NOVEMBER/DECEMBER 2017

ftm

FAMILY THERAPY MAGAZINE

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

INFIDELITY TODAY

WHAT DO WE KNOW ABOUT ONLINE INFIDELITY?
Research provides insights about the rise of online infidelity, how it has shaped the trajectory of infidelity engagement, the ways in which these relationships are maintained, and the primary couple's ability to recover
PAGE 20

ETHICAL CHALLENGES: MFTs face many challenges in the information age when helping couples facing infidelity and reconciliation. This is compacted when serving a rural community or engaging in social media | PAGE 30

EMOTIONAL AFFAIRS IN THE DIGITAL AGE: Tips for navigating this complex issue and some strategies for emotional infidelity treatment | PAGE 34

CONTENTS

NOVEMBER / DECEMBER 2017 VOLUME 16, NO.6

Couple and Family Therapy Research: What We Know About Internet Infidelity

From politicians to celebrities to our own clients, the perception that infidelity is inappropriate as a behavior, but accepted as practice, is arguably incongruent, but continues in our relationships. The rise of online infidelity has shaped the trajectory of infidelity engagement, the way in which these relationships are maintained, and has impacted the primary couple's ability to recover. **Katherine M. Hertlein, PhD**

In Session: The Unruly Path of Healing After an Affair

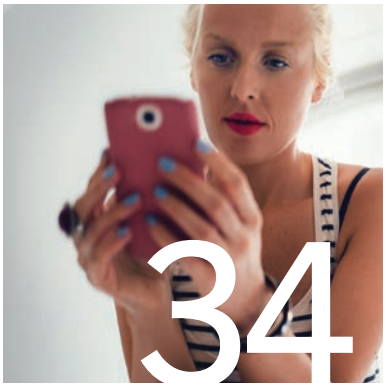
Infidelity can impose an attachment injury, especially when there is already deep hurt and disconnection prior to the affair. Both partners have a fundamental need to feel safe and loved in their marriage. The way forward must be a path that moves a couple toward safer, softer, and more emotionally responsive interactions.
Blake Griffin Edwards, MSMFT

Departments

Also in this issue

Reconciliation After an Extra-Marital Relationship in the Digital Age: Ethical Challenges

In many ways, the issues associated with infidelity have not changed since the inception of MFT as a profession. What has changed is the ways in which people engage in relationships, the increased access to potential partners, and the information about those relationships. The world of social media has created challenges not imagined by the grandparents of family therapy. **William F. Northey, Jr., PhD**



Emotional Affairs in the Digital Age: Strategies for Understanding and Treating Online Emotional Infidelity

Infidelity is a challenging subject for both clinicians and couples. Yet, it is something that most of us have experience with in our practices. Do different types of affairs require different treatments, and what are the best strategies? To help us navigate this complex issue, we must first define emotional infidelity. **Kirstee Williams, PhD**

“As much as clients can successfully navigate Facebook, Reddit, Tumbler, etc., they are not terribly well-versed in why the internet bonds us so quickly to each other, revealing personal, intimate details much more quickly than in offline relationships and gliding down that slippery slope into internet infidelity.”

FAMILY THERAPY MAGAZINE
ftm

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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.

Twenty-five percent of this paper is post-consumer recycled material and preserves 17.49 trees, saves 7,429 gallons of wastewater flow, conserves 12,387,806 BTUs of energy, prevents 822 lbs of solid waste from being created, and prevents 1,618 lbs net of greenhouse gases.

A MESSAGE FROM THE CEO

AAMFT 2017: A Monster Year

Time will tell, but 2017 may be one of the most significant in AAMFT's history.

In just the second year of AAMFT's Leadership Development program, AAMFT witnessed over 120 attendees at the Leadership Symposium. Further, another 30 enrolled in the Certificate of Leadership track. The inaugural Leadership Certificate cohort demonstrated outstanding creativity and initiative through their final portfolio project submissions. While these numbers are exciting and represent some ambitious MFTs endeavoring to evolve into leaders, these programs are also among the most diverse programs within AAMFT.

So you might be saying, "Tracy, that's impressive, but not in the monster category." Fair enough. Then, let's move onto AAMFT's involvement on the new frontier of international participation. In March, AAMFT hosted a 23 member delegation from the China Association of Social Workers. This delegation spent time at AAMFT headquarters in Alexandria, Virginia, learning about efforts on how AAMFT works to promote systemic family therapy through advocacy and education. The introduction of AAMFT to CASW has resulted in some additional relationship building efforts between the associations to bring training in systemic family therapy to social work professionals in China.

In October, while attending the Asian Academy of Family Therapy (AAFT), AAMFT met with conference planning officials and for the first time in AAMFT history, our Advanced Clinical Institutes will be held in Singapore (2019) and cohosted with AAFT. AAMFT is excited to offer our members this wonderful opportunity to enjoy both a vacation and learning experience in a city that has been labeled as the most welcoming in the world.

Thinking, "Yeah, that's nice, but still not really 'killing it'?" Okay, my first reaction is that you're a tough audience, but I have more. 2017 marked the adoption of a more flexible structure, positioning AAMFT to offer members a customized benefit experience designed to meet their changing needs. The bylaws vote, which passed by a 75% to 25% margin, will also serve to create platforms that accesses member knowledge, skills, and experiences to help advance the profession. This shift establishes AAMFT as a truly member-informed association.

The combination of exciting programming, such as the Certificate of Leadership, with international presence, and a fundamental shift in the Association's structure should affirm that 2017 was a big year for AAMFT. Yet, if you are still a bit hesitant to place it in the rarified category as one of the best on record in AAMFT history, then consider one more accomplishment.

The crème de la crème event for the ages was the exciting legal victory in Texas over the Texas Medical Association. After nearly eight years of litigation, MFTs won an amazing victory in the state when the Texas Supreme Court held that a Texas MFT licensure board rule authorizing the right to diagnose was valid.

The Texas Supreme Court found that like other mental health professionals, “MFTs in Texas are trained and qualified to perform diagnostic assessment using the DSM and are tested on that ability as part of their licensing requirements.” The court concluded that “every act that a physician may do is not automatically the unlawful practice of medicine when done by a non-physician, and terminology in one field may overlap with that of another.” The court also concluded that the ability of MDs to diagnose “does not preclude MFTs from making diagnostic assessments of emotional, mental, and behavioral problems.”

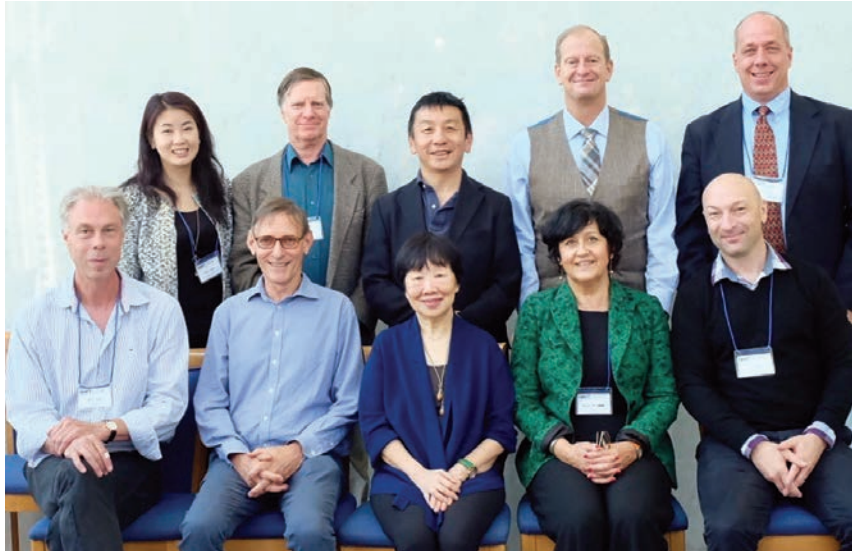
This case is a tremendous victory for not only MFTs in Texas, but the entire profession. The decision will be extremely helpful in persuading policymakers in other states and provinces regarding the ability of MFTs to diagnose. In response to the ruling, Chris Habben, President of AAMFT, expressed, "I could not be more proud of the efforts of past leaders, AAMFT staff, and all who have helped to create this wonderful victory."

These successes are not accidental. They are the result of hard work and dedication by the AAMFT Board of Directors, members, and staff… all working in collaboration to create a high-performance association. AAMFT's efforts, whether it is locally through the advancement of the profession with interest networks, or whether it is globally through AAMFT's participation on the international stage, the results of these efforts will continue to situate AAMFT as the premier association dedicated to the practice and profession of systemic family therapy.

Thank you for your membership, dedication, and contributions!

TRACY TODD, PHD

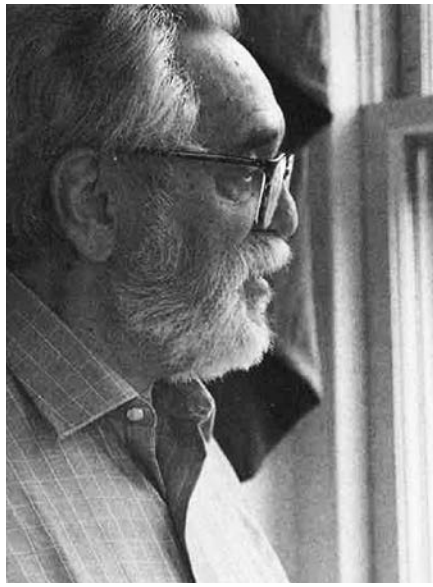
AAMFT President Chris Habben, AAFT17 Chair Takeshi Tamura, and AAMFT CEO Tracy Todd in Tsukuba, Japan.



AAMFT President Chris Habben and CEO Tracy Todd meeting with international colleagues invested in systemic family therapy.

IN REMEMBRANCE OF

Salvador Minuchin: 1921–2017



"The world of family therapy lost one of its greatest pioneers, and I lost my most important mentor. Dr. Salvador Minuchin, MD, 96, died, as he had lived—always learning. At a conference six years ago, he stated, 'I am 90 years old, and I am changing continuously.' He modeled that therapists needed to introduce the power of uncertainty by engaging and learning, and risking exposing themselves. He promoted the ability of everyone to make positive change and eliminate destructive behavior, even with entrenched personality disorders. He knew that right and wrong were not as important as how people feel, and he took different positions in the service of usefulness to the particular client. I will miss him, but I know his teachings go with me, and with many others for the greater good."

– MARY JAMES DEAN, DMIN
CARROLLTON, GA

AAMFT was saddened to learn about the passing of Salvador Minuchin in late October at the age of 96. No matter your particular field of study or clinical work, all marriage and family therapists know of Sal, his contributions to family therapy, and his legacy as the developer of structural family therapy.

Over the years, Sal's style has been described as forceful and intense, but in a manner that communicates respect for family members. He spent his career working on behalf of the poor, marginalized, and ethnically underprivileged, changing the language of therapy to make it relevant to families. Populations typically considered "unreachable" needed new ways of communicating. Sal and his colleagues developed training programs—mindful of multiculturalism—that changed the lives of many people.

Sal contributed to numerous professional journals and coauthored numerous books, many of which explore the effects of poverty and social systems on families. Among these are *The Disorganized and Disadvantaged Family: Structure and Process* (1967), *Families of the Slums* (1967), and *Families and Family Therapy* (1974).

Co-author and close friend Dr. Charles Fishman noted "At this sad moment, losing my dear friend and mentor of many decades, I can only think of the countless number of families, all over world, who have been helped by Sal's brilliance. He gave our field Structure, but for these families, he has given them so much more."

“Sal was an original. He had convictions, cared, and poured himself into his work. The reason why I accepted his invitation to join him in 1968 at the Child Guidance Clinic was because he had created a way of thinking and doing therapy meant to serve ‘the families of the slums,’ the only therapy model I know of that was given birth to speak to the poor and the reality of their experience—structural family therapy. It wasn't just technique. His heart was in it, and it changed lives. These families mattered!

Sal Minuchin was an honorable man, who made an honorable and lasting contribution that made a difference in the lives of people, who needed to be seen and given hope.” **– HARRY APONTE**

Salvador Minuchin was born in 1921 in San Salvador, Entre Ríos, Argentina. His interest in working with family-based interventions came in 1951 while co-directing residential institutions for children in Israel. There, he began to work with groups instead of individuals. Later, Sal trained at the William Alanson White Institute of Psychoanalysis in New York, where the ideas of Harry Stack Sullivan (interpersonal psychiatry) were supported. As he was training, he began practicing at the Wiltwyck School for Boys and gradually recognized that he needed to see a client’s family for full effectiveness.

Today, The Minuchin Center for the Family provides structural family therapy training to individuals, and systemic consultations to organizations, working with couples and families who have been marginalized due to racism, socio-economic conditions and/or sexual orientation.

Our deepest sympathies are with the Minuchin family, his close friends and all those impacted by his loss.

“I was always an admirer of Sal Minuchin and his work. Back in Illinois in 1994, I was attending the AAMFT National Conference in Chicago as a newly elected President of IAMFT. I remember sitting cross-legged on the floor of the mezzanine next to Sal and chatting like we were old friends. He was easy to talk with. He put me at ease before I had to speak in front of hundreds in the auditorium that day. I will always have fond memories of him!”
– CAROL HORAN, MA, GOODYEAR, AZ

“Sal Minuchin shaped my career in profound and lasting ways. I work in an area of the country where structural family therapy is hard to find—I often feel very alone as a practitioner. As a beginning therapist, I poured over his books, drinking in every word with excitement. When I set up my practice for family therapy, I built temples to my ‘gods’—Haley, Madanes, Bowen, Satir—but the altar was always saved for Minuchin. It wasn't just the practical applicability and down-to-earth thinking that got me energized, it was his insistence on the family that warmed my blood. He was a true family man—someone who knew that the family is the fabric of society, and healthy families mean healthy worlds. Rest in peace, Great Master of Families. You will not be forgotten.”

– ANGELA KAHN, MA
AAMFT-CA PRESIDENT

NOTEWORTHY

AAMFT SENDS HEARTFELT THANKS TO

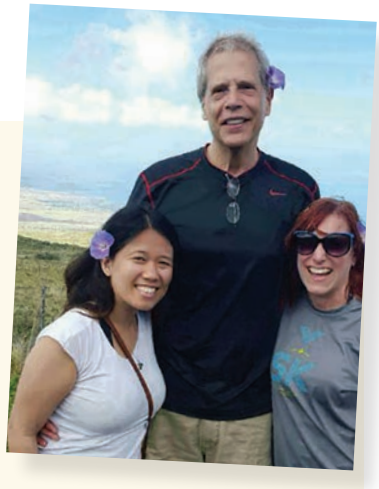
Dr. Fred Piercy

Editor of *JMFT*, January 2012 to December 2017

AAMFT would like to recognize the many years of hard work, extraordinary efforts, and outstanding leadership that Fred Piercy has provided in his role as the editor of *Journal of Marital and Family Therapy*. His commentary in the journal over the years provided a behind-the-scenes peek at the work involved in leading a journal—challenging and thoughtful work—and through it all, Dr. Piercy's devotion and dedication to our association's research publication has been evident and greatly appreciated. He remained committed to continuing efforts to address diversity and social justice, and kept the journal on the path of reflecting current clinical theory and practice. The journal has grown and blossomed during his tenure, and his presence will be felt long.

Dr. Piercy retired after 17 years at Virginia Tech, with 200 academic papers and chapters, five books, and several million dollars in funded grants. He is coauthor with Doug Sprenkle of *Family Therapy Sourcebook*, still in print after 32 years, along with studies on HIV and relationships, cross-cultural issues in MFT, ethics, research methods, and numerous other topics.

As a special goodbye, we asked a member of the journal team to write a special send off. Goodbye, Fred. We hope you enjoy your hard-earned years of retirement!



Fred Piercy: The Acrobat

Dr. Fred Piercy has been an absolute delight to work with in my role as the virtual issues (VI) editor of the *Journal of Marital and Family Therapy*! When he, and the former VI editor, Thorona Nelson, invited me into this position a few years ago, I was pleasantly surprised and honored. I cannot imagine a more supportive and encouraging person to work with in this role than Fred. He has offered thoughtful guidance, support of my ideas, and overall has been a remarkable role model and mentor. When, and if, I ever have a chance to become an editor of a scholarly journal, I will most definitely put much of what I have learned from Fred into practice.

Indeed, Fred has not only has been supportive in his capacity as the editor, he has been a kind colleague and friend. Not all that long ago, Fred and I, along with Hoa Nguyen (a former mentee of ours) and Doug Sprenkle, had a chance to do some hiking in Hawaii while we were all there for the International Family Therapy Association annual conference in March of 2016. It was at this time I learned that Fred had a gymnastics background—an area I never knew we both shared. While mental gymnastics comes up in editorial work, the physical kind is rarely called for in this capacity! We were at the beach after our hike and I was discussing my college and professional cheerleading days, and Fred suggested we do some acrobatic stunts together in the ocean. We skillfully accomplished this task, laughing the whole time, and fortunately did not harm ourselves, or Hoa and Doug, who were, of course, right there cheering us on!

It was also during this trip that I came to know that Fred is not only a brilliant and studious colleague, he is also an incredibly warm and playful person—a combination that is rare; a combination that he brought with him to his role as editor. Over the course of the conference, I had a chance to dine a few times with Fred along with some of our colleagues. Personally, this was a challenging time for me, as I was about to undergo a major surgery, and although I was appearing strong, at my core I was terrified. Fred had such a calming presence in learning about my situation—a force of ease that was so helpful at that time and has not been forgotten since.

In closing, Fred is a gem to those who have been lucky enough to professionally know him, and for those who have been fortunate enough to know Fred as a friend, he is a gift. Fred will be missed at *JMFT*, and I have no doubt that he will be thought of fondly and often by more than just the acrobatic me.

—Markie L. C. Twist, PhD

WELCOME!

Steve Harris, New Editor for *JMFT*

AAMFT is pleased to welcome Clinical Fellow Steven M. Harris, PhD, LMFT, who officially took the reigns of the journal in January, 2018.

Dr. Harris received his master's and doctoral degrees in marriage and family therapy from Syracuse University. He is currently professor and director of the Couple and Family Therapy Program at the University of Minnesota. Prior to living in Minnesota, he was an MFT faculty member at Texas Tech University for 13 years. He has been practicing as an MFT for over 27 years. His history with *JMFT* includes serving as the reviews editor from 2000-2005, and he has been on the Editorial Board since 2000. Dr. Harris is the author of over 65 peer-reviewed articles and book chapters, has written four books, and has contributed a variety of other publications to the field throughout his career. He also serves as the associate director of the Minnesota Couples on the Brink Project.

JMFT, published quarterly, is the flagship scholarly journal of AAMFT and the field of family therapy. The goal of the journal is to ensure the continued development of the science, theory, and practice of marriage and family therapy. *JMFT* disseminates relevant, current scholarship and research that moves the field forward.

AAMFT Family TEAM Hill Week

The combined efforts of our Hill Week and actions from AAMFT members from across the U.S. have brought us closer to achieving MFTs in Medicare. In early November, members of the AAMFT Family TEAM traveled to Washington, DC, to lobby Congress in support of legislation that would add MFTs as Medicare providers. There are currently two bills, one in the US House of Representatives, the Mental Health Access Improvement Act of 2017 (HR 3032), and one in the US Senate, the Seniors Mental Health Access Improvement Act of 2017 (S 1879), that would include MFTs as mental health providers eligible for reimbursement through Medicare. This event was a strategic initiative that invited Family TEAM and other AAMFT members from key congressional districts to visit their members of Congress. Key members of the House Ways and Means Committee, the House Energy and Commerce Committee, and the Senate Finance Committee, all of which have jurisdiction over Medicare issues, were specifically targeted. Eight AAMFT members participated in a total of ten congressional visits. These visits went very well, and three additional Representatives decided to cosponsor HR 3032 during the Hill Week. To coincide with our Family TEAM Hill Week, AAMFT sent out an email alert to all AAMFT members in the United States, which included an action item that allowed everyone to write their Members of Congress in support of H.R. 3032 and S. 1879. After the alert was sent on

FROM LEFT TO RIGHT: Domonique Rice, Helene Taulbee, AAMFT's lobbyist David Connolly, and Roger Smith, AAMFT's Director of Government and Corporate Affairs

November 7, over 2,700 emails were sent in support of this very important legislation. Combined with our efforts earlier in 2017, over 7,700 messages have been sent to Congress! Thank you to all of our members who have sent letters, and those who volunteered to participate in the AAMFT Family TEAM Hill Week.

If you are interested in AAMFT's advocacy initiatives, please consider joining the Family TEAM. Participating in Hill visits is one benefit of joining the TEAM, as we try to reach out to volunteers who are interested in advocacy first. Visit us at **www.aamft.org/familyteam.**

STAY INFORMED AND CONTRIBUTE:

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MFP Recognizes Dr. Phillip Greenwood as Mentor of the Year

The Minority Fellowship Program presented its first offical Mentor of the Year award to Dr. Phillip Greenwood. Dr. Greenwood has a strong marriage and family therapy background. He worked as a family therapist on the Child and Adolescent Psychiatry acute care unit at Virginia Baptist Hospital, a Centra Health facility in Lynchburg, Virginia, for 26 years until he retired in 2013. Dr. Greenwood's passion for marriage and family therapy led him to serve as an AAMFT Minority Fellowship Mentor during the 2016-2017 term as he is always eager to help students and young professionals learn and grow in the profession. Dr. Greenwood has been a part of AAMFT membership, as an AAMFT Student member since 1978, a Clinical Member in 1985, and currently an AAMFT Clinical Fellow. Later in his career, he served on the Board of Directors of the Virginia Association for Marriage and Family Therapy (VAMFT) from 1993 to 2017. After being in the field for many years, he decided to use his expertise and wealth of knowledge to serve as a mentor for the MFP. The AAMFT Minority Fellowship Program is grateful to Dr. Greenwood for his time and investment in the program and the fellows. The MFP Fellows and staff have unanimously agreed that Dr. Greenwood's approach to mentorship has created a lasting impact. Dr. Greenwood is excited to continue serving as a mentor.

THREE QUESTIONS: STUDENTS RESPONDING TO LOCAL TRAGEDY

Sarah Hechter

HOW DID THE COUPLE AND FAMILY THERAPY PROGRAM AT UNIVERSITY OF NEVADA, LAS VEGAS, COME TO BE INVOLVED WITH RESPONDING TO VICTIMS DURING THE AFTERMATH OF THE LAS VEGAS SHOOTING? The Couple and Family herapy Program in UNLV's School of Medicine is one of seven behavioral health entities on UNLV's campus that come together as UNLV's Mental and Behavioral Health Coalition. The task of the Coalition is to work together to improve access to and quality of mental and behavioral health services in Southern Nevada. The tragedy at the Route 91 Festival on the Las Vegas Strip immediately prompted the leaders of the units in the Coalition to begin connecting to prepare an organized, supportive response.

WHAT ARE SOME OF THE WAYS THAT YOU ALL WORKED TO ASSIST YOUR LOCAL COMMUNITY? The first order of business after ensuring the safety of program students and faculty was to coordinate schedules of our therapists-in-training and supervisors to provide free services, as well as walk-in services through our on-campus training clinic. This involved leadership among our CFT graduate students to organize volunteer hours, meetings with both program and clinic directors to make more treatment rooms available, and invitations to community-based supervisors to volunteer to ensure care for the extended hours we offered. Immediately following an organizational meeting from the CFT program leadership and training from supervisors on critical incident work, the CFT program sent a licensed MFT on faculty along with third-year students to Circus Circus Hotel and Resort, the makeshift headquarters for mental health professionals volunteering their time to work with the victims still on the Las Vegas strip and in the MGM hotel properties. The CFT program provided deployment teams with pamphlets and business cards to give to the victims as referrals for free follow-up care to several clinics including the Center for Individual, Couple, and Family Counseling (CICFC), and the CFT Program training clinic, which provides free and low-cost therapy to students, faculty, and members of the Las Vegas community. Immediate access to care was the goal in sending our program out to Circus Circus that day.

WHAT TYPE OF FOLLOW-UP WORK ARE YOU ALL DOING AND WHAT SERVICES WILL BE AVAILABLE TO VICTIMS IN THE COMING MONTHS? In addition to the resources we distributed for free follow-up services, our clinic is continuing to operate with extended hours, with an increase in trauma-trained supervisors onsite, and walk-in appointments. We will continue to provide these services for free to anyone affected by the shooting indefinitely and we operate and support the other clinics and entities in our hometown who have also made this commitment to the victims, their friends, loved ones, and the first responders.

DATA NOTE How AAMFT Clinical Fellows Assess and Treat Online Infidelity

20% INTEGRATIVE

16% SOLUTION-FOCUSED

11% SYSTEMIC THERAPIES

9% SOCIAL CONSTRUCTIVISM

6% EXPERIENTIAL THERAPIES

5% STRUCTURAL

5% BEHAVIORAL

4% COGNITIVE AND/OR COGNITIVE BEHAVIORAL

4% PSYCHODYNAMIC

3% VARIETY OF OTHER MODALITIES

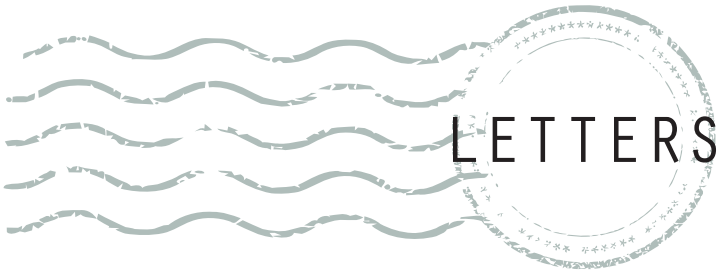
3% STRATEGIC

3% META-FRAMEWORKS

3% ECLECTIC

1% EFT

SOURCE: THERAPISTS' ASSESSMENT AND TREATMENT OF INTERNET INFIDELITY CASES," HERTLEIN & PIERCY, *JOURNAL OF MARITAL AND FAMILY THERAPY*, 2008. PERCENTAGES HAVE BEEN ROUNDED.



LETTERS TO THE EDITOR

As someone whose been practicing, thinking about and advocating for family therapy these past 40 years, I particularly appreciated James Morris' article "What's Become of Family Therapy?" in the July/August 2017 issue. I remain passionately committed to working from a family systems perspective, but in my experience with the mental health world, systems and context are scarcely considered, family therapy competencies usually do not exist, and the DSM and medicinal treatments dominate clinical environments. Services are delivered to diagnosed individuals, and if family members are seen, its purpose is to coach these 'significant others' to support already prescribed individual treatment plans.

On the other hand, community professionals and potential consumers tend to assume that family therapy services are readily available. It makes sense that if a child has a problem parents would be engaged in the diagnostic and treatment work, and that couples with problems might find a marital therapist at a mental health clinic.

After four decades, it's clear there is no quick fix, but our ideas are too important for complacency. Perhaps we need to strengthen our lobby to make family therapy a core competency within health organizations. Maybe we need to educate and empower potential consumers to demand family therapy services. And certainly we need to need to encourage MFTs to seek senior leadership positions within health organizations, where decisions about approach and resources are taken.

Thanks for this interesting issue of *Family Therapy Magazine*.

JIM MORTON, MSW
CLINICAL FELLOW, KENTVILLE, NOVA SCOTIA, CANADA

"I appreciated the essay, 'Mental Health and Black Adolescents' (Sept/October 2017). Dr. White has done all of us in the mental health field a valuable service in calling attention to the unique situation and needs of a vulnerable population, African-American adolescents. She mentions several important stressors on these young people including their cultural history of slavery, discrimination, low income, racism, and oppression. However, it seems odd for a marriage and family therapist not to mention the stress implicit in the marital and family chaos that characterizes many families, Black and White. It is beyond incredible that a person who understands family systems and their impact on children could believe that the problems of the Black family are not worth mentioning when addressing the needs of Black adolescents."

J. ROBERT ROSS, PHD, CLINICAL FELLOW, ST. PETERSBURG, FL

ANNUAL CONFERENCE RECAP:

ATLANTA, GEORGIA

Over 1,600 marriage and family therapists attended the 2017 Annual Conference in Atlanta, Georgia, for a weekend of workshops, keynote addresses, research discussions, and networking events.

David Granirer kicked off the conference with a comedic keynote on his use of comedy to bring awareness to mental health. On Friday, Froma Walsh spoke about the critical role of hope and spirituality in community-based resiliency. Later, Frank Thomas and Michael Howard led a discussion-style keynote on how MFTs can strengthen the bonds of families within the unique challenges of the military. Finally, Kim Phuc Phan Tie gave a moving account of her story as a child burned in the Vietnam War and the peace she found and now promotes.

The exhibit hall was a central gathering place for attendees to meet exhibitors, from graduate programs to products and services such as website building, books, and relationship assessment tools. Five hours of research discussions also took place, showing an exciting and innovative future for the profession. At the center of the exhibit hall was the AAMFT17 Degrees of Connection Board, a visual art project designed to show the many ways in which we are connected and the larger context that strengthens the profession.

>> Mark your calendar for AAMFT18 in Louisville, Kentucky, November 15-18, 2018!


Thomas Sm PhD
Secretary


October 5–8, 2017 | Atlanta, GA
Blow, PhD
Treasurer


AAMFT17
ANNUAL CONFERENCE AND EXPOSITION
October 5–8, 2017 | Atlanta, GA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AAMFT
William Boylin


Handbook of
LGBT-Affirmative
Couple and
Family Therapy


Anxiety
Differentiation
Attachment
Avoidance

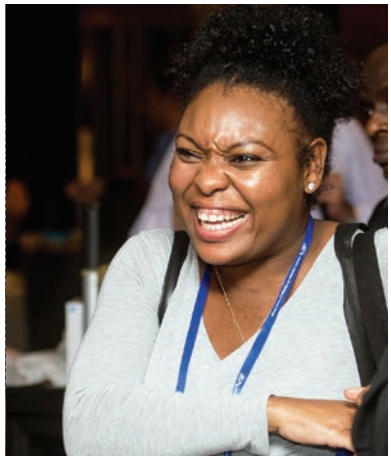

AAMFT










TimeTalk
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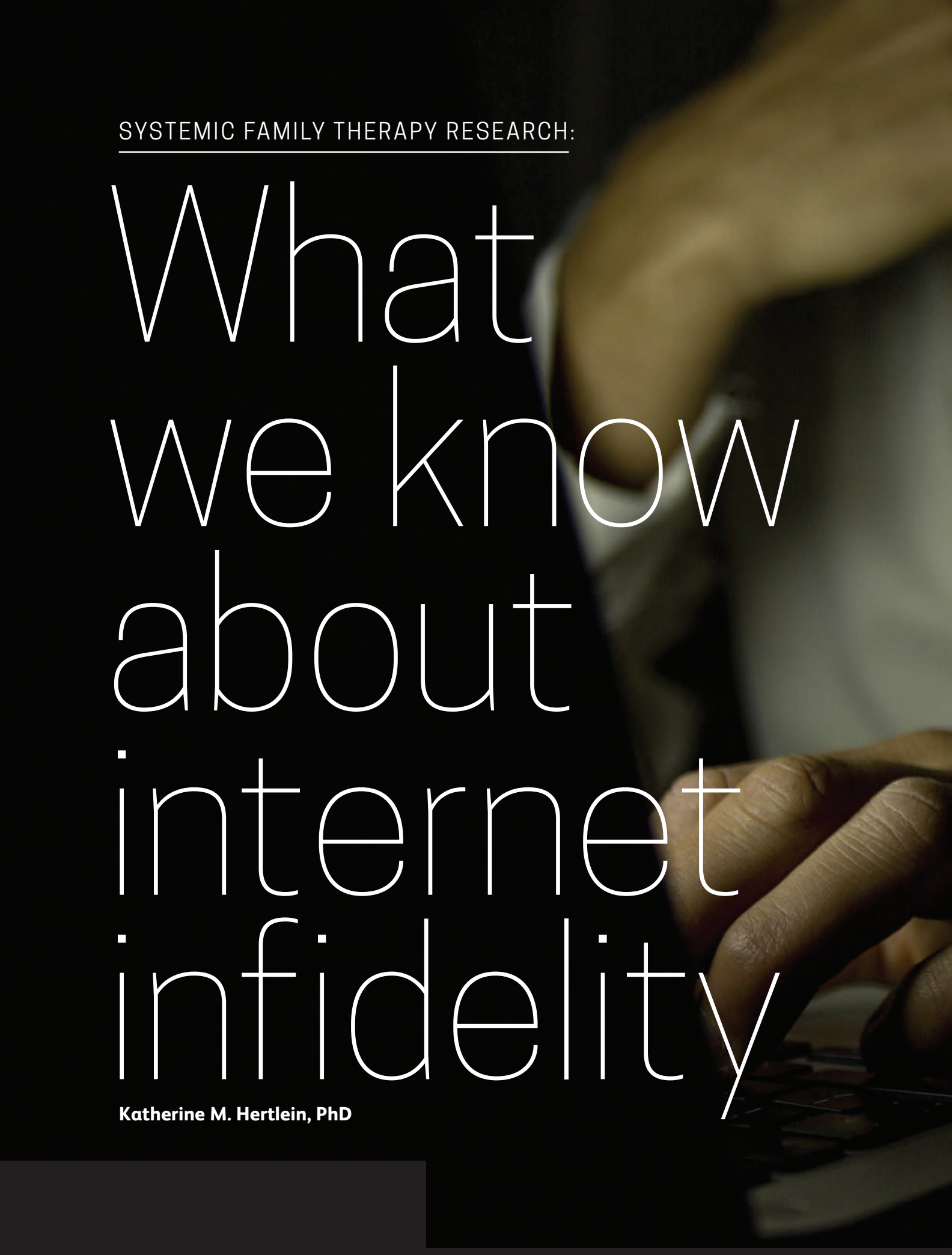
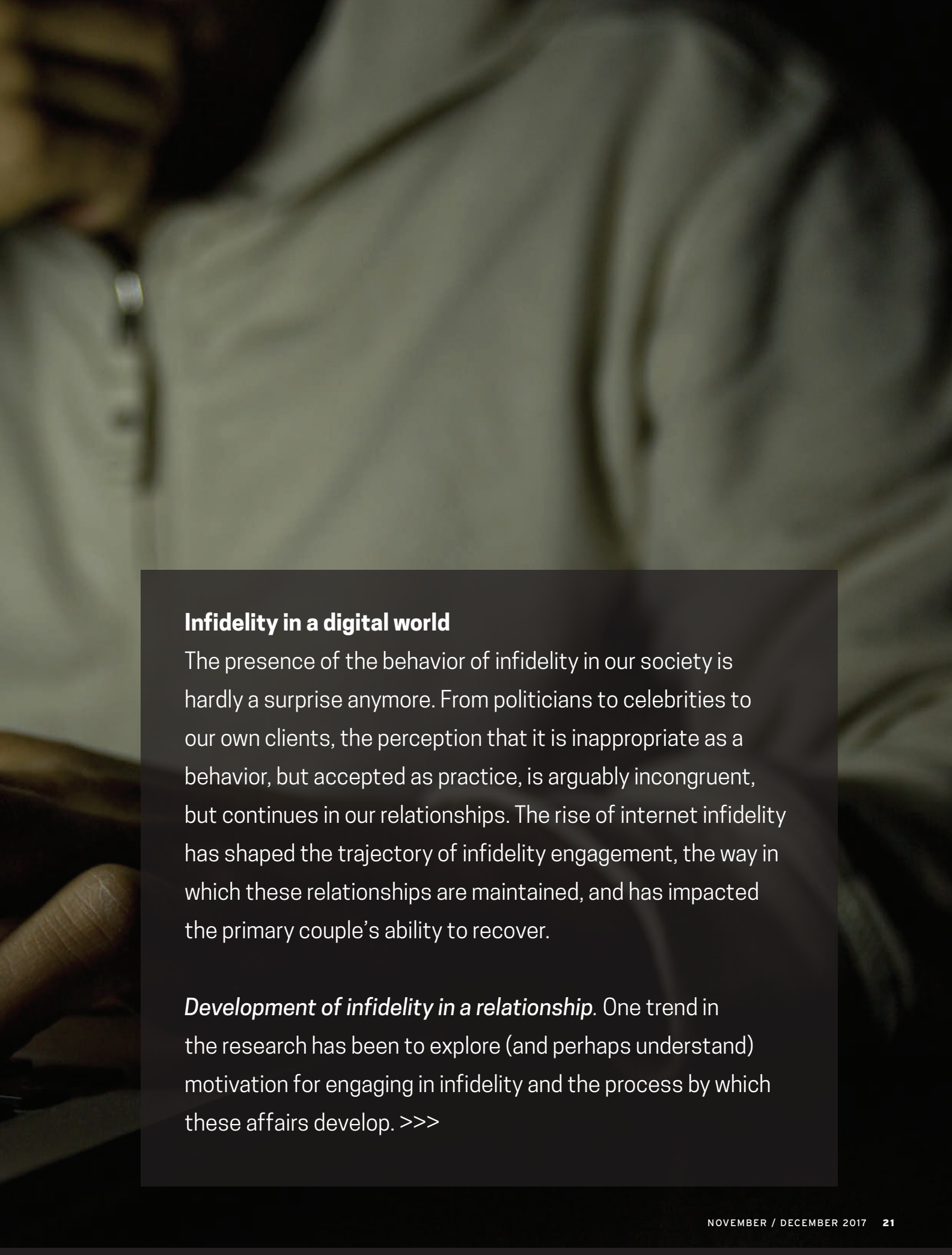
SYSTEMIC FAMILY THERAPY RESEARCH:

What we know about internet infidelity



Katherine M. Hertlein, PhD



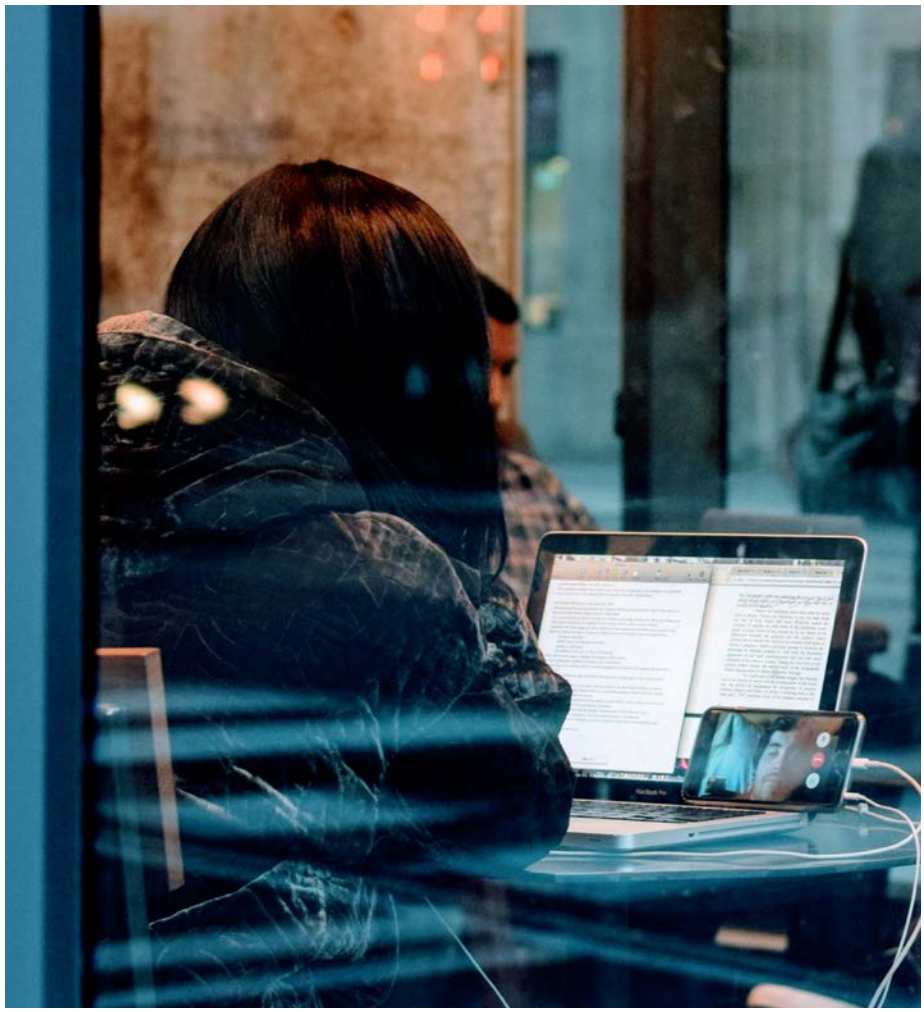
Infidelity in a digital world

The presence of the behavior of infidelity in our society is hardly a surprise anymore. From politicians to celebrities to our own clients, the perception that it is inappropriate as a behavior, but accepted as practice, is arguably incongruent, but continues in our relationships. The rise of internet infidelity has shaped the trajectory of infidelity engagement, the way in which these relationships are maintained, and has impacted the primary couple's ability to recover.

Development of infidelity in a relationship. One trend in the research has been to explore (and perhaps understand) motivation for engaging in infidelity and the process by which these affairs develop. >>>

The primary motivation for engaging in infidelity (both offline and online) was historically considered a low level of relationship satisfaction (Hertlein & Piercy, 2008). Yet over time, the research has demonstrated this finding to be inconsistent, as there are times when people with higher levels of relationship or sexual satisfaction cheat (Blow & Hartnett, 2005). In the case of internet infidelity, clinicians believe the engagement in extradyadic relationships stems from a deficit in the relationship, such as impaired communication and sexual satisfaction (Hertlein & Piercy, 2008). Scott et al. (2016) notes changes to the sexual relationship between a couple precede the engagement in infidelity of one partner. Finally, another frame applied to understanding motivation evaluating cost-benefit ratios is the decision-making model (Zapien, 2017).

Uncovering the role the internet plays in infidelity. Does the internet change why people cheat? Maybe. Opportunity is a significant factor that drives extradyadic engagement (Hertlein, 2012; Treas & Gieson, 2000). Applied to today's context and how accessible the internet is, it means the internet brings Sin City to everyone. Scholars reveal there is a certain group of people classified as "at risk" users: people who would not cheat if the internet weren't available (Zapien, 2017). They are the group that figure, with the advances in technology, a veil of anonymity, the ease of connection, and the ability to cut those connections at a moment's notice, they could ***get away with it***. The internet is both a product we consume and an entity where we are the product. As such, its access is affordable to many, as evidenced by the levels of 88.1% saturation in the US and 51.7% globally (Internet World Stats, 2017). Via smartphones, wristwatches, computers, and tablets, the internet is easily accessible: we can gain virtually any information and people—just as others can gain access to us. It is considered an equalizer of class, ethnicity, and regionality. It is perceived to be a shield through which we can launch insults, private love letters, be vulnerable, or disappear completely, believing we are protected by our devices and software.



There is a certain group of people classified as "at risk" users: people who would not cheat if the internet weren't available They are the group that figure, with the advances in technology, a veil of anonymity, the ease of connection, and the ability to cut those connections at a moment's notice, they could get away with it.

In other ways, affairs are fueled by the internet. It can be the accelerant poured on the flames of love serving to quickly enhance intimacy, connection, and commitment because of the reliance of self-disclosure rather than visual observation—a function of the medium (Hertlein & Blumer, 2013). That can be good news for a relationship needing its flame to be fanned; on the other hand, it poses a problem when one uses this tool to communicate with someone other than their partner and lights the match, unaware they are surrounded by gasoline. Further, as much as clients can successfully navigate Facebook, Reddit, Tumbler, etc., they are not terribly well-versed in *why* the internet bonds us so quickly to each other, revealing personal, intimate details much more quickly than in offline relationships and gliding down that slippery slope into internet infidelity (Glass, 2004).

Current advances in treatment

New frameworks. Cognitive-behavioral therapies are a primary theoretical orientation for managing both the effects of infidelity and working to rebuilding the couple relationship, as well as managing the jealousy that stems from infidelity in a relationship. Another theory that has been applied to treatment is emotion-focused therapy (EFT), with the ground level assumption that the couple experiencing infidelity—online or offline—needs to securely attach to one another in appropriate ways to rehabilitate their bond (Johnson, 2005). MFTs are particularly well-suited to engage in any of these approaches. For example, in EFT, MFTs can help couples talk about not only the fear that comes from the suspicion that the infidelity is continuing, but also tie that to the fear when the partner who was involved is simply using a phone—a clear trigger for the betrayed partner. Other MFTs rely on solution-focused brief therapy (SFBT) (Hertlein & Piercy, 2008) to improve processes within the relationship, and a phone or computers can be used to augment that treatment process by pointing out times where the phone can be used to establish trust. For example, in one case, I had one partner taking pictures and video of where he was and sent them to his partner when she inquired about his location as a way to demonstrate he was being trustworthy.

The Couple and Family Technology framework (Hertlein, 2012; Hertlein & Blumer, 2013) is the primary framework discussing how to assist couples in recovery from infidelity with consideration of the characteristics of the internet and the specific characteristics of the couple's relational rules, roles, and boundaries—the things predominantly fractured during infidelity. In this frame, MFTs can identify ways in which the technology can support a couple in making new boundaries, rules, and how it can change the roles in the relationship in ways that will be more bonding for the couple. Today's technology provides solid ways to "turn off" and develop a more clear boundary between couples and their external world.

MFTs, because of their unique ability to see multiple perspectives of an issue, have designed a unique way to solve this problem. The preferred practice is to broaden definitions of betrayal by adopting a postmodern approach in understanding what a specific couple considers infidelity based on their (overt or covert) rules and agreements.

Expanded operational definitions

Over time, the definition of infidelity has expanded to include any range of behaviors that constitutes a betrayal in a couple's relationship. One of the most thorough studies to date related to the definition of infidelity was performed by Thompson and O'Sullivan (2016). Across three studies, the authors confirmed there are several categories of behavior which constitute infidelity: a) emotional/affectionate behaviors, b) sexual/explicit behaviors, c) solitary behaviors, and d) technology/online behaviors. While early definitions of infidelity were consistent with the sexual/explicit behaviors category, the other three categories have emerged over the last 40 years, with some categories overlapping. For example, solitary behaviors (such as viewing pornography) may intersect with technology behaviors (if the porn being viewed is housed online). The crux, however, of any of these scenarios have not changed over time: secrecy is a significant part of defining one's behavior as infidelity.

MFTs, because of their unique ability to see multiple perspectives of an issue, have designed a unique way to solve this problem. The preferred practice is to broaden definitions of betrayal by adopting a postmodern approach in understanding what a specific couple considers infidelity based on their (overt or covert) rules and agreements. Such negotiation provides an insight into how the couple successfully resolves conflict, as well as teaches each member of the couple to value each other's perspective.

Emphasis on the experience of the betrayed individual

Early in the field, one primary research area looked at whether there was a distinguishable difference between the experience of betrayal in online infidelity versus offline. With the exception of Prueitt (2013), the bulk of studies have explored the experience of infidelity on the betrayed. Study after study finds the perceptions of infidelity are negative; the consequences of internet infidelity are akin to those from offline affairs (Cravens, Leckie, & Whiting, 2013; Whitty, 2005; Whitty & Quigley, 2008). The findings helped to further expand our definition of infidelity, as many of these articles found that betrayal is betrayal, no matter what the point of origin. Finally, research focuses on the pornography and sexting part of the individuals engaging in the infidelity and the experience of those on the receiving end.

New directions

Managing conflicting definitions

Historically, the distinction as to whether one was cheating was relatively clear cut: physical contact with another person in a romantic nature, paired with secrecy, generally constituted a breach of the relational contract. The definition expanded with the advent of the internet, making things less clear. Vossler (2016), in a review of 10 years of literature on internet infidelity, still concludes that Hertlein and Piercy's (2006) conclusion of lack of agreement of a definition is still true. MFTs can rely on their skill set in working with couples with variant viewpoints and agendas to scale back to a common definition that they both may share from this point in the relationship forward.

Managing surveillance. One core issue in clinical care that is advancing more rapidly than our treatment strategies

is the issue of partner surveillance. As quickly as one can discover a partner's infidelities is as quickly as evidence can be deleted, even remotely. This complicates both types of affairs, whether it is solely an affair conducted online or an affair that may have transitioned into some physical meetings. There is little research on surveillance in relationships. Clinically, it manifests as an impediment in rebuilding trust because evidence of continued engagement with the affair partner can be deleted, hidden, or transformed into another data point (Hertlein, Dulley, Cloud, Leon, & Chang, in press). Further, the ability to check up on a partner may transform into an obsession for the one betrayed, particularly with the relative ease and affordability for doing, in part due to the advent of GPS devices, keyloggers, software, and other mechanisms.

The other more enduring and problematic component of surveillance is the inherent power imbalance that comes with the attempt to restore trust and safety in the couple, a challenge that MFTs see as commonplace in their practice across many different presenting problems. To ensure the infidelity is no longer continuing, the betrayed partner typically requests (or demands) access to the involved partner's login information for devices, accounts, and other personal information. MFTs need to outline an appropriate timeline where the individual who has access to the accounts to check on the partner's activities is no longer granted access to those accounts, so as to not create a permanently unhealthy power imbalance. Restoring the power imbalance may involve using the social-relational approach outlined by Williams (2011), which puts power as a central focus in the recovery process of infidelity.

Forgiveness. Finally, the inability to move away from surveillance contradicts the goals espoused by some theorist to move toward forgiveness. One robust addition to the literature is the role forgiveness plays (or should play) in infidelity recovery. While forgiveness is delineated as a central component of infidelity recovery advice, forgiveness is not a panacea and MFTs assisting clients working toward forgiveness must ensure that several conditions are put in place prior to moving in that direction (Hertlein & Brown, 2017), including an assessment of the characteristics of the transgressor, the presence of psychopathology, the presence of emotional, mental, or physical abuse, and caution in advertising forgiveness without a realistic assessment of those conditions.

Addiction. Finally, there is the question of problematic internet use (characterized by some as an addiction, despite the lack of a DSM-5 classification of such) fueling extradyadic relationships. This description of online behavior echoes the claim of sex addiction, as we have seen used by many celebrities, and as we see in some of our clients. Some scholars have suggested the issue is less one of addiction and more aptly described as a compulsion or even destructive habituation. Other scholars have disagreed with that notion, suggesting that the withdrawal and tolerance are enough to engage one back in the internet and, by extension, toward a third party who was accessed through these means. The question as to whether internet addiction, sex addiction, or internet sex addiction play a part in online affairs remains to be teased out as we couple and family scholars work toward clearer classification.

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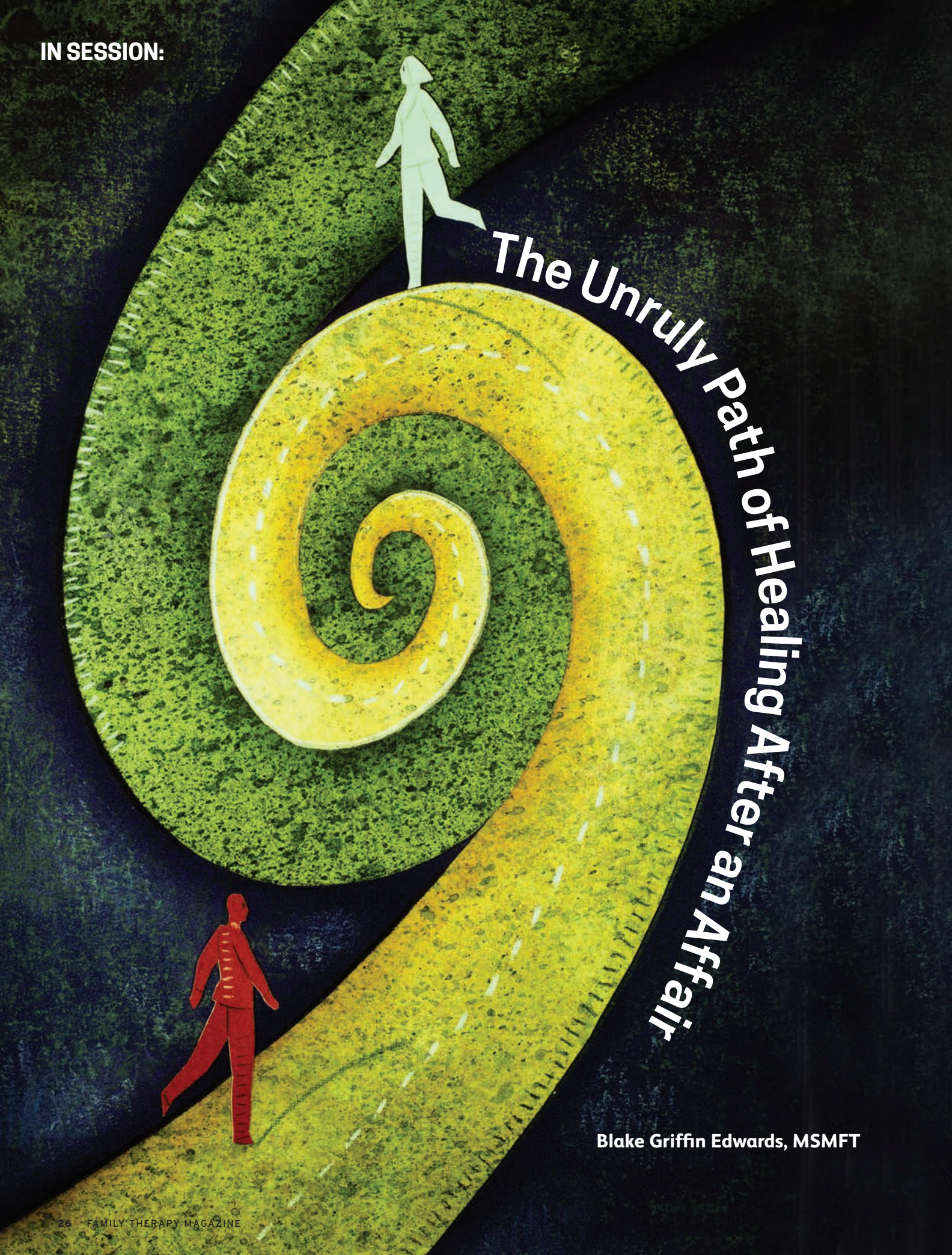


The Unruly Path of Healing After an Affair

Blake Griffin Edwards, MSMFT

Mac and Liz were somber when they arrived to their intake session for couples therapy. At some point, Liz shared a heart wrenching story of Mac's betrayal in a nine-month affair that ended nearly two years ago.

Somewhere between the third and thirteenth session—Mac said, "It feels like you want to beat me down and have justice." She turned to me and said, "When I want to talk to him about how I'm feeling about what happened, he gets defensive." **Stuck doesn't unstick itself, and there is no formula for healing after betrayal.**

SHAME, FEAR, AND ANGER

I remember one session when Liz began crying and became very visibly shaken and shared the distance she feels from Mac, especially during arguments when "I am trying to convince him of how I feel and why I feel the way I feel." As she did, Mac reached out and held her hand, but as she began to share greater detail in a timeline of Mac's stealthy activities during the affair, he kept his hand in hers, but turned away from her, held his chin with one hand, and had a very intense and disagreeing look on his face.

Liz said she is "not willing to let him in if he is not willing to put his guard down." Healing will never happen on the cold terrain of logic, and healing will never happen in the churning waves of anger. Healing happens where we're most vulnerable, in that space when we are willing to be fully who we are at a place of deep disappointment and fear, and we'll only go there if we feel safe.

Liz began to cry and shared how much she wanted to be able to speak with Mac about how hurt she was and rejected she felt because of his affair. He retorted that she is stuck in a victim posture without taking any responsibility for the distance and disconnection that had long since, in his view, characterized their marriage. She asserted he was looking for a justification for his actions. This tit-for-tat conflict went on for a little while and seemed to be a repeat of the arguments they have been stuck in for over a year.

Liz had shared that she felt "raped" by Mac's affair. He sharply defended that her use of such a word was just a vicious attack. She said it was a figurative expression of the complex traumatic feelings she had of having something that she couldn't control thrust onto her marriage without consent.

I confessed to Mac I myself had a difficult time hearing what he is feeling under his façade of anger. Mac reacted, "Yes, that's right, I'm always just the *angry man*." Then he took some time to regroup and shared, "I'm ashamed. At my age I haven't saved any money, I have no career, I'm in a job I hate, I have no self-worth left, and I'm on the verge of losing *everything*." I reflected that I heard him communicating sadness and shame, but wondered if that resonated at all with *him*. He said, "Absolutely, it does. That's what is underneath my anger."

Tailspin and liftoff

Early on, I had asked Liz, "What does moving forward look like to you at this point?" and she responded, "First it means to be able to talk to one another about difficult stuff in healthy ways, and then it means to build new memories together, courting one another again, and building a new future together." Months later, they still found themselves in the midst of not building a new future together, stuck in the same old vicious cycle of one being critical and aggressive and the other defensive and distant.

Infidelity can impose an attachment injury, especially when there is already deep hurt and disconnection prior to the affair. Both partners have a fundamental need to feel safe and loved in their marriage. The way forward must be a path that moves a couple toward safer, softer, and more emotionally responsive interactions.

Early on, I had asked Liz, "What does moving forward look like to you at this point?" and she responded, "First it means to be able to talk to one another about difficult stuff in healthy ways, and then it means to build new memories together, courting one another again, and building a new future together." Months later, they still found themselves in the midst of not building a new future together, stuck in the same old vicious cycle of one being critical and aggressive and the other defensive and distant.

Liz shared that when she is feeling fearful and distant, she has a difficult time not exploding at Mac. I reminded her of a recent episode in which she exploded initially, but had been able to identify that what she really wanted from him was "more affection" and that when she communicated again, softer and more direct about her need, he had reached out and held onto her before she even finished.

Liz asserted that she resonated with how experiencing safety builds trust and feeling trust builds confidence. I noted that it is a "virtuous loop" and that as the good stuff develops, the hard stuff is less hard. Mac again expressed that he is hopeful this is true, but not yet convinced. I expressed that such reticence can become a self-perpetuating and self-fulfilling prophecy and asked him to continue to "lean into the marriage."

Liz began one session describing a volatile fight she and Mac had just been having in the car. Mac was wearing a shirt that reminded Liz of a picture she saw of him wearing that shirt with his mistress. They had found themselves going round and round in a vicious argument full of accusation with neither feeling heard or understood. They sat at a distance on my couch and hurled accusations and defensive retorts at one another.

I intervened when Liz said to me, "Mac just doesn't know how to even show me the affection I need from him. It's like he doesn't care or is incapable of loving me at all." I asked Liz if she was open to me editing her statement, as I told her I heard underneath the words, "I want Mac to show me more affection." I asked if that was true. She said, "Yes, of course." I asked if she would be willing to simply turn to Mac rather than to me and to say to him, "I want you to show me more affection" and to then not say anything else. She told me she didn't think she could without crying, and she began crying. I told her it was okay to do this while crying.

She did turn to him and began to say this, and Mac immediately reached his arm across the couch and touched her arm while she said it. I asked how that had felt when she finished, and she said, "Better."

Liz said she feels she has to watch her back now. Mac listened intently without interruption. I shared that his listening was indeed different, less defensive. He said he thinks it's because "the further I get from the fantasy state I was in, the more I realize what it was and the easier it is to listen."

Beyond the fog of difficult conversations

Several sessions later, the couple laughed with me as they discussed their visit to a coffee shop. I was careful not to short-circuit an opportunity to revel in Mac and Liz as a bonded couple. Near the end of

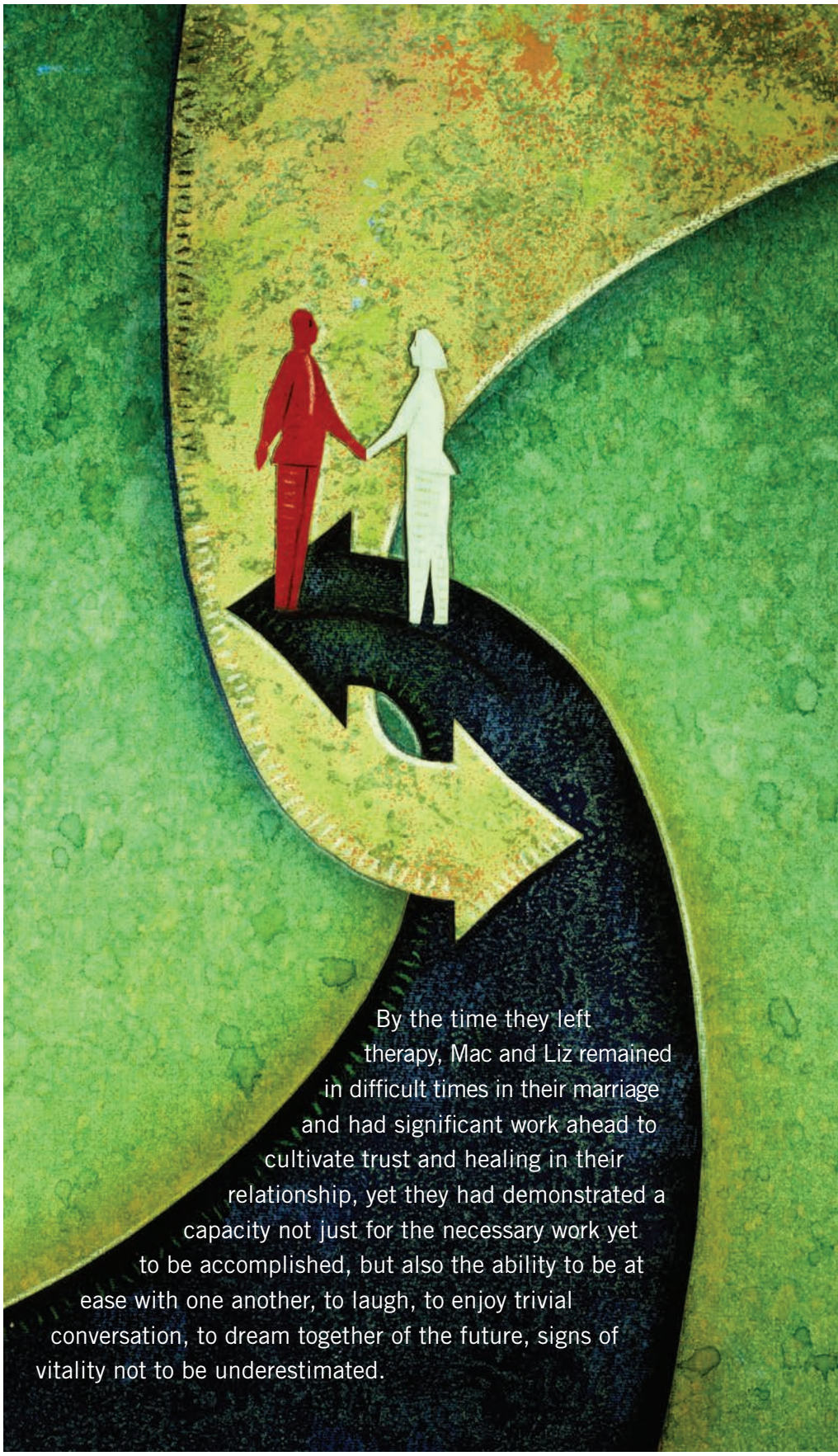
session, I cast hope in "looking beyond the fog of difficult conversations." Minutes later, we steered back into the fog.

Liz shared that she had been surveying Mac's mistress's social media activities from during the time the affair was active, speculating on every potential innuendo. He contended she was looking for triggers and making it difficult for them to move forward. She argued that she can't fully trust him, has lots of questions, and wants to better understand what happened and why. I reflected that there will not likely be *satisfying* answers.

I reflected that there was a difference in how they were now arguing, that they both seem steadier and more respectful in their posture and tone, remaining engaged versus either merely attacking or shutting down. Mac reflected that he saw what I'm getting at, but still finds such arguments very difficult and emotionally taxing.

By the time they left therapy, Mac and Liz remained in difficult times in their marriage and had significant work ahead to cultivate trust and healing in their relationship, yet they had demonstrated a capacity not just for the necessary work yet to be accomplished, but also the ability to be at ease with one another, to laugh, to enjoy trivial conversation, to dream together of the future, signs of vitality not to be underestimated.

Blake Griffin Edwards, LMFT, is a Clinical Fellow of AAMFT, behavioral health champion for the American Academy of Pediatrics, and clinical supervisor whose writing has been featured at GoodTherapy.org, RelevantMagazine.com, PsychCentral.com and in *Family Therapy* magazine, *Context*, and *Voices Journal*.



Reconciliation After an Extra-Marital Relationship in the Digital Age: **Ethical Challenges**

To quote Sir Walter Scott, "Oh what a tangled web we weave, when first we practice to deceive!"

In many ways, the issues associated with marital/couple infidelity have not really changed since the inception of marriage and family therapy as a profession. The loss of trust and confidence, confusion, grief, betrayal, remorse, and, hopefully, reconciliation and healing, have not changed much in the last 50 years. **What has changed is the ways in which people engage in relationships, the increased access to potential partners, and the information about those relationships**. The world of social media has created challenges and variation not imagined by the grandparents of family therapy.

William F. Northey, Jr., PhD

Imagine this scenario. You work in a rural community where the majority of people are a part of your religious community and you are the only MFT in town. Further, issues of infidelity are relatively common. You are working with a client, we'll call him Malcom, who is struggling desperately to reconcile with his estranged wife who had an extra-marital relationship. Currently, Malcom's wife, Carole, is not interested in coming to therapy, but Malcom reports that if he works on some of "his issues" that Carole is willing to come in to work on the relationship. So, you decide to work with Malcom to help him address the concerns that Carole has relayed to Malcom with the eventual goal of helping the couple reconcile.

Some MFTs might express some concern about working with Malcom individually because "the client" is—and should be based on the presenting problem—the marital relationship. That said, up until this point, you have not had any direct contact with Carole, and Malcom is the only one who has agreed to and signed your informed consent for treatment. You suggest to Malcom that you call Carole to get her take on things, but Malcom is adamant that Carole wants him to work on his problems first before she begins the process of reconciliation. Further, clinically you see working with Malcom individually a necessary step to help the couple begin to heal from Carole's infidelity. >>

Working with clients who are interested in reconciliation after an affair presents unique therapeutic and ethical challenges and a delicate balance between "coming clean" and "over-disclosure" is frequently complicated regardless of the community context. Now imagine that while you are working with Malcom, a Facebook post by Carole pops up on your feed because something you had posted had been "liked" by a mutual friend. The post indicated that Carole was blaming her failed marriage on Malcom's financial problems and seems to suggest that Malcom has an "addiction to porn," which Malcom has not yet mentioned to you, and that Carole is the victim in the marriage. At this point Malcom is unaware of your knowledge of Carole's rather public airing of her concerns about him.

The situation is further complicated, when your daughter relays a salacious story of a woman in your religious congregation who has cheated on her husband with another member of the congregation resulting in a rather public scandal. As your daughter shares the current gossip, you realize that the information being shared is about Carole, and while Malcom has shared some of the information with you in session, there are other aspects of the story about which you are sure that Malcom is completely unaware.

This scenario highlights several challenges that MFTs face in the information age when helping couples navigate issues of infidelity and reconciliation after an extra-marital relationship. It also calls attention to the complexities faced by MFTs working in small communities and the impact social media can have on the therapeutic process. The first question that must be considered is, "Who is your client?" Malcom or the couple (Malcom and Carole)? As noted earlier in the scenario, the goal of therapy is to help the couple reconcile, so seeing the client as the couple seems most fitting. However, Carole, to date, has not attended therapy nor has she signed an informed consent regarding treatment, which might suggest that Malcom is the client.

The question about who is the client is not simply an academic one. If you consider the couple the client, then withholding information from Malcom that you have obtained from other sources may be prudent, especially if Carole eventually enters the treatment process. On the other hand, in some ways, not sharing the information might be viewed as keeping a secret. While most of us have a "no secrets policy," it is probably focused on secrets that come from one member of the couple, but not from other sources—although the Facebook post was from Carole. One way to address the dilemma might be to get permission from Malcom to contact Carole directly so that you can better understand the issues that Carole would like Malcom to address in treatment prior to her participation. This option has several benefits in addition to clarifying the problems Carole is experiencing. It will also allow you to better assess Carole's interest in participating in treatment and ideas about reconciling.

While considering the potential impact on the couple would be important, it would be difficult to know beforehand how the sharing of information would impact the individuals, the couple, or the relationship process. Perhaps sharing the information with Carole in an individual session might create an opportunity for a resolution—but what if Carole does not wish for the information to be shared? Would you be obliged to share it with the couple if you thought it was important to the therapeutic process? Would not sharing be a form of deceit? What if you thought it was harmful? Wouldn't you have to disclose the information? Would you refer the couple, or Carole, out? We can find some guidance in AAMFT's Code of Ethics (1.10 Referrals, 2015). Would you continue to see Malcom or refer him to an individual therapist, as well? Would this be abandonment (1.11 Non-Abandonment, AAMFT, 2015)?

If we consider Malcom the client, then using the supplemental information might be considered. Malcom has stated that Carole wants him to address "his issues," and if use of pornography is one of those issues, despite Malcom's reluctance to share that information, then it could be considered beneficial to Malcom (1.9 Relationship Beneficial to Client, AAMFT, 2015). Alternatively, sharing that information might take away from Malcom's ability to decide when he wants to address a particular issue in treatment and take away from his ability to make that decision (1.8 Client Autonomy in Decision Making, AAMFT, 2015). Again, seeing if Carole might be willing to come in for a session or getting permission from Malcom to contact Carole might address some of these issues.

One of the more nuanced issues presented by this case is the impact that social media can have on the treatment process. In this case, you were a "victim" of the Facebook algorithm that provided the post in your feed; that is, you were a passive recipient of the information. Nonetheless, if you decided to use the information, explaining the process by which you obtained it to Malcom or Carole might be problematic. Given the ubiquity of social media, it is probably wise to have a position on how social media is used in your practice that is shared with your clients as part of your informed consent process. While it is not part of my written informed consent, I often talk with my clients about how

If you view withholding information the same as lying directly to someone, doing so might make it difficult to be true to your personal values. Things you might not do or value in your personal life may get stretched or challenged when trying to navigate the therapeutic process when doing what is best for clients.

I will deal with situations where I may see them in public. Nowadays, I think a requisite position on the use of social media vis-à-vis clients is also judicious.

A case like this also presents challenges to us as MFTs and people (i.e., person/self-of-the-therapist). If you view withholding information the same as lying directly to someone, doing so might make it difficult to be true to your personal values. Things you might not do or value in your personal life may get stretched or challenged when trying to navigate the therapeutic process when doing what is best for clients. For example, you may view the withholding of such information in direct conflict with the ethical principle of Client Autonomy (1.8 Client Autonomy in Decision Making, AAMFT, 2015). That is, withholding the information might make it difficult for Malcom to make an informed decision. Alternatively, sharing that information might make it difficult for the couple to reconcile if Carole eventually decides that is what she would like to do. It is hard to tell beforehand who, if anyone, might benefit from the disclosure. As marriage and family therapists, we always want to do right by our clients. Unfortunately, the complexities and intricacies of family life often present conundrums that necessitate serious soul searching.

Providing therapy to couples who wish to reconcile after an extra-marital relationship pose varied clinical and ethical challenges. As illustrated here, there are often a number of competing values and principles that make determining an obvious path complicated. Consideration of "who is the client;" beneficence and malfeasance; having an agreed upon treatment goal and plan; and inclusion of an informed consent that lays out your position on secrets, and the use of other information, including that from social media are critical to clinical success.

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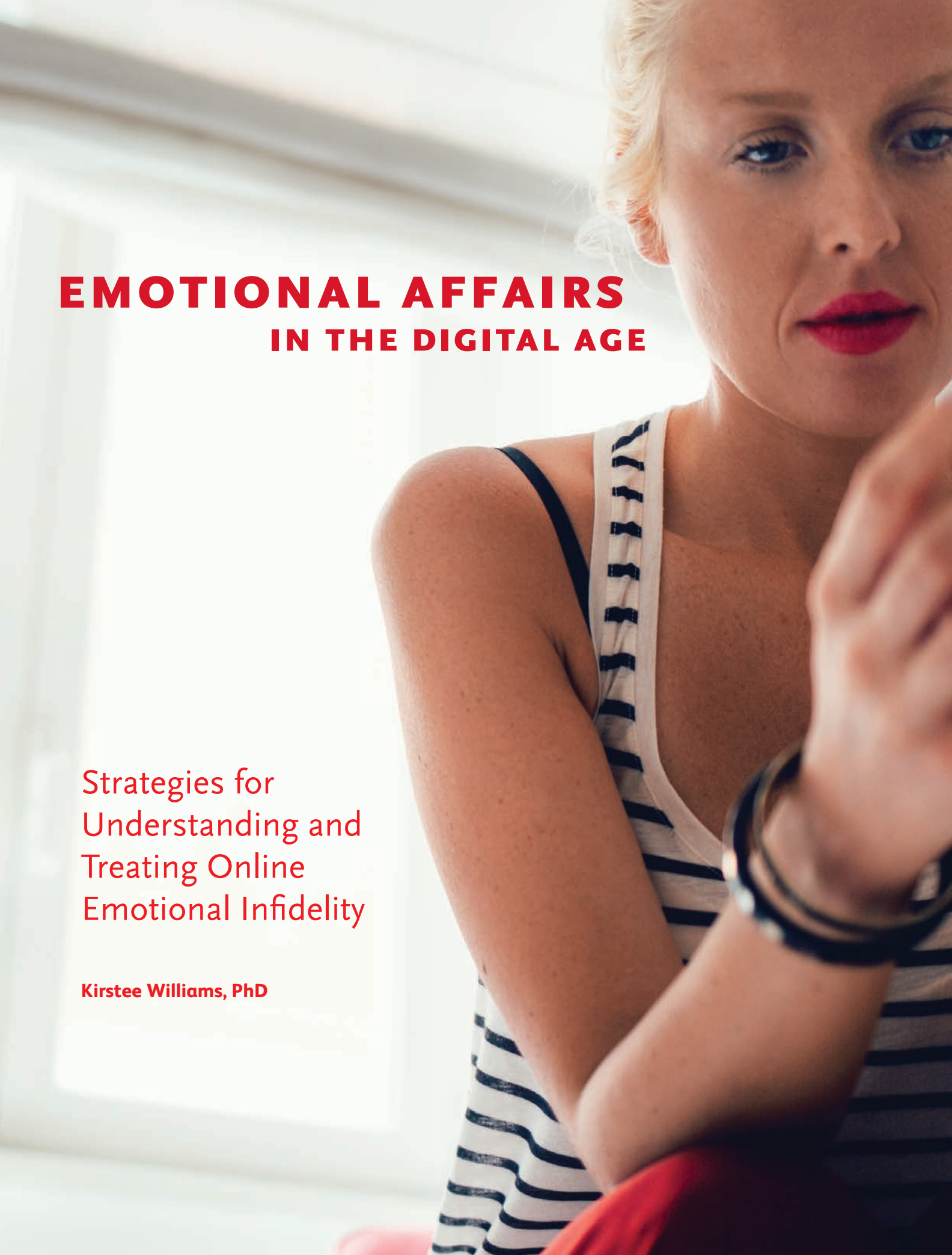
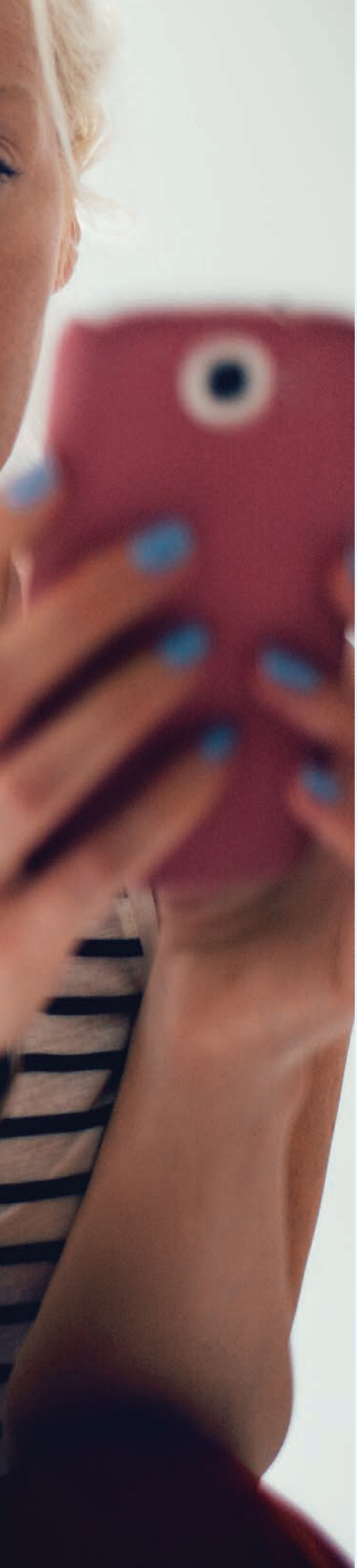


EMOTIONAL AFFAIRS
IN THE DIGITAL AGE

Strategies for Understanding and Treating Online Emotional Infidelity

Kirstee Williams, PhD



INFIDELITY IS A CHALLENGING SUBJECT FOR BOTH clinicians and couples. Yet, it is something that most of us have had some experience with, whether it be in our own practices or with someone we know personally. Despite this, clinicians have, for a long time, ranked infidelity as one of the most difficult problems to treat, second only to domestic violence (Whisman, Dixon, & Johnson, 1997; Weeks, Gambescia, & Jenkins, 2003). The clinical complexity in working with affairs is apparent as one delves into the literature for guidance only to find that there is as much diversity in treatment strategies as there are reasons for why someone is unfaithful. It can be difficult to summarize the literature, but what can be even more challenging is determining the type of affair that has occurred.

This begs the question, do different types of affairs require different types of treatment? Which strategy do I need to follow? I often see this look of bewilderment on the faces of my students who sit in my infidelity lectures. I can see in their faces the same question we as practitioners have, the knowledge is so vast, how will we ever be able to absorb it all? In this article, I will break down some of these questions, focusing specifically on defining emotional affairs and how to work with them in the digital age.

Defining affairs

It can be difficult to define different types of affairs. Historically, we have separated infidelity by four main categories:

- Sexual (solely sexualized interactions)
- Emotional (solely emotional involvement without sexualized expression) (Whitty & Quigley, 2008)
- Online (sexualized and emotional involvement with online media, person or persons)
- Traditional (sexualized and emotional involvement with a live person or persons)

Yet, in my practice and in supervision of my students' cases, I find these four aspects are more intertwined than distinct. The rise of the internet, with its affordability, anonymity, and accessibility (Cooper, 2002) makes possible extramarital relationships that may not have otherwise been imaginable. The internet also creates a certain amount of ambiguity for treating affairs, because online problem behavior can be difficult to define (Hertlein & Piercy, 2012). As Hertlein and Piercy (2012) articulate, we know that online affairs can have both sexual and emotional aspects (Henline, Lamke, & Howard, 2007; Parker & Wampler, 2003; Whitty, 2003). It is not difficult to see the challenges that can arise from sexual and emotional encounters on the web. For example, Schneider (2003) articulates that cybersex does have an extensive impact on relationships: creating feelings of betrayal, a decrease in desire for relational sex with one's partner, and the betrayed partner often making self-comparisons with the online partner(s).

In exploring wives' experiences of their husbands' pornography use, Zitman and Butler (2009) found three attachment-related impacts that progressed as the online relationships continued: "1) first the development of an attachment fault line in the relationship, stemming from perceived attachment infidelity; 2) followed by a widening attachment rift arising from wives' sense of distance and disconnection from their husbands; and 3) culminating in attachment estrangement from a sense of being emotionally and psychologically unsafe in the relationship" (p. 210).

Defining affairs

Due to the interconnectedness of sexualized and emotional behaviors online, research is limited in understanding those experiences of individuals and/or couples who experience solely emotional involvement. Some researchers do suggest that online behavior is largely motivated by emotional connections to the online person(s) (Underwood & Findlay, 2004). Yet, it has been this clinician's experience that sexualized behaviors and emotional involvement are more intertwined than separate for those using digital media for unfaithfulness.

Research highlights gender differences related to fears regarding emotional verses sexual affairs. In general, men and women do not differ in the amount or frequency in which they experience jealousy in their primary relationships (Buss, 2000). Yet, research does find that men and women do differ somewhat in their concerns regarding types of affairs; with men in general more upset by sexual infidelity and women by emotional affairs (Whitty & Quigley, 2008). Despite these gender differences, we as clinicians know that it is imperative to help couples explore their own definitions of infidelity, as these vary based on the couple's context, such as culture, family of origin, beliefs, values, and trauma history. (Piercy, Dolbin-MacNab, & Richardson, 2011).

I have found that in dealing with emotional affairs specifically, most of my client couples hyper-focus on a single question, "Do you love him/her?" I have seen that the answer to this question is a powerful organizer of the trauma for the couple and often the relational outcome. It has been my experience that emotional affairs can outrank solely sexual affairs in having a damaging impact on a relationship for many reasons. The first being that emotional affairs are difficult to define and couples often argue whether an affair actually took place, making establishing boundaries in affair recovery extremely difficult. Second, emotional affairs are hard to get over for both the betrayed and involved partner. Involved partners who are in love with their affair partner often have significant grief work that has to be done before they can reinvest fully in the primary relationship, if they choose to stay. Third, most clinicians agree that ending an affair prior to couples work is a necessary step (Piercy, Dolbin-MacNab, & Richardson, 2011), but emotional involvement can be a one-sided experience that continues long past the affair itself. This can prolong the healing process and impede therapeutic work. Lastly, emotional involvement may mean a partner is in fact done with the primary relationship, so the possibility of saving that relationship is not probable. These factors must be assessed in treatment, as they tend to be critical elements that can limit the ability to move couples forward.

Working with emotional online affairs

In general, the literature outlines traditional affair work as a three stage process: 1) assessment and crisis management, 2) working through how the affair occurred, and 3) forgiveness and moving forward (Williams & Knudson-Martin, 2013; Williams, 2011). Yet, within each stage there is tremendous diversity based on client need and therapeutic modality. The next section will address working with emotional affairs in the digital age through a three-step model, incorporating those unique considerations that both emotional and online behaviors require. There has been much written on dealing specifically with online affairs (Hertlein & Piercy, 2012; Hertlein & Piercy, 2006; Hertlein & Piercy, 2005) and this type of infidelity needs some special consideration because it is different than a traditional affair. It is also important to note that this three-stage process is not linear, but circular. As couples move through one stage, they may need to repeat first stage work depending on what information arises during treatment.

Assessment and crisis management

Initial interventions in the first stage of treatment typically explore several important aspects—the couple's commitment to working on the relationship, helping couples develop an accountability plan, facilitating emotional expression between the hurt and offending partners, and assessing for perpetuating factors, such as duration of the affair, family of origin issues, and individual personality and cultural features of each partner (Williams & Knudson-Martin, 2013; Williams, 2011). Yet, when dealing with emotional online affairs, many of these important aspects become all the more challenging. For example, what is the couple's commitment to working on the relationship if one is in love with the affair partner? A few suggestions and questions for consideration when working on this stage of recovery: 1) assess the level of emotional involvement with the offending partner, 2) establish an accountability plan for dealing with internet use specifically, 3) how does individual/couple access to the internet need to change as a way to establish some boundaries to aid in healing? In addition, Hertlein and Piercy (2012) suggest that in dealing with online affairs, therapists must walk through a variety of steps in treatment, the first two including developing physical boundaries regarding computer use, and psychological boundaries by helping the couple define what constitutes appropriate online behaviors.

Working through how the affair occurred

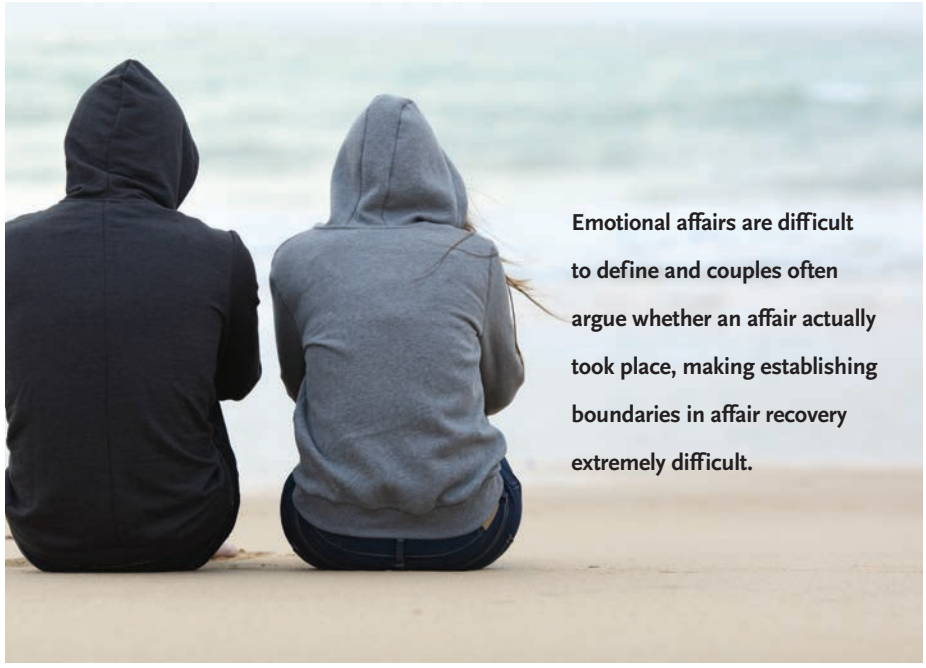
Once the initial crisis of discovery has subsided and boundaries have been established, clinicians typically view

the second phase of treatment as the opportunity for in-depth processing of how the affair occurred (Williams & Knudson-Martin, 2013; Williams, 2011). This is often the longest stage of treatment. For example, what was the individual and relational context like during the online affair behavior? Some items for consideration at this stage: what are the individual vulnerabilities that led to seeking an online partner(s); what are the contextual considerations like power inequalities, gender discourses, or a sense of entitlement to privacy/secrecy (Williams, 2011); how much grief is the involved partner in upon losing or terminating the affair relationship (this may have to be processed individually for a while during this stage if there is significant grief work to be done); and how is the couple making sense of or creating meaning around the affair? Hertlein and Piercy (2012) also suggest it is important to manage accountability, trust, and feelings; increase client awareness around etiology of the online relationship; assess the couple's context and readiness for change; and assess the presence of unique circumstances surrounding the affair.

Forgiveness and moving forward

Finally, in the third stage of treatment, clinicians typically focus on interventions that range from developing hope to exploring the meanings of forgiveness and apology, changing old patterns and expectations, and pursuing the relationship or starting a separation process (Williams & Knudson-Martin, 2013; Williams, 2011). Following are some final questions and suggestions for consideration in this stage: help couples define forgiveness; who is expected to be forgiven or to seek forgiveness; how do couples decide when separation would be necessary or important; process how therapy has been helpful up to this stage and what changes the couple has experienced in their interactions with each other and the internet; what work does the couple say is still left to be done (normalize setbacks); and create a plan for setbacks.

Affairs are challenging work, and online emotional affairs even more so. However, with a general outline, treatment can be manageable. It is important to stay current on infidelity literature as we live in a society where extramarital involvement is in rapid transition with more possibilities than ever before. Yet, hope and healing are possible and it has been my privilege to sit with my clients as they seek this journey.



Emotional affairs are difficult to define and couples often argue whether an affair actually took place, making establishing boundaries in affair recovery extremely difficult.

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PERSPECTIVES

Rebecca Morrison Gleed, MA

Making a Case for MFTs in the Field of Crisis Intervention

With demand on the rise for emergency mental health services in the United States, marriage and family therapists (MFTs) can expect to conduct increasingly more crisis intervention. The Centers for Disease Control and Prevention (CDC, 2015a) reports there were 41,149 suicides in 2013 in the United States—a rate of 12.6 per 100,000 is equal to 113 suicides each day or one every 13 minutes. Further, death due to drug overdose is on the rise. Opioids remain the main driver of drug overdose deaths and have quadrupled since 1999 (CDC, 2015b). Suicide, violence, and opioid overdoses in many jurisdictions are characterized as epidemics and have enacted regulations in response. For example, the Commonwealth of Virginia, subsequent to the suicide of Senator Creigh Deed's son, passed a bill requiring state hospitals to admit someone under an emergency custody order if a bed is not secured within eight hours (Code of Virginia, 2017).

As a crisis intervention specialist within county mental health emergency services, I found myself acting as a petitioner on a case for which I had recommended (then issued by a magistrate) a psychiatric temporary detention order. During the hearing, the county and respondent's attorney intensely debated whether or not I qualified as an expert witness. My degree in MFT became the pinnacle of debate. One question asked by the respondent's attorney stands out in my mind: "Are MFTs even trained in mental health evaluations, risk assessments and mental status examinations?"

According to AAMFT (2017):

> MFTs are mental health professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems… They evaluate and treat mental and emotional disorders, other health and behavioral problems, and address a wide array of relationship issues within the context of the family system…Marriage and family therapists are recognized as a "core" mental health profession, along with psychiatry, psychology, social work and psychiatric nursing.

Beyond being a core mental health profession and able to positively contribute to the field of crisis intervention, what unique contributions do MFTs bring to crisis intervention and how do we highlight these contributions in various milieus, such as hospital emergency departments, community services board emergency services, intensive home-based services, mobile crisis units, the Department of Veteran Affairs, and other agencies and organizations?

Unique contributions of MFTs to crisis intervention

Clinical Triage. Clinical triage is an integral and necessary aspect of crisis intervention. Whether you are the responding clinician to a telephonic notification from first responders stating that the individual is en route to your facility, the assigned clinical triage supervisor, or a psychiatric liaison in an emergency department, clinical triage is critically important not only in gathering relevant information regarding risk, but setting the stage for intervention. Friends, family, and significant others are frequently involved at the peak of crisis, at times the initial interveners in that they pursue immediate assistance on behalf of the individual. What an opportunity for MFTs to draw upon training related to relationships and families while triaging cases. Following are two scenarios utilized to highlight how MFTs might do so.

Friends, family, and significant others are frequently involved at the peak of crisis, at times the initial interveners in that they pursue immediate assistance on behalf of the individual.

A 14-year-old adolescent male is brought to your private practice by his mother for an intake appointment and shows you fresh self-inflicted cuts which are seemingly deep and have perforated tissue.

Relational/familial considerations

Medical concerns will clearly be addressed first and foremost, but what's next? What is the nature of the parent-child relationship? What have you observed thus far? Can she safely transport him to the nearest emergency department or should you request an ambulance? Are there alternative family members you can utilize for transportation? Other clinical examinations unique to an MFT might include relational triggers to cutting, as well as the process of incorporating them and addressing those triggers into future treatment. If you are triaging then assigning this case to another clinician, how might you present the presenting primary clinical concerns to include relational, parent-child and familial considerations?

An intoxicated 59-year-old married female is transported to her Community Health Center by her Alcoholics Anonymous sponsor. She relapsed last night after eight years of sobriety.

Relational/familial considerations

Once imminent safety and risk concerns are surveyed and addressed accordingly, in conjunction with a comprehensive clinical triage, MFTs might assess the marital relationship and explore relational triggers to relapse. Relational conflict can, for example, trigger relapse. Understanding the relational context can inform first steps in your clinical approach. In addition to involving her AA sponsor, would she like to include any other supportive persons?

Case conceptualization

Case conceptualization indubitably informs and influences a clinician's approach to crisis intervention, including the clinical disposition. I often observe clinicians entirely omit questions related to relational and familial functioning during risk assessments and mental status examinations, when doing so prevents them from developing a comprehensive clinical picture of the individual. Assuming, for instance, that a teen resumed self-harming behavior solely in response to discontinuing his anti-depressant, could fail to realize the relational/familial complexities and precipitants to self-harming relapse. MFTs' knowledge and perspective that individuals function within the context of relationships and family systems allows for a greater, more comprehensive clinical conceptualization, resultant of more efficacious interventions and dispositions.

A 24-year-old male withdrew from college after his first psychotic episode. He moved home to utilize the support of his mother and stepfather while he

initiates psychiatric treatment. Once stabilized, he intends to return to college. He presented with his mother and stepfather to the emergency department with a primary complaint of worsening auditory hallucinations. You are employed at this ED as a crisis intervention specialist.

Once relevant clinical information for diagnostic clarification is gathered, what's next? Some relational and familial-based questions are:

- Is there family history of psychosis?
- How might you briefly assess family dynamics, rules, boundaries, etc.?
- What is the nature of the parent-child relationship? Sibling relationships (if applicable)?
- Are there stressors within the home environment that might exacerbate psychotic symptoms?
- Are delusions, if any, focused on any particular family member? If so, are these delusions incorporated into a long-standing dynamic?
- Is medication adherence influenced or impacted by the family system?

Crisis intervention (safety planning)
Utilizing Roberts' Seven-Stage Crisis Intervention Model (2005), various relational and familial focused questions, interventions, and techniques are explored to offer and highlight the MFT perspective.

Planning and conducting an assessment
Many variables are considered when planning and conducting biopsychosocial and risk assessments. Not uncommonly, individuals in crisis are not able to meaningfully participate in the evaluation or intervention process. Collateral and historical (if available) information, then, becomes key. In addition to collateral information collected from first responders and treatment providers, collateral information from family members provides information, often critical, for the clinical and risk assessment, intervention process and disposition formulation. Furthermore, lack of familial connection, such as loss of contact or intentional cutoff from the individual, and the *why* or *when* surrounding the contact loss or cutoff, can provide useful information. More importantly, what could be missed during a crisis if a family member who has had recent contact with the individual is not interviewed?

Making psychological contact with and rapidly establishing the collaborative relationship is both a skill and an art. Doing so in a crisis situation, particularly rapidly, can be a sensitive and challenging process.

In assessing risk to self or others, what questions can be added to a risk assessment to integrate an MFT perspective?

- You mentioned having urges to cut today which decreased when your mom returned from work. What was it about your conversation with your mom that calmed these urges?
- You reported suicidal thoughts precipitated by increased auditory hallucinations (voices). You talked with Dr. Smith who has since modified your medication. In the past, you've mentioned the positive impact of reducing stress at home. Is it possible to include your wife in the session to discuss ways to reduce stress in the home environment?

Establishing the collaborative relationship
Making psychological contact with and rapidly establishing the collaborative relationship is both a skill and an art—sometimes impossible in severe circumstances, such as psychotic mania, intoxication, or catatonia. Doing so in a crisis situation, particularly rapidly, can be a sensitive and challenging process. "A time of crisis seems to be an opportunity to maximize the crisis clinician's ability to intervene effectively as long as he or she is focused in the here and now, willing to rapidly assess the client's problem and resources, suggest goals and alternative coping methods, develop a working alliance, and build upon the client's strengths. At the start it is critically important to establish rapport while assessing lethality and determining the precipitating events/situations" (Myer, William, Ottens, & Schmidt, 1992, para. 7).

A question I often ask myself during initial contact and the rapport building process is, who will I include and why? Furthermore, will I include this person throughout or during a specific phase? These questions highlight the underlying importance of thoughtful, purposeful and swift clinical decision-making throughout the entire process.

Identifying major problems
Identification of major problems is critically important in the realm of crisis intervention. Identifying major problems and precipitants is not always a swift or easy venture, but a lengthy and challenging one due to subtleties, covertness and incomplete information. It becomes the task of the clinician to do so rapidly and efficiently. If a major problem cannot be ameliorated, the likelihood for symptoms and subsequent risk remains high.

Through observation and discussion with colleagues, I am surprised at the omission of relational and familial exploration during this stage. As an MFT, maintaining the perspective of "the individual within his or her relational context" can direct the development of relational and familial-focused questions pertaining to major problems and precipitants. Some examples of scenarios to spotlight how this lens can provide vast insight include

complicated grief, recent disruptions in the parent-child attachment, relational abuse, or new familial stressors. A further point to highlight is the importance of identifying factors that could change in the near future to increase or decrease the level of risk. Undoubtedly, this perspective is valuable and bolsters the argument to include and welcome MFTs in the field of emergency mental health.

Exploration of feelings and emotions

Encouraging an exploration of feelings and emotions during crisis intervention requires the clinician to skillfully draw upon techniques. If you are not the primary provider for this individual (frequently the case during crises), maintaining awareness of your specific role is essential, as this will influence how and to what extent you facilitate this exploration of feelings and emotions. More extensive exploration can be offered once the crisis has passed. Although far from a comprehensive representation of relational and family system modalities from which to draw, following are two examples to illustrate the application of such during this stage of crisis intervention.

Narrative therapy. When someone presents in crisis, it is common for the presentation to be a final attempt to seek help. One route for intervention is taking a collaborative approach with the individual to explore "hidden possibilities," as ascribed in narrative therapy (White & Epston, 1990), as well as to identify accompanying feelings and emotions. Externalization, the idea that "the person is not the problem, the problem is the problem" is an additional narrative technique to assist in further emotional exploration. Moreover, it can result in significant distress reduction. I recall an instance when a young adult male externalized his heroin addiction, which allowed him to move from contemplation to action, resulting in voluntary admission to a detox center.

Patient and family stress can be reduced by creating an environment that is predictable and supportive. The therapist can suggest clear rules and reasonable expectations to aid in simplifying interactions and help facilitate interpersonal and generational boundaries.

Structural family therapy. Another approach for promoting emotional exploration is structural family therapy (SFT, Minuchin, 1974). Although not developed with the purpose of crisis intervention, SFT and can be adapted for application during crisis intervention. Family mapping, for instance, can be used to promote individual, relational, and familial communication and emotional exploration. Sometimes, a single technique can resolve the major problem or precipitant, or reduce it enough to safely manage symptoms on an outpatient basis.

New coping strategies

Integration and inclusion of family members and friends to aid in coping strategies is shown to be not only feasible and practical, but highly effective when supportive of the individual's recovery. Family members, friends and other supportive relationships can positively alter the individual's environment. Anderson, Hogarty, and Reiss (1980) note that patient and family stress can be reduced by creating an environment that is predictable and supportive. The therapist can suggest clear rules and reasonable expectations to aid in simplifying interactions and help facilitate interpersonal and generational boundaries. A simple discussion with an adolescent and her parents, for example, surrounding the topic of ways to reduce stress in the parent-child relationship and/or sibling-child relationship, as well as home environment alterations, is one example of how to incorporate relational and familial considerations. Additional familial and relational coping strategies could include: increased utilization of a supportive family member for emotional ventilation; visual cues throughout the home environment to prompt usage of coping strategies; and adoption of family rituals to encourage fun and humor.

Action plans and follow-up

Since the ultimate goal is to ostensibly restore functioning, it becomes critical for a clinician to evaluate if the

individual can and will implement the action plan. If determined that the individual is not capable or is unwilling to implement the plan, alternative measures to increase his or her capacity and/or willingness should be explored. If impossible or infeasible, more intensive and/or restrictive treatment options should be explored, identified, and coordinated.

Should an individual have the capacity and is willing to implement the plan, how can the clinician incorporate family members and friends at this point? Whether the action plan consists of a psychiatric inpatient admission, returning home immediately after evaluation, or something in between, family members and friends can be included in this process as a core or peripheral support. Some examples of this might include safety monitoring, encouragement of medication and treatment adherence, positive feedback, and emotional availability. Supportive friends and family can even support the implementation of an action through pragmatic measures, such as financial means, assisting the individual to locate an in-network treatment provider, or transportation assistance.

MFTs should celebrate and advocate for these contributions, as they are lifesaving!

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PERSPECTIVES

Martha Teater, MA

Treating Chronic Pain

What MFTs Need to Know to Move Clients from Hurt to Hope

James is clearly distressed as he describes his life with pain. He shifts in his chair, trying to find a comfortable position as he looks at you expectantly.

"I can't stand this anymore! I've been hurting for so long, and nothing has helped. I don't think anything or anyone can help me. I've seen doctors and therapists but nobody has been able to fix this. I can't work anymore, I hurt every day, and I'm irritable and moody. It keeps me anxious and worried. I just hate it. I'm afraid I'll never get better. Can you help?"

You may have tremendous empathy, a solid set of therapeutic skills, and a fervent desire to relieve suffering, but is that enough? Probably not. Without a plan and specific skills in treating pain, you may find yourself frustrated when working with James and others like him.

As an MFT, you've likely worked with people with persistent pain. Current estimates show that one-third of the population is living with chronic pain (Institute of Medicine, 2011), so it's safe to assume that you've had many people like James come to you for help.

Let's talk about what you need to know to see more robust results.

What is chronic pain?
Chronic pain lasts longer than three months and doesn't respond well to medication or invasive treatments. It may—or may not—be related to actual tissue damage in the body. There is *always* an emotional component. Mental health and substance abuse issues may contribute to symptoms. Living with pain impacts many areas of life—physical, emotional, social, and thoughts.

An estimated 23.4 million adults report experiencing a lot of pain, while an estimated 126 million adults report some type of pain in the past three months (National Institutes of Health, 2015). Pain exists, unbidden. It limits activities, leading people to become less active and more deconditioned. Sleep quality is affected, which is a contributor to (as well as a consequence of) pain. There is often loss of strength and a focus on pain sensations.

Emotional challenges include anxiety, depression, fear, hopelessness, and catastrophizing. People worry about how much they hurt, how long it will last, and if it will ever get better. Upsetting emotions actually make pain worse.

Most people in pain report they are more socially isolated or withdrawn. Relationships may become frayed under the pressure of living with pain. Former interests and activities may fall by the wayside as pain takes center stage. Thoughts often become more pessimistic and negative. Optimism and hope are in short supply. There may be discouraging expectations of improvement. Catastrophic thinking contributes to increased pain of longer duration.

Living with pain impacts many areas of life—physical, emotional, social, and thoughts.

Central sensitization
Central sensitization is a condition of the nervous system that is associated with the development and maintenance of chronic pain. When this condition occurs, the nervous system goes through a process called *wind-up* and gets regulated in a persistent state of high reactivity. This persistent state of reactivity lowers the threshold for what causes pain and subsequently comes to maintain pain even after the initial injury might have healed (McAllister, 2017). Pain is felt, often with little or no input from the body. The scrambled brain messaging increases pain and traditional interventions are proven ineffective.

While pain is felt in various parts of the body, the real problem is not in the area that hurts. The issue is in the brain. Probably the best example of this is phantom limb pain. Central sensitization is the reason that people can have pain in a limb *that no longer exists*. We don't know why some people have more central sensitization. There is often a link to prior trauma.

Trauma and pain
There is clear evidence of a link between trauma and chronic pain. You might think of it as a "trauma triangle." The three sides of the triangle are trauma, chronic pain, and opioid misuse. People who have more ACE (adverse childhood experiences) points are more likely to have pain (Olivieri, Solitar, & Dubois, 2012; Van Houdenhove, 2006). They are also predisposed to opioid misuse (Anda, Brown, Felitti, Dube, & Giles, 2008; Dube et al., 2003). It makes good sense to assess for trauma when you begin working with someone in pain.

The allure of opioids
The opioid epidemic is big news these days, for good reason. We now have 64,000 drug overdose deaths in the U.S. annually, half of which are opioid overdoses (Centers for Disease Control and Prevention, 2015). Most of these people began using opioids through a legitimate prescription from their dentists or doctors.

The evidence is in, and we know that opioids lead to a worse quality of life and *more* pain, due to opioid hyperalgesia (Eriksen, Sjøgren, Bruera, Ekholm, & Rasmussen, 2006). The risk factors far outweigh the benefits, and the side effect profile is ominous. There is no benefit to using opioids for chronic pain. The only appropriate use is for end-of-life cancer pain or for short-term (just a few days) acute pain. The idea that opioids are our strongest painkillers is a myth. Research shows that one extra-strength acetaminophen taken at the same time as a 200 mg ibuprofen provides more effective pain relief than any opioid (Gaskell, Derry, Moore, & McQuay, 2009).

What are our treatment options if opioids and invasive interventions aren't going to do the trick?

Treatment options
Evidence-based choices for treatment are cognitive-behavioral therapy (CBT) (Robertson, 2013) and mindfulness (Grossman, Niemann, Schmidt, & Walach, 2004). These are straightforward and successful interventions. Best of all? They're risk-free.

Cognitive-behavioral approaches
People with pain usually have distressing emotions. They assume that the pain *causes* those feelings. In truth, it's not the pain that causes the emotions; it's their *thoughts* that lead to those emotions. The problem stems from what we tell ourselves and what we think about the pain that causes our emotional suffering.

James had a recurring distressing event, which was his pain. What did he tell

himself about it? He thought that he would never get better, no one could help him, and he'd probably always hurt. It's those negative thoughts that lead to his emotional distress.

What would happen if James could tell himself a different set of thoughts? If he can modify his thoughts and what he's telling himself, there's a good chance that he'll have a different set of emotions.

Let's imagine that James chooses to focus on these types of thoughts, "Even though I've been hurting for a long time, I guess it's possible that I could still get better. Maybe if I continue in therapy, increase my activity level, and modify my thoughts I could get some relief. I have dealt with pain for a while, but there are some tools that I haven't tried yet." When James adjusts what he's telling himself, he'll be better able to have a different set of emotions as a result.

There are many CBT tools that can be used effectively with pain, such as thought distortions, evidence-review, decatastrophizing, downward arrow, and modifying cognitive distortions (Otis, 2007).

Mindful approaches with chronic pain

There is a wide array of mindful options that can ease suffering and pain. The goal of these interventions is to move toward greater acceptance and less resistance and avoidance. Resistance to pain is what increases suffering.

The easiest starting point with mindfulness is probably breathing. You might introduce your client to diaphragmatic breathing to ease stress, feel more at ease, and reduce pain. You could demonstrate this as early as the first session and lead off future sessions with a simple breathing activity. This moves people toward mental and physical relaxation and a reduction in pain. You can also teach clients meditative practices. There is strong evidence of benefit emotionally and physically (Grossman, Niemann, Schmidt, & Walach, 2004). Further, progressive muscle relaxation is a simple exercise that helps people get in touch with their bodies as it boosts comfort and relaxation.

Helping people develop imagery can be a meaningful intervention that can give immediate relief from emotional distress (Robertson, 2013). Once the person develops their own imagery, they can return to it anytime. You can ask your client to imagine a place that they really enjoy. It could be the beach, the front porch, or anywhere peaceful and calm.

The next step is to ask the client to fill in as much sensory detail as possible. Let's say that the client's imagined place is on the front porch swing. What is visible (trees, blue sky, a dog)? What smells are in the air (freshly cut grass, burgers on the grill)? What are the physical sensations in the imagined place (a gentle breeze, warm sunshine)? What tastes are present (lemonade)? And what sounds (a neighbor's lawn mower, barking dogs)?

Once you have a clear direction for treatment, you'll move forward with more confidence and less frustration. James, and others like him, will reap the benefits of your skills and live fuller lives with less pain.

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Additional Resources

- *Treating Chronic Pain: Non-Pill Approaches to Move People from Hurt to Hope* (Teater & Teater, 2017) provides worksheets and tools to provide real help to your clients. It also presents a structured program to guide your treatment.
- *Treating Chronic Pain: A Cognitive-Behavioral Approach* (John Otis, 2007) gives a clear treatment protocol that's useful for individuals or groups.
- The Department of Veterans Affairs has developed a comprehensive treatment model. You can find information at https://www.healthquality.va.gov/guidelines/pain/cot
- For more information about the opioid issue, visit www.teaterhs.com. There are white papers on this site about opioid effectiveness and side effects.

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