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FAMILY THERAPY MAGAZINE

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

A LOOK AT CURRENT

Systemic Research

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“Better understanding how interventions achieve positive change is a critical step toward developing more efficient and cost-effective programs that can be better implemented in everyday practice and enhance public health impact.”

FEATURES

DEPARTMENTS

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A Message from the President

SOMEONE ASKED ME earlier this year, "What is the theme of your presidency going to be—or is it too early to know?" I appreciated the question, as I'd been thinking about that quite a lot. In a word, the theme for my term as president is inclusivity. This theme does not begin on my watch, though I am happy and excited to advance it. This time last year, I had the privilege to serve as chair of the Diversity and Inclusivity Steering Committee. The charge of our committee was to operationally define diversity and inclusivity relative to AAMFT corporate expectations; identify existing barriers to meeting diversity and inclusion expectations in AAMFT governance units, and; to make specific board recommendations and steps to effectively eliminate barriers to diversity and inclusivity within AAMFT governance structures. The good work of that committee reflects a vital commitment to intentionally advance a more inclusive culture of belonging at all levels within AAMFT. The board and staff aim to create systems of inclusivity as both an ethical imperative and as association best practices.

I used to take a special pride in the very selective nature of AAMFT membership and her history. It felt inherently special to have graduated from a COAMFTE-accredited program and earned the keys to membership. I saw our association as the only one holding the banner and carrying the torch for systemic clinical practice. I was socialized to see marriage and family therapy as distinct and special, with a professional identity differentiated from other paths in the mental health field. Of course, I still see it that way, but through a more evolved and inclusive lens. Yes, I am proud to be a licensed marriage and family therapist. I value the special theoretical knowledge, clinical skill, supervised experience and training it took to achieve that title. I have always prized the rigorous path of my training, but I appreciate there are many ways in which to get there.

I became a Clinical Member (now Fellow) of AAMFT at the point of graduation from Purdue University's doctoral program. It was a "one-two punch" as I was eligible for licensure at the same time. I worked my way up the ladder from student—skipping the Associate Member level—to Clinical Member. The first time I heard about clinical membership was long before we had licensure in very many of the states. It was a path of professional destiny for me. I was committed to the movement to advance recognition of the profession, lobbying for certification while in graduate school, and later to win licensure in my home state. I remember the caution members voiced about the grandfathering period for other licensed mental health providers (social work, counseling, psychology), and the concern about qualifications, standards, and the so-called dilution of the field if we let everyone in who wanted to become a licensed marriage and family therapist. We soon discovered however that the tent got bigger and more vibrant in the professional community, and those with systemic inclinations include more than MFTs.

I must admit my necessary humbling along the way. Equifinality informs us that in open systems there are many ways to arrive at a desired state. While we have heroically championed, codified, and advanced the clinical standards for marriage and family therapy, we did not create the big idea of systemic family therapy. It took many thinkers, scholars, clinicians and the committed systemic practice of many leaders over decades to do that. I'm not sure how we can continue that growth and advance the field by holding parochially to a narrow gate for the top tier of membership.

Reading the Nichols (1992) history of our association, it is easy to see that from our inception, we were unapologetically exclusive and elitist. From the beginning, there were intense rigorous debates about who should be eligible to become members. There were a variety of litmus tests to make sure that qualified applicants were systemically and professionally worthy of membership. Members needed to have the right subject base and theoretical pedigree. Applicants needed to provide clinical demonstration of their work, be recommended, submit to the standards of specified content areas, specific clinical experiences and supervision requirements, etc. And if this sounds familiar, well it's because we still operate with many of these standards, which of course remain strongly held and highly prized.

The rich developmental history of our association illustrates that the innovators and leaders of our field emanated from disparate paths of training and inquiry, yet they banded together to form an organization that embodied that most fundamental of systemic truths. We are a more than a sum of our parts. Those historic tensions in our association relating to how distinct, exclusive, and special we are no doubt helped to launch us as a field and a profession. But as a professional organization with a mission to protect and advance the profession and practice of marriage and family therapy, those old tensions and barriers are impediments to meaning and relevance and more importantly carry historic inequities which need acknowledgement. Barriers to membership will not help us evolve and remain vital in the field. The current membership categories are confusing and exclusionary. Those hurdles to a sense of full belonging and access don't serve an increasingly nimble, diverse, global, and inclusive association.

From a position of equity, how might we lift the barriers to membership for highly qualified systemic professionals, and not exclude them simply because they arrived on a different track in their training? I'm certain we all know highly qualified clinicians who practice with stellar systemic ability but who hold a license other than MFT. Some members may hold tightly to the paradigm of our uniqueness and ask how can AAMFT become

inclusive without abandoning her standards? I might reframe the question as, how do our current member categories hinder us from advancing those standards and competencies more broadly and inclusively to the wider field?

In the upcoming election cycle, there is a ballot proposal to modify the bylaws and simplify the membership categories. The current membership system with its six (6) distinct categories is not only confusing, but clearly privileges the license and the geographic boundaries of the U.S. This poses an exclusive and geocentric system for which the unintended consequence is it limits those highly qualified applicants who can be "full members." While Groucho Marx might assert he would not join a club that would have him as a member, most of us would not join an association if we couldn't enjoy the benefits of full and equal membership or could acknowledge that our organization endures such obvious exclusion in admission. Our current membership system poses distinct barriers to those from other clinical training programs, other geographic areas, and prohibits them from striving for our most prized designation: Approved Supervisor. The new bylaws propose two (2) categories: Professional and Student. It also offers equitable and reachable aspirational goals for those who wish to develop and advance their unique systemic family therapy skills: Approved Supervisor (AS) and a new Clinical Fellow (CF) designation.

The key difference in the newly conceived designations is that any AAMFT member can pursue attainment—regardless of degree—as neither the AS nor CF designation will be tethered to license title. The effect of this bylaw change is greater equity and inclusion in AAMFT. It will level the member playing field. Some may argue that it jeopardizes the license and accredited programs. However, it still affords those electing to train in premiere COAMFTE-accredited programs and pursue the license as a marriage and family therapist a clear, bright path to those highly respected and meaningful designations.

I wanted to title this column "The big tent is still big, again." For me, that first part acknowledges our historic roots, while signaling an emerging and renewed openness. We can certainly argue how big that tent was back in the days before licensing and regulation. But the origins of our association drew together a wide variety of systemically-minded individuals who helped champion a relational paradigm for understanding couple and family development and health, and new ways to understand and address the problems of living. That big tent attracted individuals from a broad spectrum of clinical training origins—medicine, social work, nursing, psychology, ministry or pastoral care, and others from diverse areas of study who steered their epistemological leanings to emerging systemic clinical lenses. In the early days, our membership was small but ever growing—expanding from 700 to 7,000 members between 1969-1979, and then doubling from 9,000 in 1982 to 18,000 by 1992 (Nichols, 1992). Today, our membership hovers around 25,000, but has not changed substantially in the past two decades. The structural impediments of our current member categories impose severe limits on further penetration. The imminent retirement bubble guarantees significant member loss in the very near future. While I could strenuously stake my position for change on the case of equity and inclusion, there are other compelling trends that argue in favor of your support of the bylaws vote, as well.

Please join me and the Board of Directors in our unanimous support of the bylaws revision for a more vital, vibrant and inclusive AAMFT. Thank you.

TIMOTHY F. DWYER, PHD

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LETTERS TO THE EDITOR

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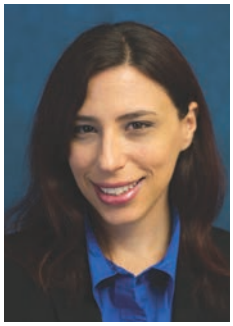
NOTEWORTHY

AAMFT's Stefanie Frank Recognized as One of DC's Top In-house Attorneys



Stefanie Frank, AAMFT's associate counsel, has been recognized by DC Live as one of the Washington, DC region's top in-house attorneys. Stefanie was nominated by one or more leaders in the Washington legal and corporate communities and selected from a deep pool of candidates for this honor. She has been active in legal-related events in the DC area through the Association of Corporate Counsel, an association representing in-house attorneys. Among other endeavors, Stefanie organized and led a successful networking lunch for corporate counsel in the Old Town area, which was held March 27. Stefanie's activities not only help AAMFT learn about ideas and projects we could adopt from other associations, but also promotes AAMFT within the DC business and association community.

Congratulations to Stefanie for this honor! She will be recognized along with honorees from Northrup Grumman, SpaceX, Bloomberg, Verizon, Capital One, and many other companies.

data note

Unique concerns identified for couple and family telehealth

- Need for individual assessment for therapy contraindications and safety planning
- Escalation occurs during session, and provider cannot ensure physical separation to facilitate de-escalation
- In-home sessions are interrupted by day-to-day activities
- Typical session nonverbal cues are missed via video
- Difficulties "joining" with the couple/family
- Collection of self-report measures, consent forms from different family members
- Referrals for families or couples

Learn some recommendations to help navigate these challenges by reading Wrape, E. R., & McGinn, M. M. (2018). Clinical and ethical considerations for delivering couple and family therapy via telehealth, Journal of Marital and Family Therapy, *45(2), 296-308.*

therapy talk

"People who don't give up on their goals (or who get better over time at not giving up on their goals) and who have a positive outlook appear to have less anxiety and depression and fewer panic attacks, according to a study of thousands of Americans over the course of 18 years."

"Perseverance Toward Life Goals Can Fend Off Depression, Anxiety, Panic Disorders," ***Science Daily*****, May 2, 2019.**

on the web

Check out the AAMFT Blog **"ARE YOUR PEOPLE IN SRI LANKA OKAY?"** Clinical Fellow Laurie L. Charlés, PhD, LMFT, reflects on the patterns that affect families across space and place. **blog.aamft.org**

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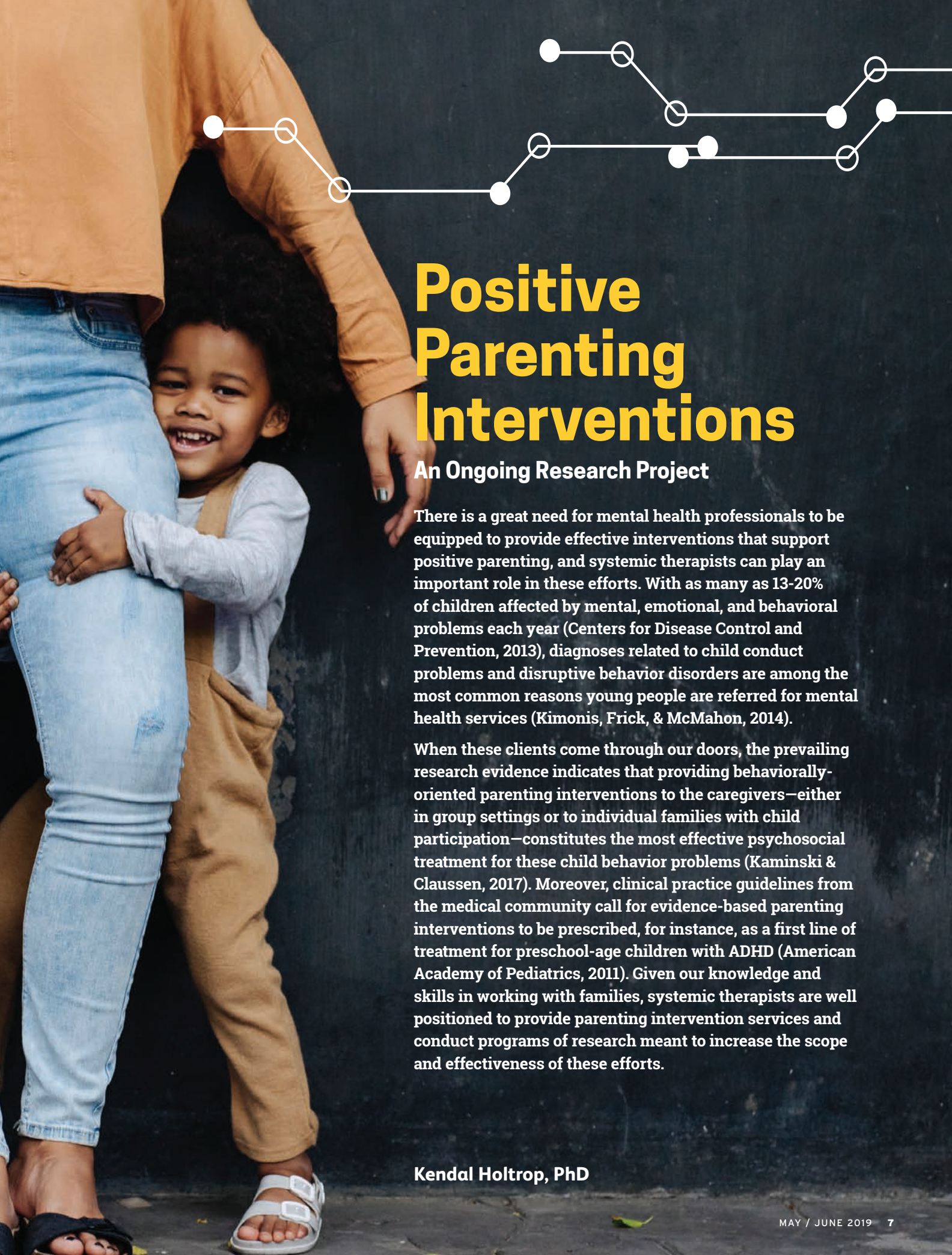


Positive Parenting Interventions

An Ongoing Research Project

There is a great need for mental health professionals to be equipped to provide effective interventions that support positive parenting, and systemic therapists can play an important role in these efforts. With as many as 13-20% of children affected by mental, emotional, and behavioral problems each year (Centers for Disease Control and Prevention, 2013), diagnoses related to child conduct problems and disruptive behavior disorders are among the most common reasons young people are referred for mental health services (Kimonis, Frick, & McMahon, 2014).

When these clients come through our doors, the prevailing research evidence indicates that providing behaviorally-oriented parenting interventions to the caregivers—either in group settings or to individual families with child participation—constitutes the most effective psychosocial treatment for these child behavior problems (Kaminski & Claussen, 2017). Moreover, clinical practice guidelines from the medical community call for evidence-based parenting interventions to be prescribed, for instance, as a first line of treatment for preschool-age children with ADHD (American Academy of Pediatrics, 2011). Given our knowledge and skills in working with families, systemic therapists are well positioned to provide parenting intervention services and conduct programs of research meant to increase the scope and effectiveness of these efforts.

Kendal Holtrop, PhD

My first exposure to evidence-based parenting interventions came while I was in graduate school—a critical period for couple and family therapists to gain expertise in such interventions (Wittenborn, Blow, Holtrop, & Parra-Cardona, 2019)—when I had the opportunity to receive training in GenerationPMTO. GenerationPMTO is an evidence-based parenting intervention that helps prevent and treat child behavior problems by working with caregivers to boost their positive parenting practices and reduce coercive parent-child interactions (Forgatch & Gewirtz, 2017; Forgatch & Patterson, 2010). It is a strengths-based, empowering, and active approach. Caregivers are introduced to new parenting tools, practice them in session, try out the skills at home with their children, and then review and troubleshoot their experiences in the following session. GenerationPMTO has been used across the United States and around the world for a number of years and has a well-established track record demonstrating positive outcomes for children and families (Forgatch & Gewirtz, 2017; Forgatch & Patterson, 2010).

Many things about the GenerationPMTO model resonated with me, and I found it highly useful for informing my clinical work with families. I soon became involved with efforts to research the intervention and learn more about how it could be applied with diverse populations (Holtrop & Holcomb, 2018; Parra-Cardona et al., 2012, 2014). The more I witnessed the intervention in action and learned from parents about their positive experiences, the more I became interested in how it worked. This inspired me to dive into the literature on GenerationPMTO (Forgatch, Patterson, & DeGarmo, 2005; Patterson, Forgatch, & DeGarmo, 2010) and to conduct research specifically focused on learning from parents about the change processes they experienced stemming from

the GenerationPMTO intervention (Holtrop, Parra-Cardona, & Forgatch, 2014; Wolford & Holtrop, 2019). Eventually, I became very curious about what was taking place during the intervention sessions and how each different component of the intervention was operating.

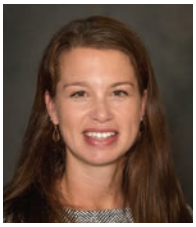
This was not just an academic question. In fact, better understanding how interventions achieve positive change is a critical step toward developing more efficient and cost-effective programs that can be better implemented in everyday practice and enhance public health impact (Blase & Fixsen, 2013; Weersing, Rozenman, & Gonzalez, 2009). This motivated a grant submission to the National Institutes of Health (NIH). In 2018, after much hard work, my research team and I were awarded a research grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) at NIH to investigate the functional components of GenerationPMTO. I am excited to be leading this project along with my amazing collaborators, Dr. Marion Forgatch (co-investigator), the executive director and developer of GenerationPMTO, and Dr. Jared Durtschi (co-investigator), an AAMFT Clinical Fellow and associate professor at Kansas State University. The objective of this two-year study is to measure the intervention components delivered in the GenerationPMTO intervention and examine links between each component and parent and child outcomes over time.

For this project, we are using existing data from a completed prevention trial with 238 recently separated mothers and their school-age sons. The mothers were randomly assigned to either the GenerationPMTO condition, where they received the intervention in a 14-16 week group-based format, or to a no-intervention control group. Findings from that randomized controlled trial demonstrated positive outcomes over a span of nine years, including reduced child externalizing behaviors, reduced child internalizing behaviors, as well as a number of other benefits for the youth and families (Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Patterson et al., 2010). Since we have already seen the successful outcomes, the current study is somewhat like reading a book backwards—we know there is a favorable ending and now we want to go back to the beginning of the story to learn how it all started. We are accomplishing this by studying video footage from the original intervention sessions. The first phase of this project involved developing a fidelity rating system to measure the delivery of eight GenerationPMTO components: the five core parenting practices (skill encouragement, limit setting, problem solving, monitoring, and positive involvement) as well as three supporting elements (clear directions, emotion regulation, and effective communication). We are now using this rating system to measure the intervention components delivered across nearly 180 intervention sessions.

Our nickname for this study is the EPIC project, meant to reflect our ambitious examination of Evidence-based Parenting Intervention Components. More importantly, this moniker is a fitting label for my EPIC research team—pun intended—that works together to make this study possible. I am grateful for the support

of my project manager, Debra Miller, a doctoral student in the CFT program at Michigan State University. The research team also includes my doctoral student, Melissa Yzaguirre (AAMFT Minority Fellowship Program alumna), as well as four undergraduate students. Together, we have spent hundreds of hours rating videos, achieving and maintaining reliability, and working hard to further this important line of parenting intervention research.

Once we finish generating data from all of the parenting group videos, we will examine links between each GenerationPMTO component and parent and child outcomes over time. Specifically, we intend to use multilevel growth models to determine the extent to which each GenerationPMTO component is associated with changes in parenting following the intervention, and then to examine long-term associations between each component and child outcomes, mediated by changes in parenting. The results will shed light on the most influential components of the program, including how they work to improve parenting practices and bring about long-term positive outcomes for children and families. This could have important implications for future GenerationPMTO programs and training practices. Study findings may also inform future efforts to adapt and/or tailor evidence-based parenting interventions for diverse populations. Overall, our goal is to enable evidence-based parenting interventions to be delivered more readily in everyday practice contexts by systemic therapists and other mental health professionals so that more children and families can benefit from these programs.



Kendal Holtrop, PhD, LMFT, is an associate professor in the Couple and Family Therapy (CFT) doctoral program at Michigan State University. Her program of research focuses on parenting and parenting interventions, with the goal of addressing mental health disparities by expanding the reach of evidence-based parenting interventions among underserved populations. Holtrop is the principal investigator of a grant funded by the National Institutes of Health (NIH) to determine the functional components of the evidence-based GenerationPMTO parenting intervention. She is also leading a project funded by the Michigan Health Endowment Fund to develop and pilot test an online parenting intervention program based on selected content from GenerationPMTO, with the goal of providing more families with access to research-supported parenting strategies. Holtrop is an editorial board member for the *Journal of Marital and Family Therapy,* an advisory editor for *Family Process*, and a mentor for the AAMFT Minority Fellowship Program. She is an AAMFT Clinical Fellow and Approved Supervisor.

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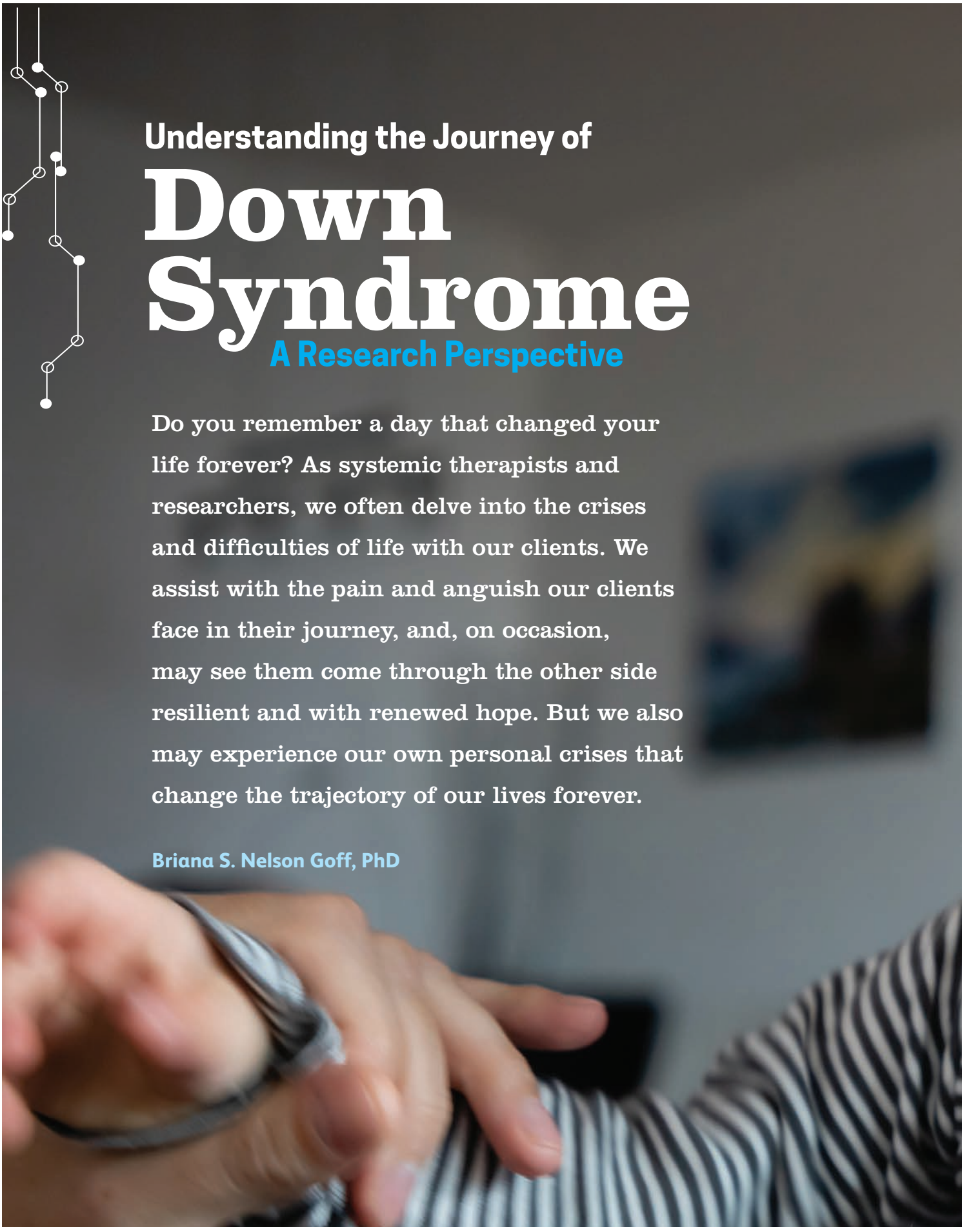

Understanding the Journey of

Down Syndrome

A Research Perspective

Do you remember a day that changed your life forever? As systemic therapists and researchers, we often delve into the crises and difficulties of life with our clients. We assist with the pain and anguish our clients face in their journey, and, on occasion, may see them come through the other side resilient and with renewed hope. But we also may experience our own personal crises that change the trajectory of our lives forever.

Briana S. Nelson Goff, PhD

Twelve years ago, February 13, 2007 at 1:40 p.m., my life took a dramatic turn with the birth of my son, who was born diagnosed with Down syndrome (DS).

We often talk about life with an intellectual and developmental disability (IDD), or the most recent DSM-5 terminology, neurodevelopmental disorder (NDD; American Psychiatric Association, 2013), as a "journey," but this was not a journey I had planned and did not know I would be on until my son was born. I immediately wanted to turn back or wake up from what I was sure must be the worst nightmare a parent could experience. As the mother of a child with DS, I have shared many of the same experiences as other parents; but as a researcher, I have also had the privilege to learn about and study the experiences of other parents and bring voice to those experiences.

My personal journey with DS began in 2007, but it would soon also impact the trajectory and focus of my professional work, as well. In late 2008, I reconnected with a colleague from my time in the doctoral program at Texas Tech University, Dr. Nicole Piland. Nicole had returned to Texas Tech as the MFT clinic director, but soon we realized another connection—we each had a child with Down syndrome. After several discussions, and the awareness of the privilege we held as educators, clinicians, and researchers, we decided to launch a study on the experiences of parenting a child with Down syndrome, with an emphasis on positive parenting experiences. We contacted several DS organizations to recruit parents, with plans to obtain 150-200 parents, particularly married couples, to participate in the research study. What started out as a relatively small study, ended up with almost 650 parents completing the online survey. It was exciting, emotional, and thrilling to read the parents' comments and stories. I can remember reading their stories with tears streaming down my cheeks, as I related to their pain, heartache, anguish, but also their triumphs and moments of resilience and hope.

Since the study was launched in 2009, we have focused on identifying the key resilience factors in families who have navigated this difficult transition and provided empirically-based information and resources for families facing this journey in the future. The study includes participants from 37 states, and two other countries, who have completed the mixed-method online survey, which includes both quantitative measures and qualitative research questions. Our participants were predominantly female (90%) with an average age of 42 (ages ranged from 16-87 years old). Their children with DS ranged in age from 0 (currently pregnant) to 55 years old, with an average age of 7.18 years old.

Our original goal was to compare experiences between spouses—the 150-200 "coupled" participants we anticipated. We actually had very few paired couples within the dataset, and our sample was predominately White, married females who reported a high socioeconomic status, which is also the primary population in other IDD research. We did attempt to generate participants with a range of demographic variables, and specifically recruited more diverse parents through ethnicity-based parent and fathers' groups at an annual National Down Syndrome Congress conference. Thus, while the size and national sample of our study participants was a strength, the lack of diversity was a limitation.

However, having a large national sample of 650 parents allowed us to do some different analyses than originally planned. In the 10 years since we launched this study, we have published 10 academic journal publications or book chapters from data analyses conducted with this research dataset, presenting our findings at national conferences, including AAMFT and National Council on Family Relations. These presentations and publications have focused on comparing prenatal and postnatal diagnosis parent groups

and parents with high and low relationship satisfaction, as well as understanding parents' experiences across different life span phases, identifying the unique experiences of fathers as well as mothers, and recognizing the various ways parents advocate for their children with DS.

While we have conducted several analyses with this data set, we believed a practical, but research-based resource for professionals and families was missing in the field. After further discussion and a conference presentation that gained the attention of a publishing company book editor, we had the opportunity to complete an edited book with a team of outstanding scholars in the fields of IDD, education, healthcare, law, social work, and marriage and family therapy. *Intellectual and Developmental Disabilities: A Roadmap for Families and Professionals* (Nelson Goff & Piland Springer, 2018) is intended for family members of and professionals working with individuals with an IDD or NDD diagnosis. Our goal was that this book would have a significant impact on the disability community, because the publications in this area often are not research-based. Many of the current mainstream publications for parents focus on either the many problems facing children with DS or other IDD/NDD diagnoses in technical, medical language, or they are comprised of stories from parents that are not based on empirical information. Our goal in developing this book for professionals and parents of children with an IDD/NDD diagnosis was to make this long-term project of benefit to the broader network of parents, caregivers, professionals, and others working with children and adults with intellectual and developmental disabilities. We wanted to create a tool that could be useful to family members and caregivers of individuals with an IDD/NDD diagnosis, in addition to serving as a resource for professionals from a variety of areas: disability advocates, healthcare service providers, school personnel…and anyone who is personally or professionally connected to an individual with IDD/NDD.


Dalton, the author's son

There are no guarantees with any child, and parenting a child with DS is truly more similar than different from raising a "typical" child; and at times even better than one could imagine.

How does this area directly impact clinicians? First, you may have a client, supervisee, or student who is expecting a child and faced with a difficult decision after a prenatal screening or testing procedure that indicates a chromosomal or other abnormality. They may be faced with pressure from medical professionals to terminate the pregnancy (yes, even in 2019!), without providing their full range of options. Connecting individuals with the plethora of resources and organizations can provide additional information on the many positive aspects of having a child with a disability and support families in obtaining the services that are necessary on this journey.

Parents may feel very isolated and alone initially, but one of the most important things professionals can do to assist is to get them connected to other parents and resources related to the specific disability—communicating with other parents already on the journey. This normalizes their reactions and empowers them through knowledge and advocacy. Second, families may seek therapy services at different transition points. Research has found that the transition to adulthood from the school system (usually at 21 years of chronological age) and later/end of life transitions of elderly parents are the most challenging periods, after the initial diagnosis (Simons, 2004). As with the beginning of this journey, it is critical to assist families with accessing available services and resources later in the life span. Preparing for these transitions well in advance is also important. Finally, helping families at points where advocacy for their child is necessary may be a critical role for therapists. In our study on parental advocacy, we found that parents of children with DS advocate for their children frequently, in a variety of settings, including school and healthcare settings, particularly therapy services, IEP meetings, and early intervention programs. Many parents reported being persistent and assertive with professionals, coordinating services focusing on the personal needs of their child, and setting high expectations for their child. Their goals often focused on inclusiveness, equality, and acceptance. Supporting parents in navigating the many systems with which they will interact

over the course of their child's life is a critical role for professionals.

The initial impact of receiving an IDD/NDD diagnosis is often characterized by shock, fear, sadness, anger, grief … a wide range of human emotions. However, these types of responses are often considered normal given the circumstances of adjusting to a different life than was originally imagined. Parenting a child with a disability involves a process of readjusting expectations, seeking out resources and supports, and identifying a new future. This parenting journey is filled with challenges, like any other parenting experience, but is often described as life changing in very positive, meaningful, and often unexpected ways. Ultimately, there are no guarantees with any child, and parenting a child with DS is truly more similar than different from raising a "typical" child; and at times even better than one could imagine. Twelve years ago, a chromosome changed my life forever—and I'm so glad it did!

Briana S. Nelson Goff, PhD, LCMFT, is a Clinical Fellow of AAMFT and professor in the School of Family Studies and Human Services at Kansas State University. She received dual Bachelor of Science degrees in Psychology and Life Science and a Master of Science degree in Marriage and Family Therapy, both from Kansas State University. She completed a Doctoral degree in Marriage and Family Therapy from Texas Tech University, before returning to Kansas State University in 1998. Nelson Goff and her husband have two children, Dalton and Gracyn. Dalton was diagnosed with Down syndrome at birth.

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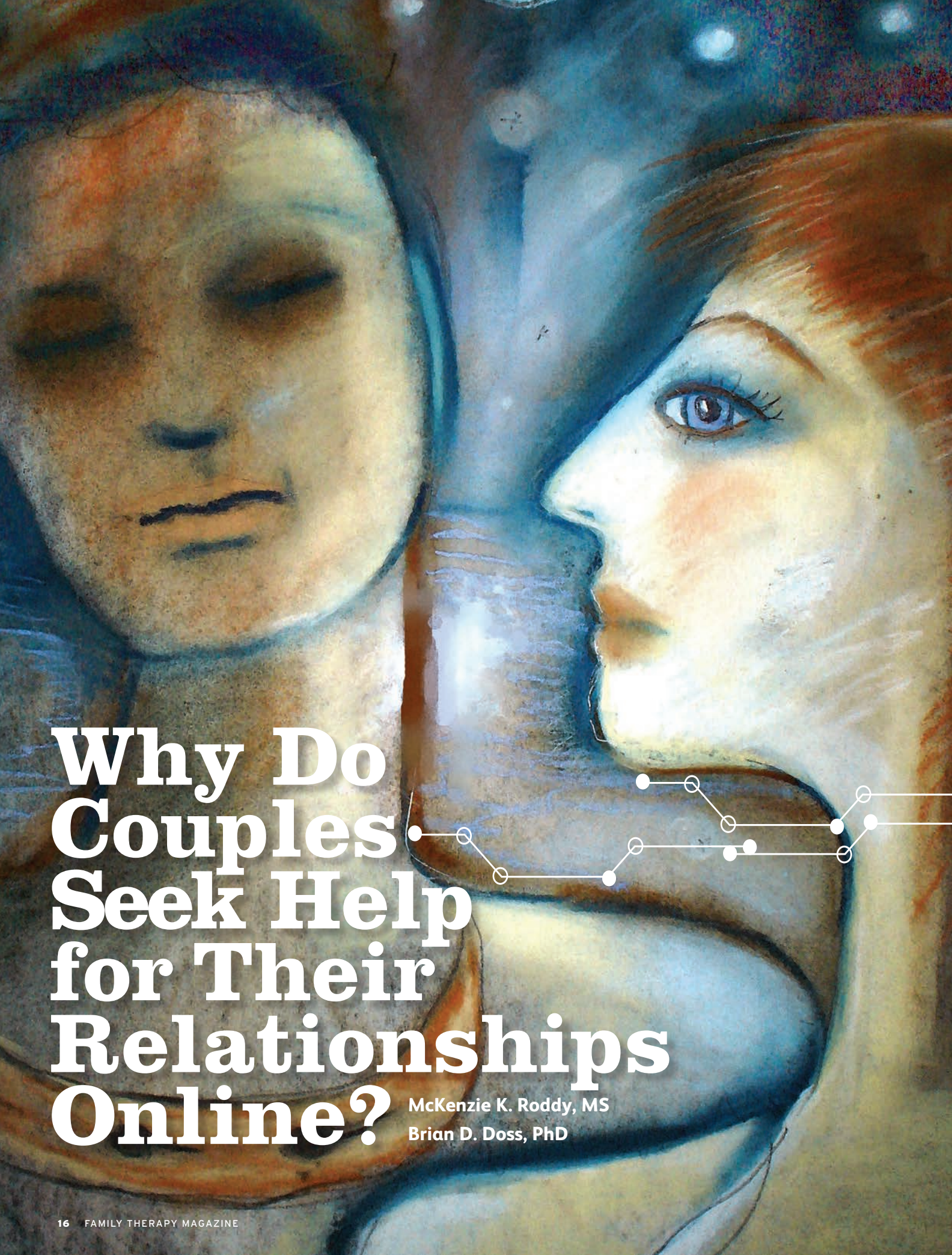
on the web

More information on *Intellectual and Developmental Disabilities: A Roadmap for Families and Professionals* is available at **https://bit.ly/2VYn0EQ.**



Why Do Couples Seek Help for Their Relationships Online?

McKenzie K. Roddy, MS
Brian D. Doss, PhD

As we likely need not explain to readers of *Family Therapy*, relationship distress is incredibly common in the United States (Whisman, Beach, & Snyder, 2008). On the bright side, we have efficacious treatments that alleviate distress (e.g. Fischer, Baucom, & Cohen, 2016). Unfortunately, however, most couples are not receiving the help they need. In fact, couples generally wait six years before seeking face-to-face therapy (Notarius & Buongiorno, 1992, as cited in Gottman & Gottman, 1999), and one estimate suggests only 37% of couples attend therapy before getting divorced (Johnson et al., 2002). Common barriers to seeking treatment, such as geographical distance from services, mental health stigma, and lack of financial means, may also hinder many couples from getting the professional help they need (Fox, Blank, Rovnyak, & Barnett, 2001).

Online relationship programs

In an effort to overcome many of the traditional barriers to treatment, numerous mental health apps and online programs have been developed for mental health symptoms such as anxiety and depression. Within the relationship field, both the Prevention and Relationship Education Program (Renick, Blumberg, & Markman, 1992) and Integrative Behavioral Couple Therapy (Christensen et al., 2004) have been adapted to online formats. Not only do online relationship programs allow flexibility for completion outside of traditional business hours from the privacy of couples' homes, but they provide a degree of anonymity and possibly decreased stigma. In fact, in an online survey, couples indicated they would be more willing to seek an online program than in-person couple therapy, individual therapy, relationship workshops, and self-help material (Georgia & Doss, 2013).

The online adaptation of IBCT—the OurRelationship program (Doss, Benson, Georgia, & Christensen, 2013; Doss et al., 2016)—was created by Drs. Brian Doss and Andrew Christensen. Currently, through support from the Administration for Children and Families, the OurRelationship program is being offered for free to low-income couples nationwide and is available for purchase for a small fee to couples not interested or eligible in the research study. Over the last seven years, tens of thousands of couples have visited www.OurRelationship.com to learn about the program and over 2,000 couples have enrolled.

During the OurRelationship program, couples work through three phases of online material and have four brief calls with a telehealth coach. During the first phase, the Observe phase, couples receive feedback on their relationship compared to national norms and select a biggest relationship problem to address during the program. During the second phase, the Understand phase, couples develop a framework for how individual differences, emotions, external stressors, and patterns of communication contribute to and maintain their biggest relationship problem. Finally, in the Respond phase, couples learn about acceptance and change and how it relates to their relationship problem. Project coaches meet with couples via video or phone calls at the start of the program and at the end of each phase. Calls are short—on average 15 minutes each for a total of one hour across the program—and help couples expand the concepts covered in the program, apply the program material to their own relationship, and address any technical or logistical barriers to completion.

Women were more likely to identify spouse-specific reasons and men were more likely to identify physical intimacy as a top problem.

A series of nationwide randomized controlled trials demonstrate that the OurRelationship program significantly improves relationship functioning (e.g., increasing relationship satisfaction and decreasing conflict) and improves symptoms of anxiety and depression

(Doss et al., 2016). Furthermore, couples reported maintaining the gains they saw during the program at least a year later (Doss, Roddy, Nowlan, Rothman, & Christensen, 2019). These results have been replicated within a low-income population—further generalizing the results of this program (Knopp, Rhoades, Huntington, Nowlan, & Doss, 2019). Attempts to reduce coach time from the full four-call condition to a single, 20-minute call resulted in equal program benefit in terms of intent to treat analyses for effect sizes in relationship satisfaction and depressive symptoms—and greater reductions in anxiety symptoms for the full contact condition (Roddy, Rothman, & Doss, 2018). However, more couples dropped out of the reduced coach condition (64%) than the full coach condition (34%; Roddy et al., 2018). Finally, removing the coach altogether even further reduced completion rates (only 6.1% of couples completed the program; Rothman, Roddy, & Doss, 2018). Therefore, personal contact through the program is important to program completion.

Why do couples seek relationship help online (vs. in-person)?
Previous research has examined why couples seek couple therapy. Emotional intimacy, communication, concerns about divorce, and conflict resolution are the most common reasons among chronically distressed couples seeking in-person couple therapy (Doss, Simpson, & Christensen, 2004). Furthermore, women are generally more likely to seek therapy than men (Doss, Atkins, & Christensen, 2003; Stewart, Bradford, Higginbotham, & Skogrand, 2016).

Similarly, the most common problems couples want to work on during the online program were issues with communication (27.2% of individuals endorsed), emotional intimacy (26.5%), and spouse-specific reasons (e.g. personality problems, drug/alcohol use; 19.9%) followed by arguments, physical intimacy, and specific areas of marriage (e.g. housework, finances). Individuals could endorse several areas they wanted to work on during the online program. Women endorsed more areas than men, and generally couples agreed on the top problems in their relationship. Additionally, there were interesting gender differences between women and men. Specifically, women were more likely to identify spouse-specific reasons and men were more likely to identify physical intimacy as a top problem.

In general, the reasons couples seek the OurRelationship program are similar to the reasons they report for seeking in-person couple therapy; this similarity is important for several reasons. First, it suggests efforts to adapt couple therapy to online formats will meet the needs of couples seeking help online. Second, many techniques used in-person will likely be helpful to couples seeking help online such as communication training and problem solving techniques.

However, there are some important differences when the online sample is compared to couples who sought help in-person. Specifically, in-person couples are more likely to endorse concerns around social time together and child/parenting concerns, which may have been a function of the fact that in-person couples were on average about four years older than online couples, and therefore more likely to have children.

A second important difference, online couples are significantly more likely to endorse issues surrounding trust and infidelity. The online program may be especially attractive to couples with infidelity concerns because it offers more privacy than in-person help-seeking. Additionally, the online program may have been easier to access for low-income couples who have increased rates of these types of relationship problems like commitment and infidelity (Trail & Karney, 2012). Specific interventions for healing following an affair have been developed and tested (e.g. Gordon, Baucom, & Snyder, 2005; Snyder, Baucom, & Gordon, 2008). As divorce is frequently cited as one of the leading causes of separation (Amato & Previti, 2003; Scott, Rhoades, Stanley, Allen, & Markman, 2013), online adaptations of these interventions, or inclusion of additional materials or resources, would likely be beneficial.

What does this mean for therapists?
For MFTs working with couples, this research highlights several implications. First, online programs such as the OurRelationship program are designed to handle the most common issues that drive couples to seek help. Therefore, if a couple's schedule or situation (e.g. finances, partner unwilling to come to therapy) are incongruous with in-person treatment, referring them to an online program could help to close the gap between couples in need and traditional in-person services.

Second, therapists could incorporate online programs into their practice in several ways. First, therapists who are burdened with long waitlists could offer couples an online referral while waiting for a spot. This stepped care approach may leave some couples satisfied following the online program, while others would continue to want to work with a therapist in-person to address remaining issues. Second, therapists wishing to expand the reach of their practice could work as coaches with online programs. Telehealth coaches in trials of the OurRelationship program were master's students in MFT programs and doctoral students in clinical psychology programs. By adding telehealth services, therapists are able to serve rural couples, long distance couples, and overcome other barriers that traditionally precluded couples from participating in treatment. Finally, therapists could use online

programs as homework assignments to supplement the work done during sessions.

McKenzie Roddy, MS, is a doctoral candidate at the University of Miami. She received her MS in psychology from the University of Miami in 2016 and her BS in psychology from the University of North Carolina at Chapel Hill in 2014. Roddy's research interests include dyadic telehealth interventions and the interplay between relationship and individual functioning. Her dissertation, funded by the Administration for Children and Families, focuses on individual mental and physical health outcomes, as well as moderators and mechanisms of effects from the OurRelationship program. She has served as the lead coach supervisor and trainer for the last two years and previously worked as a coach for nearly four years on OurRelationship.com.

Brian Doss, PhD, is an associate professor of psychology at the University of Miami. He received his PhD from UCLA, completed his internship at the Medical University of South Carolina and the Ralph H. Johnson Veteran Administration Hospital, and was an assistant professor at Texas A&M University for five years before moving to Miami in 2009. Doss has received multiple grants from the National Institutes of Health and the Administration for Children and Families. He teaches undergraduate and graduate classes on couple therapy and romantic relationships. His research is focused on ways to increase the reach of couple interventions, including OurRelationship.com and a self-help book titled *Reconcilable Differences*. His research has been cited on *The Today Show,* CNN, MSNBC, *The New York Times*, the *Miami Herald*, and elsewhere.

on the web

www.OurRelationship.com
Facebook: @OurRelationship
Instagram: @OurRelationshipProgram

Authors' note: More information about the details of this study can be found in Roddy, M. K., Rothman, K., Cicila, L. N., & Doss, B. D. (2018). Why do couples seek relationship help online? Description and comparison to in-person interventions. Journal of Marital and Family Therapy. Advance online publication. doi: 10.1111/jmft.12329. We would like to thank our co-authors for their contributions to this work.

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Download your free MFTs in Healthcare handbook

As the healthcare industry expands its interest in incorporating behavioral providers into conventionally-biomedical settings, it has compelled major changes in workforce training across all behavioral health disciplines. Several such disciplines have responded to this by creating competencies that guide their members in developing the knowledge, skills, and abilities necessary for delivering care. AAMFT now offers a Healthcare Competencies guide and a Topical Interest Network focused on MFTs in Healthcare.

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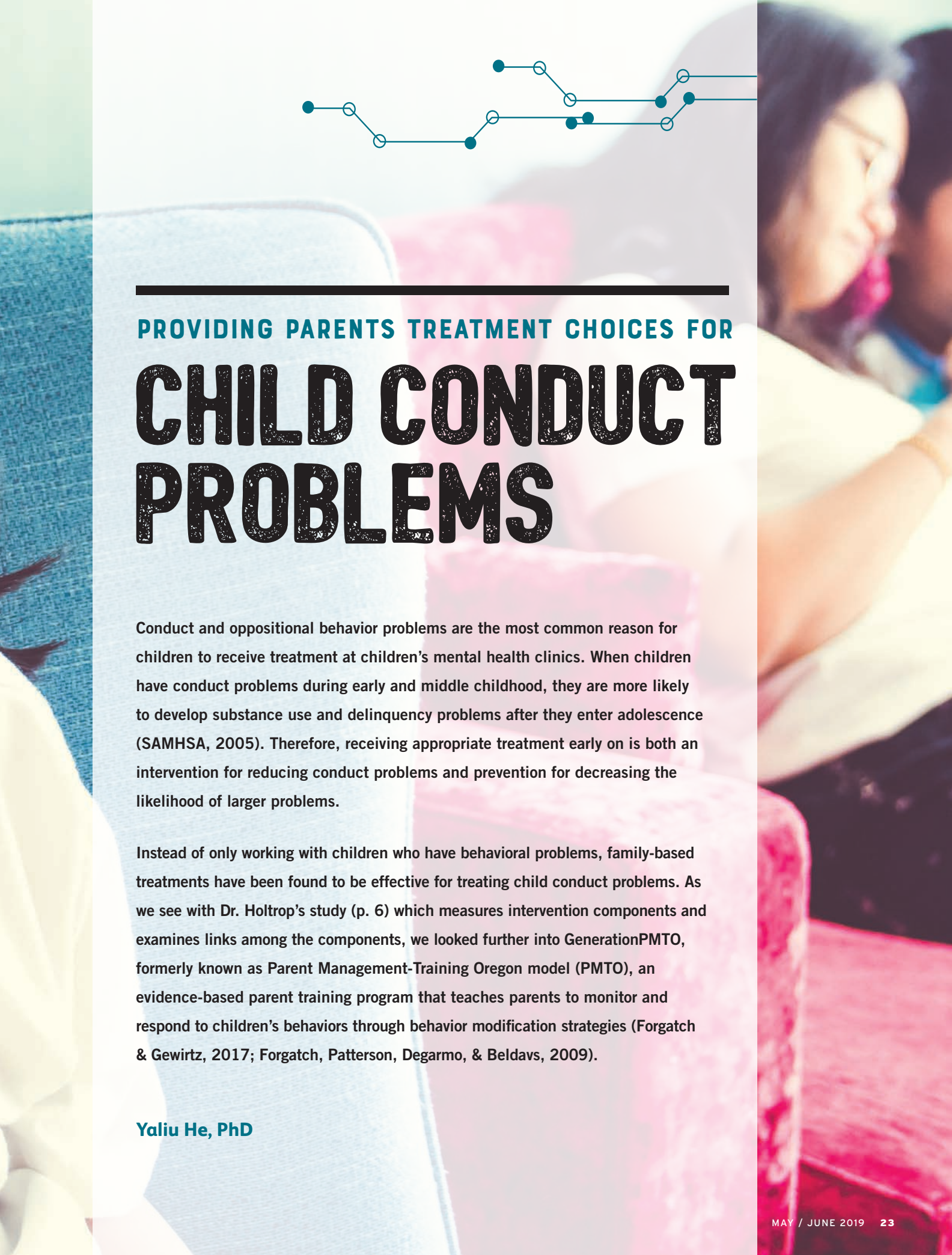


PROVIDING PARENTS TREATMENT CHOICES FOR

CHILD CONDUCT PROBLEMS

Conduct and oppositional behavior problems are the most common reason for children to receive treatment at children's mental health clinics. When children have conduct problems during early and middle childhood, they are more likely to develop substance use and delinquency problems after they enter adolescence (SAMHSA, 2005). Therefore, receiving appropriate treatment early on is both an intervention for reducing conduct problems and prevention for decreasing the likelihood of larger problems.

Instead of only working with children who have behavioral problems, family-based treatments have been found to be effective for treating child conduct problems. As we see with Dr. Holtrop's study (p. 6) which measures intervention components and examines links among the components, we looked further into GenerationPMTO, formerly known as Parent Management-Training Oregon model (PMTO), an evidence-based parent training program that teaches parents to monitor and respond to children's behaviors through behavior modification strategies (Forgatch & Gewirtz, 2017; Forgatch, Patterson, Degarmo, & Beldavs, 2009).

Yaliu He, PhD

The philosophy of the GenerationPMTO is that parents are children's best teachers and child healthy development is fostered through improved parenting practice. Therefore, only parents are involved in this program. Empirical evidence supports the effectiveness of the GenerationPMTO on reducing child internalizing, externalizing behaviors, substance use and delinquency (Forgatch & Gewirtz, 2017). However, there have been concerns regarding the low attendance rates and poor treatment outcomes in parenting intervention, especially for high-risk families, such as families with low socioeconomic status. **We suspected that one of the reasons is that the treatment is universally provided in a "one-size fits all" way, which does not address families' unique characteristics, needs and preferences.**

My team and I were interested in a personalized approach that tailors interventions to populations based on their characteristic, needs, responses, and preferences. Basically, we wanted to figure out what intervention works for whom under what circumstance. Several important concepts from the medical field including precision medicine, patient-centered care, and shared decision-making inspired the current research project. Patient-centered care (PCC) is defined by the Institute of Medicine (2001) as "a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care" (p. 7).

Because parents ultimately decide upon treatment for their children, we were interested in the question: Does providing parents with the treatment they prefer increase the likelihood to complete the treatment and have better treatment outcomes? We hypothesized that parents who are offered a treatment they want would feel empowered as they can make their own decision. We also hypothesized that offering treatment choices may address some of the families' logistical issues, such as lack of transportation and their comfort level of participating in an individual setting or a group setting. We felt these options could increase treatment attendance and better outcomes. Fortunately, PMTO has multiple delivery formats, including an individual in-person format offered at the clients' home, or at the mental health clinic and group formats. Therefore, we ran a pilot study in Michigan funded by the National Institute of Mental Health (with Abigail H. Gewirtz as the principle investigator) that used a doubly randomized preference trial to test if providing treatment choices enhances treatment attendance and outcomes.

We conducted this pilot project in three mental health clinics in Oakland County and the city of Detroit. The clinic intake staff informed families with children ages 4-12 years old seeking services for child conduct behavior problems the opportunity to participate in an intervention study. A total of 129 families met the study inclusion criteria and consented to participate. Research coordinators randomized them into either the no-choice group or the choice group. Four treatment options existed, including an individual family home-based PMTO, an individual clinic-based PMTO, a multi-family group PMTO, and child psychotherapy. Research coordinators provided a description of each treatment format to the families who were randomized to the choice group and invited them to select their preferred treatment. Those families then received their preferred treatment.

In contrast, those parents in the no-choice group did not know the treatment options. Research coordinators randomized them again into one of the four treatment options. Because of the doubly randomization design, the only difference between families in the choice group and the no-choice group was whether they were provided with a choice and received their preferred treatment. Therefore, if we were to find any significant difference between the two groups in terms of participants' attendance and outcomes, we could be confident that the difference is due to choice offerings. All therapists were providers at the clinics, licensed as psychologists, social workers, or marriage and family therapists. Therapists providing PMTO modalities were certified in PMTO and received weekly supervision. Families assigned to, or selecting, child therapy were treated by therapists trained in child psychotherapy.

We published three articles based on the findings of this study. In our first paper (He, Gewirtz, Lee, Morrell, & August, 2016), we found that parents in the choice group were more likely to complete the treatment than those in the no-choice group. It confirmed our hypothesis that providing treatment choices can enhance treatment attendance. In-home PMTO was the most preferred format. For our purposes here, I will focus on the method and findings of the second study, which was published in the *Journal of Marital and Family Therapy* (He, Gewirtz, Lee, & August, 2018). In this study, I examined whether providing treatment choices could

improve parenting practice, which is the proximal outcome for child conduct problems. We predicted that offering parents their preferred treatment would increase their sense of confidence for parenting and improve their adaptive parenting behaviors.

Parents in the study were on average 32 years of age and their children's average age was seven years old. Sixty-one percent of the parents were African American and 75% reported their family annual income was less than $20,000. Only 15.4% of children reported living with two biological or adoptive parents. Forty-eight percent of children lived in a single parent household. The research staff assessed changes in parenting skills through both parent self-report questionnaires and objective coding of videotaped parent-child interactions. One parent from each household filled out questionnaires that assessed their demographics, their sense of confidence as parents, and their psychopathology. Research assistants visited each family's home to videotape parenting behaviors while observing parent-child interactions. Those assessments were conducted three times: prior to treatment, post-treatment, and six months after completion. The three-time measurement provides rich information about the long-term effect of providing treatment choices.

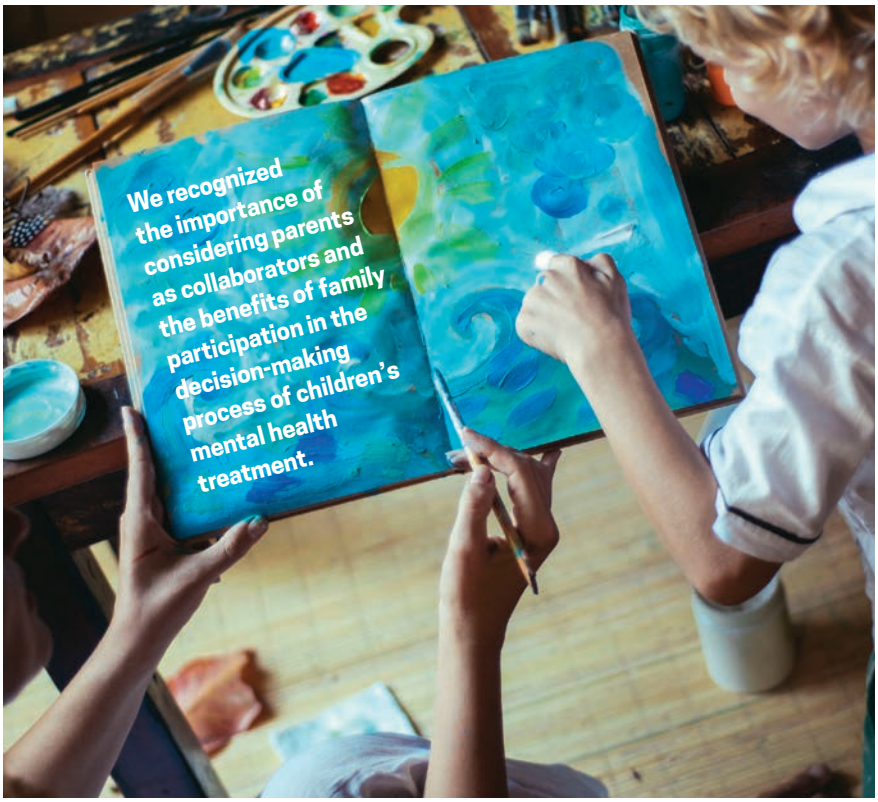
I used mixed-effects modeling to analyze the longitudinal data. Different from my hypothesis, I did not find any statistical difference in parenting outcomes between parents in the choice group and parents in the no-choice group. That means providing treatment choices was not directly associated with improved parenting practice. However, I discovered that families in the choice group who chose any of the PMTO formats showed higher confidence as parents and greater improvement in parenting skills than families in the choice group who selected child therapy.

Competence as parents and parenting skills improved steadily from pre-treatment to six-month post-treatment for parents who chose PMTO formats.

Interestingly, competence as parents and parenting skills improved steadily from pre-treatment to six-month post-treatment for parents who chose PMTO formats. In comparison, parenting skills and confidence decreased over time for those parents in the choice group who selected child therapy. We speculated that parents who were provided treatment options and chose PMTO may embrace more systemic thinking than those who chose child therapy. It is possible that parents who chose PMTO had a stronger motivation to improve their parenting skills and felt that they should be included in their child's treatment. Previous studies showed that mothers who believed that they were responsible for their child's behavior problems had better treatment outcomes than mothers who believed it is purely their child's problems (Morrissey-Kane & Prinz, 1999).

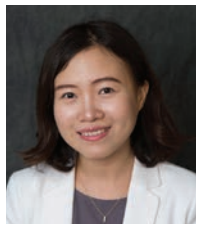
Additionally, there is a difference in effectiveness between the two treatments. PMTO has shown effectiveness in improving parenting practices and parental confidence, whereas there is less evidence for the effectiveness of child therapy on improving parenting skills. Therefore, when parents perceived themselves playing a role and were willing to receive evidence-based treatment to improve their parenting skills, providing choice can empower their self-efficacy and enhance their parenting practice. Because those parents make the treatment decision to improve their parenting, they are more likely to stick to the treatment and have greater gains. On the contrary, if parents choose child therapy over parenting intervention, they may only see the problems as residing within the child, and become less likely to make changes in themselves.

These findings suggest that providing treatment options that fit parents' values and needs alone may not lead to better treatment outcomes. It is plausible that a shared decision-making process between professionals and clients is needed. It is not unusual for parents to bring their children to see MFTs and want MFTs only to work with their children. For some, bringing a child to a clinic requires much less effort on the parents' part than going to the clinic themselves. Systemic therapists may respect clients'



preferences, however, we should also try to understand parents' beliefs about their child's treatment and help them see the benefits of family-based treatment. It is possible that a solid dose of child therapy may be helpful to reduce child conduct problems, but systemic treatment may bring changes in multiple family subsystems, which could maintain the positive changes.

To summarize, we recognized the importance of considering parents as collaborators and the benefits of family participation in the decision-making process of children's mental health treatment. This particularly applies to the participants of this study who had multiple stressors, such as poverty, ethnic minority, low parental education, and single parent status, and often showed low treatment attendance and poor treatment outcomes in community mental health settings. Empowering them to participate in the decision-making of their treatment may be useful to increase their self-efficacy and engagement. Notably, our third study reported benefits of providing choices on reducing child conduct problems (Gewirtz, Lee, August, & He, 2018). In addition, we acknowledged that the relationship between parent preference and treatment outcomes is complex. Providing families with decision aids and psychoeducation by MFTs may help them navigate these important choices. When multiple treatments and delivery formats are available in mental health agencies and the community, offering families the choice and providing information about the pros and cons of each option may increase participation and treatment outcomes. Because this is a pilot study, future studies should be conducted to replicate the findings.



Yaliu He, PhD, LMFT, is an assistant professor in the Department of Marriage and Family Therapy at Iona College, New Rochelle, NY. She is an AAMFT Clinical Fellow and Approved Supervisor. Her research interests include personalized intervention and the application of patient-centered care in mental health treatment. She is passionate to investigate client factors in the realm of common factors research.

Further information about the study can be found in: He, Y., Gewirtz, A. H., Lee, S., & August, G. (2018). Does providing parents choices matter? A double randomized preference trial in community children's mental health settings. Journal of Marital and Family Therapy, 33*(4), 716-729.*

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Family TEAM

Advocacy is an important element in nearly every field and business. Indeed, it took dedicated advocates in every state to ensure that Marriage and Family Therapy became a recognized, licensed profession. As the profession continues to grow and lead on mental health issues, AAMFT sought to harness the power of member voices and expertise to create a strong grassroots advocacy system. The Family Therapy Education and Advocacy Movement, or Family TEAM, is AAMFT's network of members interested in advancing pro-MFT policies at all levels of government.

The Family TEAM is free to join for any AAMFT member and TEAM members have a variety of participation options based on their interest area and time. Each state and Canadian province has a Family TEAM in addition to a U.S. federal Family TEAM to advance issues such as:

- MFTs in Medicare (Federal Family TEAM)
- MFTs in VA (Federal Family TEAM)
- MFT Provincial Regulation (Provincial Family TEAMs)
- Medicaid Recognition (State Family TEAMs)
- Major Insurer Recognition (State Family TEAMs)
- MFT Licensure Law Modernization (State Family TEAMs)

Additional advocacy issues are undertaken based on the needs of the state or province. The Family TEAM plays a vital role in defending the profession from groups that seek to delegitimize or prevent MFTs from practicing to the full extent of their education and training. In 2018, the Arizona Family TEAM successfully defeated legislation that would have delicensed MFTs and other mental health professionals.

Other Family TEAM successes include:

- Medicaid reimbursement for temporary licensed MFT in Iowa
- Medicaid inclusion for MFTs in Alaska
- Passage of legislation to maintain MFT representation on the South Carolina composite licensing board
- Over 12,000 advocacy messages sent to Congress in support of MFTs in Medicare
- Inclusion of MFTs in federal opioid legislation

These and other victories are not possible without members like you on the front lines with AAMFT. Prior advocacy experience is not needed to become a part of the Family TEAM, just passion for the profession. AAMFT's Government and Corporate Affairs staff work collaboratively with Family TEAM members to offer Family TEAM trainings, informational webinars, podcasts and more. A sampling of some of resources and activities available to TEAM members are:

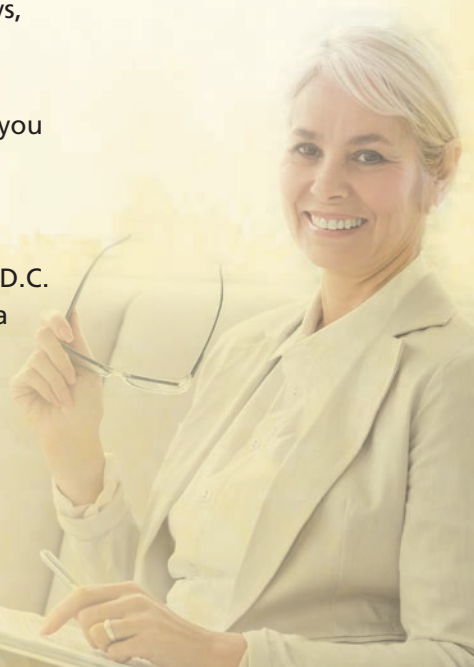
- Quarterly TEAM webinars – Stay tuned for the MFT Licensure Portability Webinar this winter!
- Family TEAM Discussion Forum
- Monthly newsletters with updates from TEAMs across the US and Canada
- Family TEAM Hill Visits
- Podcasts
- Resource Library full of content to share with legislators or other AAMFT members
- Annual Conference Events
- Advocacy Blog

Looking to get even more involved in MFT advocacy?

Consider a leadership role in your Family TEAM! Leaders help organize lobby days, represent the profession to policymakers, and more.

The Family TEAM in the below states are actively seeking members interested in leadership. Don't see your state? Email FamilyTEAM@aamft.org to find out how you can help in your state.

Alaska	Hawaii	Mississippi	Vermont
Arizona	Illinois	Nebraska	Virginia
California	Maine	New Hampshire	Washington D.C.
Delaware	Maryland	New Mexico	West Virginia
Florida	Massachusetts	Oklahoma	Wisconsin
Georgia	Michigan	Texas	Wyoming



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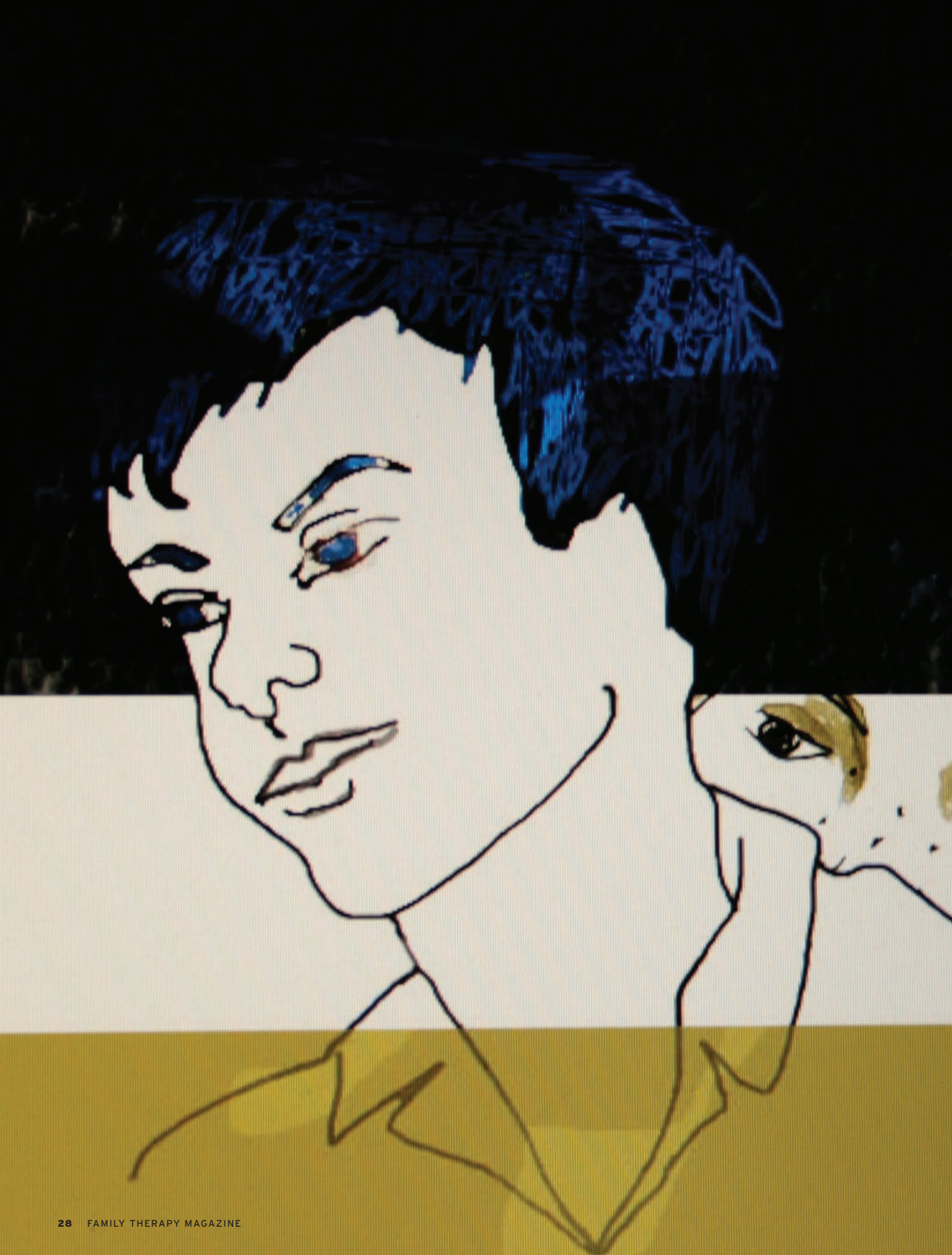
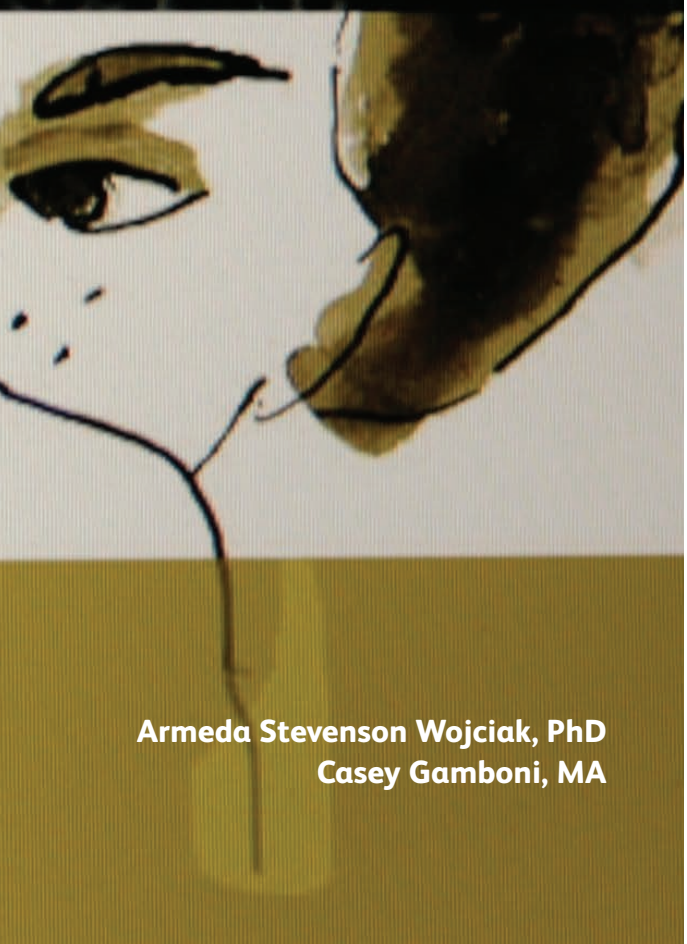


Considerations for Systemic Therapists Working with **Biological Parents in the Child Welfare System**



Armeda Stevenson Wojciak, PhD
Casey Gamboni, MA

In 2017, there were 4.1 million calls into child protective services regarding the welfare and well being of 7.5 million children in the United States (U.S. Department of Health and Human Services [US DHHS], 2019). Three and a half million children and their families were part of an investigation by child protective services. Over one million children and their families, who were not placed in foster care, received post response services from the child welfare system (USDHHS, 2019). Post response services can entail family preservation, family support services, and if necessary, foster care.

Understandably, most attention is paid to youth outcomes of those involved in child welfare; however, for the majority of cases, 56% of those placed in foster care, the primary goal is reunification with biological parents (Adoption and Foster Care Analysis and Reporting System [AFCARS], 2018).

Despite this goal, little research has centered around work with biological parents involved with the child welfare system. Working with these parents requires thoughtful action to understand the familial and environmental context surrounding their involvement with the child welfare system. Thus, creating an opportunity for couple and family therapists, as systems thinkers, to help navigate and improve outcomes for these children and families.

When considering the familial and environmental context of biological parents involved with child welfare, it is important to note that scholars have repeatedly demonstrated that parents who have been the victims of childhood abuse and neglect are more likely to have children who are also involved with child welfare (Berlin, Appleyard, & Dodge, 2011; Pears & Capaldi, 2001). The intergenerational transmission of abuse is difficult to disrupt even when parents have an intention to try and parent differently (McWey, Pazdera, Vennum, & Wojciak, 2012). Understanding how and why parents may experience difficulty in breaking the cycle requires an understanding of the complex impact child maltreatment has on adult functioning.

Acknowledging that parents who have abused or neglected their children are likely to have experienced their own type of child maltreatment is key to shifting our own perspective when working with these parents. This may be particularly difficult, as these parents are involved with the child welfare system because of suspected or confirmed child abuse and neglect of the most vulnerable in society. The child welfare system is designed, and rightfully so, to protect children, even if it is from their parents. However, operating from this lens only perpetuates the cycle of abuse; there is an awareness of abuse happening and intent to change, but how do they change and break the cycle? The application of a trauma informed lens helps couple and family therapists with this process by shifting the question of "what is wrong with this parent?" to "what has happened to this parent?" The shift in questions enables us to change our way of thinking about and working with parents. Hopefully, changing the dynamics leads to successful reunification for the family and outcomes are improved for parents, children, and the family. An application and sustained trauma informed lens require an understanding of current research to impact our clinical work.

Over the past two decades, there have been advancements in our understanding of the negative lifelong effects of adverse childhood experiences like abuse, neglect, and family dysfunction on later health outcomes (Felitti et al., 1998). The Adverse Childhood Experiences (ACEs; Centers for Disease Control and Prevention, 2019) study was the first to demonstrate in a large, predominately white and middle-class sample, that childhood trauma doesn't just go away, but it has lifelong effects on the body. Bessel van der Kolk's (2015) *The Body Keeps the Score* accurately reflects Felitti's findings and provides a great guide to understanding how the brain, mind, and body are all impacted by trauma. He also provides ways to work with those who have experienced trauma.

Advancements in neuroscience have demonstrated the impact that trauma has on brain functioning and development (Carrion & Wong, 2012; Glaser, 2000). Degregorio (2012) reviewed existing research surrounding the impact of childhood abuse and neglect on adults' brain functioning, particularly the social brain—the part that would be most active in responding to children and forming a secure attachment. Berthelot and colleagues (2015) examined the attachment styles of mothers who experienced child abuse and neglect, the attachment styles of their infants, and the role that reflective function had on their infants' attachment styles. Of the 57 women in the study, 68% reported having an insecure attachment style themselves, and 83% of the children in the study demonstrated an insecure attachment style. The authors also report a dose-response relationship, similar to those of the original ACEs study (Felitti et al., 1998), in that those with a greater number of different types of child maltreatment had a greater likelihood of having an unresolved attachment style.

One of the most significant findings of this study, particularly for systemic therapists working with this population, was that mothers who were able to consider the impact of their trauma, and how it has influenced

them, were less likely to have children with insecure attachment styles. This indicates the need to not only have a trauma informed lens, but to help parents understand how what happened to them in childhood could be impacting their current parenting practices. Seigel (2001) coined the term interpersonal neurobiology to discuss how attachment influences brain development and consequently our response to others. He pays particular attention to the role that integration—doing the work to bring the impact that trauma has into one's narrative—has on ones' well being (Seigel, 2008). As couple and family therapists, we can help biological parents do the work they need to bring awareness to the impact childhood trauma has had on their lives and how it is impacting their parenting.

In addition to an understanding of the neurological and attachment perspectives that may influence a parents' behavior, it is also important to consider what these implications mean for parents currently involved with the child welfare system. First, from a neurological perspective with a trauma informed lens, we would look at the parents' experience from a fight, flight, or freeze stress response. Having child protective services involved in your life, even if rightfully so, can be perceived as a threat by the parent and the body and mind respond accordingly. Their fight, flight, or freeze response may be activated. Experiencing trauma in childhood is associated with a more sensitive threat-sensitivity trait (Thompson, Hannan, & Miron, 2014). Applied to involvement with child welfare, fight might be realized as verbal or physical attacks on child welfare personnel or community providers. Flight might entail doing everything possible to avoid the situation, which might be turning to unhealthy coping mechanisms like substances, unhealthy relationships, or anything else that can get them away from their

Acknowledging that parents who have abused or neglected their children are likely to have experienced their own type of child maltreatment is key to shifting our own perspective when working with these parents.

feelings. Freeze may be depicted as not doing anything, not participating in any treatment, and possibly suffering from depression that is debilitating. Either one of these stress responses hinders their ability to effectively navigate the child welfare system and do the work that is necessary to be reunited or maintain custody of their children.

To further contextualize parents' experiences and how their stress response system may work, parents may also have to navigate a lot of providers to complete their case plan dictated by the child welfare system. For instance, depending on the reason for child welfare involvement, parents may need to participate in substance abuse treatment, individual therapy, domestic violence psychoeducation, parent training, and so forth. Depending on one's stress response system and existing conditions leading to child welfare involvement, one's ability to mobilize and do all that is necessary in the most productive way could be incredibly difficult. In my experience (Wojciak), one of my most impactful memories I had while working with parents involved with child welfare occurred when I called a mom to discuss mandatory services with her.

She answered the phone and sounded really down, and as if it were a lot of effort for her to talk. I talked to her about participating in a parent training program to which her caseworker had referred her. She said something along the lines of "What? I don't know what I am supposed to do. I have had multiple caseworkers all telling me what to do, and I don't know what to do to get my kids back. Is this even it?" I heard utter despair in her voice and then she hung up on me, not out of anger, but rather in a way in which she was accepting the fate of what was to happen to her as part of the child welfare system. I was never able to get a hold of her again, and often think what I could have done differently in my very brief conversation. While I did not and probably could not do anything differently in that instance, I could change the way I understand and interact with biological parents moving forward.

For those who have retained custody of their children, or whose plan it is for reunification, there is hope. A trauma informed lens in which we consider "what has happened to this parent" to understand how we can help them can completely shift the way we work with parents. Within the child welfare system, parents can be dehumanized. Yes, their children were in harm's way, we don't want to negate that, but if possible, we can use this lens to help reach the goal of reunification or prevent potential child maltreatment. Operating from the standpoint that a parent has likely experienced trauma, and recognizing the deleterious negative impact it has had on them, enables a different starting point to begin our work—a starting point that allows parents to be an important part of the healing process and one that is reliant on their engagement.

Lastly, looking at therapist characteristics, researchers who have examined successful parent/provider relationships report that parents who felt the provider was warm and supportive tended to rate the programs as more successful (Estefan, Coulter, VandeWeerd, Armstrong, & Gorski, 2013; Gockel, Russel, & Harris, 2008) as well as providers who were non-judgmental, positive, down to earth, honest, and had a good sense of humor (Salveron, Lewig, & Arney, 2009). Parents also discussed the hardships they experienced getting to mandatory services such as parent training. Such hardships include financial strain, transportation difficulties, being a single parent, childcare, and violence in the home (Bolen, McWey, & Schlee, 2008; Salveron et al., 2009).

Having a trauma informed lens that considers the parent's family of origin and contextual factors in their current life enables systemic therapists to have greater empathy, understanding, and ability to work with these parents within their unique life circumstances.

Armeda Stevenson Wojciak, PhD, LMFT, is an assistant professor in the Couple and Family Therapy program at the University of Iowa and a Clinical Fellow of AAMFT.

Casey Gamboni, MA, LMFT, will be graduating from the University of Iowa's Couple and Family Therapy Doctoral Program in the spring of 2019 and is currently on staff at the Family Institute at Northwestern University.

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Benjamin Caldwell, PsyD

What's New
in Family Therapy Ethics

Consensus about what makes for ethical professional behavior is a moving target. In the 1970s, roughly one in eight psychologists acknowledged having a sexual relationship with a client at some point in their careers. Today, with clear ethical standards prohibiting such relationships, and a greater professional awareness of the potential harms that result from therapists having sex with clients, fewer than 1% acknowledge ever having crossed that line (Pope, 2001).

Our ideas about good (or even minimally acceptable) professional behavior change in part based on research. Studies examine 1) therapists themselves, looking for shifts in opinions and behavior; 2) client outcomes, to learn more about how even well-meaning therapists can do damage; and 3) ethical standards, either to critique those standards or to discuss their application.

These studies can have dramatic impacts. Research on the harms of so-called "reparative" or "conversion" therapy—therapeutic efforts to change a client's sexual orientation—led AAMFT to produce a statement suggesting that reparative therapy on any client is potentially unethical (AAMFT, 2009). That statement, alongside similar conclusions from other organizations of mental health professionals, has been instrumental in legislative efforts around the country to ban licensed professionals from performing reparative therapy for minors. So far, 15 states, the District of Columbia, and several cities have done so (Movement Advancement Project, 2019).

Other studies are influencing how MFTs identify and resolve ethical issues in their work. In many cases, these studies seek or propose solutions to modern ethical dilemmas, rather than trying to identify a standard for what should be minimally acceptable. As such, they are often able to propose specific and useful techniques for resolving ethical issues that our existing ethics code may leave gray. Here are a few recent examples, intended to be a sampling rather than a comprehensive list. I've focused here on some areas where our shared understanding of what is best appears to be meaningfully evolving.

Participatory ethics

Some authors have encouraged ethical decision-making models that reconsider who has the knowledge most relevant to those decisions (e.g., Tarvydas, Vazquez-Ramos, & Estrada-Hernandez, 2015). While clients are of course not expected to know therapists' rules or limitations, these authors suggest that clients' voices and preferences deserve a seat at the table in ethical decision-making. Allowing client voices to influence the process can help ensure that MFTs and supervisors keep the human consequences of their decisions at the forefront, rather than reducing ethical decision-making to an academic exercise.

Resolving ethical dilemmas

My colleague Dana Stone and I wrote an article proposing a scoring method to help facilitate ethical decision-making (Caldwell & Stone, 2016). This method is most useful when our ethical standards are unclear, or when multiple standards appear to conflict with one another. For example, while the AAMFT code takes a default position of respecting individual confidences, it leaves ambiguity

when an MFT is considering whether to inform the parents of an adolescent client about the adolescent's non-suicidal self-injury (specifically in our example, cutting).

In our article, we suggest developing multiple potential courses of action, and then evaluating them based on how well they adhere to the general ethical principles of autonomy, beneficence, non-malfeasance, justice, and fidelity (Beauchamp & Childress, 2009). With the adolescent in our example who is cutting, we determine that maintaining confidentiality appears to be more consistent with our field's general ethical principles than disclosing would be. The intention is not precision in measurement—these are, after all, judgment calls—but rather to help facilitate the development of consensus about a preferred course of action in consultation, teaching, or supervision.

Competency

As our understanding of diversity continues to be more inclusive, MFTs are thoughtfully examining how we deliver our work to different populations.

The technology supporting therapy via telehealth continues to rapidly improve. AAMFT has released a Best Practices document for MFTs wishing to work with clients via telehealth (Caldwell, Bischoff, Derrig-Palumbo, & Liebert, 2017). While this document does not change any of the ethical standards for MFTs wishing to use technology, it does represent a useful operationalizing of those standards. Given that MFTs' reluctance to embrace technology stems in part from anxieties surrounding unclear legal and ethical guidelines (Blumer, Hertlein, & VandenBosch, 2015), this document may represent a meaningful step in the right direction. It was further expanded upon by Wrape and McGinn (2018), offering specific case examples to demonstrate the unique ethical issues that can arise when couple and family work is done via technology.

The intention is not precision in measurement—these are, after all, judgment calls—but rather to help facilitate the development of consensus about a preferred course of action in consultation, teaching, or supervision.

We are also closely examining the ethics of working with populations whose ideas and values radically differ from those of the therapist. Sherbersky (2016) wrote about working with religious fundamentalist families. She suggested that MFTs working with such families need to deeply and actively question their own ideas about religious fundamentalism—including whether they believe fundamentalism has pathological roots.

Emerging issues

As other mental health organizations revise their codes of ethics, a handful of issues have emerged that are not currently addressed in the AAMFT code.

Death with dignity. The current American Counseling Association Code of Ethics (ACA, 2014) allows counselors to maintain confidentiality (with some caveats) if a terminally ill client is planning to die by suicide in accordance with a "death with dignity" law. While the AAMFT code defers to applicable laws surrounding confidentiality, this leaves ambiguity in states that have death with dignity laws but do not have corresponding confidentiality protections (therapists are often required to intervene, including breaking confidentiality if needed, to prevent a threatened suicide). An MFT wishing to respect a client's legal right to die by suicide may still believe they are ethically bound to attempt to prevent the client from carrying out their plan.

Client anonymity. In California and some other locations, applicable law requires therapists engaging in telehealth to gather the full name of each client at each telehealth session (California Code of Regulations, 2016). How does this impact MFTs working on crisis lines or in other contexts where clients wish to remain anonymous? On one hand, some crisis services argue that what they are providing is, by definition, not therapy. When services are provided solely on a crisis basis, the goal is to get callers to a safe place, not to engage in a therapeutic relationship over time. On the other hand, some clients would surely prefer to remain anonymous in a lasting therapeutic relationship. Doing so may allow them to be more honest about embarrassing topics.

The current NASW Code of Ethics comes down firmly on the side of disallowing anonymous services (NASW, 2017). In contrast, the AAMFT online best practices document specifically acknowledges that it is not intended to prohibit anonymous services. Our ethics code does not specifically address the issue, though it may be more difficult for an MFT to establish that they had obtained informed consent from a client when they do not have identifying information for that client.

Emotional support animals. The use of emotional support animals in travel and housing situations as grown rapidly. Flight attendants have raised concerns about ESAs' impact on passenger safety, considering how often ESAs prove disruptive or even dangerous on flights. Concerns have

also arisen about therapists' potential complicity in providing ESA letters to clients who simply want to save money on keeping their pet with them, and do not actually need an ESA. Current rules do not specify what assessment criteria a therapist should use when determining whether to write an ESA letter. As such, MFTs are often unsure whether to write such letters at all, and if they do, what assessment criteria to use (Spotts-de Lazzer, 2015).

We all seek to do good as MFTs, even as our definitions for that good may differ. In a more pluralistic professional world, it may be increasingly difficult for MFTs to find consensus around a set of shared professional values. This underscores the importance of continued discussion and refinement of our ethics code as an imperfect, living document. As is the case for the families we serve, our understanding of the best ways to do good are always adapting to a changing world.

Benjamin E. Caldwell, PsyD, is the education director for SimplePractice Learning (https://learning.simplepractice.com). He is a licensed MFT, AAMFT Clinical Fellow, and former member of the AAMFT Ethics Committee based in Los Angeles.

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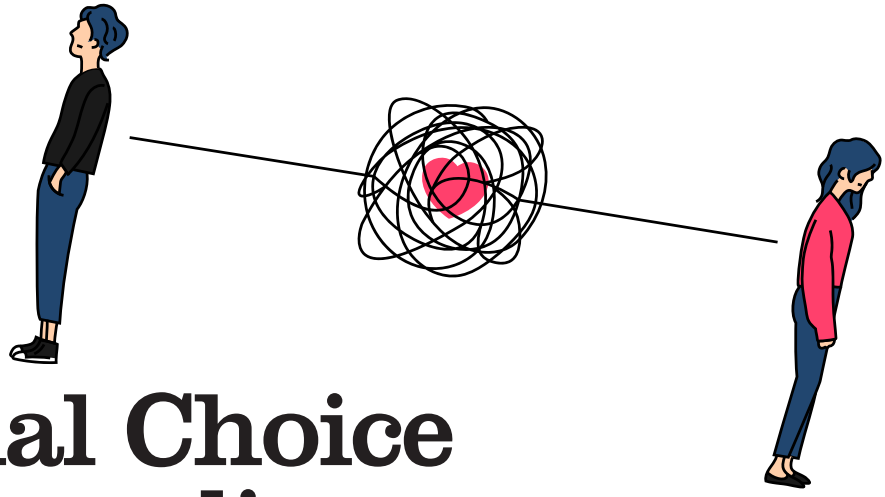
Blake Griffin Edwards, MSMFT



The Crucial Choice Every Struggling Couple Must Make

When clients enter psychotherapy, we cultivate therapeutic space where they may face their troubles in a way that is helpful and, ultimately, growth-inducing. Within the therapeutic crucible, our past experiences intermingle with temperamental predispositions, hopes, fears, and hesitations—intertwining, evolving, and ever influencing our thoughts, emotions, and behavior.

Relational anxiety has power to foster growth. Experiential therapy, at its best, has the potential to act as a solvent, and problem anxiety a dissolvable solute. In the process of attunement, evocation, and reprocessing, the toxicity of the solute is disarmed with the resulting figurative biochemical solution acting to enliven the growth processes inherent within the relationship itself. There is certainly an art to the science; a burgeoning field of neuroscience reveals there is also certainly science to the art.

Yet, simultaneously at work—hypnotic, self-fulfilling preconvictions and perseverating interpersonal habits have power to paralyze our capacities for relational reflection and emotional responsiveness. It's not easy to listen humbly and negotiate vulnerably through the tremble of raw emotion. Nevertheless, when empathy is experienced, togetherness is more likely to be experienced, even in conflict. Dr. Sue Johnson (2008), a leading expert on couples therapy, wrote of fighting couples, "Both are terrified; they are just dealing with it differently. Trouble is, once they start this blame-distance loop, it confirms all their fears and adds to their sense of isolation" (p. 47).

Oliver and Sophia reported a "same" week and that "nothing" had improved. When asked what it would look like to take steps toward one another—their mutual goal—they both shrugged in uncertainty. Neither had any preference for how we spent the day's session, no complaints, and no feedback whatsoever. Oliver appeared very sleepy again, drinking an energy drink—he usually brought either an energy drink or coffee to session and typically nodded off anyway.

At one point, I asked Oliver whether he had any desire to fight for his marriage. He responded that he had "tried once" to do so and nothing worked. When pressed, he struggled to produce any narrative evidence of his "fight" except for a special gift he had given to her a number of years ago, which she presumably received with insufficient appreciation. He made it clear he would make no change in his behavior while simultaneously reporting he wanted the marriage fixed. He believed Sophia was responsible for "getting over it," yet he harbored resentments for her infidelities while excusing his own.

Oliver refused to make any real, active choice toward his wife, and she expressed being paralyzed in the relationship—uncertain how, albeit willing, to regain trust, which she pointed to as their singular hurdle if the marriage were to be rebuilt. She would wait for him to initiate the leap. Oliver remained silent and began nodding off near the end of session, at which point I leaned over and told him, "You may want to take a few sips of your drink."

I posed solution-focused, intimacy-building questions to stir opportunities for Oliver and Sophia to begin to take

steps toward one another, yet both seemed frozen. Session after session, I observed emotional pain; attempted to coach Oliver to acknowledge Sophia's or his own; nudged both toward any semblance of vulnerability; attempted to join with Oliver, the most resistant member; then emboldened Sophia in spite of Oliver. Yet again and again, I watched Sophia look at Oliver, asking, "Nothing?"

The perceived provocations and failures of the ones we love have power to overwhelm us and paralyze intimacy. Couples therapist Terry Real (2011) has cautioned that too often we move from personal disempowerment to personal empowerment. We must learn to cultivate relational empowerment.

During our ninth session, Oliver shared how his 12-year-old daughter, Joanne, had come home one day and balled up on the couch crying. He shared that in those instances he has no idea what to say or do so he just gives her space, but later that day he spontaneously took her to the mall and paid for her to get a makeover. Her comfort became his joy, and her cold distance on the ride there was a stark contrast from the chatter and banter they enjoyed on the way home. He said he "felt much closer to Joanne." I reflected that in this anecdotal story he may have revealed something of the answer to the burning question: "What might it look like to take a step toward Sophia?"

By the end of the 10th session, I saw no steps being taken toward one another. I questioned whether either was prepared to make a choice toward the marriage or whether this was an empty effort.

I essentially challenged that the velocity of the relationship was moving ahead whether or not they made active decisions. The session ended near-silently, as it had in previous sessions, with Sophia warmly thanking me with eye contact and a handshake and Oliver sleepily picking up his drink and walking toward the door, barely snagging my offer of a handshake as I confirmed, "See you next week?" They spoke in unison: "Yes, we'll see you next week."

Our peace is as fragile as our pride is impenetrable. Being emotionally responsive is about our capacity to understand and meaningfully respond to the individualized needs of our particular partner in particular moments of need.

The couple appeared ambivalent about whether to take active steps toward one another. Both seemed unwilling to engage together in interventions aimed toward cultivating mutuality, validation, or connection in their relationship.

Our peace is as fragile as our pride is impenetrable. Being emotionally responsive is about our capacity to understand and meaningfully respond to the individualized (read: quirky) needs of our particular partner in particular moments of need. Dr. Ted Huston (Huston, Caughlin, Houts, Smith, & George, 2001) at the University of Texas studied predictors of divorce and concluded that when marriages fail, it is not increasing conflict that is the cause. It is decreasing affection and decreasing emotional responsiveness.

By our 16th session, Oliver and Sophia had maintained their ambivalence, and in the last minutes of the session, Oliver revealed that he had participated in therapy sessions to appease Sophia for the sake of their daughter but had no desire, hope, or intention toward the marriage. Only Sophia returned to my office thereafter.

Sometimes couples do not take the necessary steps toward one another. They allow emotional infection to spread in spite of medicine they are fully capable of administering. Neither understanding nor forgiveness, healing nor intimacy is for the therapist to cajole or control. The couple, together, must first make a crucial choice—that is, to engage and, therefore, to risk vulnerability at the risk of further pain. Only within the risky space shall any chance for hope, healing, and growth remain.

Note: Identifying names and details have been altered to protect client privacy.

Blake Griffin Edwards, MSMFT, LMFT, is behavioral health director at Columbia Valley Community Health in Washington State and author of "The Empathor's New Clothes: When Person-Centered Practices and Evidence-Based Claims Collide" in *Re-Visioning Person-Centred Therapy: Theory and Practice of a Radical Paradigm* (Routledge, 2018), and the Children's Behavioral Health Integration and Value Transformation Toolkit (WCAAP, 2018). His writing has been featured by the Association for Family Therapy and Systemic Practice in the UK, the Association for Humanistic Psychology in Great Britain, the Irish Association for Counselling and Psychotherapy, and the American Academy of Pediatrics. Edwards is a Clinical Fellow of AAMFT.

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