men and women have participated in an educational process to achieve, at the least, a master’s level degree. In other professions, upon graduation, this level of education places the individual into a category that promotes their success rather than relegating them to an intern status, which is often viewed pejoratively.

From a systemic perspective, a culture has developed that enables pre-licensed therapists to work for substandard wages. Internships, where one receives even the most meager of wages, are sought after and prized; however, many do not even receive compensation for the mandatory hours toward licensure. This is an oppressive practice that promotes the use of individuals without fair compensation. Do the agencies that train future therapists promote fair wages for these individuals? Do we, as supervisors, collude with the structures that promote maintaining a segregated workforce in which supervisees are seen solely within a cost-profit model and financial security for the supervisor and/or agency is acquired through the free hours provided by pre-licensed therapists?

As a supervisor, what is your attitude about supervisees? Are you able to cultivate a culture, or attitude, in which supervisees believe they are professionals offering a professional service? I have heard many supervisees state that they are “simply an intern.” At face value, this is accurate; however, it is the tone in how it is expressed. “Simply an intern” is thus translated as “I’m not worth much right now and I am somehow lesser than.”

The system which trains pre-licensed therapists creates a population that is marginalized and powerless. The system, by its very nature as a governing body for licensure, promotes compliance and submission. Pre-licensed therapists struggle with finding their place and to share in the many resources they acquire through their education and supervisory experience.

Unfortunately, to shift a system like this takes time; however, as supervisors we have agency to help the situation. If you are a private practice supervisor, what are your own pay practices? For all supervisors, do you treat supervisees collegially or promote an attitude that they must “pay their dues.” Since finances are a very difficult reality for most agencies, can supervisors promote other practices to benefit their supervisees, such as training opportunities, developing split-fee clients, and community building among pre-licensed and licensed staff? What ideas can you come up with to help the attitudinal disparity so entrenched in the system and internalized by so many pre-licensed therapists?

Moving rapidly into the 21st century, we, as leaders and trainers, have inherited an imperfect system. As with other systems and institutions, there is a shift occurring that is looking at deconstructing the meaning of these systems, with the hope of moving away from the hierarchical, exclusionary practices of the past. This article only touches on a few of these dynamics and there are many more to be explored. As clinical supervisors, we are charged with advocating for social responsibility for our supervisees. In shifting the status quo, we will foster the development of and environment of “reflection and action upon [the supervisory relationship] in order to transform it” (Freire, 2000).

Linda Buck, CSJ, MA, LMFT, is in private practice in Orange County, CA. She is an AAMFT Clinical Fellow and Approved Supervisor. Buck serves as adjunct faculty at Pepperdine University’s graduate program in clinical psychology, with emphasis in MFT. In addition, she is a clinical supervisor with IAS Counseling Services, working with pre-licensed therapists to develop their professional skills and identity. Her interests include the integration of spirituality and psychology, as well as liberation and post-colonial psychologies and theologies. Buck is a Sister of St. Joseph of Orange.

References


MFTs in the Media: Professional and Social Responsibility

Shatavia Alexander Thomas, DMFT

A local production team contacts you to ask if you are interested in participating in an on-camera session for a reality television show. What is your role? Who is your client? What is the intent of the show? Is there a predetermined slant of the scene or show, or will you be allowed to naturally engage in conversation? How will your employers and colleagues react? Will your involvement be seen as promoting the profession or cheapening the value of the otherwise confidential, therapeutic relationship?

What kinds of media opportunities exist for MFTs?

How do you position yourself to be considered?

Many AAMFT members have been featured for their work with the media (see “Media Mentions” on www.aamft.org). These opportunities involve print media, such as newspapers and magazines, as well as daytime talk shows, local and national news, documentaries and reality television shows. As evidence of the growing interest and involvement in media, consider how frequently “As Seen On” or “Press & Media” links appear on mental health professionals’ websites. Scripted dramas and sitcoms also feature therapists, as MFTs were featured in last season’s Emmy-winning show, *Modern Family* (K. Bryce, Personal Communication, May 31, 2014). Off-camera opportunities include offering program development consultations, assessing audience response, researching impact, advising film and television executives, and/or serving as a referral source for cast members (Fishoff, 2005; Luskin, 2012; Rockwell & Giles, 2009).

My association with the media stemmed from my doctoral research on sports and entertainment families. Unlike the plethora of features highlighting stories of legal trouble and dysfunction, my applied clinical project served as a resource-based systemic collaboration between stakeholders, professional athletes and their families. Akin to my willingness to work with the media, my intent was to: 1) normalize challenges and experiences; 2) maximize strengths and resources; and 3) collaborate on ways to improve family relationships. This movement beyond pathology exemplifies the uniqueness of our training as systemically-trained MFTs (Alexander, 2008).

Although I eagerly created a business website and online professional profile soon after obtaining my doctorate and licensure, I have been cautious about social media interaction. Admittedly, I am slowly recovering from my former position as a social media phobe! I now realize that social media is simply another way to build relationships by sharing my story (Rutledge, 2012). A production team for a local reality show found my professional profile online. After reviewing my website and summary of training and experience, they emailed to inquire about my interest in filming a therapy scene. We later arranged a
meeting to discuss the aim of the show and to assess mutual fit. Increased exposure and social media engagement led to additional opportunities to write articles on relationships and family issues for popular press magazines.

Positioning yourself to be considered for media opportunities largely involves having an online presence. Whether your comfort level includes connecting on professional networking sites, blogging, promoting your professional webpage or building your brand via social media, there are many ways to share your voice.

**What are the benefits and risks of media involvement? How do ethical principles and social responsibility apply? How can you determine if an opportunity is a good fit?**

At best, media involvement offers therapists a chance to promote the profession and educate the public. With increased visibility, MFTs in the media help to normalize help-seeking behaviors, validate human experience and demystify the therapeutic process. As a form of social justice, working with the media allows MFTs a chance to take therapy off of the couch and out of the room. Our reach is extended to those who may never choose to see a therapist. Encountering our spirit of advocacy, along with our efforts to “promote agency and autonomy” not only helps to reduce the stigma of therapy, but it also expands our role in influencing larger systems (Gehart, 2012, p. 446). As Thomas (2003) posits, “the next generation of MFTs will further this commitment to social justice from the therapy room to the community and world at large.”

Risks of media involvement include generalization of information or approach, entertainment versus education, potential exploitation and lack of influence in editing. Researchers and clinicians deem the media (namely, reality television) responsible for sensationalizing problematic behaviors, perpetuating stereotypes and sending the message of false optimism (Kosovski & Smith, 2011; Reid, 2013; Sampson, 2013). Likewise, some mental health professionals reduce media portrayals of therapy as total misrepresentations of process, violations of confidentiality, proponents of misinformation and downright exploitive (Barr, 2013; NASW, 2010).

Professional reputation may be at risk, as judgments can be made by colleagues and clients. I personally recall comments such as, “I would never do _that_ kind of show…” “How could you work with _those_ people?” “I’m not a fan of reality television. I think it distorts ‘reality’ and normalizes narcissism and histrionic behavior!” (Anonymous, Personal communications, 2013). In terms of both risk and fit, another consideration is that therapists must “identify their issues with money, power and celebrity” when working with people of a certain status or influence (Hokemeyer, 2013).

Just as problems may exist with being quoted in print media or interviewed live for breaking news, there are some drawbacks to engaging in social media and television shows. Regardless of the setting, therapists are urged to employ ethical decision-making principles, such as autonomy, nonmaleficence, beneficence, fidelity and justice. Using the Code of Ethics as a resource (AAMFT, 2012), there are many ethical considerations relevant to media involvement, including:

- **Informed consent, Limits of Confidentiality & Written Authorization to Release Client Information (Principles 1.2, 2.1 & 2.2)**—Have you discussed how/when information will be disclosed? If seeing a couple/family directly, have they waived confidentiality? What is your role in obtaining consent/documentation?
- **Multiple relationships (Principle 1.3)**—Is there a potential for exploitation or impaired judgment?
- **Self-awareness and Furthering own interests (Principle 1.7)**—Are you merely considering personal gain in offering referrals or services? What are your personal connections to issues portrayed in the media? Are you mindful of your perspectives, motives and intentions for engaging with people of certain affluence?
- **Scope of Competence (3.11)**—Are you functioning within the bounds of your skills, training and experience?
- **Public Statements, Accurate Professional Representation & Specialization (Principles 3.13, 8.1 & 8.8)**—Are you sensitive to influence in making public statements? Are you genuine in presenting competencies? Do you have the specialized experience relevant for the television show, radio interview or article?
- **Professional Identification, Educational Credentials & Correction of Misinformation (Principles 8.4, 8.5 & 8.6)**—Is your signage/title accurate? Are your credentials properly noted? If not, did you notify media personnel? Will you identify as an MFT, Media Expert, or Celebrity Therapist?
- **Social Media Concerns**—How do you (or will you) handle social media connection requests and interactions? (See AAMFT, 2011; Spotts-De Lazzer, 2013; Zur, 2011)
- **Social Justice Connection**—How do you effectively advocate for those marginalized or judged? What are the implications of your work in terms of societal change? (Thomas, 2003)

As essential as it is, assessing fit for
media involvement can be quite a daunting task. Sometimes, like therapy, “you have to be open to who shows up and work it from there. And, you can’t know if you can really be of help until you are in the relationship” (D. Nixon, Personal Communication, May 28, 2014). As MFTs, we are trained to consider context, assess fit and embrace a not-knowing stance. If my skills and experience do not meet the needs of the media or if they seem contrary to my therapeutic style or personality, I respectfully decline because I do not work outside my knowledge base and scope of practice. Since I do not yell at clients, judge them, place blame and/or take on an expert position in solving their problems, I would not take on a media role where I am expected to do so. My style embodies collaboration, empowerment and exploration of strengths and possibilities. Hence, my contribution to the media represents the same. Working within the context of the media may call for a shift in thinking and language (such as, “Dr. Shay” instead of “Dr. Thomas”). However, I personally prefer the title of “marriage and family therapist/MFT” or “couple/family therapist” rather than “relationship expert.” While I am not condemning those with different styles or preferences, I see this as another instance of being authentic and congruent. Social responsibility in this sense refers to my attempt to have my title consistent with my stance towards working with clients, as I believe that clients are the experts on their lives. An opportunity is a good fit if you can genuinely display professional competence, attunement and integrity. In other words, professionalism and person-of-the-therapist trump five minutes of fame.

I view working with the media from the same lens through which I view working with clients. I reframe them as opportunities. I honor multiple realities (yes, even reality television). I choose to work systemically and collaboratively. I address risks and strengthen resources. I focus on process and possibilities more than problems. I am curious about interactions and influence more than issues. I care about culture, context and creativity. I listen more than I speak, and I learn just as much about myself as I do about others. I offer hope, and I believe in ripple effects and miracles. I appreciate humor, and I express empathy.

And with all of that, I put my best postmodern foot forward in respecting the rights of those who choose not to do that kind of show, or write for that kind of publication, or work with those kind of people. For I value the multiple realities and ways to advance the goals of the MFT profession in an innovative and responsible manner. Equifinality, right?

Join Dr. Shay in the AAMFT Community to talk about MFTs in the media: www.aamft.org/MFTsMedia

Shatavia Alexander Thomas, DMFT, LMFT, is a Clinical Fellow of the AAMFT and a licensed marriage and family therapist in Georgia. She received her doctorate in MFT from Nova Southeastern University in Fort Lauderdale, FL. She owns and operates Dr. Shay Speaks, LLC, offering private practice and consulting services to individuals, couples, businesses, and families and is a faculty member at Northcentral University.

References


Soulful Gestures

Christina Neumeyer, MA

foster (fôs’ter) v. cherish, nurse, nourish, raise

I remember the first day of graduate school when the professor asked how many of us had children. Very few hands went up and mine wasn’t one of them. Then, in a foreboding tone he prophesied that we would most likely not become parents because this career path would realize our instinctual motherly needs.

He was right. Of the 23 years that I have worked in social services, I have only been a mother the last four. My maternal needs were, in fact, met by my clients. Good healthcare providers nurture their clients, of any age.

My mentors have all been childless, all work horses: two rock-solid women and one wise-as-a-library gentleman. All three had the real-deal look of a social worker, that mystical combination of fatigue and enthusiasm—flyaway hair, comfortable clothes, tired faces—always hurrying towards their feeble vehicles loaded with boxes and files.

Today, I am a dinosaur in social services: pencil, clipboard, common sense. It’s a draining job and the rewards must come from within one’s own internal dialogue about making a difference and how the world is better and all that smart self-talk.

But, the real reason I put off bringing a child into this world for so many years was because I rarely experienced a happy kid. The only children I knew were raging rivers, sad, and unable to attach; their psychic injuries manifested in a thousand different ways.

It’s a bit like trying to re-weave a basket, with the reeds stiffly jutting out of shape, except they are tiny hearts and minds. TLC is necessary, but no longer sufficient to meet the developmental needs of the kids in my care. Once a child’s folder has been handed to me, the child has not only been abused, but she has now abused others.

Being pregnant was a chilling time for me. A social worker often becomes the central authority figure in a family’s life, and to the children involved, my
pregnancy signaled one more inevitable abandonment. Angry adolescents assault and lash out, mostly towards their consistent and safe adults.

Children raised in foster care, crudely referred to as “system kids,” know how to find your vulnerable area; like bloodhounds, they seek out a soft spot and target it. Even the sweetest child who is happy to see me will wish a miscarriage upon me so I don’t leave her, for my new “real” family.

They know every square inch of their environment—scan, study, memorize. Abused kids are especially hypervigilant; often their very life has depended upon it. When I wonder if a client’s mom has returned to drugs, the child always knows after “hello.” From a block away, he can tell. He will know instantly, yet do his best to hide his discovery from me (I may not be able to read her but I can most definitely read him).

The names of clients rattle around in my head—press in on my heart—and seem to be unforgettable; but they are, over time. I try to recall the girl with the long hair and pretty teeth. She was quick; broke a staff member’s nose during physical education. She later cut her hands on a window in my office during a therapy session with her pedophile father. Another client was found dead at the age of 20 in a nearby park after “aging out” at 18, with nowhere to go.

Or the seven-year-old blond girl who had witnessed so much perversion that she would masturbate against bedposts, door knobs, and trees, with a maniacal energy—pitifully unable to manage her anxiety and overexposure.

Still, there are a few names that I will carry to my grave, like “Milo.” He was an obese boy with an electric face. He needed his second hip surgery and it fell upon me, alone, to be with him through that surgery. His mother came to visit each week. She started showing a pregnancy about the same time I noticed she was using drugs again. Mom made a long trek by bus, always punctual, soft-spoken and polite. It was sickening and surreal to witness; those slow gray lids as the baby inside her grew a little each week. The baby was born premature and blind.

And another girl, “Rebecca,” was the oldest of seven children, who was beat by her father when she got in the way of him roughing up mom. Rebecca’s mom could hardly make eye contact and had severe depression. Yet, she would bring her daughter complete meals, like fresh salad, accompanied by silverware and real plates: the family’s best to sit at our dirty picnic tables with some feeling of normality. Mom would bring her other six children when visiting, including a newborn. To this very day she was the most agile nurse I have ever seen. I remember her hazily mentioning that this was to be her last baby—she had her “tubes tied” when the doctors declared one more pregnancy would kill her. I always wondered about that.

The foster care child of today is usually hit in all major arteries. There are numerous reasons a child enters foster care, but the cornerstone of all social services recipients are those evil twins known as economic and psychological calamity.

Physical touch and professional boundaries have become words with the single most weight these days. In the current climate, it’s best if I don’t make physical contact, but, maybe a quick hug, in broad daylight only, and after asking, of course. My touch is authentic, but feels dryly clinical. In Noelle Oxenhandler’s exquisite book (2001), The Eros of Parenthood, she contends that the prevailing no-touch policy has inadvertently amplified the risk for inappropriate touch to occur.

For two years, I ran a monthly “rap session” for mothers in maximum-security prison. It’s not hard to guess that the sentiment most echoed, wrenchingly so, was the void of their children. The inmate uniforms were identical, yet, each woman would tie yarn threads in such a way as to make it hers, individualized. The big stories and personal dramas don’t tug at me as much as the dainty poetic human behaviors. I would come home from that morning visit and sleep for the rest of the day, limp from exhaustion.

Early on, single and in my 20s, I optimistically volunteered as a mentor for an at-risk youth program for a brother and sister pair living with their disabled grandmother. Grandma made me tamales sabroso at Christmas—her only condition in our ongoing relationship was that I be out of the neighborhood before dark. Occasionally, the kids would stay overnight with me in my small apartment near the beach. We would gather shells, bake cookies and attempt...
to wash my gigantic dog, until the laughter overcame us. But my best memory is an out-of-town drive we took to visit my family—they inhaled those two children and everyone was better for it. This could never occur today.

I ran into that little boy, now a gorgeous young man, while standing in line with my baby at the DMV. He had grown up well, strong and responsible. He had just come from seeing his mother hospitalized, one more time. His sister had followed his mother's legacy into a life of prostitution and heroin addiction. We exchanged numbers, but I never heard from him again. But he said that I had made a difference in his life.

When I become judgmental, I take inventory and remember that I am very lucky. I live in a safe neighborhood, have health insurance, and reliable transportation. I can afford nutritious foods and am grateful for the luxury of (accidental) good fortune. As James R. Lowell (1896) says it, “That best academy, a mother’s knee.”

And, when I sometimes wonder if these experiences have made me a better mom, I realize, yes, they have broadened my scope of human nature. I trust my intuition and encourage others to pay close attention—be present at all times. I have sat with enough perpetrators...I look into their eyes, and say, “I know,” and they look away.

My father told me that he avoids this shadowy “other” existence, while I run directly towards it, and I know this is true. I defer to the wide and textured arc of humanity because darkness is true, too, pulsating. Supposedly an artist should pursue a career in art only if he cannot imagine doing anything else for a living. The same philosophy would apply for social work as well. Only do this if you cannot imagine doing anything else.

AAMFT and You — Better Together
Protecting Your Right to Practice

AAMFT has made great strides in claiming a place for marriage and family therapists in the behavioral healthcare market. Those gains, however, are being challenged. In Texas, the Texas Medical Association (TMA) is challenging MFTs’ ability to diagnose. In North Dakota, a third party vendor is denying MFTs the opportunity to provide individual psychotherapy, and in Louisiana, the Attorney General made claims that MFTs are not qualified to diagnose.

These threats are real and pose severe challenges to MFTs and their ability to practice. AAMFT is asking you to help in defending against those striking out against our profession by making a contribution to the AAMFT Practice Protection Fund.

How can you help?
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Christina Neumeyer, MA, LMFT, has worked with children and families for over 30 years. From 2009-2012, she was a research study therapist at Veteran’s Medical Research Foundation UCSD/VA working with veterans and PTSD, using Prolonged Exposure Therapy and Cognitive Processing Therapy. Neumeyer is CPT certified and a trauma specialist, also certified in Duluth domestic violence training, crisis counseling and drug and alcoholism counseling. She was an adjunct professor at the University of San Diego, Department of School, Family and Mental Health Professions School of Leadership and Education Sciences.

References

No Holds Barred: The Irony & Dignity of Couples Therapy

Blake Edwards, MS

Sue and Roger had been married for seven years when I first met them in therapy. I saw Sue and Roger 13 times over 10 months. They came to therapy because they were experiencing “hopelessness” in their marriage, and they described intense bouts of conflict. Sue would experience hurt and express anger. Roger would experience hurt and either express anger or emotionally withdraw.

The heightened emotional bond of marriage puts partners continually at risk for conflict. Murray, Bellavia, and Rose (2003) wrote, “The experience of slights and hurts at the hand of a partner is inevitable. After all, conflicts of interest routinely surface, and even ambiguous behaviors, if sufficiently scrutinized, might seem to reveal a partner’s irritation, disappointment, or disinterest in oneself” (p. 128).

I believed that as Sue and Roger became disciplined in their responses during conflict, they would learn how to cultivate vulnerability and mutuality during conflict and in their marriage. As it was, they reacted reflexively whenever disagreement or inequity was perceived. Every fight left the bitterness of feeling misunderstood, unsupported, and unappreciated. They said of themselves, “We fight mean,” and, “We can both be Dr. Jekyll and Mr. Hyde.”

They both agreed that conflict began whenever Roger perceived Sue as being “preachy.” Sue expressed a desire to address unresolved conflicts from the past, mentioning disappointment that they were unable to have a big wedding. Such conversations were riddled with caustic retorts. When negative interactions evolve into patterns, couples often experience a heightening of fear in their relationship, burying more vulnerable emotions and engaging in self-protection.

The central goal of therapy for Sue and Roger was “to learn to talk to each other again,” to regain the experience of being in the relationship, rather than merely enduring one another.

In the third session, they reported having a “not so good last couple of weeks.” They found themselves frequently getting into heated arguments around Sue forcing Roger to have conversations with her about subjects that he did not want to talk about. Roger described feeling “like my whole life is I’m sorry,” because Sue always “nagged” him about the things that she thought he should be doing.

Roger frequently felt overwhelmed when Sue approached him about multiple concerns at once. Roger said he needed “time and space to breathe and think.” Sue said she wanted to process through these issues immediately. Sue and Roger came to our fourth session still emotionally charged from a fight. Both described not feeling heard. I coached them on the practice of active listening in an attempt to promote understanding and slow the argument.

During session seven, I guided them to reflect on the bodily sensations they experience during conflict and whether they perceive the other’s bodily reactions. Roger reported that when conflict is present, “I don’t want to talk about it.” He described “tiredness, numbness, deadness.” Sue said, “He feels threatened by my body language, and I feel threatened by his.”

Sue shared in our eighth session that she experienced hope and safety when Roger looked at her in the eyes when she wanted to talk to him about something, rather
than tuning her out. Roger asserted that he experienced hope and safety when he was given space to sit in the disagreement and then communicate about it again later.

Sue and Roger came into our tenth session wanting to tell me about positive experiences, which had occurred over the Thanksgiving break. Amidst Thanksgiving dinner at Sue’s family’s home, Roger opened up to her entire family at the dinner table and told them that he was thankful for Sue’s father and her family and apologized for not asking for Sue’s hand in marriage. She said, “He had everyone crying.” Additionally, Roger bought Sue a new wedding ring, symbolizing a new season of marriage.

Roger and Sue had a fight immediately before our twelfth session. Roger had been feeling exhausted and overwhelmed earlier in the day. When Sue brought him coffee as a gesture of love and support, Roger told her, “That’s the last thing I need right now.” This started an escalation, in which Roger became withdrawn.

As I labored to coach Roger to explore his desire for emotional space, he became visibly uncomfortable. I found myself compelled to press, almost demanding cooperation. Eventually, I recognized the parallel process between my interaction with Roger and Sue’s. Changing course, I asked Sue to brainstorm about what Roger may have wanted to say to her. Interjecting among Sue’s speculation, Roger began to speak for himself, expressing regret for his behavior earlier in the day and speaking supportive words to Sue.

By the thirteenth session, Roger and Sue had cancelled three appointments since we had last met two months prior, and I made a decision to confront them on their investment in therapy. I informed Roger and Sue that they were responsible for their investment in therapy and that I was committed to being invested with them only as long as they were themselves invested.

I felt disappointment at their shortage of attendance, a sign to me of a deteriorating therapeutic relationship. And so I did not expect the speech Roger would give. Roger mused aloud about therapy, telling stories illustrating how they had become more capable and confident in their marriage over the past year. Having more positive experiences with each other, Roger expressed feeling less energy toward therapy and more energy in life itself and with each other.

Roger commented, “Before we came in today, I told Sue we might be in a place where it would be better just to sit down with each other over coffee and discuss our relationship by ourselves.” By the end of the session, they confirmed that they would like to terminate therapy.

Sue and Roger, like many couples, struggled in knowing how to manage intense, reactive conflict. They learned that, with practice, they were capable of gaining distance from the powerful influence of anxious emotions. We are not necessarily determined by our impulses.

As Roger began to acknowledge ways that he withdrew from Sue at the whim of momentary anxiety, he began to act in spite of his anxiety, remaining engaged with Sue in an honoring way. As he did, he became more confident and less volatile. As Sue began to acknowledge ways that she pressed for resolution on issues of difference, she began to make peace with anxieties that drove her behavior in the relationship. As she did, she became more confident and less volatile.

As intentionality increased little by little, confidence increased. As confidence increased, conflict increasingly resulted in experiences of mutuality, rather than anger and fear. Sue and Roger gained a greater degree of freedom through restraint and a greater degree of attraction through differentiation, and this is the irony and the dignity of therapy.

Blake G. Edwards, LMFT, LCPAA, is a clinical director at Metrocare Services in Dallas, Texas, an expert contributor at GoodTherapy.org, and a poet and storyteller at The Poetic. Edwards has presented numerous workshops on therapy, recovery, parenting, trauma, and child development in local communities. He is a Clinical Fellow of AAMFT.

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