MAY/JUNE 2016

ftm
FAMILY THERAPY MAGAZINE
THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

Practice Issues Today and Roles for MFTs

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FAMILY THERAPY MAGAZINE
ftm

> A dandelion rooted in a field is labeled a common weed or a thing of beauty—depending on perspective—or the colloquial "eye of the beholder." If I pluck it from the earth, spread its transparent orb with hearty breath, making a wish in superstitions of childhood, or if the wind whips it from its place, as wind inevitably does, the dandelion's seeds scatter. The seeds pocket themselves in air and disperse. Whether I tamper with its trajectory or leave it untouched, the dandelion scatters itself from field to field. The scattering continues, whispering by, tossing its seeds wherever it drifts. Seeds spill, planting themselves in systems that further its reach. Everything is connected. p.34

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LETTERS TO THE EDITOR

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

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A MESSAGE FROM THE PRESIDENT

Leadership: Expectations and Futuristic Considerations

In the January/February issue, I wrote about the business of governance with the intention of providing members with information about how the Board of Directors and Executive Director work together to ensure that the business of the association is conducted well. One of my passions is responsible "ownership" of the profession, which I believe requires an ever-growing understanding of the field as a whole, including the role and function of professional associations. To that end, I am continuing with the theme of governance, but with a different emphasis: What are the duties and responsibilities of those who serve, and what do those have to do with your membership?

No matter the level of leadership service, those who serve on boards (whether for-profit, non-profit, or public) have three legal fiduciary obligations. These include the duty of care, duty of loyalty, and duty of obedience. I freely admit that, as a newly elected board member, hearing about these for the first time—especially the duty of obedience—was disconcerting. I didn't like the "title" of that last one, and more importantly, did not realize these were not specific to AAMFT. These legal obligations are so important that each year, the AAMFT staff, President, and President-Elect provide training for incoming board members about what these mean as part of new board member orientation and review them as appropriate throughout the year. Failure to abide by these legal duties can have very real legal consequences for the individual and association.

Basically, fiduciary duties require that all those in positions of responsibility in associations, whether volunteers or employed staff, "act reasonably, prudently and in the best interests of the organization, to avoid negligence and fraud, and to avoid conflicts of interest" (Tenenbaum, 2002; ASAE). In all work that is done, up to and including the strategic and generative levels, the well-being of the organization as a whole has to be considered. While a full discussion is beyond the scope of this column, a brief description of the three obligations involved in fiduciary duty may provide a better understanding how fiduciary responsibilities connect with the strategic emphasis of AAMFT as a corporation. For those of you who, like me, always want to look things up yourselves to check accuracy or to get more information, the language used in this column is common. You can find it in AAMFT's governance documents, but you will also find more detail with a quick internet search.

The *duty of care* is a broad one. In essence, it is the obligation to act in a way that an ordinarily prudent person in a similar position would act under similar circumstances. The last part of that sentence is important. It is not sufficient to consider what *anyone* else would do—it is what someone in a similar position and similar circumstance would do. Mistakes may happen, but there must be a reasonable basis for our good faith actions. The *duty of loyalty* has to do with giving undivided allegiance to the association when making decisions that impact the organization. Other interests cannot be put first. Thus, when those

in positions of responsibility make decisions, they are required to put the long-term well-being of AAMFT ahead of their own preferences. For that reason, potential or perceived conflicts of interest must be disclosed so that a determination can be made about whether a real conflict of interest exists. Real conflicts of interest must be avoided. The *duty of obedience* refers to the responsibility to act in accordance with the association's articles of incorporation, bylaws, and other governance documents. That is one reason it is so important that division charters and bylaws must be in compliance with those of AAMFT.

Beyond these legal duties, there are other important facets of governance that are important as we think about responsibility for and to the association and its members. As noted in a previous column, the AAMFT Board focuses on long-range strategic vision and generativity. We think about what we *will be doing* for members and for the field in the future in addition to monitoring and assessing what we are doing today. An article in *Association Now* addresses the key role of foresight and "disciplined focus on the future" (De Cagna, 2016). The author pointed out that denial of dramatic and rapid changes that are impacting professions and associations will significantly limit the ability of associations to thrive. De Cagna indicated that we must recognize transformations that are happening in order to have strategic legitimacy. We should be forward-looking and ready to learn.

What does this have to do with your membership? What immediately comes to mind is that decisions being made today are made with these fiduciary responsibilities in mind. Assessment of programs is a constant process that allows the Board and Executive Director to check ourselves about behaving prudently in the present as we plan for the future. Deliberate attention to the future and thinking about what member needs will be is critical. In other words, are the decisions we are making today good for the long-term and strategic position of the association, its members, and the field? Will these decisions allow the association, members, and the profession to thrive?

I believe that enhancing our knowledge of how associations can and should work optimally is one part of responsible "ownership." How can you use information about fiduciary responsibilities to help you thrive in your service to, personal responsibility for, or engagement in the association in the field? How can you engage in disciplined focus on the future as you think forward about your career, the association, and the profession?

Warmly and with excitement about the future,

- Marvarene Oliver, EdD, LMFT, LPC

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AAMFT COMMUNITY www.aamft.org/Community // **AAMFT RESEARCH & EDUCATION FOUNDATION** www.aamftfoundation.org

NOTEWORTHY

THREE QUESTIONS

Martha Teater, MA

WHAT IS ONE AAMFT BENEFIT OR SERVICE THAT YOU FIND HELPFUL?

I use the TherapistLocator listing. Being listed on TherapistLocator brings referrals and inquiries without me having to lift a finger. People who visit the site can easily search for me by name or location. Searchers see my profile pop up, along with my photo and information about my practice. This has been a solid way for me to enhance my referral base in a way that's easy, low maintenance, and free.

WHAT ARE SOME OF THE BENEFITS IT PROVIDES?

TherapistLocator provides an easy way to highlight experience and skills for people searching for a therapist. It is a simple, yet powerful and effective means of showcasing your particular areas of interest for clients. It can also boost your level of exposure. Plus, prospective clients have the security of knowing that as a part of TherapistLocator, I adhere to the AAMFT Code of Ethics and I'm a member of this esteemed professional body.

HOW CAN A MEMBER START USING THE SERVICE?

There are over 15,000 AAMFT members already on TherapistLocator. If you aren't one of us, please join in! It only takes a few minutes to create your profile and start receiving referrals. About 60,000 people visit the site each year. The sooner you sign up, the sooner you'll start seeing results. Go to TherapistLocator.net and select the "Professionals" tab to get started.

Notice from Erin Schaefer, Elections Council Chair, regarding the 2016 AAMFT Preliminary Slate:

An individual on the slate has withdrawn and an alternate candidate has been named. The revised Preliminary Slate is shown below. The council is pleased to announce the preliminary slate for the 2016 elections.

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Timothy F. Dwyer, PhD
Shelley A. Hanson, MA

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Carl F. Greenberg, MS

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Sharon Y. Ramsay, MDiv
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Kami L. Gallus, PhD
DeAnna Harris-McKoy, PhD

COAMFTE
Elizabeth B. Fawcett, PhD
Dale Hawley, PhD
Anne M. Prouty, PhD
James J. Ungvarsky, PsyD

Q&A

How do I access my student liability insurance?
Generally, within 7 to 10 business days of processing a new student application, the insurance company AAMFT endorses, CPH and Associates, sends the student policy via email to the address provided on the application. At that time, student members will also be able to pull a copy of the student liability insurance policy from CPH's website. To access your student policy online, go to CPH's website at www.cphins.com, select "look up my policy documents" and search by personal information. If unable to access your policy, you can also reach them at (800) 875-1911 and request that they send you another copy. AAMFT does not retain a copy of your policy, nor is it available directly through our website.

DATA NOTE

Homeless with Mental Illness

578,000
Total homeless in United States

257,300
of the 578,000 have Mental Illness or Substance Abuse

119,800
Homeless with Mental Illness in Canada

520,700
Inadequate Housing with Mental Illness in Canada

SOURCES: SAMHSA.GOV AND THE HOMELESS HUB

DIVISION ADVOCACY

Interested in advancing the profession? Join AAMFT's Family TEAM to help advance our issues at all levels.

www.aamft.org/familyteam

In several states, the 2016 legislative sessions have already ended. Below is an overview of some of the division advocacy accomplishments.

FLORIDA: The Florida division supported two bills that made it through the legislature and were signed into law by the governor in March and April. One bill, **House Bill 373** makes several changes to the laws concerning the registration and regulation of MFT interns. The second bill, Senate Bill 12 makes several important changes to the Florida Baker Act, the state law governing the involuntary commitment process. One change under **Senate Bill 12** will allow LMFTs and other licensed mental health providers to sign a certificate requesting an emergency assessment or admission. Previously, only a physician could issue such a certificate.

HAWAII: The division succeeded in accomplishing its 2016 advocacy goal by passing legislation that changes the title of the MFT license. The official title of the MFT license in Hawaii is currently "marriage and family therapist." To avoid confusing the public regarding whether an MFT is licensed or not, the Hawaii division supported legislation**, Senate Bill 2333**, that would add the term "licensed" in front of the "marriage and family therapist" designation. This bill passed the legislature and was signed into law by the governor on April 28.

IN HAWAII, A BILL WAS SIGNED INTO LAW THAT ADDED THE TERM "LICENSED" IN FRONT OF THE MARRIAGE AND FAMILY THERAPIST DESIGNATION.

MISSOURI: For several years, the division has supported legislation to add MFTs as Medicaid providers. Unfortunately, the state Medicaid agency has refused to add LMFTs as Medicaid providers, and has provided legislators with an unrealistic estimate of the cost of adding MFTs as Medicaid providers. This year, due to this opposition, the division supported legislation that would require the state to perform an analysis of the cost impact to reimburse MFTs as Medicaid providers. The provision requiring this study was included in a larger appropriations bill. This bill passed the legislature. On May 6, the governor signed this legislation into law.

Congratulations to the divisions on these accomplishments!

FOUNDATION *Chat*

AAMFT RESEARCH & EDUCATION FOUNDATION

The AAMFT Research & Education Foundation asked Development Committee member Linda Schwallie to contribute her thoughts on topics in practice today. Schwallie is a Wisconsin Licensed Professional Counselor and a Wisconsin Registered Nurse specializing in individual, couple, marriage and family therapy. With over 30 years of experience, she currently maintains a private practice working with a broad spectrum of clients. She shared with AAMFT some of her experiences with medical family therapy.

"I'M SO SCARED," she murmured softly, and her eyes filled with tears. I had the privilege of working with this woman and her husband intermittently in earlier years when she was diagnosed and successfully treated for cancer. She returned to therapy when she learned her cancer had aggressively re-occurred, and she was facing a shortened life span. She was a wife, mother, grandmother, good friend, and community activist. She anticipated the loss of those roles, as well as the loss of sharing relationships and building ongoing memories with family and friends.

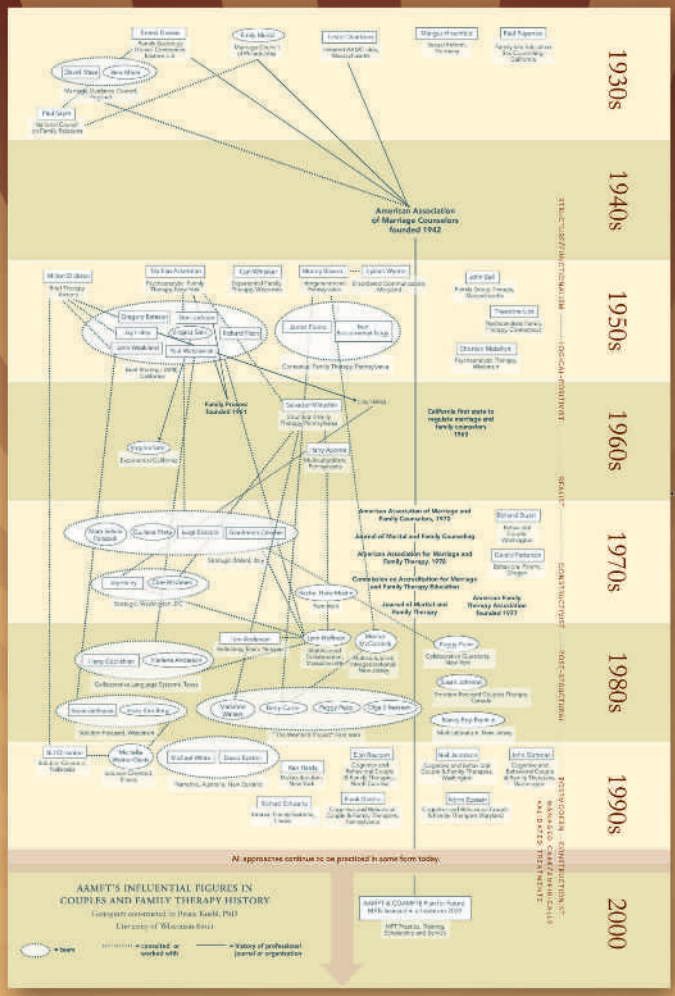
I continued to work with this woman, her husband, their adult children and their families. They celebrated family relationships, special times and connected with their social, emotional, and spiritual support networks.

Medical family therapy is one component of my private practice of marriage and family therapy, and this case is an example of a kind of health challenge that might bring individuals, couples, and families into my office. Other capacities include clinical work with women and couples experiencing fertility challenges, pregnancy and/or infant loss, perinatal depression, or more broadly, individuals and families experiencing chronic or acute illness or special needs of a family member. I appreciate, depend on, and integrate the evidence-based research and education informing my clinical work in these areas.

I support the AAMFT Research & Education Foundation because it provides a proactive focus on evidence-based education, research, and global outreach within the marriage and family therapy community. Research equips us as marriage and family therapists with the tools to provide the highest level of client care; education provides leading edge learning opportunities to keep us at the forefront of the field; and outreach facilitates our working alongside each other as MFTs, as well as with AAMFT in advancing the field. I encourage you to join me in making a commitment to the MFT profession and the AAMFT Foundation.

Linda Schwallie, LMFT, LPC, RN
AAMFT Clinical Fellow and Approved Supervisor
AAMFT Foundation Development Committee Member
www.aamftfoundation.org

FAMILY THERAPY PIONEERS
Genogram Poster



Constructed by Dr. Bruce Kuehl, this poster is derived from the genogram that was created for the September/October 2008 issue of *Family Therapy Magazine.* The issue has long sold out, but now you can get the genogram in poster size!

The poster includes many of the most influential leaders in the couples and family therapy field across history. It is an excellent resource and reference for MFT instructors and students. This vertical poster is 24x36 inches. Non member price is $30. Members pay only $25. Shipping is free.

Order now at www.aamft.org/poster.asp

Disability as a Cultural Experience

The 2010 Census revealed that nearly one in five Americans has a disability, suggesting people with disabilities comprise one of the largest marginalized populations in the United States (2012). Yet, people with disabilities experience significant silencing and invisibility.

Parisa Emam, MS

Models of disability

Activists behind the Americans with Disabilities Act (ADA) created a global standard for disability access and civil rights over 25 years ago. Despite this achievement, the U.S. culture at large continues to view disability as solely a medical, rather than cultural, phenomenon. This is especially relevant to note in the field of mental healthcare, as disability can be situated in a medical context and often remains absent from conversations about social inequity. Couple and family therapy systemic lens, which emphasizes context and relational interaction, can expand the cultural competency of the healthcare system by creating space for disability as a social experience.

Disability scholars illuminated the dominant discourse surrounding disability (Lewis et al., 1975), naming it the medical model of disability. The *medical model* suggests that an individual's physical condition causes their disability. For example, a client's cerebral palsy is viewed as a medical issue that limits the client's ability to function in day-to-day life. As a result, the disability becomes a problem residing within the individual. While the medical model of disability prevails in U.S. culture, couple and family therapists must call into question any framework that pathologizes the individual rather than attending to contextual factors.

In contrast with this medical model, the *social model* emerged as a subjugated story of disability. The social model posits that external barriers limit participation in society and foster a climate of oppression. It is these barriers that actively disable individuals, rather than their physical condition. Examples include a client using a wheelchair who might be disabled by a building entrance with no ramp; widespread prejudice about the suitability of disabled people as romantic partners; or discriminatory hiring practices in the workplace. In bumping up against constant inaccessibility and inequality, people with disabilities can be viewed through the social lens of "encountering problems rather than having a problem" (Sue & Sue, 2013, p. 51).

We can broaden our understanding of illness and disability by zooming out to examine macrosystemic influences on health.

Disability as a social phenomenon also encourages the view of disability as a cultural experience. By expanding the view of disability to include cultural identity, therapists acknowledge client experiences that are unique to marginalized group membership. For example, a therapist can recognize that a client's identification as Deaf (with a capital D) denotes that they belong to Deaf culture, a community with its own language, history, and social norms. Additionally, this affiliation between disability and culture reminds therapists that disabled people as a community experience prejudice, discrimination, and daily slights. There must be recognition that people with disabilities experience microaggressions. Sue and Sue (2013) use the term *microaggressions* to define everyday messages that communicate inferior status to marginalized individuals and reinforce their otherness, regardless of intention. Knowing this, mental health practitioners must acknowledge that a client's most painful and challenging experiences with disability may have less to do with their physical condition than with their experience of microaggressions.

Medical family therapy (MedFT) and disability

The emerging field of MedFT illuminates the role of family systems in disability and illness. Yet, the field grants little space to the concept of disability as a cultural experience. In a review of MedFT literature from 1965 to 2004, Linville, Hertlein, and Prouty Lyness define MedFT as a systems-informed, biopsychosocial-spiritual approach to care that spans clinical disciplines (2007). The authors identify common themes that emerge from the body of MedFT research, including the correlation between a client's significant relationships and their physical health. In particular, Linville and colleagues cite several studies that identify a link between relational quality and physical well-being (2007). As systems therapists, I believe we ought to expand beyond the microsystemic level of interpersonal relationships. We can broaden our understanding of illness and disability by zooming out to examine macrosystemic influences on health. For example, how does dominant cultural discourse surrounding illness and disability interact with the family system? How do constructs like microaggressions, societal barriers, and structural inequality affect our clients' relational well-being? The social model of disability can be an asset in this expansion of MedFT, as it already provides a framework for understanding disability in the context of social systems.

Clinical approach

Despite the overwhelming size of the disability community, family therapy students receive scant amount of training in working with this population from a cultural lens. Given that the term "disability" encompasses psychiatric, cognitive and developmental conditions in addition to physical conditions, students can expect to work with clients

with disabilities across the span of their careers. Thus, they would benefit from specific training and supervision surrounding disability culture. Couple and family therapy programs can look to experts in the disability community for guidance in incorporating culturally-relevant course material. This may include collaboration with the university's disability studies program, mental health providers who specialize in working with disability, or a local disability organization or ADA chapter. Training must emphasize intersectional issues in the disabled community, as clients with disabilities are more likely to live in poverty, experience abuse, and face barriers to needed services.

Additionally, family therapy programs must seek out—and sufficiently accommodate—students with disabilities. Programs must dismantle barriers that prevent disabled students from applying to, attending, and succeeding in higher education. As with any marginalized group, disabled people have unique insights and lived experiences to contribute to therapy and the field as a whole. For example, as a disabled therapist, I have received referrals from clients who preferred to work with a person with a disability. Clients have shared that one of the most meaningful aspects of our therapeutic relationship is my ability to empathize with disabled existence.

Furthermore, couple and family therapists can attend to self-of-the-therapist issues to identify implicit biases against disability. The dominant cultural discourse in the U.S. equates disability with poor quality of life. Therapists must examine their own biased associations between disability and inadequacy, abnormality, and fear of mortality. By unveiling the hidden messages we have absorbed about disability as something to be concealed, cured, or eliminated, we dismantle harmful beliefs that impede effective work with our clients. I envision my attendance to self-of-the-therapist issues in the room using Eve Lipchik's "dual track thinking" concept (2002). While one track of my mind engages with client data, the other attends to my own cognitive and emotional responses to the data. For example, one track may register a client's comment "Nobody will want to be my partner because of my disability," while the other track notices responses such as, "I feel sad that this client does not yet have a sense of disability pride; I want to challenge this belief without minimizing her lived reality of being overlooked as a potential partner."

Couple and family therapy as a field emphasizes the importance of incorporating a client's beliefs in clinical decision-making. In working with clients with disabilities, therapists can incorporate client data by looking to their clients for preferred language. For example, some people with disabilities prefer person-first language (language that positions the person before the disability), while others prefer identity-first language (language that highlights the disability as an identity, often through capitalizing the first letter of the disability). By looking to disability activist communities for guidance, family therapists can learn the most up-to-date terminology for people with disabilities, while avoiding words that are archaic, paternalistic or offensive (such as handicapped, special needs, or crippled).* Additionally, therapists should engage with disability culture through community events, media, and social action to broaden their disability competency.

Many in the disability community remember activist and attorney Harriet McBryde Johnson's *New York Times* article, "Unspeakable Conversations" (2003). In the article, McBryde Johnson contrasts her worth as a human with Princeton Professor Peter Singer's assertion that parents should be able to euthanize disabled babies. In response, McBryde Johnson stresses "…choice is illusory in a context of pervasive inequality. Choices are structured by oppression." Our disabled clients exist in a context of oppression, in an environment structured by the belief that disabled lives are not worth living. It is up to us as therapists to acknowledge this context. As Michael White notes, couple and family therapists do not have to be "… condemned to the role of unwitting accomplices in the reproduction of the dominant social order" (2011, p. 52). We can create experiences for our disabled clients that do not reinforce microaggressions (and macro threats to existence) experienced elsewhere. We can make overt the influence of oppressive discourse on difficult decisions surrounding healthcare, caregiving, and other facets of disabled life. We, as systems therapists, can actively choose to name the systems of pervasive inequality that restrict disabled clients' autonomy. And in the process, we can enhance the mental health field's competency in serving this community.

Parisa Emam, MS, is an AAMFT Pre-Clinical Fellow. She is an adolescent and family therapist at Ophelia's Place, a prevention-based organization dedicated to helping girls make healthy life choices through empowerment, education and support. Emam speaks and writes about disability from Eugene, Oregon.

*** The National Center on Disability and Journalism publishes an annual style guide for those who seek appropriate and accurate language regarding disability: www.ncdj.org.**

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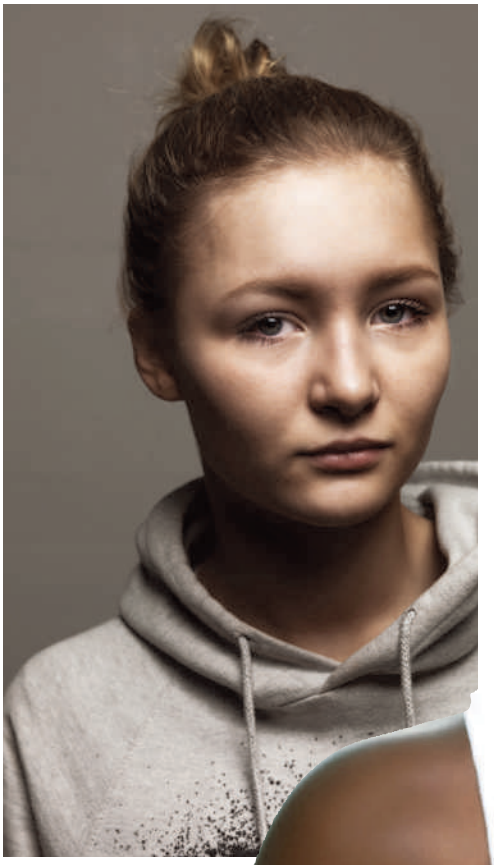

MY JOURNEY TO THE

JUVENILE JUSTICE SYSTEM

After receiving my undergraduate degree in communications from Ohio State in 2001, I knew from the bottom of my heart that I was completely finished with school. The pressure that came with school was something I could not see myself experiencing again. Also, I figured that my undergraduate degree would be sufficient enough for me to have the career of my dreams. The reality was that after my graduation day, I did not have a clue what I wanted to do. In fact, I did not have one single job offer. I recall lying on the couch at my mother's home one evening when this peculiar feeling started resonating with me. I would compare that feeling to driving somewhere for the first time and getting lost. For a minimal amount of time, you don't know what to do in that situation and that was how I felt for a month. **>>**

SHELDON A. JACOBS, PSYD

My first job offer

I received the phone call that changed the trajectory of my life one evening. Ironically, the other person on the phone that day was my maternal aunt offering me a job. She owned a family business that consisted of group homes for abused and neglected adolescent boys, many of whom were also on probation. There were numerous horror stories about the group homes, such as the boys stealing the vans from the group homes or violent assaults on the staff. I was hesitant to even take her call due to the infamous stories I heard. I told my mother to tell my aunt that I was not home, but that didn't work because the phone was sitting on my lap with my aunt repeatedly saying, "hello, hello, "

The group home setting

I needed that phone call to remind me of what my purpose in life was. I knew that I always wanted to help others in some capacity, but I did not know how. Working in the group homes gave me valuable experience, learning the functions of two distinct systems, which were child welfare and juvenile justice. Second, I learned how to work with stakeholders from different backgrounds, also known as multidisciplinary teams (Wood & Gray, 1991). Third, we had a licensed marriage and family therapist (MFT) on staff. His job duties entailed facilitating process and psychoeducational groups, providing weekly individual sessions with each youth and conducting family therapy for the youth who were transitioning back into the homes of their biological families. The work I saw being done by our resident MFT inspired me to want to have the same impact on families.

The significance of graduate school

The experience I gained working in my aunt's group home business provided me with the direction and sense of purpose I needed to finally recognize my calling. However, this journey would entail graduate school. Returning back to school was something I did not want to do, but I realized that in order to become an MFT, I needed to at least earn my master's degree. I also came to the realization that in order to make a profound impact in my career with at-risk children, I would need to further my education. My mother called me one day, sensing her son's anxiety with the notion of returning to school, and she simply encouraged me to reach for the stars, which meant not only attaining my master's degree, but going for my doctorate.

I was never the type to run from challenges, but rather to embrace them. Before I knew it, I was applying to marriage and family therapy programs with doctoral programs. I ended up being accepted into my first choice school, which was Alliant International University-San Diego Campus. I was in the dual master's/doctorate MFT program. The research, along with the course offerings yielded through my educational experience, was vital for my career. Besides earning a certificate in Chemical Dependency Counseling, I was able to conduct a pilot study examining the process of change for former gang members, which later became the basis of my dissertation.

I completed my pre-doctoral internship at an outpatient clinic that targeted the Hispanic population. My work at this clinic substantially increased my Spanish-speaking skills, which is significant due to the low number of Spanish-speaking marriage and family therapists. I also provided individual, family and group counseling and I was able to utilize various theoretical orientations.

The culmination of my academic journey brought me back to the reason why I wanted to become an MFT in the first place, which was to impact second-order change. According to Watzlawick, Weakland and Fisch (1974), second-order change can lead to change that is permanent. Thus, it is imperative when working with children that the process toward change involve their families to achieve the goal of second-order change.

Prior to entering graduate school, I knew I wanted to work in the government sector. My mother worked for the government, along with several family members, and a handful of individuals I really admired. They always stressed to me the importance of job security, retirement and benefits, such as vacation, sick time and health benefits. Hence, all of these factors were important to me, especially when I considered having to support a family. However, a factor that was dear to me was working with the at-risk adolescent population that in many respects is underserved. Working in the private sector would not have afforded me this opportunity. It was interesting to me that a high number of my cohorts in graduate school wanted to go into private practice (not that there was anything wrong with that). However, it seemed that many of them did not have a plan or sense of direction. They seemed to figure they would have a lucrative practice that provided them with a sustained income and life would be great. Ironically, many of them seemed to be in the same place I was after I had finished my undergraduate degree.

My dream job

Prior to completing my doctorate degree, I started applying for government positions. After several months of applying, I landed my dream job within the government sector, which was working with juveniles in the juvenile justice system.

My first position included a broad range of job responsibilities, but the focus of the position was on aftercare. My department operates a structured camp that is nestled in the mountains. The camp is far removed from the city life with which most of the at-risk youth in the juvenile justice system are familiar. Youth are court-ordered to attend the camp and the sentences committed

range from moderate to severe. The youth are usually placed at the camp for a minimum of six months, but various factors can extend or shorten this time period.

I was responsible for facilitating psychoeducational substance abuse groups for the youth placed at the camp. My experience facilitating groups during my pre-doctoral internship, coupled with the courses I took, helped prepare me for facilitating groups for delinquent youth. However, the core tenets of effectively facilitating a group remains true for youth in the juvenile justice system, such as establishing trust, identifying goals and effective modeling (Corey, 2004; Yalom, 1995). Just like any group involving adolescents, finding the right balance in setting limits for inappropriate behavior and rewarding positive behavior is important. However, if you are not genuine with them, the group process will not be effective. Some of the best advice I received from my clinical supervisor at the time was to simply be myself and not try to be something I wasn't. Furthermore, Corey (2004) stated, "To be effective as a leader, you must be psychologically present in the group and be genuine" (pp. 92-93).

When the youth were transitioning home from the camp, one of my duties entailed facilitating a parent-youth group. The first half of the group involved only the parents of the youth. The focus was primarily on effective parenting techniques and reinforcing effective communication strategies. I would provide individual and family counseling to the families that needed more support or to the families that were court-ordered for counseling. I went from using some of the more traditional approaches in other outpatient settings, such as Bowen family systems therapy and structural therapy, to more of the evidence-based approaches, such as cognitive behavioral therapy, multisystemic therapy and functional family therapy. Multisystemic therapy (Greenbaum, Foster-Johnson, & Petrila, 1996) and functional family therapy (Randall, Henggeler, Pickrel, & Brondino, 1999; Thompson, Riggs, Mukulich, & Crowley, 1996) have both been proven to work effectively with juveniles with delinquency issues and their families. What I like most about these two approaches is the collaboration that takes place between the therapist and the family, along with empowering the families to be self-reliant (Greenbaum, Foster-Johnson, & Petrila, 1996; Thompson, Riggs, Mukulich, & Crowley, 1996). Often times, families with youth in the system are either overwhelmed due to various factors, such as ambivalence or stress, or they are overly dependent on the system to fix their child. I believe that which ever approach is used, it is incumbent upon the therapist to elicit the strengths and competencies of the family in a creative manner. An effective therapist is also aware of the resources in the community (Mulvey & Repucci, 1993). Due to the varying levels of needs of each respective family, it was imperative that I link them to different services. For instance, a homeless family may need referrals to shelters and vouchers for food and clothing. Case management is necessary to ensuring that the family's needs are met.

The second clinical position that I held within my department entailed working with non-adjudicated youth. Thus, any youth who received a first-time alcohol or drug-related charge in Clark County was referred for a substance abuse assessment. The assessments were comprised of clinical interviews with the youth and parents and a 139-item measure that the youth completed on the computer. Risk levels were determined by results from the test measure and the information extrapolated from the clinical interviews. If a youth was determined to be low-risk for a substance abuse issue, then he or she was referred to a substance abuse class. If a youth was either moderate-risk or high risk, then he or she would be referred for treatment. There were often factors that would sometimes make the referral process complex. For instance, a youth could be low-risk for a substance abuse problem, but may have a significant

> "It is imperative when working with children that the process toward change involve their families to achieve the goal of second-order change."

> Often times, families with youth in the system are either overwhelmed due to various factors, such as ambivalence or stress, or they are overly dependent on the system to fix their child. I believe that whichever approach is used, it is incumbent upon the therapist to elicit the strengths and competencies of the family in a creative manner.

amount of systemic issues in the home or may demonstrate some mental health concerns that may increase overall risk. My experience conducting various assessments, such as biopsychosocial assessments, allowed me to be effective in this position.

I conduct court-ordered evaluations in my current position. Conducting evaluations is a two-part process, which entails assessing and interviewing the youth and their parent(s), and taking the information gleaned from the evaluation and synthesizing it into a report. The report highlights the results from the test measures given, mental health, substance abuse, school, peers and family histories. The conclusion ties all of the information together and incorporates recommendations for the youth and sometimes the family. Determinations are made about the type of intervention, such as substance abuse or mental health, inpatient or outpatient, the modality, such as individual, family, group, and if applicable, placement options are also considered, such as commitment or a residential treatment center.

Looking back on the past 15 years since I completed my undergraduate degree, I can acknowledge where the journey has taken me. There have been a fair share of ups and downs, but I can honestly say that despite them, I woke up each morning looking forward to the challenge that each day held. I often wonder what life would had been like if I decided not to attend graduate school. I think I know the answer.

Sheldon A. Jacobs, PsyD, MFT, has worked with children and adolescents for more than 15 years. He is an AAMFT Clinical Fellow, a core faculty member at the University of Phoenix, Las Vegas Campus, and an adjunct instructor at the College of Southern Nevada. His clinical experience includes conducting court-ordered clinical evaluations for juvenile offenders and contracted mental health services in the community. He is currently writing his first memoir about his life experiences scheduled to be published in 2017.

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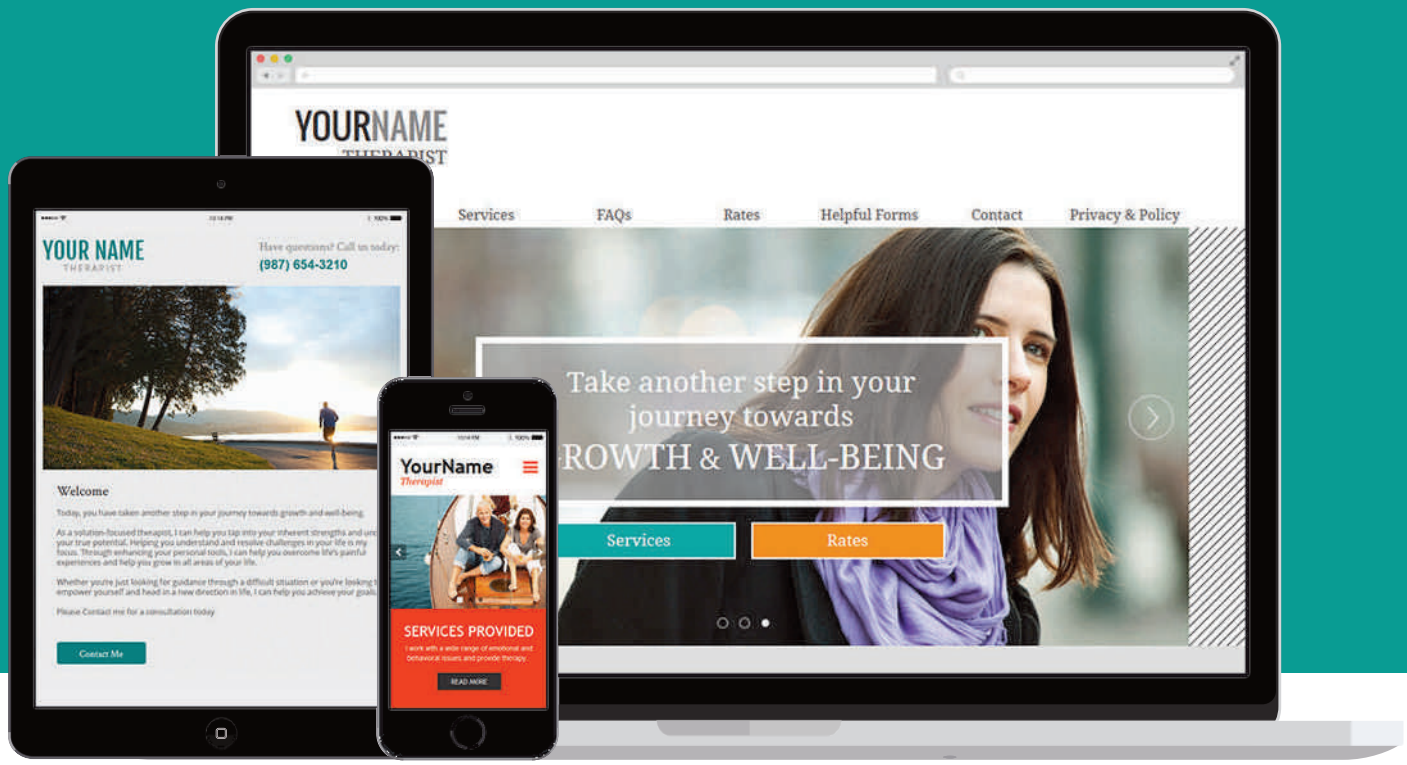

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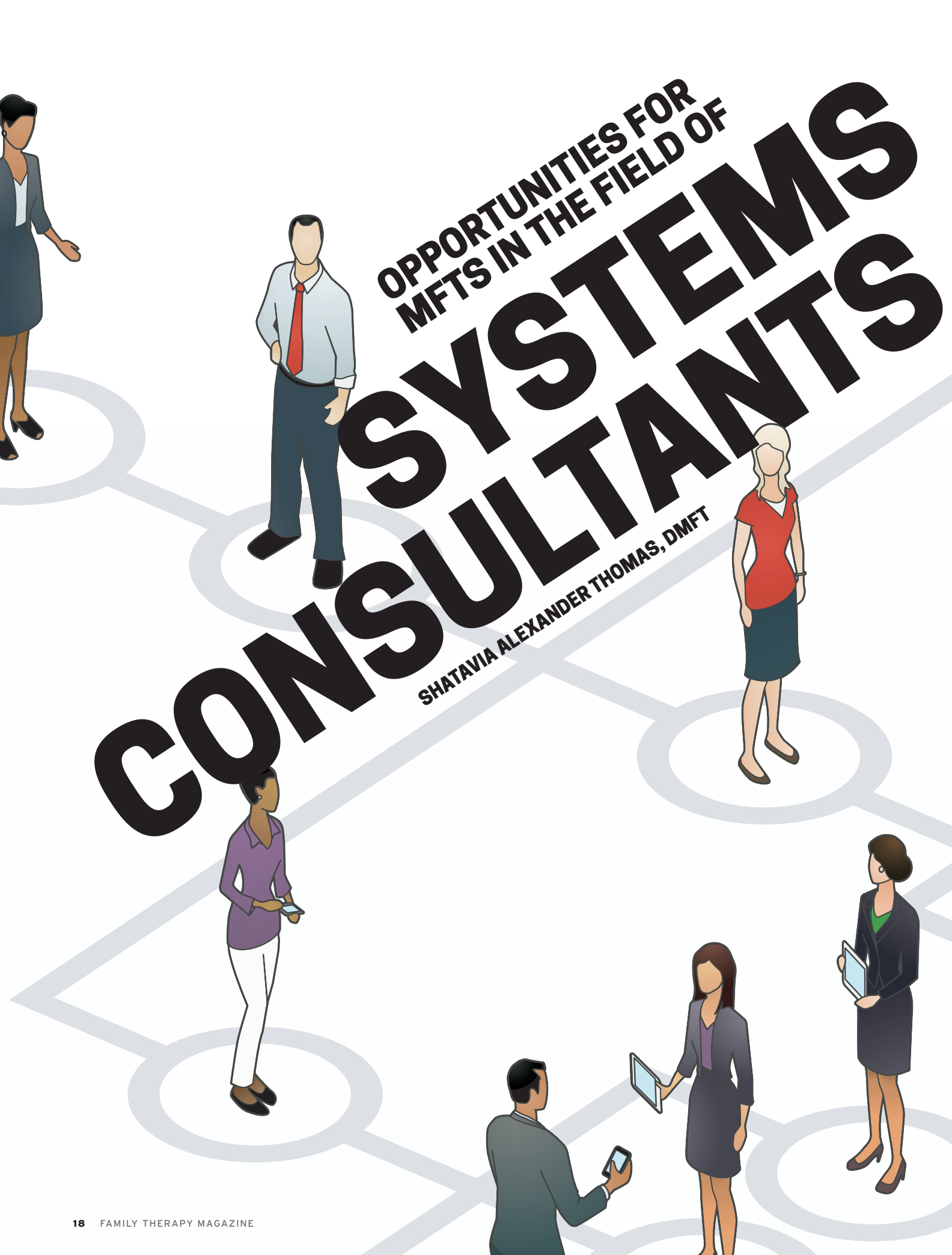

OPPORTUNITIES FOR MFTS IN THE FIELD OF

SYSTEMS CONSULTANTS

SHATAVIA ALEXANDER THOMAS, DMFT

One of my favorite courses during the third year of my studies in the doctor of marriage and family therapy (DMFT) program was Family Therapy Topics: Organizational Systems and Consultation. Learning how organizations function as systems akin to families, we identified relevant principles applicable in various settings (Checkland, 1999; Senge, 1990). Our professor, a doctor of psychology (PsyD) and director of the doctoral programs, challenged us to think outside of the box.

Similar to the role of a therapist, consultants build rapport, assess needs, evaluate fit, and clarify mission and vision. Systems consultants are aware of culture, attune to dynamics, sensitive to diversity, and focused on strengths and resources.

He presented the role of "human systems consultants" as distinct from healthcare providers or mental health clinicians. He described consultants as professionals who work with people, rather than professionals who treat symptoms or problems. Promoting this unique professional development, he reserved the last 15 minutes of class as time for us to develop our business plans. With my background and experience from a practitioner-oriented degree program, consulting seemed like a natural fit.

Role of system consultants

Systems consultants enhance organizational relationships and help improve functionality. As consultants, MFTs may observe staff, debrief meetings, facilitate trainings, ponder personnel decisions, and make policy recommendations. Similar to the role of a therapist, consultants build rapport, assess needs, evaluate fit, and clarify mission and vision. Systems consultants are aware of culture, attune to dynamics, sensitive to diversity, and focused on strengths and resources. MFTs as consultants are also mindful of concepts related to systems theory such as process (as compared to mere content or outcome), homeostasis, boundaries, reframing, and first/second order change. Although they are not solely responsible for organizational change, systems consultants collaborate with stakeholders as partners in the change process.

Opportunities for systems consultant exist in:

- healthcare and hospitals
- academia
- corporations and nonprofit sectors
- family businesses
- law and public policy
- religious settings
- athletic associations and media

Healthcare consultants help medical professionals address larger systemic issues related to patient care such as access to services, expansion of services, and social support. School-based systems consultants assist with training, crisis management, curriculum development, parent engagement, and coordination of services. Highlighting the impact of relational dynamics, systems consultants working with family businesses focus on roles, triangulation, coalitions, loyalty, and legacies. MFTs working with legal professionals help with mediation, parent coordination, and relational conflict. Consulting with the military requires an awareness of chain of command, consideration of standard operating procedures, and assistance with adjustment services. Faith-based consultants need to be mindful of values, traditions, culture, life cycle stages, and burnout. Sports and entertainment consultations may involve helping athletes with performance, addressing family-related concerns, and dealing with transitional issues.

Coming full circle: Student becomes teacher, clinician becomes consultant

Ten years after completing the Family Therapy Topics course as a doctoral student, I (as a faculty member) was asked by my university's curriculum director to develop a DMFT course on Systems Consultation. Reminiscing on the prior coursework and contemplating contemporary issues, I began to outline potential topics, learning objectives, and assignments. Much of the information about being a systems consultant can be found in what I call the "bible" of systems consulting (Wynne, McDaniel, & Weber, 1986). This resource has a wealth of information on the similarities and distinctions between therapy and consulting. Special topics and settings are addressed, including application of principles and practices.

My course development project serendipitously occurred at the same time I was contacted by a former colleague from a local nonprofit. The former colleague, now the chief executive officer, wanted to explore how they could expand their services after being awarded a mental health and wellness grant. Before I began offering services, I reflected on the importance of understanding the organizational culture, including current programs and structure. During the entry and engagement stage, I met with the administration and key program staff

We are continuously assessing needs and fit, as we work to facilitate meaningful organizational change.

to assess needs and brainstorm ideas. I inquired about existing relationships and potential referral sources. In addition to gathering information from the staff, I suggested that we conduct a survey to get an idea of trends and interests of agency clients. Although some consultants take on more of an expert role when problem-solving specific issues, I realized that my role as therapist was isomorphic to my style as a systems consultant: collaborative. This phase of assessment entailed considering context of "the center" (their language) and privileging client's voices.

Early stages of systems consultation also include establishing scope of practice, identifying allies, drafting documentation, clarifying timelines, and tracking progress. Nearly six months into offering mental health consultation services, I am grateful for the power of connections and the value of my doctoral course on systems consultation. We are continuously assessing needs and fit, as we work to facilitate meaningful organizational change. Moreover, we are committed to continued collaboration on best ways to help "the center" achieve its goals of serving the community. I hope to utilize these experiences to inform my current and future work as an MFT faculty member and systems consultant.

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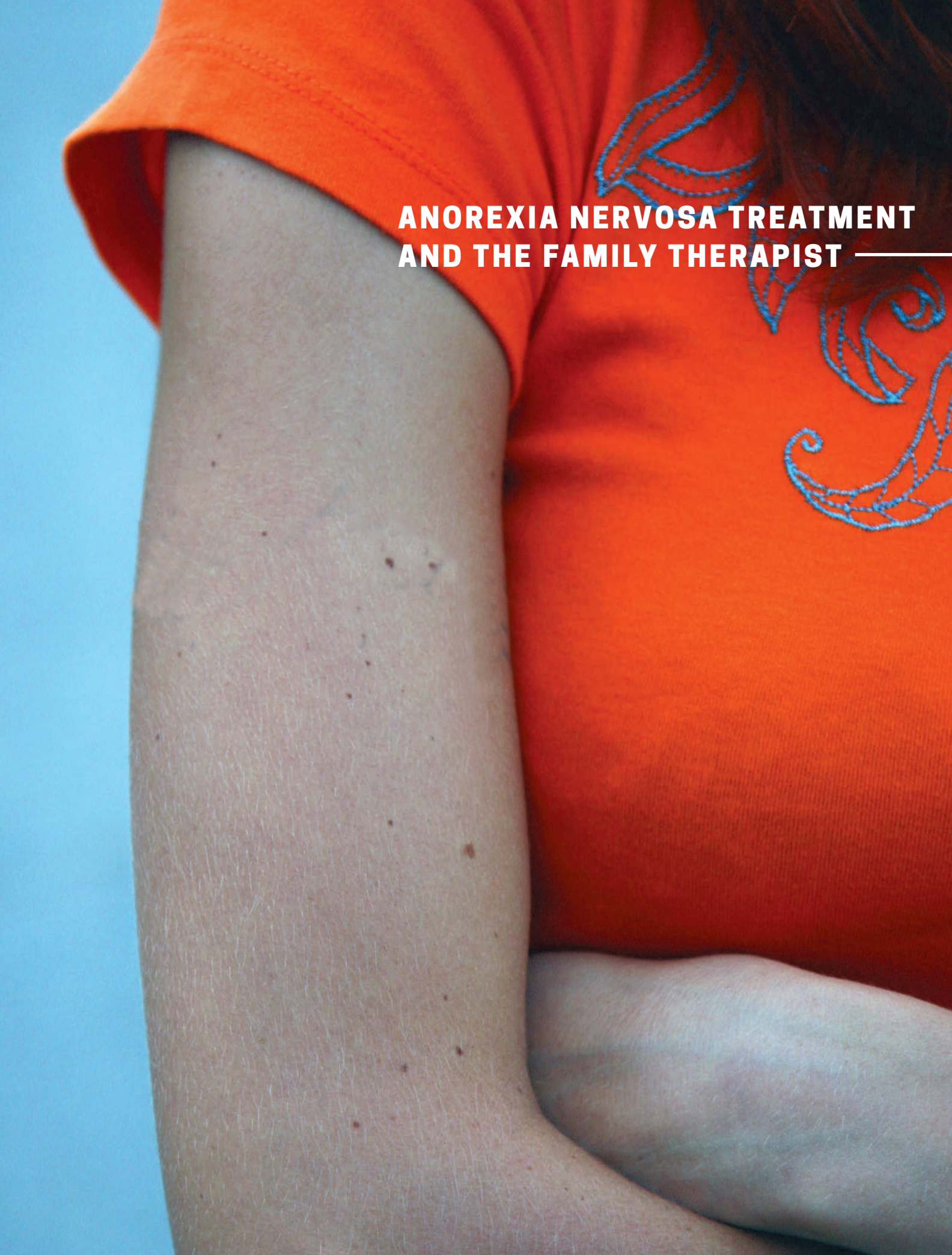

ANOREXIA NERVOSA TREATMENT AND THE FAMILY THERAPIST

FAMILY THERAPY IS THE BEST APPROACH

Recently, a colleague referred 14-year-old Maria to me. Maria had been suffering from Anorexia Nervosa (AN) for six months. During this time, she had lost 22 pounds, ceased menstruating, and exercised compulsively. Along with these physiological symptoms, Maria suffered from severe emotional disturbances; she alternated between physically aggressive outbursts and a low, persistent dysphoria. At one point, while an in-patient, her dysphoria resulted in a suicide attempt—tying a plastic bag over her head.

Maria was hospitalized three times and fed via nasogastric intubation. Upon discharge, she resumed her self-starvation. This led to her re-hospitalization, and the cycle continued…

Charles Fishman, MD

During Maria's treatment, she missed six months of educational continuity. There was much strife in the family with her father's family blaming the mother for the AN, since she had briefly been anorectic as a teen. In terms of the broader system, the hospital staff put Maria on a legally mandated treatment order (which is called a Mental Health Act where I practice in New Zealand). They sought a legal injunction, preventing the father from seeing Maria—"because of his over involvement."

The family stated their daughter's anorexia "was the worst time of our life. We were powerless, watching her fade away while everyone battled. Our lives interrupted. "

The family's experiences of in-patient care are sadly common. Such long-term hospitalizations can have a profound impact on the family. The family members watch their daughter go in and out of the hospital with little lasting improvement; they begin to lose hope. Conflicts arise as the family struggles to cope. These conflicts can become increasingly entrenched. Meanwhile, the child who is experiencing this cycle of hospitalization finds her education and social networks disrupted. In the institutional environment, medical professionals become the enemy, while AN sufferers share techniques to camouflage their weight, often competing over who can be skinniest. In terms of long-term outcomes for residential eating disorder treatment, there remains a lack of controlled trials showing long-term efficacy (Friedman et al., 2016).

This is not to say there is a shortage of treatment facilities available in America. Indeed, according to the *New York Times*, there is an epidemic of programs. Over the last 10 years, there has been an explosion of residential eating disorder centers—from 22 in 2006 to 75 today (Goode, 2016).

Residential care is a painful interruption of these sufferers and their families' lives, not to mention the cost to the healthcare system. On average, a residential program for a client costs $30,000 (Alderman, 2010). Residential treatments for eating disorders are not necessary; they are costly, disruptive, and questionably effective.

There should be a better treatment—and there is! The SFT treatment model

There certainly is a more effective treatment—namely, structural family therapy. In the 1970s, Minuchin, Rosman and Baker presented a highly effective family-based treatment for

Maria

COURSE OF TREATMENT Maria's treatment was complicated by the fact that her parents had been divorced over a decade. My theory of change, however, played out in an identical fashion as compared to my first anorectic family many years before. Maria's mind was immanent in the context. Whether or not she was anorectic depended on the parental system—when they were split, she was anorectic; when her parents were together, she was not anorectic.

The course of her therapy was slow, as her parents were not accustomed to working together. Her mother was the custodial parent. Her father was responsible and committed to his daughter, but functioned more as her friend. He was reluctant to support her mother's attempts to adhere to the protocol for fear of upsetting Maria.

When Maria's parents finally worked in unison, her weight turned the curve to her target weight of 115 pounds. This goal weight was established by her family physician, with her parents' support.

Our goals went beyond just weight gain and extended to Maria's overall functioning. In the course of treatment, she became happier and more outgoing—both socially with her friends and at her new job at a coffee kiosk.

At the conclusion of therapy, I received the following text message from Maria's father:

I just wanted to give you a little bit of feedback after our meeting last night. I took Maria for a walk around the block and couldn't believe her happy laughing and joking attitude. It was so beautiful to see my daughter so happy since this nightmare began. As for the weight gain, it is just like magic!

AN. For simplicity, I will refer to their psychosomatic family model as the SFT model. In the many times I have employed the model over the decades, I have often marveled at its immediate effectiveness. In the course of the first session, not infrequently, the starving youngster begins to eat. The delivery system of the intervention is, if you will, the girl's family.

This treatment begins with a family lunch session where parents feed their child together. At home, a behavioral paradigm is instituted in which both parents are charged with insuring their child gains an agreed-upon amount of weight or she stays in bed.

The research outcomes of this model, published by Salvador Minuchin, Bernice Rosman, and Lester Baker, in *Psychosomatic Families: Anorexia Nervosa in Context* (1978), showed 86% of 52 young people had good two- to seven-year outcomes regarding their symptomology and psychosocial function. I met Minuchin during this time, when I was a young child psychiatry fellow at the Philadelphia Child Guidance. Some months into my Fellowship, I saw my first anorexic teenager. Her therapy began with a lunch session, in which her parents were charged with feeding their starving daughter. This parsimonious, highly effective intervention quickly addressed the ubiquitous parental split (central to maintaining AN) while successfully getting their child to eat again.

My instructions to the parents were very simple: *work together*. In the session, if they worked together, their child would take a bite of the sandwich. If there were even a subtle split between the parents, the child would refuse the sandwich. By the end of the session, the anorexic child had eaten most of her meal. If not, the family would come back the next day.

The model is effective because it directly addresses the interactional patterns that maintain the patients' AN. This method is based on the SFT technique of enactment (Minuchin and Fishman, 1981); it brings both the problem and the solution into the treatment room. Via enactment, both problems—the parental split and the AN—were addressed by the therapist and parents.

> Anorexia nervosa is not a profound psychopathological condition. It is contextually influenced and thus readily amenable to social systems interventions such as family therapy.

The modern iteration of this early work is the Maudsley Method (Russell, Szmuckler, Dare, & Eisler, 1987), considered by many, based on its evidence-based research (EBM), to be the treatment of choice for juvenile AN.

The Maudsley Method is most often based in teaching hospitals. I believe that SFT treatment for this problem mode should also be available in the families' communities. Furthermore, community-based structural family therapists, working in conjunction with a knowledgeable primary care physician, are well suited to provide this care.

What is anorexia and why is family therapy such an effective treatment?

AN in adolescence is a mysterious—and potentially dangerous—condition. It has captivated the public imagination and defeated many treatment regimens. Researchers have reported that roughly eight in every 100,000 people struggle with AN each year; its prevalence amongst adolescent females is around 0.4% (Hoek, 2006). This condition can involve serious health risks. The mortality rate for AN is around 5% per decade; more commonly, deaths result from medical complications rather than suicide (American Psychiatric Association, 2013).

Using this SFT model, there are three perspectives I use to understand this disorder:

The first and most important perspective is to view AN as serving a function in families. This point is central to family therapy theory. The invention of videotaping allowed pioneering family therapists to perceive the circular relationship between the emergence of symptoms and the diffusing of familial conflicts. In other words, conflict emerges between the couple, the child then exhibits anorectic behaviors, which draws the parents' attention, thus diffusing their tension. To the extent that their conflict was diffused, the disputed issue is not resolved, and there is the continued need to focus on their anorectic daughters' symptom to stabilize the system and so on.

The second perspective sees AN akin to hysteria; highly emotional group behavior. Teenage girls may hysterically impact each other with challenges of, "Who can be the thinnest?"

A third way to look at anorexia is in terms of the instigation of the disorder. Random comments can spark the process. For example, a coach could say, "You're getting a little hefty; you need to lose some weight." When AN behavior emerges, the symptoms can serve a function in the family—by defusing conflict as described previously.

From these perspectives, AN is not a profound psychopathological condition. It is contextually influenced and thus readily amenable to social systems interventions such as family therapy.

Why are well-trained family therapists best suited to effectively treat AN?

Family therapists are so well suited to treat AN because we understand

systems, we understand the circularity of family processes, and *we have the skills*. Most importantly, many family therapists understand that distinct paradigms are not reducible into one another. One doesn't just add a little family therapy into an array of interventions. Family therapists understand AN is a *family systems* problem and must be treated as such.

In my years of experience, I have found that pure system interventions for AN, such as the one presented here, are the most effective. Mixing paradigms can serve to dilute the interactional focus, hampering progress. This doesn't mean that you do not develop a supportive relationship to the adolescent, understanding and sympathizing with her struggle. Still, the "active ingredient" for change is the parents working together.

In closing, I see family therapists as doing invaluable work—transforming problems in the most crucial unit of our society—the family. I do hope that family therapists can expand our practice, embracing the treatment of anorexia nervosa; it would be a great contribution to hopeless young people and their families in our communities. Furthermore, for the clinician, turning the curve with a struggling youngster can be lifesaving and supremely gratifying. Magic!

Charles Fishman, MD, is a Clinical Fellow of AAMFT and a clinical professor of psychiatry at the University of Hawaii John A. Burns School of Medicine and clinical director at Reconnect Family Services, Auckland New Zealand. Among his books are *Family Therapy Techniques* with Salvador Minuchin and *Enduring Change in Eating Disorders: Lessons from Long-term Followups*.
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Further Resources

While the focus in this article is anorexia, this family therapy model, with some minor variations, is effective with other eating disorders (such as Bulimia Nervosa and Compulsive Overeating). In my book E*nduring Change with Eating Disorders: Lessons From Long-Term Follow-Ups*, I document the successful follow-up Structural Family Therapy treatment of AN and other disorders (Routledge, 2006).

On my website, the reader can find tools for treating AN and other eating disorders, such as a bed rest protocol for families and a therapeutic checklist for clinicians. There is also a field for clinicians to post their client outcomes.

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Barriers to Treatment: Evidence-based Medicine and Results-based Accountability

In 2006, I authored "Juvenile Anorexia Nervosa: Family Therapy's Natural Niche" for *Journal of Marital and Family Therapy* to encourage clinicians to step up and provide invaluable family therapy to sufferers and their families. No professionals, I argued, were better suited to treat this condition than well-trained, structural family therapists. I would hope this is happening, but I fear it is not.

Is evidenced-based medicine (EBM) part of the problem?
Today, I believe the proprietary, evidence-based Maudsley Method programs provide excellent outpatient SFT for juvenile anorexia nervosa in the US. The challenge is how to provide access to SFT treatment to other communities across America. I believe the capacity is there. It may seem heretical to suggest that a significant barrier to the introduction of community-based SFT treatment of AN may be the Evidence Based Medicine Movement (EBM) itself. EBM has saved millions of lives (Goldacre, 2012). However, for front-line family therapists, it may inhibit progress.

In this era of increasing insistence on EBM data, how do we generate reliable performance data? In the community, we do not have the resources for statistical analyzes or the numbers for control groups. *We need an alternative framework to document our effectiveness.*

Expanding the universe of evidence: Doing better by knowing more
"Expanding the Evidence Universe: Doing Better by Knowing More" (Shor & Farrow, 2011) is a classic paper by two leaders in children's mental health services. The authors examine the issue of how, despite our constant research, today's youth continue to confront a multitude of complex and daunting issues in their lives. According to the authors:

> *Research and experience over the past two decades have produced more knowledge than ever before about what it takes to improve the outcome for disadvantaged children and families, but despite the expanded knowledge, we have not been successful in achieving significantly better outcomes at a magnitude that matches the need for critical areas (p. i).*

Shor and Farrow continue, "The boundaries which the prevailing framework draws around acceptable evidence can limit the knowledge base available to policy makers, program designers" (p.1). Their position is that evidence-based practices, policies, and strategies must be undiminished but the definition of "what counts as credible evidence" must be expanded.

This is certainly true for the treatment of AN. We need an outcome-tracking model to help us expand the boundaries of acceptable data and credibly document our effectiveness. To expand the universe of data, we need an alternative framework to track our outcomes.

Enter results-based accountability (RBA)
In the mid-90s, Mark Friedman, Chief Financial Officer of the Maryland Department of Children's Services, was concerned whether children were better off despite huge financial expenditures. In response, he developed Results Based Accountability (RBA). RBA, an accountability framework, has revolutionized governmental services in over 30 countries. The "Turning the Curve" (2009) tool is central to RBA; it can facilitate the tracking of clinical outcomes. Turning the Curve means turning the curve away from the baseline. This simple, practical tool is central in the business world. For example, in assessing my work with anorexia sufferers like Maria, I have to ask myself, "Has her weight changed over the last six months?" Has the curve turned in the right direction?

Acting together and getting the numbers on the board
Here's the challenge: An academic researcher can publish positive articles in refereed journals and voila, their ideas are established as "evidence-based." To meet this challenge, I submit that we must operate as clinician researchers, tracking and posting our outcomes using simple tools like the Turning the Curve framework.

As we treat AN and other clinical problems, we can track and post our outcomes, maintaining our own portfolio of performance. In a sense, we are developing our own personal curve of clinical effectiveness for our clients. This would be valuable in terms of our own quality improvement as clinicians.

The need is pressing. According to a recent study, three million people suffer from eating disorder in the US. AN is less common, but more dangerous than other eating disorders (Arcelus, Mitchell, Wales, & Nielsen, 2011; Wade, Kesi-Rahkonen & Hudson, 2011). Many communities could benefit from our skills in treating this less common (but severe) eating disorder.

Once we have the data, we can find ways to share this evidence. With the right numbers, we can demonstrate to the gatekeepers the necessity of expanding their acceptable universe of data, beyond EBM data.

Understanding and Treating the Pain of

Borderline Personality Disorder

We have all had them—whether in a community mental health, hospital, or private practice setting, you have patients with some tacit quirk that seems to reach under your professional façade and frustrate you. Sometimes, we can figure out what the trait is, and at other times, we can't quite put a finger on what is creating the obstacle to joining. Other times, we begin heading down the road to diagnosis of borderline personality disorder (BPD).

Brett Novick, MA

These clients represent one of the most difficult diagnosis in which to treat. As frustrating as this disorder may be for therapists, it is perhaps one of the most debilitating for clients and their families alike. Often, these clients are desperate for help, and yet, as desperate as they are, they struggle for a means to tread water in a world in which they cannot understand or thrive.

The following are some highlights for treatment of borderline personality disorder:

1. Borderline personality disorders tend to bleed together with other disorders. When treating a client with BPD, it is important to assess and treat other potential mental health disorders that often accompany this diagnosis. The diagnoses that are comorbid with BPD tend to be major depression, dysthymia, substance abuse and a concurrent disorder such as narcissistic personality disorder or antisocial personality disorder. Therefore, any client who seems to present with this possible disorder would strongly benefit from a comprehensive psychiatric evaluation.

2. Underlying assumptions of BPD patients. Those who suffer from BPD tend to personify the concept of cognitive distortions in the area of "black and white" thinking. They classify themselves and others as "good or bad" and in "shades of gray." Those who are on the positive side should be rewarded, while those on the negative side need to be ostracized or punished. This "black and white thinking" must be addressed. For example, a BPD client may tell you that you are the "best" therapist, but the next day he or she could swing to the other side of the pendulum quickly and unpredictably.

3. Look to previous history to find current reasons for diagnosis. Abuse, especially sexual (it accounts for as much as 70% of client history), as a child seems to be a key trigger for development of this personality disorder. Parental separation or disengagement is also a co-occurring factor with these patients.

4. There are a host of misconceptions in the therapy arena about BPD. Many believe that BPD is a "female" disorder. While it is more common in women, it still occurs in men. Another myth is that therapy is ineffective with BPD. While it is true that BPD is resistant to many paradigms, certain models are more effective in working with this population.

5. Responsibility is a key: Clients must begin to accept responsibility in all facets of treatment. This is the key to successful treatment for clients with BPD. If a client has substance abuse issues, this precludes effective treatment for other issues, and therefore he or she must seek substance abuse treatment. In all relationships, the client must seek to recognize his or her responsibility in development of maladaptive relational patterns. Responsibility in relationships must also be confronted directly, as opposed to using maladaptive patterns of fleeing, blaming, going on the defensive or using substances to dull the pain of relational issues.

6. Look under the anger for the larger roots. Those with BPD tend to recognize an overwhelming anger that comes in waves and often threatens to jeopardize even the closest relationships. While some clients may state they are in need of anger management, the truth is they need to recognize a spectrum of emotions that are at the roots of this anger. Frustration, fear, anxiety, depression, and jealousy are all root causes. Therapists can help clients identify and address these underlying emotions and their impact on relational matters.

7. Cognitive distortions and cognitive behavioral therapy are important elements. Common cognitive distortions issues of "black and white thinking, generalization, blaming" and a host of other distortions listed in the DSM must be addressed in sessions. Journaling will help clients be aware when they are using cognitive distortional thinking and help them stay on a healthy mental track when out of session.

8. Dialectical behavioral therapy (DBT) is determined to be an effective modality for BPD. DBT recognizes that certain people tend to have particular sensitivities to, and reactivity to, situations that may present emotionally challenging circumstances. That being said, these people also tend to have an extremely difficult time in self-soothing and returning to a baseline level of emotional stability. Conversely, they also lack the coping skills for seeking a means of returning to a base level of emotional calm and need to be taught these strategies.

9. Developing an outline for DBT sessions. DBT sessions consists (ideally) of weekly individual meetings with the therapist, where a review of the past week's issues that have occurred are addressed, as well as deeper issues that may have created the conditions for BPD. Post-traumatic stress disorder and self-esteem issues that crop up from these discussions must be handled accordingly. Finally, suicidal ideation must always be assessed on a session-to-session basis. BPD patients tend to be highly emotionally reactive and impulsive, which creates an ideal environment for suicidal ideation.

10. Counseling therapy with a DBT paradigm should be considered. BPD patients tend to view their relationships in comparison to others. With this in mind, group work with a DBT paradigm can be an excellent modality when working with these clients. This is especially effective in addressing and modeling relational issues.

11. Be "mindful." Those with BPD are very quick to judge situations immediately and harshly. Teaching them in session to look at a situation without any judgment, but instead observing, learning and participating, is key. Also important are "staying present," learning to "self-sooth" and decreasing stressors.

12. Taking care of one's self. Due to a chronic lack of awareness of self and others, BPD clients often do not know how to do self-care. Encouraging them to eat right, sleep right, and avoid substance usage are important life skills that can go a long way to avoid aggravation of BPD symptomology.

13. Why it is not bipolar disorder. There are important distinctions between these diagnoses. Bipolar disorders will often cycle without any apparent social trigger. Those with BPD tend to have mood cycles in reaction to an event, often relational or perceived abandonment issues. BPD client will often discuss these triggers in terms of "love-hate" relationships, where those with bipolar disorder will not have a noted social trigger.

14. Suicidality assessment as often as possible is key. BPD clients tend to be impulsive and reactive. They have been demonstrated to have a greater level of suicide ideation and attempts more than any other diagnosis. When

they are in pain, they often describe wanting to find any and all means to escape this feeling (including, unfortunately, suicide). It is important to develop a safety plan (even if there is no active suicidal threat). This may mean getting family members involved to recognize psychiatric emergencies and know when and where to utilize resources accordingly.

15. Family therapy. Living with someone who is diagnosed with BPD can be very difficult. They can be very close and loving one moment, and demonstrate hatred and distancing the next. Family therapy, therefore, will not only help the family, but will help support the client when she or he needs it most, including during a psychiatric emergency.

16. Marital therapy. Concurrent marital therapy may be suggested or needed, as communication skills are typically weak for those with BPD. Learning "I" messages, seeking realistic versus grandiose expectations of a spouse or partner, as well as teamwork versus power struggles are all elements for marital therapy.

Often times, when a BPD client comes through the door of a therapy office, he or she may be described as difficult, irritable, and demanding toward the therapist. This, however, is nothing compared to the pain that a BPD client feels on a daily basis. They are deathly afraid of abandonment and will grab onto others to avoid drowning in their own fears. Unfortunately, they often fulfill the prophesies they so fear, and thus create even more anxiety. BPD patients often describe the pain of relationships like that of a fresh and raw sunburn that is aggravated with each perceived social slight that they inevitably feel on a daily basis.

As therapists, we may be the only ones who can apply a therapeutic salve to ease that pain. We can see beyond anger, irritability, and criticism to a vulnerable and hurting human being who is in desperate need of help, but cannot find a means of escaping the quicksand—the constant thought of abandonment. ◆

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Factitious Disorder Imposed on Another

How Do You Know When the Illness Isn't Real?

Jeff Louie, MD **Jerrod Brown, MS**

Formerly known as Munchausen Syndrome by Proxy, Factitious Disorder Imposed on Another (FDIA) is characterized by the caregiver, typically one of the biological parents, fabricating or causing harm to those under their care (Zaky, 2015). The victim of this form of child abuse can be of any age, but it is typically young children who have yet to develop verbal skills. Because recognition of FDIA often takes an extended period of time, children are often exposed to several unnecessary medical procedures. This can include painful procedures, such as multiple blood draws or bladder catheterizations, or even require anesthesia or sedation (Vennemann, Bajanowski, Karger, Pfeiffer, Köhler, & Brinkmann, 2005). Following is a brief overview of FDIA's origins, characteristics of individuals with FDIA, and difficulties in diagnosing FDIA.

This rare form of child abuse was first described by Richard Asher in 1951. He coined the term Munchausen's Syndrome to highlight the exaggerated stories a caregiver would use to describe a child's acute or chronic condition. The term was inspired by Baron von Munchausen, who was a fictional character based on Hieronymus Karl Friedrich von Münchhausen who lived in the mid-1700s. He was famous for telling wondrous and unbelievable yarns about his military experiences during the Russo–Turkish War of 1735-1739 (Olry & Haines, 2012). His highly exaggerated tales later became fictionalized in short stories penned by the German writer, scientist, and con artist, Rudolf Erich Raspe. The stories adversely glorified von Munchausen as a liar and ruined his social status among the European aristocrats (Olry & Haines, 2012). The grandiose tales never contained medical stories, yet his name has been associated with child abuse since the 1950s and Munchausen Syndrome by Proxy has been researched by pediatricians and psychiatrists ever since.

The DSM-5 (American Psychiatric Association, 2013) describes FDIA as a psychiatric disorder where an individual persistently falsifies illness in another individual, even when there is little or nothing tangible to be gained (Bass & Glaser, 2014). To make matters worse, caregivers with FDIA often methodically harm the child to induce illness. Biological mothers are typically the perpetrator in comparison to the father (Sheridan, 2003). About 25 percent of individuals with FDIA have previous healthcare knowledge, and often aspire to have close relationships with medical professionals (Bass & Glaser, 2014). This may drive them to pursue additional testing and procedures that are often painful or emotionally stressful to the child. The prevalence of FDIA victims is estimated at 2.8 per 100,000 children younger than one year of age and 0.5 per 100,000 children younger than 16 years of age (McClure, Davis, Meadow, & Sibert, 1996). Nonetheless,

THERE IS A PLETHORA OF CASE DESCRIPTIONS OF FDIA. ALTHOUGH MOST CASES DO NOT RESULT IN DEATH, FATALITIES REMAIN A DEVASTATING POSSIBILITY. INDIVIDUALS WITH FDIA OFTEN DESCRIBE ILLNESSES SUCH AS APNEA OR SEIZURES WHICH FAMILY MEMBERS AND MEDICAL STAFF NEVER WITNESS BUT HAVE DIFFICULTY CONFIRMING THE EVENT.

these prevalence estimates likely underestimate the true magnitude and impact of FDIA, given many cases may be unreported, undiagnosed, or misclassified.

There is a plethora of case descriptions of FDIA. Although most cases do not result in death, fatalities remain a devastating possibility. Individuals with FDIA often describe illnesses such as apnea or seizures—which family members and medical staff never witness—but have difficulty confirming the event. Evaluations of the child may be normal, but caregivers can induce seizure symptoms by temporarily suffocating the child.

The diagnosis of FDIA is often delayed. One reason may be that medical staff typically believe patients and caregivers. Alternatively, the perpetrators may seek multiple evaluations at different hospitals. In rare instances, perpetrators have been caught by video cameras placed in the hospital rooms of patients.

Although rare, delays in diagnosing FDIA allows continued harm to children. Victims may suffer physical and emotional pain from excessive medical procedures. As such, medical professionals must maintain a high index of suspicion when presented with highly unusual and repetitive complaints from parents that conflict with evidence of normal examinations. In such situations, identification and diagnosis typically require a multidisciplinary team of physicians, specialists, and social workers to intervene and remove the child from the perpetrator. Once this occurs, the child ceases to have any medical events, as described by the perpetrator, or completely recovers from induced medical illness caused by the parent.

Once the immediate physical threat is removed, therapists can begin the important work of emotional recovery with the child, which may include integration into a relative's family or foster family, and assisting with any needed navigation of the social services system.

Future directions should include better communication among mental healthcare providers (with primary care doctors) whose patients have children and exhibit somatoform or factitious disorders. A seamless electronic healthcare database would allow healthcare providers to review a child's care, thus obviating need for repeated studies or procedures. This could also alert providers to consult child abuse experts if the parents seek medical care at multiple hospitals. Finally, child protection services should not delay in removing any child from the caregiver if evidence is highly conclusive. Perpetrators often face a long road of mental health treatment, and legal consequences often involve incarceration or forfeiting parental rights. ◆

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PERSPECTIVES

Whole Health & Wellness

Monica Stevens-Kirby, MFT

A dandelion rooted in a field is labeled a common weed or a thing of beauty—depending on perspective—or the colloquial "eye of the beholder." If I pluck it from the earth, spread its transparent orb with hearty breath, making a wish in superstitions of childhood, or if the wind whips it from its place, as wind inevitably does, the dandelion's seeds scatter. The seeds pocket themselves in air and disperse. Whether I tamper with its trajectory or leave it untouched, the dandelion scatters itself from field to field. The scattering continues, whispering by, tossing its seeds wherever it drifts. Seeds spill, planting themselves in systems that further its reach. **Everything is connected.**

What does nudging or coaxing a client toward improved health and healthier lifestyle choices do to create a climate of mutual responsibility between clinician and client? In our transparency with clients, we, the clinicians, can offer choices within a spectrum of useful options. We are actively instructive and engagingly collaborative by attuning our practice habits to include nudging for the right reasons (DeAngelis, 2014).

So, what role do MFTs play in supporting our clients' whole-body wellness? And what role *should* we play?

When I present to my internal medicine doctor, nurse practitioners, physician assistants, licensed practical nurses, and lab/medical techs are the faces I typically see first. Internists often serve as the "name and face" of their practices. They are also at the center of all business conducted under their licenses.

To meet with the medical doctor is a final step in configuring appropriate treatment. Support staff consults with and takes direction from the MD. Diagnoses, patient education, and prescriptions are followed by support practitioners under the banner and supervision of the medical doctor. As a result, internists open their practices to greater patient loads and increase efficiency, time management, and financial resources when they assign nurse practitioners and physician assistants to write scripts and perform the majority of frontline tasks.

As MFTs, we are posted along the front lines of our modern healthcare system. We assess and advise as "first responders" to individuals and families seeking emergent care in hospitals and at clinics. Our profession requires that we continuously develop and refine robust clinical skills, offering immediate attention to crises, including homicidal and suicidal clients, active psychosis, current presenting symptoms, and even basic needs. In effect, we fluidly move in and out of Maslow's Hierarchy: assessing, referring, treating, and acting within a range of systemic properties descriptive of our field.

MFTs wear multiple hats in our work as "first responders." Homeless families presenting to clinics where we do intakes propel us to embody the role of a social worker. We provide resource lists and direct clients to institutions where donated food, clothing, and diapers may be easily accessed by transient populations. MFTs are ambassadors for adults and children in the throes of family violence, and it is our duty to discuss and flesh out plans for safety with them, assisting our clients in confirming temporary shelter in times of exposure to acute violence.

Beyond our biopsychosocial helm, MFTs are expectant multitaskers in a medical culture that mandates thorough documentation for educationally-driven and experience-guided decisions we are asked to make with quick precision. No clinician is perfect, nor is any institution or agency. In an environment that revolves around and exists for stabilizing, and sometimes saving, human lives, there is little, if any, margin for error, and, more and more, margins are stretched outside comfortable lines for even the most seasoned clinicians to accomplish well.

Stepping outside emergency centers, MFTs in outpatient settings, whether private practices or agencies, are responsible for treating clients with research-based interventions, developing treatment plans that are clear, concise, and realistically met within a select span of time. Clinicians seek to meet these goals, not only for our clients, but for ourselves as trusted advocates and wellness partners. These competencies are fundamental to our collective reputation as clinicians capable of being employed on the front lines.

We are saturated by a culture accustomed to and wired for direct input equaling direct output. Whether we like it or not, MFTs serve a common denominator culture that craves instant gratification. The medical and social science fields, along with our direct service consumers, are all "products" of this evolving process. What, then, is our overarching clinical response to provide for and treat the whole client and wider client system as we encourage total wellness?

MFTs undergo rigorous academic and field training as students and potential candidates for licensure. As such, we are pointedly exposed to demographics ranging in socioeconomic status, age, race, gender, ability, and severity of dysregulation and/or dysfunction. These populations form our client base. MFTs treat systems within systems within systems.

Is it an MFT's place, then, to insert our expertise into critical layers of this suggested hierarchical framework? Is the concept of "nudging" our clients to whole-body, brain, and system wellness a direction MFTs are obligated to commit ourselves, individually and as an association? Science is, by its nature, a hypothesis existent within a continuum of learning, examining critically, and refining (Newell, 2014). Can an MFT ethically recommend regular exercise to a client fighting depression, citing experimental studies that underline exercise's natural serotonergic boost? Do we bear responsibility to combat complications furthered by poor nutrition and lack of attention to general health? Can we contribute to a solution that begins to end the cycle of diabetes and heart disease related to depression and the interplay of separate conditions (Richardson et al., 2005)?

Is it within an MFT's scope of practice to provide clients with accessible, lay-spoken research that supports exercise as a companion therapy to medication and cognitive behavioral therapy and other talk therapies? After consulting with a client's physician, is exercise an augmentation therapists should continue to follow, or is this type of guidance prohibited territory, strictly the possession of prescribers, and not to be crossed by MFTs under any circumstances?

As a clinician working with children and families, I fall into the majority of health professionals who believe clients are ultimately at the reigns of their

treatment and treatment outcomes, as we empower them to share in responsibility for their treatment. Client satisfaction is profoundly dependent upon the proactive selfadvocacy of clients enthusiastically engaged with the healthcare professionals to whom they entrust their care (Jallinoja et al., 2009).

Interventions are ideal when families extend themselves to supports, including, for example, occupational therapists, speech therapists, physical therapists, and other comparable professions working together for and with families who value the function of each cog in the proverbial treatment wheel. But how do we, on the frontline brigade, keep that wheel spinning at a steady pace, rhythmic and allowing for crescendo and decrescendo, legato and staccato, irregularities that are characteristic of healing? Are MFTs the projected "internists" of a changing mental healthcare landscape, navigating clients to surrounding systems to address comorbid conditions?

Family therapy, psychiatry, cognitive-behavioral therapy, and social rhythm therapy are clear examples of how clients with chronic mental illnesses can make best use of integrative models promoting interdisciplinary collaboration (*New York Times*, 2013).

Are MFTs floating islands, isolated banner bearers of a recognizable culture specific to MFTs, or are we called to embrace components developmental psychologist Urie Broffenheimer (1979) proposes in his Ecological Systems Theory of Human Development? Is it our right, our business, or our place to entrench ourselves into clients' lives for the sake of their wholebody health?

In my experience, it is. We are therapists educated in systems and conditioned to understand that our clients are more than just the bodies present before us in the therapy room. Our clients are the people who share in the pain and

DO WE BEAR RESPONSIBILITY TO COMBAT COMPLICATIONS FURTHERED BY POOR NUTRITION AND LACK OF ATTENTION TO GENERAL HEALTH?

abuse, the perpetrators and the victims. Our clients are ones suddenly lost to death and those left behind dwelling in grief. Our clients are those uninvited to this sacred space, the therapy room, and those refusing to sit on our couches and in our chairs. They, too, are alive and present in our identified clients, the people physically present in our rooms.

If we identify ourselves as authentic advocates of systems and systems theories, we must maintain proficiency and attain mastery consummate with providing systemic, whole-body wellness across nontraditional borders. We must outline our intentions and carve out more detailed roles.

Therapy is a word we contextualize within healing. A physical therapist helps his or her client regain strength and flexibility. A speech therapist swabs mouths and tongues and reshapes the formation of language, a necessity to communication, and a precursor to a viable, meaningful quality of life in a world that inherently asks us to be in relationship.

At this juncture, we have a choice: to exist in isolation, or to collaborate more widely with our clients and their supports, acknowledging whole health as a way to be well and stay well. What if MFTs seek to educate, assess, and practice even more systemically and collaboratively for the purpose of impacting the whole-body health of those we treat?

Will the seeds of our field move by our choosing—by our deliberate, motivated, researched commitment to treat systems within systems and to treat our clients accordingly—or will we be budged into transition by higherups, prone to dictating protocols and outlining for us what we have historically fought to define? ◆

Monica Stevens-Kirby is a licensed marriage and family therapist in Georgia. She works with child and adult survivors of sexual trauma, same-sex couples, and transgender individuals, and delights in her work with young children, infusing play and expressive arts with traditional, evidence-based therapies. Stevens-Kirby publishes regularly in *The Huffington Post* and currently serves as an adjunct instructor of psychology at Middle Georgia State University. She is a Clinical Fellow of AAMFT, serving on AAMFT's Research & Education Foundation Development Committee. The committee is composed of members who volunteer their time to spread the vision and mission of the Foundation, while engaging in peer-to-peer fundraising.

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