NOVEMBER/DECEMBER 2021

# ftm

FAMILY THERAPY MAGAZINE

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY


**The solid ground of integrated ethical practice** A higher standard of authentic relationships will move us toward social justice in our personal and professional lives

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**Service members, veterans, and their families** Learn how MFTs can navigate relevant ethical issues while considering clinical practice guidelines and federal military regulations

page 14

**Client-generated prejudice** How do we handle hostility and client-generated prejudice in therapeutic sessions?

page 26

FAMILY THERAPY
MAGAZINE
ftm

**When we begin to consider relational ethics in all our relationships, we are held to a higher standard of authenticity.**

## FEATURES



The AAMFT systemic ethics textbook is underway! The text includes 35 chapters covering the AAMFT Code of Ethics and a wide variety of topics featuring over 90 authors! This issue of FTM offers a preview of authors and topics. Please enjoy this sneak peek of the upcoming book!

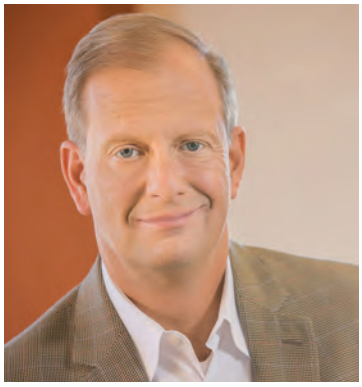
– Kristina Brown, PhD, Editor

## DEPARTMENTS



## ALSO IN THIS ISSUE

# A Message from the CEO



It has been 12 years since Montana, as the last state, obtained licensure (literally days behind West Virginia). Since that time, AAMFT has worked with divisions and more recently, Family TEAM to strengthen the license throughout the United States. We won a hard-fought battle with the Texas Medical Association over our ability to diagnose. Last year, AAMFT had a record number of cosponsors for the MFTs in Medicare bill.

Fast forward to 2020, and add in a global pandemic no one saw coming, and suddenly, behavioral health made a massive shift from in-person to telehealth, literally, overnight. The pandemic acted both as a disruptor and an accelerator of change. Fortunately, AAMFT had recently published Best Practices in the Online Practice of Couple and Family Therapy (2017) aiding MFTs and other mental health professions, but we needed more. AAMFT and our members were literally tasked with creating resources overnight, lobbying for executive orders to extend MFTs' right to practice in new circumstances, and providing much needed connection and support in our suddenly disconnected world.

Amidst these challenges, achievements, and opportunities, LMFTs have quietly increased in numbers. Now, with an estimated 62,000+ licensees, and often cited by U.S. News and World Report as one of the top social service jobs, we are in a better place than ever before. MFTs are employed in a wide variety of agency settings, and many are doing very innovative and creative work. Some good examples are housed within the AAMFT Research and Education Foundation: Ben Erwin and Damir Utrzan will soon release a webinar, Developmental Impact of Displacement-Induced Trauma, and Amy Morgan's study, Developing a Redemptive Identity: A Mixed Methods Study Exploring Post-incarceration Resiliency, is underway.

These successes have increased the profession's recognition. In 2020 and 2021, the Mental Health Liaison Group (MHLG), an advocacy group of over 70 mental health organizations, for the first time ever, wrote a letter in support of LMFTs inclusion in Medicare Part B. Another key recognition of the profession's growing influence involves the University of Michigan Behavioral Workforce Research Center, whose mission is to conduct research on the behavioral health workforce to strengthen it. AAMFT has partnered on research projects and has a staff member participating in the Center's Advisory Group. Earlier this year, AAMFT partnered with the Center on a workforce study and surveyed 5,000 members and 866 members responded—AAMFT sincerely thanks those members for taking time to participate.

These shifts and areas of growth strongly suggest that AAMFT has evolved to a place where it must begin to better understand workforce issues impacting LMFTs and how we as an association can continue to support those, while removing unnecessary barriers:

- What are the entry points to the field?
- What are barriers to completion from germination of the idea to license "in hand?"
- How has the pandemic altered the practice and profession permanently moving forward?

These are just a sampling of the topics needing better understanding. Immediately, however, we must focus on how to improve portability of the license and continue to pressure Members of Congress to include LMFTs in Medicare Part B.

To assist in accomplishing these goals, AAMFT has commissioned two research projects. The first is to study seniors' attitudes towards mental healthcare as well as access issues such as barriers to access and entry paths (i.e., primary care physicians, family members, senior living centers). The second area of study will involve focus on the MFT industry at large to examine three main areas of interest:

- Entry points to the MFT field being utilized
- The current working environments and characteristics of employment of LMFTs
- Shifts from the COVID-19 pandemic and their potential long-term impacts on the industry at large in areas such as adoption of telehealth or interest in licensure law adaptations and changes such as portability

The outcomes of these two research projects will enable AAMFT to more engage in advocacy efforts and workforce development initiative that will strengthen the position of LMFTs within the overall mental health employment arena. Member participation is vital as we look to understand these complex shifts. So please watch for more information, and if you are invited, I sincerely hope you will take a few minutes to participate. Your input can help to shape the future of our profession.

It is very likely that these efforts will reveal changing needs in everything from standards of education and training to the Code

of Ethics. This issue of FTM typifies the work settings and ethical challenges facing today's LMFTs. I trust you will see both the ethical difficulties and the workforce development areas of concern contained within the important contributions highlighted through the authors' discussion of the following:

- Client generated prejudice
- Military issues
- Queer MFTs
- Professional competence and integrity

While we are currently exploring numerous options for increasing portability of the license, AAMFT will continue to pursue Medicare inclusion as our highest federal advocacy priority. Improving employment opportunities within the Veterans Administration will certainly remain a focal point. State licensure laws must continue to stay on par with other mental health professions.

Not only is it evident that AAMFT must remain diligent in its efforts to advance the profession, but it is also clear that AAMFT must take the next step of expanding its own scope to include workforce development information, resources and initiatives. Over the next several years, AAMFT will embark on projects that will help inform us about the challenges and opportunities facing the profession. We must better understand and formulate strategies challenging the LMFT, as well as position LMFTs as a strongly desired mental health discipline within all possible work environments.

To quote Bob Dylan, "The Times They are A-Changin" and AAMFT will remain steadfast in its commitment to protecting and advancing the practice and profession.

Sincerely,

**TRACY TODD, PHD**

## REFERENCE

AAMFT. (2017). *Best practices in the online practice of couple and family therapy*. Alexandria, VA: Author.

## RESOURCES

**University of Michigan Behavioral Workforce Research Center**
www.behavioralhealthworkforce.org

**Advisory Group**
www.behavioralhealthworkforce.org/about-us/advisory-group

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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.

# data note

## Maintaining an Ethical Practice

*Source: Maintaining an Ethical Practice, AAMFT, https://aamft.org/Legal_Ethics/Tips_Ethical.aspx*


**on the web**

AAMFT's resource for legal + ethical information
**www.aamft.org/ethics**

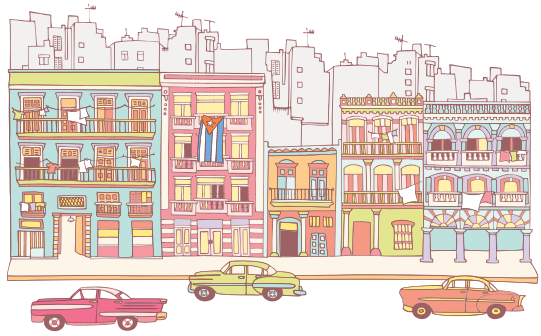
## GLOBAL PERSPECTIVES

### A Multifamily Therapy Model in Havana, Cuba

Interfamily therapy (IFT) is a specific model for multifamily therapy of recent expansion in Latin American and European countries. The term multifamily therapy refers to a range of therapeutic interventions carried out in multifamily groups, which are therapeutic environments in which both patients and their family members participate together. In IFT, a multifamily group becomes a community of learning where professionals and family members establish collaborative relationships and participate in dialogues.

The World Health Organization has indicated that mental health problems account for 16% of the global burden of disease and injury in the infant-juvenile population. Failure to address these problems has consequences that extend into adulthood, affecting both physical and mental health, and limiting opportunities for a satisfying adulthood. Considerable progress has been made in recent decades in developing effective therapies for children and adolescents with mental health conditions involving the family.

This study used a qualitative phenomenological approach to explore the participants' perspective of 14 members and ex-members of two IFT groups conducted in Infant-Juvenile



Mental Health Centers in Havana, Cuba. IFT was well accepted and effective, and it was perceived as beneficial due to its positive influence for participants, with benefits on a personal, family and social level. In addition, participants articulated a series of therapeutic elements of IFT that were essential to promote these benefits. IFT seems to be a useful therapeutic model in the treatment of children, adolescents and their families in a Cuban psychiatric setting.

Read the full study in the *Journal of Marital and Family Therapy.*

Ruiz-Íñiguez, R., Carralero-Montero, A., Martínez-González, A., Méndez-Parra, E., Valdés-Díaz, Y., & Sempere, J. (2021). Interfamily therapy, a multifamily therapy model settled in infant-juvenile mental health services of Havana (Cuba): A qualitative study from participants' perspectives. *Journal of Marital and Family Therapy*, 00, 1-21. https://doi.org/10.1111/jmft.12542

# The Results of the 2021 Student Ethics Competition Are In!

In 2021, AAMFT held the sixth annual Student Ethics Competition. This competition is designed to encourage MFT students to foster an interest in ethics issues and enhance their ability to analyze and respond to the various ethics issues that they will undoubtedly encounter throughout their careers. In this team competition, participants submitted an essay analyzing and responding to a hypothetical scenario.

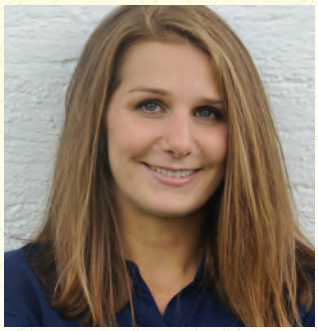
The submissions were scored by current and former members of the Ethics Committee and current and former members of the Judicial Committee. After the final review of the score, the winning teams have been announced. Winners received a cash award and a plaque. The first-place winners will be recognized during the 2022 Leadership Symposium.

Join AAMFT in congratulating the winning teams on their excellent work!

**First place:** Tahlia Harrison, Midori Ferris-Wayne, and Monica Maragos (Lewis and Clark Graduate School Education and Counseling)

Tahlia Harrison

Midori Ferris-Wayne



Monica Maragos

**Second place:** Carson Outler and Patrick Tremaglio (Mercer University)

Carson Outler

Patrick Tremaglio

**Third place:** Ronald Asiimwe and Jennifer VanBoxel (Michigan State University)

Ronald Asiimwe

Jennifer VanBoxel

## The first place team's essay is included here:

The hypothetical presented here follows Josephine, a licensed marriage and family therapist of two years working with Marcus, a 12-year-old boy referred by a child and adolescent psychiatrist for presenting concerns related to his diagnosis of attention-deficit hyperactivity disorder (predominantly inattentive). After working with Marcus in a traditional in-person therapy setting, Josephine is confronted with how the global pandemic has changed the context within her practice, Marcus's presenting concerns, and realignment of telehealth to the boundaries and expectations set forth previously with Marcus's parents. Josephine is not unique in these circumstances; the pandemic disruption created an unprecedented shift which has forced many clinicians to adapt quickly to offering telehealth services with flexible interventions to meet the moment, while simultaneously adhering to shifting professional ethics codes (Harris, 2021). Unsurprisingly, Josephine's intention to be creative and adaptable in her practice and to address her clients' presenting concerns landed her in situations requiring further investigation of her ethical responsibilities with each decision.

**Method for ethical action guidance**

When considering ethical implications in family therapy practice, clinicians and supervisors share an obligation under the binding expectations of the AAMFT Code of Ethics (2015) to maintain familiarity with principles and application to our professional services. At the onset of treatment, it is also imperative for therapists to choose clinical interventions that promote welfare and minimize harm to the family and any members within the therapeutic relationship (Zygmond & Boorheim, 1989). Given the complexity that clinical decision-making entails, evaluation of an ethical dilemma stands to benefit from consultation with multiple resources alongside the active professional codes, and consideration of a decision-making framework which accounts for the intricacy involved. For example, Kitchener's model of ethical decision-making acknowledges that ethical decisions are contextually nuanced (Kitchner, 1986), and considers personal and group values, clinical decisions, and context to create effective action guidance (Zygmond & Boorheim, 1989).

Using current resources examining ethical decision making (Miller & Springer, 2020) and the Kitchener model (1986) as a reference, we will identify and review the ethical issues that are in violation of the AAMFT Code of Ethics (2015) and of the law and will indicate alternative actions that may have been taken in the hypothetical case study. For the purposes of this evaluation, we will assume that Josephine is treating Marcus as the identified client. Additionally, since the location of the client and his family are undisclosed, we will assume the AAMFT Code (2015) as a higher standard than the law in their governing state and will adhere to the commitment required of the AAMFT Code (2015) to resolve conflict responsibly.

**Evaluation of adherence to AAMFT Ethical Code of Ethics**

Standard I: Responsibility to Clients. The first standard of care listed by the AAMFT Code of Ethics (2015) is the therapist's responsibility to prioritize clients' welfare. Josephine's decision to incorporate video games as part of Marcus's new treatment plan may have been implemented to increase her own comfort and sense of competence as a therapist at the expense of previously expressed treatment goals from his parents. Josephine does not appear to have prioritized Marcus's wellbeing, particularly since Marcus's parents reported concerns that Marcus's symptoms were worsened by video games. Increasing reliance on technology that has previously been identified as problematic for the family has significant ethical implications and may even indicate negligence (Young, 2009). Josephine does not appear to have assessed for internet gaming disorder, the presence of which would provide contraindication for incorporating video games into therapy. Additionally, ethical concerns expressed by researchers about video gaming conditions replicating online gambling reward systems suggest that an adolescent whose gaming behaviors already pose parental concerns may even be at greater risk for future mental

health problems (Torres-Rodriguez et al., 2018). Given these concerns, regardless of whether Marcus's parents provided informed consent, the use of video games in therapy would need careful consideration and monitoring for efficacy and therapeutic value.

Due to Marcus's status as a minor (in most states), informed consent is to be obtained from his parents, encompassing adequate and significant information concerning Josephine's treatment processes and procedures (S1.2). Initial parental involvement in Marcus's treatment suggests that Josephine complied with informed consent collaborating with the family around treatment planning and was also in consideration of Marcus's mom's concerns around the use of video games. Marcus has come to therapy as a referral from a third-party practitioner (psychiatrist) whom Marcus's mom has been contacting with concerns about his progress in therapy. Initial informed consent should have identified the nature of the relationship to this referral and addressed the limits of confidentiality within (S1.13). Without touching base with either parent since the onset of the pandemic and moving to telehealth, Josephine's feeling that her informed consent needs updating is accurate. With precedent for concern in the context of screen time and video games, initiating the use of these formats without prior consent is out of bounds with the families' expectations and therefore represents an ethical violation.

Since moving to telehealth, Josephine employed methods without generally recognized standards; updated informed consent forms and ongoing consent for implementing new treatment processes must communicate the potential risks and benefits of new treatment methods and be approved by Marcus's parents (S1.2). Without established consent for using new modalities, and with Josephine's growing concern around her difficulty connecting with clients online, the relationship may no longer be beneficial to the client; (S1.9) consultation is needed, and if appropriate, referrals to another clinician (S1.10) to ensure non-abandonment (S1.11) must be adhered to.

Standard III: Professional Competence and Integrity. Josephine has continued to see Marcus weekly through telehealth services and has found herself struggling to connect to the children she sees online as clients. To adapt to the new format, Josephine first tried some interactive interventions through arts and crafts, though found them ineffective. With her increasing frustration, it is evident that she was questioning what would be within her scope of practice as an effective intervention. This indicates some awareness of the possible ethical concerns in continuing the therapeutic relationship with this client.

Josephine has also been resistant to consultation, and the professional status of the friend who gave her the recommendation, as well as the source of the one-hour webinar on incorporating video games in therapy, are unknown. To comply with maintenance of competency (S3.1), Josephine may pursue knowledge of new developments through something akin to this training, though she has not been seeking assistance around the struggles she is experiencing as a clinician (S3.3) or considering if this training adheres to ethical and professional standards (S3.2). Offering a new skill after one-hour of training without supervised experience in a specialty area may not be the appropriate education to ensure competence, creating a risk of harm to the client (S3.6). Without seeking professional assistance for the issues Josephine experiences around her work performance and clinical judgement (S3.3), she is at risk of treating problems outside recognized boundaries of competency (S3.10); along with providing a service that is in conflict with Marcus's parents' boundaries around video games (S3.4). Standard II: Confidentiality and VI: Technology Assisted Professional Services. Josephine moved her practice during the pandemic from an office space to her home working in a shared kitchen space, changing her methods for maintaining confidentiality. These changes were not disclosed and updated for her clients to review to inform the family of specific risks and limitations inherent in technology assisted services (S2.1, S6.1, S6.2). The use of third-party platforms and online games may change the security of confidentiality, requiring disclosure (S2.1), written authorization if client information must be released (S2.2), and changes to protocol in the protection of records (S2.5). Josephine has been initiating platform changes when there are technical difficulties without disclosing the platforms and their limitations of protections to the clients and consideration of best current technology practice (S6.3, S6.6). Alongside these changes, the shift from family therapy to individual sessions with Marcus indicates a shift of role required to be communicated by the ACA ethics code (A.6.d), making it ambiguous which client is to be protected and considered in confidentiality. Although Josephine would like to revert back to family therapy, she has not consulted whether the laws in her location, and Marcus's father's location (when out of state), allow for technologically-assisted means to practice across those state lines (S6.5).

**Conclusion**

In the context of the global COVID-19 pandemic and the need to transition to telehealth for family therapy, ethical dilemmas might be considered par for the course. However unprecedented the situation, Josephine could still have navigated this rocky territory more effectively and avoided ethical pitfalls related to her obligations regarding responsibility to the client, professional competence and integrity, and special circumstances

involving confidentiality and technologically-assisted means to practice. By seeking outside resources, she could have learned there are comparable outcomes and benefits of family teletherapy to in-person therapy (de Boer et al., 2021), and read updated research to expand competency in telebehavioral health specific to family therapy practice (Hertlein et al., 2021). Proceeding now with supervision will give Josephine the necessary guidance around her ethical responsibility to update informed consent and fulfill the appropriate competency requirements before continuing new methods of clinical intervention (S4.4) with Marcus. Rather than disregarding her intuition and avoiding consultation, Josephine may also benefit from building awareness of her own values-based actions in order to reflect more carefully on clinical decisions supporting her clients' values and best interests (Wilcoxon et al., 2013). Moving forward, continuing supervision and maintaining her familiarity with the AAMFT codes, alongside adopting a decision-making framework, while exploring outside ethics concepts, like virtue ethics, Josephine may gain the insight needed to prevent future ethics violations while refining her core values around "goodness in ethical practice;" attending to the humanity of clients through protecting clients from harm, an element that can be considered core to clinical and ethical competence (Miller & Springer, 2020).

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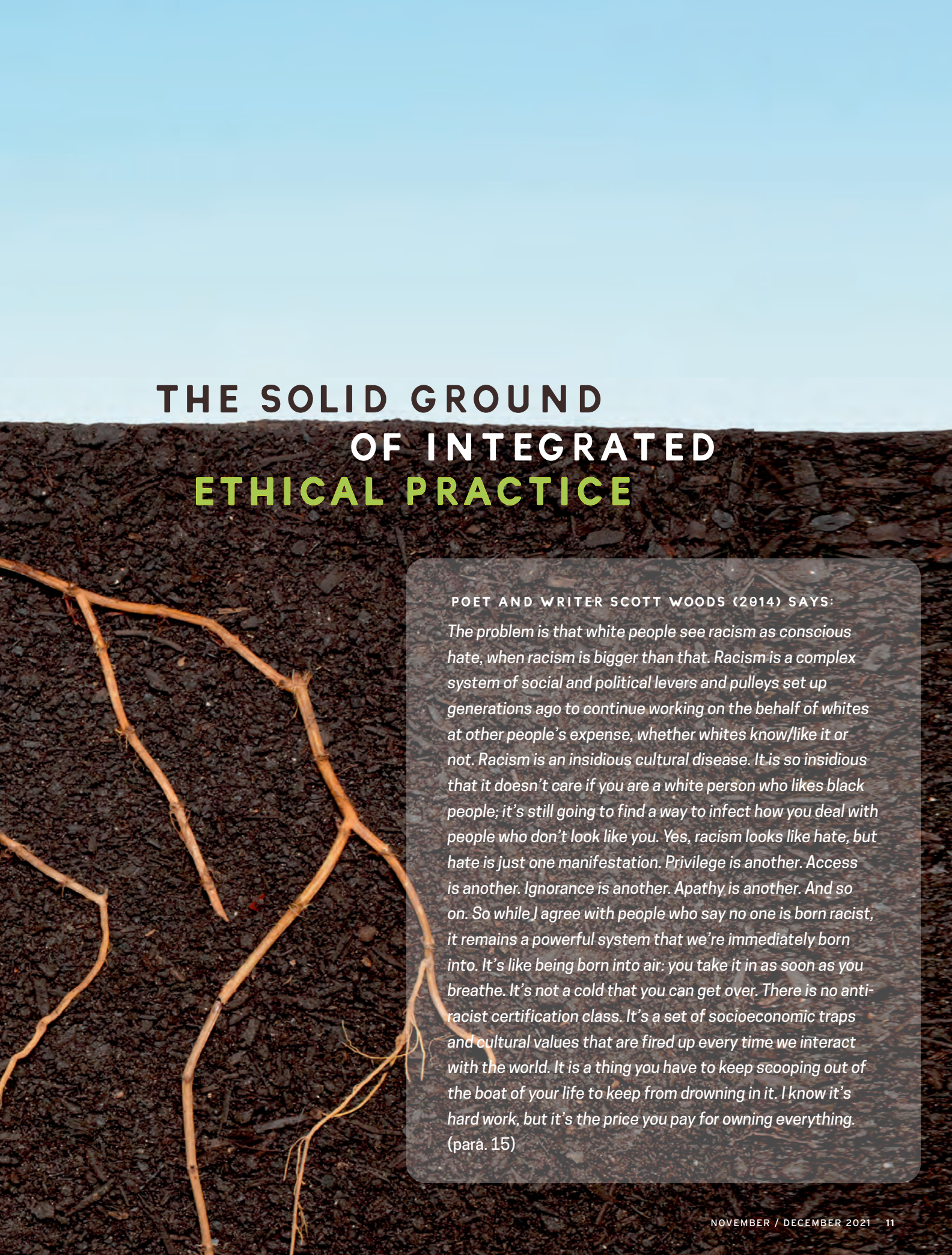
Toni Zimmerman, PhD
Marj Castronova, PhD

# THE SOLID GROUND OF INTEGRATED ETHICAL PRACTICE



**POET AND WRITER SCOTT WOODS (2014) SAYS:**

*The problem is that white people see racism as conscious hate, when racism is bigger than that. Racism is a complex system of social and political levers and pulleys set up generations ago to continue working on the behalf of whites at other people's expense, whether whites know/like it or not. Racism is an insidious cultural disease. It is so insidious that it doesn't care if you are a white person who likes black people; it's still going to find a way to infect how you deal with people who don't look like you. Yes, racism looks like hate, but hate is just one manifestation. Privilege is another. Access is another. Ignorance is another. Apathy is another. And so on. So while I agree with people who say no one is born racist, it remains a powerful system that we're immediately born into. It's like being born into air: you take it in as soon as you breathe. It's not a cold that you can get over. There is no anti-racist certification class. It's a set of socioeconomic traps and cultural values that are fired up every time we interact with the world. It is a thing you have to keep scooping out of the boat of your life to keep from drowning in it. I know it's hard work, but it's the price you pay for owning everything.* (para. 15)

**The five grounding principles**

In our view, there is an expectation, a written and unwritten rule, a personal and professional imperative, that in order for couple and family therapists to practice from an ethical foundation, we stand on the solid ground of the following five principles: 1) the AAMFT Code of Ethics (AAMFT, 2015), State Laws and Regulations, 2) AAMFT Core Competencies (Nelson et al., 2007), 3) current CFT literature, 4) practicing as a socially just therapist, and 5) relational ethics. These five foundational principles collectively all include significant attention and attunement to implicit bias, discrimination, and intersectionality in our personal and professional lives. When we step off this solid ground to shaky ground, we put our client's wellbeing in harm's way. The ground you are standing on is not simply something you refer to when an ethical dilemma comes up in your practice, rather it is the essential ingredient of what you follow and integrate in all that you do as a therapist, in and out of sessions, in order to have an ethical and competent professional practice.

Let's consider an upcoming appointment a therapist has with an unmarried couple, where the caller indicated they were coming to therapy because of a recent disclosure of infidelity. The caller reported the affair was discovered when the partner Jeff noticed a text with sexual content on his partner Eric's phone. In preparation for seeing this couple, we believe the therapist needs to consider all five grounding guidelines and reflect on many questions. For instance, does the therapist have appropriate written policies concerning informed consent that clearly address secrets and the limits of confidentiality in couple's therapy? Does the therapist have clear policies related to not providing individual therapy to one or both clients, in addition to couple's therapy? If one client comes to the session and the other doesn't, what are the policies to ensure fair and balanced couples therapy? Is the therapist prepared to have a collaborative, transparent conversation about these policies with the couple during the intake? Is the therapist familiar with the current CFT literature on treating infidelity? Is the therapist familiar with specific infidelity literature related to unmarried clients and clients who are in same-sex relationships? What assumptions does the therapist have about monogamous relationships, or assuming monogamy of these clients? Has the therapist examined any relevant biases they may hold such as viewing an unmarried client relationship differently or as less serious? Has the therapist examined biases that may be related to client identities such as race, religion, ability, sexual orientation, ethnicity, age, gender, socio-economic status, etc.? Is the therapist aware of the many ways in which various marginalized identities are discriminated against by major institutions including housing, economic, judicial, educational, healthcare, etc.? How might this impact the couple and therapy? How might the therapist's own identities and self of the therapist influence their work with the couple?

In our experience, in order to do no harm and to provide best practice therapy with the highest ethical standards, a therapist must consider the ground they are standing on with all client interactions from the first contact and intake to termination. This type of integration instills in us a habit of thinking through the five foundational essentials and using them as guideposts in our everyday practice as well as when ethical dilemmas arise.

**Standing on the ground of Principles 1 and 2: The AAMFT Code of Ethics, state laws and regulations, and AAMFT Core Competencies**

While our AAMFT Code of Ethics is clear that we may not discriminate, state laws and regulations may not be so clear. For instance, in some states, there are new laws that are allowing therapists to reject a client based on the provider's beliefs and values. This means that in our case example of Eric and John, a therapist could refuse to accept them as clients and not provide treatment based on one of their identities, such as their sexual orientation. This would be a clear violation of the AAMFT Code of Ethics 1.1 and many of the AAMFT Core Competencies that give the directive to provide therapy to persons without discrimination. Part of advocacy work for the profession may include therapists working to challenge laws that allow discrimination. Knowing what your governing laws are in your geographic area (state or country) is imperative. Laws and regulations change, and it is ultimately the therapist's responsibility to review them on a regular basis to ensure you are standing on current regulations while considering the implications of the AAMFT Code of Ethics and Core Competencies.

**Standing on the ground of Principles 3 and 4: Literature and social justice**

As therapists, it is imperative that we are familiar with the current CFT literature related to best practice of our clients' presenting problems and identities, including intersectionality. Therefore, with our case example of Eric and John, it isn't enough to be familiar with the infidelity literature or even the literature on infidelity in same-sex relationships. The intersections that impact this couple may be complex and we could do harm by ignoring different identities. If Eric is a Christian, black

man from the Caribbean and John is a white male who has been recently diagnosed with a chronic illness that is impacting his ability to work and his sexual performance, we will want to be informed by the literature on these various aspects of the situation. We owe it to our clients to never stop learning and growing as professionals. Providing therapy in a way that is attuned to diversity, equity, and inclusion requiring knowledge, self-awareness, and skills is essential. The presenting client problem cannot be considered in a vacuum but rather with social identities, so we are standing on ground that considers the treatment of oppressed social groups based on deep understanding.

**Standing on the ground of Principle 4: Relational ethics**

With the advances in neurosciences over that past decade, we are more aware of how our "automatic responses" are developed over a lifetime of influence and experiences that trigger our reaction to relational stimulus. This has influenced how we consider the relational ethics that involve the way we reflect on, think about, and decide on our obligations and responsibilities to self and the other; while considering our personal and community values, morals, and preferences. Relational ethics also involve our ability to be empathetic; to put aside our view and begin to see the world through another person's view. When we are being relationally ethical, our moral identity is deepened, our moral sensitivity is sharpened, and our empathic alertness and responsiveness are enhanced.

We believe a more collaborative, transparent, and reflective process versus an automatic response in ethical decision making is needed. Since the relational self is continually under construction in all our relationships, we understand that our interactions with others are participating in our own constructing and in the constructing of others. Since not all people have equal access to power in society and in their relationships, and since certain people experience a greater level of privilege in their relationships, it is important to acknowledge that both partners may not have equal power in shaping the stories of their partners' lives, such as in the couple case of Eric and John. When we begin to consider relational ethics in all our relationships, we are held to a higher standard of authenticity. It is this higher standard of authentic relationships that will move us toward social justice in our personal and professional lives.

**We believe a more collaborative, transparent, and reflective process versus an automatic response in ethical decision making is needed. Since the relational self is continually under construction in all our relationships, we understand that our interactions with others are participating in our own constructing and in the constructing of others.**

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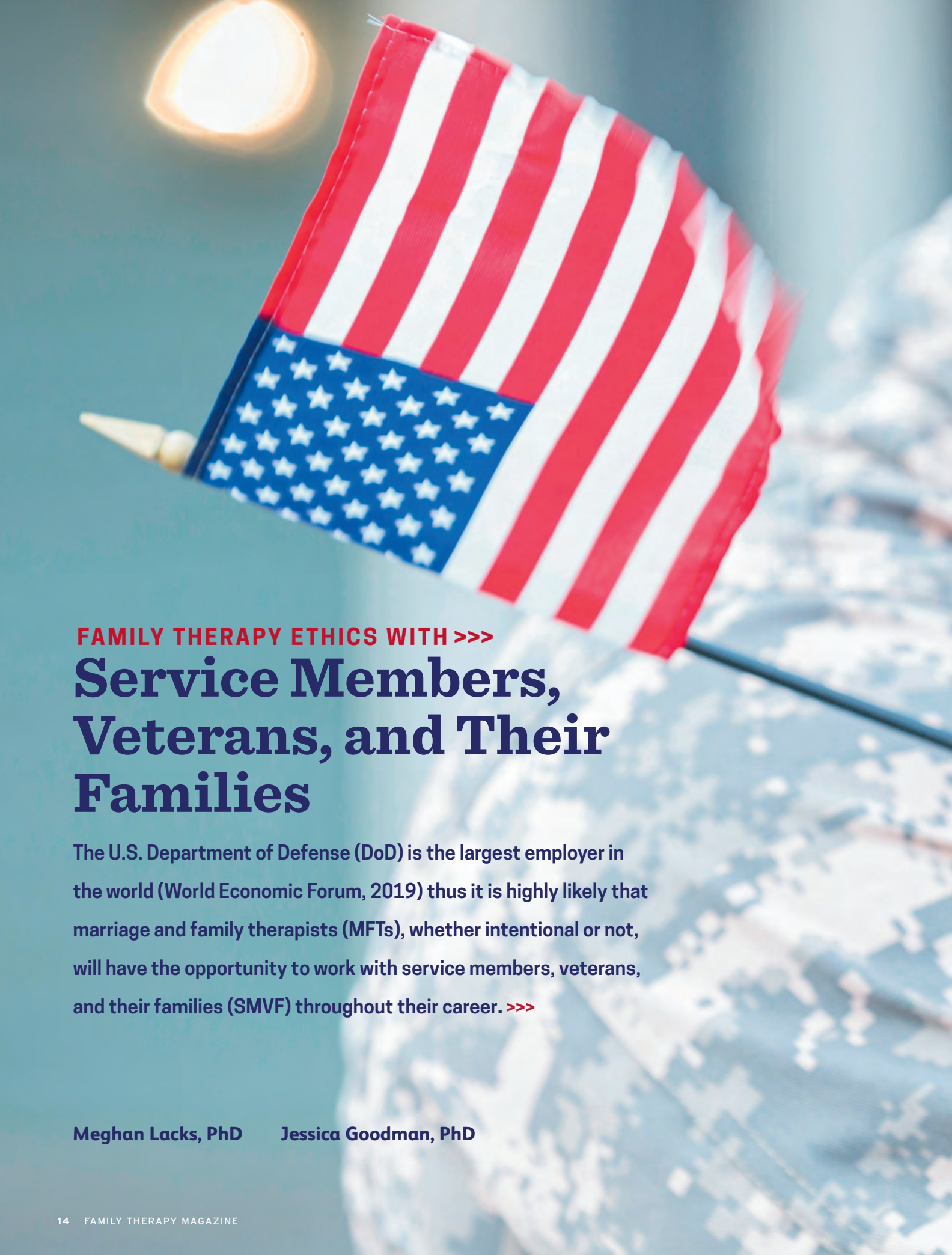
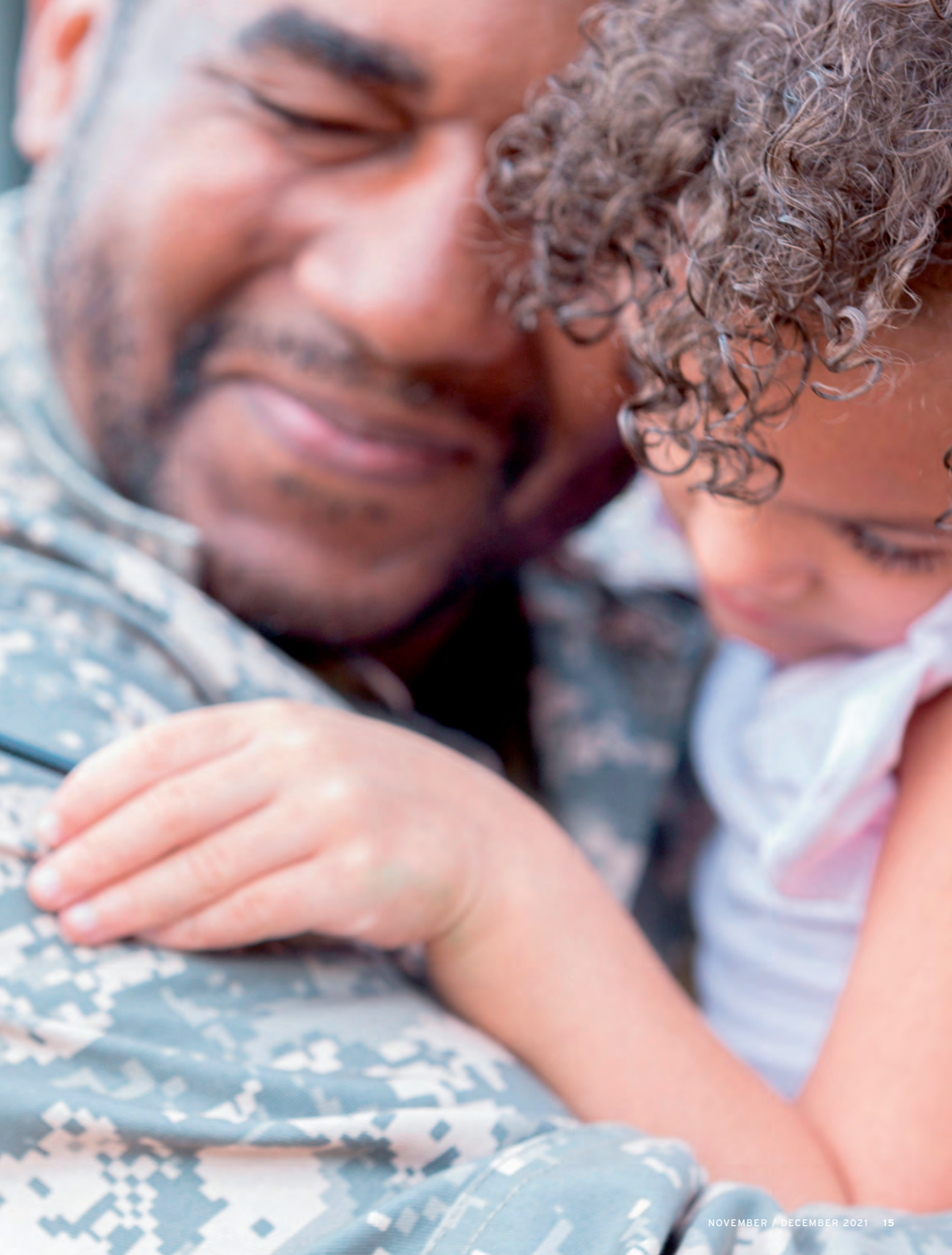


FAMILY THERAPY ETHICS WITH >>>

# Service Members, Veterans, and Their Families

The U.S. Department of Defense (DoD) is the largest employer in the world (World Economic Forum, 2019) thus it is highly likely that marriage and family therapists (MFTs), whether intentional or not, will have the opportunity to work with service members, veterans, and their families (SMVF) throughout their career. >>>

**Meghan Lacks, PhD** **Jessica Goodman, PhD**



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There are over 2.8 million military personnel between active duty, National Guard or Reserve, or civilians who are permanently assigned for duty (Defense Manpower Data Center; DMDC, 2019) and over half of current U.S. military personnel have a family (i.e., married with or without children or are single with children; DoD, 2019). In addition to current service members and their families, there are 19 million veterans in the U.S. (Shaeffer, 2021), approximately 60% of whom are married, and 14% with children living in their homes (National Center for Veterans Analysis and Statistics; NCVAS, 2019).

Given the likelihood that civilian providers will encounter SMVF in the U.S., it is imperative that MFTs understand the ethical considerations present for this unique population and are prepared to competently assess, diagnose, and treat SMVF across a variety of healthcare settings (e.g., Military Health System, Veterans Health Administration [VA], community healthcare). Although MFTs are in a unique position to support SMVF due to their extensive training in general systems theory that allows them to simultaneously consider how a person's biopsychosocial-spiritual health factors as well as their diverse military-related experiences (e.g., service branch, rank, and military occupational specialty [MOS]) influence wellbeing, not all traditionally-trained therapists are equipped to meet the complex needs of this population nor are aware of the nuances in ethical decision making compared to non-military populations. This article, in conjunction with the AAMFT Code of Ethics (AAMFT, 2015) and the *Competencies for MFTs Working with Service Members, Veterans, and Their Families* (AAMFT, 2020), will help MFTs navigate relevant ethical issues while considering clinical practice guidelines and federal military regulations.

**Clinical practice with SMVF**

Though MFTs are obligated to abide by the ethical standards set forth by The American Association for Marriage and Family Therapy, those working with military populations, particularly active-duty service members, must be aware of additional considerations in their clinical practice. For example, maintaining confidentiality is an essential component for all therapeutic relationships and although limits exist in any setting (e.g., child or elder abuse, duty to warn, harm to self, etc.), there are additional limits that exist for military clients or in military settings compared to non-military populations. It is essential to shed light on these unique considerations given that behavioral health providers who work with military populations have reported that limits to confidentiality are one of their biggest ethical concerns (Hoyt, 2013).

First, it is helpful to keep in mind that the overall mission of the military is combat readiness and optimization. In efforts to achieve this goal, there is a special exemption protected under the Health Insurance Portability and Accountability Act (HIPAA; Defense Health Agency, 2015) called the Military Command Exception that permits the disclosure of protected health information (PHI) from military clients without consent. This exception does not apply to all behavioral healthcare services, but the intention is that information that could impede mission readiness is to be shared with a military client's command staff. There is a specific instruction, DoD Instruction 6490.08, that outlines the criteria that need to be met to disclose PHI without consent (DoD, 2011). These circumstances include serious risk of self-harm, harm to others, or harm to a specific military mission, members in the Personnel Reliability Program or those identified as having potentially sensitive or urgent mission responsibilities, admission to inpatient care, acute conditions that interfere with assigned duties, substance abuse treatment, command-directed mental health evaluation, and other special circumstances (DoD, 2011).

In addition to the limits of confidentiality for military personnel discussed, the Uniform Code of Military Justice outlines the rules and regulations that define criminal behavior for military members that may also indicate a duty to report to command staff (Myers, 2019). These behaviors include inappropriate sexual contact, extramarital sexual contact, computer crimes such as cyberstalking, intimate partner violence, and fraternization (Myers, 2019; Sheftick, 2019). It is important to keep in mind that although the release of certain PHI without client consent is unique to military clients, the DoD aims to foster a culture that promotes seeking mental health treatment and even when PHI is required to be disclosed, only the minimum amount of information needed should be shared (DoD, 2011). MFTs working with

military populations must stay abreast of the special laws and regulations that exist for military personnel before engaging in treatment to appropriately inform clients about their limits of confidentiality and to know how to engage with a military client's larger system, if warranted.

**Engaging with SMVF larger systems**

MFTs are equipped to work with SMVF because military personnel not only exist within their family systems, but the military as an entity is composed of complex larger systems and hierarchies; MFTs are able to use their systemic and relational lens to conceptualize how each of these systems may impact SMFV wellbeing. While MFTs are accustomed to engaging and collaborating with other providers in a client's life, working with military personnel means that MFTs will be required to disclose certain behaviors to work supervisors which is not appropriate for non-military clients (AAMFT, 2020). However, similar to non-military clients, MFTs should engage military members in the process of disclosing PHI in an effort to preserve the therapeutic relationship. If MFTs believe their professional code of ethics conflict with military regulations, it is recommended that they are purposeful about developing a process for ethical decision making (i.e., define the problem, review statutes, professional consultation, consider alternative actions, document the process, and monitor outcomes; Johnson, Grasso, & Maslowski, 2010) and seek support and consultation when appropriate.

**Ethics in record keeping with SMVF**

MFTs' documentation practices differ when working with SMVF versus civilians, and between SM (i.e., regulated by the DoD) and V (i.e., regulated by VA; Department of VA, 2017; National Archives Federal Records Management; NAFRM, 2019). For example, time requirements for record storage are two years from the date of service in the DoD (see National Archives and Records Administration Disposition Authority Number DAA 0428-2012-0004-0005) versus the standard seven years for civilians (Sturm, 2012), and in some cases much longer for the VA (e.g., five years onsite at Vet Centers and 45 years offsite; Department of VA, 2021).

**Confidentiality and informed consent via record keeping**

Compliance with relevant government policies, military regulations, and AAMFT Code of Ethics (2015) can be particularly challenging when working with military couples and families. For example, on a military installation, couples therapy will be documented under the "sponsor's" (i.e., active duty personnel) file. If the "dependent" (i.e., non-personnel) member of the couple wants access to session documentation, they may request it under the Privacy Act (DoD, 1974), however they will only receive portions of the record pertaining to themselves, the "requestor," while anything pertaining to the "sponsor" is redacted.

Conversations with service members about ethics and documentation are best interposed in three particular therapy circumstances: (1 start of treatment, (2 concern pertaining to safety of self, others, or risk to mission readiness, and (3 sessions including a service

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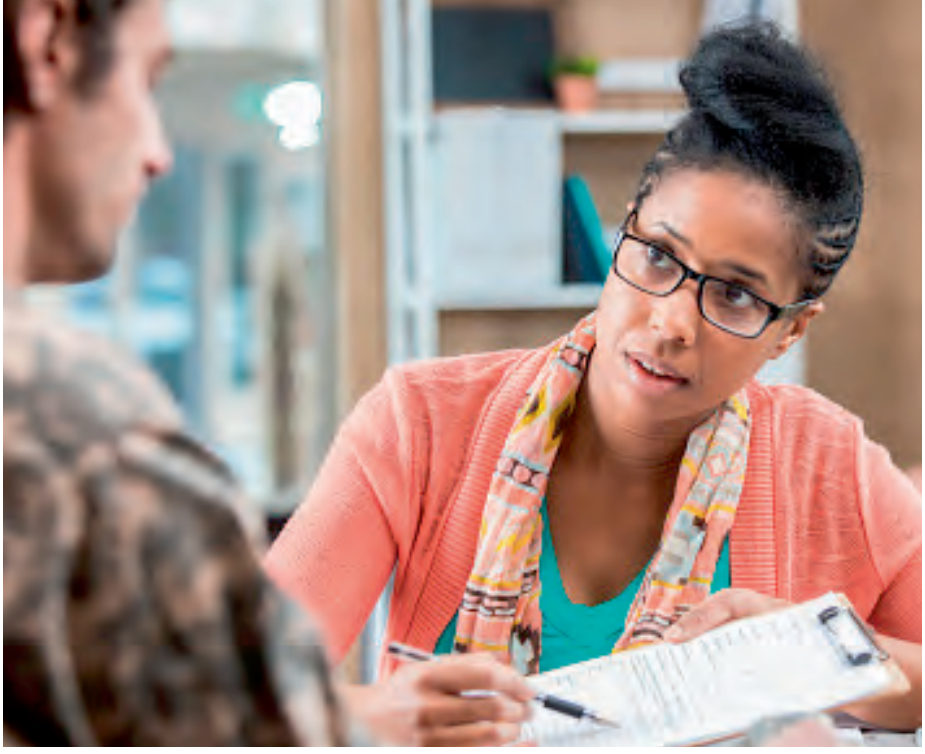

MFTs are equipped to work with SMVF because military personnel not only exist within their family systems, but the military as an entity is composed of complex larger systems and hierarchies; MFTs are able to use their systemic and relational lens to conceptualize how each of these systems may impact SMFV wellbeing.

member's partner or family. Obtaining a written verification that the service member understands fully the limits to confidentiality, how documentation is maintained, and how content from the session may be released is imperative. For example, discussion of record keeping on topics associated with safety and mission readiness is of utmost importance, and documentation pertaining to this specific topic varies by branch of service (e.g., DoN, 2018). In these instances, details from the session and/or documentation may warrant a Command Need to Know (CNK; DoD, 2011).

**Ethics for technology-assisted therapy services with SMVF**

Teletherapy services provide strengths when working with SMVF, including easier access, particularly when the service member or veteran is not located in the same state or country as their family (e.g., due to deployment or permanent change of station [PCS]). However, MFTs must provide informed consent that meets the same standards as in-person care (AAMFT, 2015), including on the topics of safety and mission readiness, made available in writing.

MFTs need to ensure they are following protocol for written communication via email or in the electronic health records (AAMFT, 2015), as military systems of communication adhere to standard formats that all personnel (active duty and civilian, physician and behavioral health clinicians) must follow. MFTs who document clinical care for SMVF into an EHR that is housed on government networks will also provide informed consent so that clients understand that no system is impenetrable, and document accordingly (e.g., limited to the course of treatment, substantiate clinical decisions, service planning, safety assessment, and progress).

**Ethics for SMVF research**

Given the connection between awareness of the evidence-based practices indicated for a given population served within the therapy context and strong ethical practice, MFTs must be good consumers of the research and evaluation (AAMFT, 2020; see Competency 1.4a). Therapist-researchers should pay particular attention to the power dynamics in researcher-participant relationships (AAMFT, 2015), ensuring that clients realize their treatment will not be altered or diminished should they not participate in on-site research programs. Therapist-researchers must also make-known the institution and sponsor of the research, while enacting additional steps to protect confidentiality when sponsored by the former.

***Data confidentiality***

The DoD and Department of Veterans Affairs aim to protect human subjects via IRB-approved protocols, informed consent processes, and compliance in data collection, management, and dissemination. Family therapist-researchers conducting research and evaluation sponsored or funded by the DoD or Department of Veterans Affairs should prepare to receive clearance from at least two IRB boards if engaging in research on a military or Veteran installation. It is particularly important to attend to topics that may be sensitive in nature to the well-being of the SMVF (e.g., military sexual trauma, other service-related trauma, suicidal ideations, infidelity, substance abuse/dependence, mental health issues) and to the privacy and autonomy of military partners (i.e., "dependents").

***Ethical interpretation and dissemination of findings***

Family therapist-researchers can maximize ethical behaviors by implementing a research protocol that has been vetted by experts in the field, individuals who represent the population, and the institutional review board for all institutions involved in the program of study. Furthermore, dissemination of

findings is one of the most essential steps in ensuring that the participants' time in the study was not all for not.

**Conclusion**

There is no shortage of need for SMVFs who deserve quality and ethical care from MFTs. This article is one way of conveying the importance of ethics, laws, and military regulations for MFTs who are interested in making a difference by serving those who serve or have served our country. Although there are added ethical and legal dilemmas when working with military populations, as systemic thinkers, MFTs must not shy away from advocating for SMVFs in making changes in the Military Health System when appropriate (AAMFT, 2020; see Competency 2.3a).

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**How do you know if you're a competent MFT?**

**If you complete a graduate MFT degree and pass the AMFTRB National Exam, are you a professionally competent MFT?**

**Do years of experience with client systems lead to improved therapeutic competence and better clinical outcomes?**

**How do you know if you maintain high standards of professional integrity?**

# PROFESSIONAL COMPETENCE AND INTEGRITY

The competence and integrity of the marriage and family therapist may well be the most important and fundamental components of ethical behavior and practice. Ethical standards, such as the AAMFT Code of Ethics (2015), define professional expectations and rules of practice. Competence embodies professional knowledge, skills, and clinical decision making. Integrity refers to the character, or the qualities, reasoning, and morality of the marriage and family therapist.

Competence is largely assumed to be in place (as in competent to practice) once a marriage and family therapist (MFT) has completed graduate training and is under clinical supervision during the post-graduate period. An MFT is assumed to be competent once an independent license (LMFT) to practice is attained from a state regulatory body. It is important to note that the focus of state regulation of the MFT profession is to ensure that the public is protected, and thus to recognize that the licensed MFT meets minimum standards of practice competency (as opposed to professional organizations, such as AAMFT, which seek to promote the highest standards of practice).

Integrity in terms of ethics and ethical practice refers to the character, values, and morals of the MFT. The MFT's character or level of integrity is central to the process of ethical decision-making. Integrity is bound up in the MFT's commitment to the moral concepts of autonomy, beneficence, nonmaleficence, justice, and fidelity, all in service of the client system's welfare.

**James Morris, PhD** **George Stone, MA**

**There are several components in Standard III of the AAMFT Code of Ethics that speak to the process of maintaining competency. Marriage and family therapists are expected to keep abreast of new developments in the field through required continuing education and training (and through supervised experience for those at the beginning stage of their career).**

There are several components in Standard III of the AAMFT Code of Ethics that speak to the process of maintaining competency. Marriage and family therapists are expected to keep abreast of new developments in the field through required continuing education and training (and through supervised experience for those at the beginning stage of their career). Further, MFTs should also take the necessary steps to ensure the competence of their work when developing new skills in specialty areas through education, training, and/or supervised experience. MFTs must maintain accurate and adequate clinical and financial records (in accordance with applicable laws). Ensuring accurate and adequate clinical and financial records reflects competency by assuring client systems that both the treatment process and accompanying financial records are properly documented. Should any potential concerns arise regarding the treatment, these records could be scrutinized by state licensing boards, and any inadequacies therein would necessarily reflect a potential compromise in competence.

Maintaining integrity involves therapist self-care, being engaged in supportive practice environments, developing strategies for managing risk, imparting meaning to clinical work, and enjoying client contact (Clark, 2009). Being aware of developmental processes and maturational changes that occur as the MFT grows is important in maintaining integrity. The melding of the personal and professional lives over the course of an MFT's career requires the skillful negotiation of ethical gray areas, maturity, experience, and ongoing supervision/consultation. Maintaining integrity as an MFT requires self-nurturance, balance, connectedness, and awareness of family of origin (Protinsky & Coward, 2001).

Being a marriage and family therapist necessarily entails a commingling of one's personal and professional life. Patterson, Williams, Edwards, Chamow, & Grauf-Grounds (2009) note that "therapists need to be aware of their personal boundaries and clear about how their personal lives can affect their work" (p. 264). The personal and professional attributes that an MFT embodies are central to maintaining integrity in the treatment process. Sparks and Duncan (2010) state that "it appears that the person of the therapist, his or her own style of engaging with others and appreciating clients, and general attributes of warmth and communicated caring are strong contributors to success, as is the therapist's ability to form strong alliances" (p. 370).

Threats to competence may take several forms. Hurlburt, Garland, Nguyen, and Brookman-Frazee (2010) reported that therapists working with child/family problems in community-based settings held more inflated perspectives about the relative intensity and number of goals which they pursued clinically with client systems compared to how trained observational coders rated the same variables. The authors note that "if therapists do tend to overestimate the intensity with which goals and strategies are pursued in sessions, this could also impact efforts to improve care quality" (p. 240). That is, it would be important to help family therapists develop more accurate perceptions of the goals and strategies pursued in the clinical treatment process. Further, Goldberg et al. (2016), in a longitudinal study, challenged the assumption that therapists improve with time and experience (that is, become more competent) by noting that "in the aggregate, therapists did not improve with more experience, operationalized as either time or number of cases" (p. 7).

Karam, Blow, Sprenkle, and Davis (2015) highlight the potential drawbacks of focusing too exclusively on MFT models to the relative exclusion of including a focus on common factors in psychotherapy in general, and importantly in MFT specifically. The notion that specific models are superior relative to other models for disorders has been largely debunked (Duncan, Miller, Wampold, & Hubble, 2010). An ongoing focus on a particular MFT model, to the relative exclusion of a common factors approach, may well hamper MFTs from more competently delivering clinical services.

Marriage and family therapists who may face issues that could impair

their work performance or clinical judgment are expected to seek appropriate professional assistance. Maintaining an ongoing professional relationship with other MFTs for clinical discussion, consultation, and support is an important feature of helping to maintain clinical competence.

Standard III of the AAMFT Code of Ethics points to several areas that may be potential threats to integrity. Marriage and family therapists are warned to avoid providing services that create a conflict of interest, resulting in impaired work performance or clinical judgment. For example, when an MFT begins individual work with one partner of a couple relationship, and then subsequently includes the other partner in couples therapy, whilst continuing to see the initial client in individual therapy, the MFT is amid a conflict of interest (Gurman & Burton, 2014).

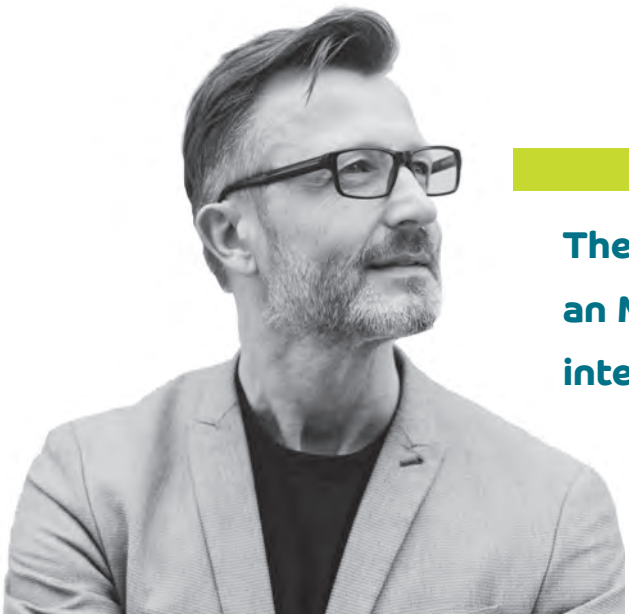
While MFTs are expected to make financial arrangements with clients that conform to accepted professional practices, there may come a time when an MFT is faced with receiving a gift from a client, or even the possibility of wanting to give a gift to a client. MFTs have a responsibility to advance the welfare of clients and should take into consideration both cultural norms and the potential effects that receiving or giving gifts may have on clients and on the integrity of the therapeutic relationship.

Marriage and family therapists may be invited or called upon to offer their professional recommendation or opinions in a public forum or through testimony. While the chance to advance MFT in the public square may be enticing, caution should be exercised to ensure that the MFT agree to speak only about that with which they are qualified and prepared. The MFT should take care to ensure that the sponsor is both reliable and respectable and should understand how their words will be presented and the intended audience (Gladding, Remley, Jr., & Huber, 2001).

Marriage and family therapists do not engage in harassment or exploitation of clients, supervisees, employees, colleagues, or research subjects. For example, MFT supervisors avoid exploiting supervisees' trust by engaging in efforts to sexualize the relationship (Ryder & Hepworth, 1990). Additionally, Standard III highlights the critical area of professional misconduct that may result in termination of membership in AAMFT or other disciplinary action (Coy, Lambert, & Miller, 2015).

The hegemony of biological psychiatry and its accompanying document of classification, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013), present a challenging and ongoing threat to the integrity of every family therapist. For example, the adverse side effects of SSRI antidepressants (including sexual dysfunction) are well established. The conventional wisdom is that psychotherapy + drugs is the optimal course of treatment for couples with a depressed partner. Yet, the inclusion of antidepressants with psychotherapy produces inferior results to psychotherapy alone (Jackson, 2005).

The aspirational core values of AAMFT, as identified in the AAMFT Code of Ethics, include a commitment to integrity as evidenced by a high threshold of ethical and honest behavior, as well as excellence in the delivery of systemic and relational therapies. Marriage and family therapists are thus committed to maintain high standards of professional competence and integrity. Competence embodies professional knowledge, skills, and clinical decision making. Integrity refers to the character, or the qualities, reasoning, and morality of the marriage and family therapist. Practices to maintain competency and integrity in professional practice include continuing education, consultation, supervision,



**The personal and professional attributes that an MFT embodies are central to maintaining integrity in the treatment process.**

incorporating client feedback, tracking clinical outcome, and keeping abreast of clinical and research developments. The marriage and family therapist must be vigilant in defending against potential threats to competence and integrity such as avoiding conflicts of interest, exploitation, and harassment.

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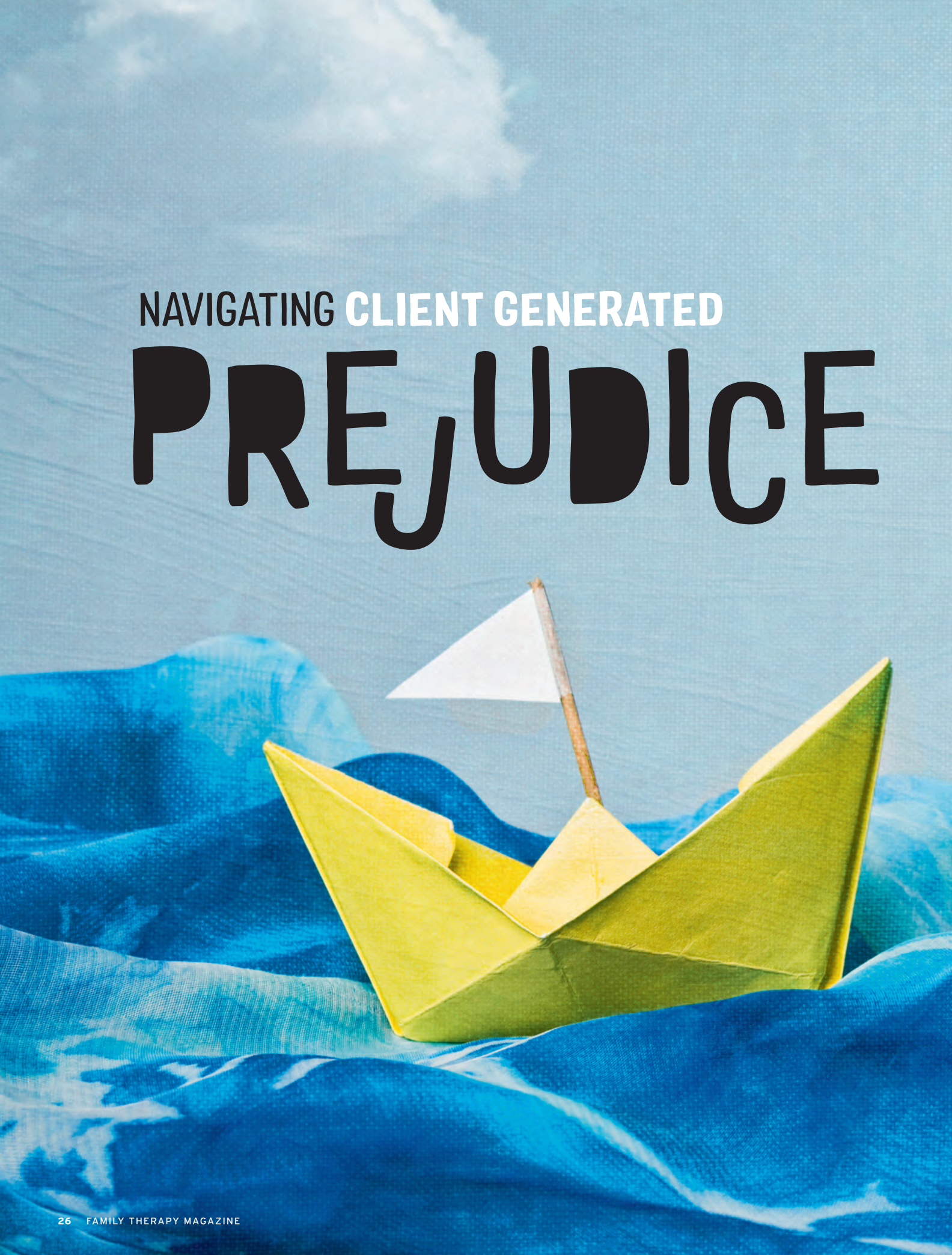
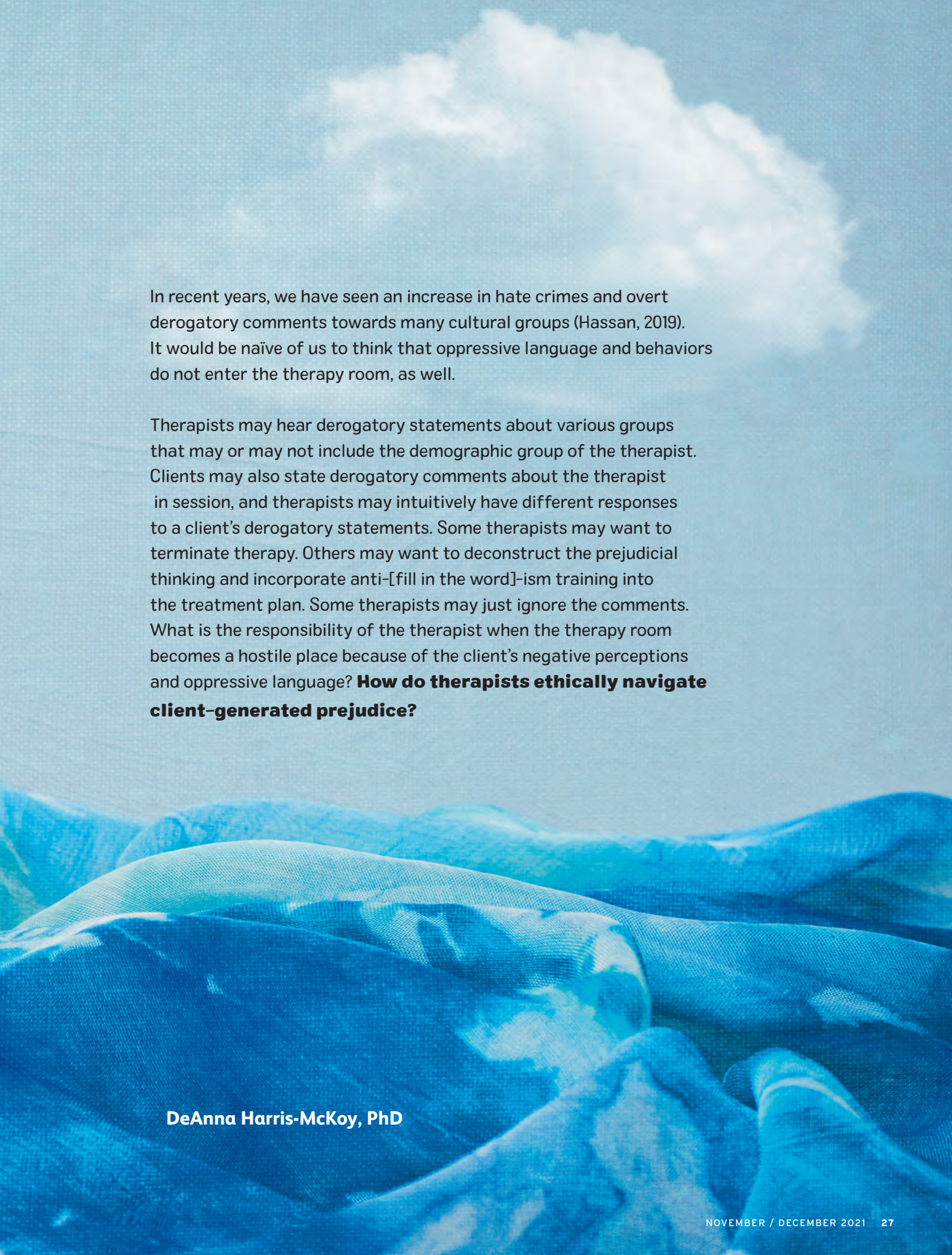
**Competence embodies professional knowledge, skills, and clinical decision making. Integrity refers to the character, or the qualities, reasoning, and morality of the marriage and family therapist.**

The topic of this article will be covered in a chapter in the upcoming AAMFT textbook on ethics.

# NAVIGATING CLIENT GENERATED PREJUDICE





In recent years, we have seen an increase in hate crimes and overt derogatory comments towards many cultural groups (Hassan, 2019). It would be naïve of us to think that oppressive language and behaviors do not enter the therapy room, as well.

Therapists may hear derogatory statements about various groups that may or may not include the demographic group of the therapist. Clients may also state derogatory comments about the therapist in session, and therapists may intuitively have different responses to a client's derogatory statements. Some therapists may want to terminate therapy. Others may want to deconstruct the prejudicial thinking and incorporate anti-[fill in the word]-ism training into the treatment plan. Some therapists may just ignore the comments. What is the responsibility of the therapist when the therapy room becomes a hostile place because of the client's negative perceptions and oppressive language? **How do therapists ethically navigate client-generated prejudice?**

**DeAnna Harris-McKoy, PhD**

**Client-generated prejudice**

The field has made slow, yet concerted efforts to incorporate intentional consideration of cultural context into the training of marriage and family therapists, clinical research, and clinical practice (Awosan, Sandberg, & Hall 2011; Castro, Barrera, & Steiker, 2010; COAMFTE, 2017). Therapists understand the importance of discussing culture in building and maintaining the therapeutic relationship in an effort to engage clients in the therapeutic process (Owen, Tao, Leach, & Rodolfa, 2011). Therapists also understand how to incorporate culture into treatment without "othering" the client, and how negative perceptions of differences between the therapist and client can undermine the therapeutic work.

To maintain the therapeutic relationship, therapists may tolerate hostile language or behavior from a client due to client's transference (van Leeuwen & Harte, 2017). Therapists may rationalize the hostile behavior as client's projection, that has little to do with the therapist as person. Rarely is "othering" discussed as something therapists may have to endure, especially as it relates to ethical treatment of clients. Acts of hostility by the client towards the therapist due to personal and/or cultural identities was termed as [client] generated prejudice by Mbroh, Najjab, & Gottlieb (2019). Similar to "othering," this hostility generally has its origins in prejudiced belief systems and can be demonstrated in numerous ways.

**Ethical considerations**

When client-generated hostility is due to the therapist's role as a mental health professional, the therapist should call on their clinical training. It is necessary to remember the circumstances which bring our clients into our offices. The client is most likely in a state of distress and struggling to cope with a significant mental/emotional difficulty. Unlike our clients, we have resources of supervision, peer consultation, and the AAMFT ethics hotline to help us in deciding the best course of action. Many of our clients confide solely in their therapist about the vulnerable parts of their life.

Although there has been increased emphasis placed on multicultural competence, diversity, and equity (COAMFTE, 2017), there fails to be adequate guidance on how family therapists are expected to handle client-generated prejudice, especially as it relates to the AAMFT Code of Ethics (Steele, 2011). While the profession may agree that this type of hostility does exist and may be cognizant of this occurring with therapists who present with minority or marginalized identities, it is less clear what types of protections therapists may have in these situations.

As clinicians, we are trained to diffuse intense situations and to manage the emotionality of others. For even the most experienced clinician, it can be difficult to anticipate what may cause a client to direct anger and discontentment towards a therapist during a session. We have all had sessions that end very differently than they began, or had a client express unhappiness with a piece of feedback we provide. How, then, do we ethically handle open hostility when it is related to our personal/cultural factors?

Rarely is "othering" discussed as something therapists may have to endure, especially as it relates to ethical treatment of clients.

Therapists may want to consider their person-of-the therapist (POTT) concerns, the client's history and diagnoses, the therapeutic relationships, and professional responsibility/ethical codes. Being a clinician does not equate to being a punching bag, but it does mean that we have the greater responsibility to bear in managing the situation. We must be able to acknowledge our own emotions, appropriately respond to what is happening in the moment, and figure out our next steps.

Safety is always the priority. There is no situation in which a therapist should compromise physical safety. In case of any physical emergencies, 911 should be called immediately. The therapist should also observe and follow any local guidelines about when and how to properly breach confidentiality to report harm towards others. If there are no safety concerns, the therapist should consider whether the hostility is related to their racial/ethnic background or any other identity-related or psychosocial factor.

Whether the social location of the therapist is visible to the eye or not, the therapist has to assess if treating this particular client could potentially cause harm to either person.

We learn in our training programs about the importance of facilitating change in our client's life and we are taught how to challenge them out of their comfortable cycles of chaos. While in the midst of the therapy process, we can often forget how difficult being asked to change can be. This is not to suggest that we are to blame for client-generated prejudice, yet rather to highlight that we should anticipate how a client attempting to manage their change process may present as misplaced anger. Addressing the hostility

Client-generated prejudice can be upsetting and traumatic, but it can also be transformative and create a new pathway to healing.

and allowing the client to openly speak to their mixed emotions can serve to strengthen the therapeutic relationship.

Appropriately managing client-generated prejudice is an important part of providing treatment in any clinical setting. The occurrence can be upsetting and traumatic, but it can also be transformative and create a new pathway to healing. Barring the use of derogatory language, a client expressing hostility may be a function of vulnerability. We can use this emotional transaction to address the client's treatment goals and incorporate it into what needs to be worked on. Conversely, the outward discontentment can help facilitate a conversation about whether there is a goodness of fit between the therapist and client. In this case, providing appropriate referrals and discharging the client may be best for both parties.

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The chapter concerning Navigating Client Generated Prejudice in the upcoming AAMFT ethics textbook provides a structure to begin discussion on how to confront client-generated prejudice. The chapter provides a definition of hostility as it relates to clinical settings and discusses the various ways hostility and client-generated prejudice can present in therapeutic sessions. There are steps, informed by various sections of the AAMFT Code of Ethics, for therapists and supervisors to follow when addressing concerns of hostility. Along the way, there are various vignettes and reflection questions focused on different aspects of othering and client-generated prejudice.

# QUEER THERAPISTS
## PRACTICING IN THEIR OWN CULTURAL COMMUNITY

M. Evan Thomas, PhD  Mary R. Nedela, PhD

***"If you are ever at the local drag show and you see me there, do not worry. I will not approach you and say hello. If you acknowledge me first, I will wave. I will not come up and start a conversation with you. This action is not me ignoring you, but it will allow us to maintain a healthy therapeutic relationship. We can chat about the show at the start of the following session if you would like. Does this boundary make sense, and are you comfortable with it?"***

Suppose you have ever had a similar conversation during an intake session. In that case, you might be a queer therapist (for the purpose of this article, queer refers to any person who identifies on the LGTBQIA+ spectrum) who specializes in working with the queer community in a smaller city. You might have learned through trial and error the ethical-decision making that you are constantly navigating. You might have realized that this type of ethical-decision making was not discussed in your training program.

This article aims to provide the reader with the common ethical dilemmas that a therapist who works within their queer cultural identity may encounter and steps to take to be proactive and minimize any negative impact.

### Ethical decision making

Ethics is about doing the "right thing" when working as a marriage and family therapist. An ethical dilemma includes any situation in which the welfare of clients may be at risk (Hecker & Murphy, 2016). Therapists must provide services that benefit the client and do not cross any professional boundaries to inhibit therapeutic progress or the therapeutic relationship. Therapists are expected to practice benevolence, which may take on a new meaning while practicing within the therapist's cultural community.

Currently, numerous ethical decision-making models have been proposed for psychotherapy. Most ethical decision-making models assume that the therapists across community types share similar dilemmas and the number of occurrences (Gonyea, Wright, & Earl-Kulkosky, 2014; Hecker & Murphy, 2016; Pope & Vasquez, 2011). Many of the current ethical decision-making models provide the following for the resolution of the ethical dilemmas: be aware of potential ethical issues, understand and state the problem clearly, know and practice the core competencies of the ethical codes, stay up-to-date with research, be aware of ethical and legal pitfalls, gather all relevant information from multiple sources if possible, respect the client's autonomy, and seek supervision as needed (Hecker & Murphy, 2016; Pope & Vasquez, 2011). Lastly, therapists must document the process, take responsibility for their decision and its consequences, and understand the effect of their decision on the future of their client and themselves (Hecker and Murphy, 2016; Pope & Vasquez, 2011).

### Cultural communities

As a queer therapist who works in their queer cultural community, it is essential to understand potential ethical dilemmas that may arise. Therapists must know that these dilemmas are most likely to occur, and the most prominent ethical dilemma includes the potential for dual relationships (Addison, 2019; Everett, MacFarlane, Reynolds, & Anderson, 2013; Heins, 2013). As queer cultural communities can be small, especially in smaller cities, there is a higher risk of interacting with clients outside the therapy room. For example, as a queer therapist in a smaller city, Author Thomas (he/him) makes the ethical decision not to attend the weekly "Queer Nights" at the local coffee shop. His decision includes ensuring that his clients have a safe space outside of the therapy room to connect with other queer community members. Within himself, he has decided that the queer event can be more impactful for his clients than for him because he has the privilege of building his queer community through his networks outside of the city in which he practices. This decision works best for him, and he worked with his clinical network to make this ethical decision. This is an example of navigating a potential ethical dilemma following the steps of being aware of the potential ethical issue, understanding the problem clearly, understanding the ethical codes, and making the best choice that allows for client autonomy (AAMFT, 2015).

### Suggestions for practice

The best method for maintaining ethics includes being proactive and normalizing potential ethical dilemmas, especially the potential for dual relationships. Following are specific steps to take to stay proactive, inclusive, and ethical.

**1. Be open and honest about the likelihood of running into each other.**
Discuss the potential dilemma during the first session. Work with your client to be proactive rather than reactive, which allows for a more ethical relationship. The narrative shared at the start of this article is an example of being open and honest. At first, it might seem uncomfortable sharing with your new client that you like to attend drag shows (or any other queer community space/event), but in the long run, it will allow for ethical boundaries to stay firm.

**2. Offer clients referrals to an alternate affirming therapist if they become less comfortable.**
Start the therapeutic relationship by normalizing the option to terminate services if the boundaries become uncomfortable. A potential narrative to address this problem could mirror: "While we are working together as a therapist and client, please do not hesitate to inform me if you feel as though we know too many of the same people or enjoy too many of the same social events and spaces. This is due to the ethical codes that I have to abide by, and you might realize that we are in the same social circle before I do. Specifically, I am not legally allowed to disclose that you are my client. This means that I am not sharing your name with anyone. You are more than welcome to share that I am your therapist. This dynamic might allow you to realize before I do that we know the same people." This exact scenario has happened a few times to one author, and all clients were able to ask for a referral comfortably. In addition to

When clients are comfortable with shared community spaces, negotiate how each of you will navigate these spaces. Collaborate with your clients about what spaces you can share and which spaces should be separate. This could depend on the importance of spaces to your clients, and the degree of blurred boundaries.

encouraging clients to inform you if they become uncomfortable, it is your responsibility to elicit feedback occasionally to ensure continued therapeutic safety. It is important to normalize this process and provide a list of referrals that includes therapists who are not queer but are allies to the community.

**3. Negotiate ethical dual relationships**
When clients are comfortable with shared community spaces, negotiate how each of you will navigate these spaces. Collaborate with your clients about what spaces you can share and which spaces should be separate. This could depend on the importance of spaces to your clients, as referenced earlier, and the degree of blurred boundaries. For instance, you may jointly decide that attending city pride parades is acceptable, but not drag events due to the number of attendees. It would be best to discuss what boundaries and interactions are required for each setting to ensure confidentiality and comfort. Should there be a verbal greeting, a nonverbal greeting, or no greeting? How might you handle situations when you sit near each other at an event? What should happen when shared acquaintances try to introduce you to each other? Your client should drive the decision-making car with you in the passenger seat, providing suggestions and considerations. These discussions can be held at the beginning of treatment, as well as throughout treatment when events arise.

**Telehealth can be your friend.**
During the global pandemic, telehealth has become more frequent and normalized. Telehealth can be an excellent asset for queer therapists because it allows them to work outside of their community network. It opens up the entire state they are licensed in, which lowers the possibility of dual relationships and interacting with clients at queer community events in the city where they live. For Author Nedela (she/her), who provides telehealth services in a separate state from which they reside, this provides a clear separation of the local community and clinical treatment for the therapist and clients. Do not be afraid to market yourself as a virtual therapist, and abide by the telehealth guidelines set forth by your state and the state in which you practice. As a private practice owner, this is extremely important, and it allows you to be a resource to the queer community in your entire state. Working with clients outside of your city or state will enable you to lower the likelihood of navigating the aforementioned scenarios.

These guidelines are simply suggestions for queer therapists to be proactive when working in smaller queer communities. These guidelines could potentially be translated for other cultural minority therapists who work in their own cultural community. Dr. Sheila Addison provided a webinar for AAMFT's Queer and Trans Advocacy Network on Multiple Relationships in Small Communities & Subcultures that further discussed this situation. The webinar is available in Teneo for further training. Training programs need to include discussions of multiple relationships in small communities, such as queer communities, in their ethics courses. Cultural minority therapists are an asset to their

community and navigating potential ethical dilemmas proactively can ensure that these therapists provide the best services they possibly can. This topic might be overlooked, but as our field increases in diversity (race, ethnic, sexual orientation, and cultural), it is essential to adjust the ethical training conversations.

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Benjamin Erwin, PhD

# Bridging the Divide:
# Creating Respectful Dialogue

We live in a divisive world. So much of what we see and hear as part of the socio-political narrative is filled with argument and contention that polarizes discussion, ideas, and sometimes even people. Whenever I watch the news, it almost seems like the world stage has become my therapy office, with a high conflict couple, flooded with emotion, unable to talk to each other. And not surprising, the divisive, polarizing social discourse seems to be just as effective as any of my high conflict clients' dialogue.

Even for therapists, it can be hard to help clients and ourselves be able to have respectful dialogue across this divide, especially when it comes to emotionally charged issues such as race, religion, and sexual orientation. But we can and we must do so; respectful dialogue is the best way to bring about understanding, mutual support, and cooperation to bring about change and progress. It may sound difficult, or even impossible to do so, but fortunately there are some great examples of therapists who do just that.

One such example is the Reconciliation and Growth Project (RGP). This is a group of mental health professionals and academics, based in Salt Lake City, Utah, who have come together to bridge the divide and found some common ground with one another. The group is made up of five individuals who primarily represent the LGBTQIA+ perspective and 4 individuals representing a religious conservative perspective. This group meets weekly for two hours to discuss a variety of issues, with the goal to gain mutual understanding through respectful dialogue with each other.

The group was originally created in March of 2013 after a workshop on best therapeutic practices to address sexual orientation and non-traditional gender identity. There were a lot of concerns about how therapists were helping clients reconcile their sexual orientation and religious beliefs. Some therapists, while well intentioned, may have been engaging in therapeutic practices that were harmful for clients; both helping a client explore and affirm their sexual orientation, as well as being congruent with their faith tradition or religious world view. A small group of therapists wanted to engage in an ongoing discussion around this topic, and thus RGP was created.

At the outset, having a group comprised of passionate and dedicated mental health workers from opposite sides of the socio-political spectrum may seem like an impossible group to be able to find consensus on much of anything, let alone anything related to faith-based values and sexual and gender diversity. Could they create enough safety and respect within the group to effectively have a productive dialogue? Was there anything they could agree upon? Would the group fizzle out and end?

Although I have never been an official part of the group, I have had a front row seat, watching them come together as a group, and progress into what they are now. I have attended their presentations, trainings, and watched them as they advocate for more respectful dialogue. And although it hasn't been easy, they have been very successful, especially compared to normal social discourse on the subject.

One of their biggest achievements is creating standards, *Resolving Distress Between Faith-Based Values and Sexual and Gender Diversity: An Abbreviated Guide* (RGP, 2017), for working with anyone who is struggling to resolve faith-based values and their sexual orientation or gender

Two core principles, “doing no harm” and “facilitate self-determination” were the foundation for the work RGP has done. The guidelines provide context and a rationale for each principle.

identity. This document outlines important and ethical principles such as: “It is essential to provide a safe environment for individuals to explore, define, and articulate their own identity in order for each to discover their authentic self;” and “approaches are inherently harmful if they….limit the exploration of sexual orientation, gender, faith, and cultural identity and expression possibilities (personal communication, September 21, 2021).

These standards help clinicians promote safety and respect to any clients who might be feeling their way through a complex journey between sexual orientation, gender identity and faith-based values or a religious world view. The standards are also meant to provide a framework for licensing boards to regulate therapy in this field and help de-escalate the divisive discourse around legislation issues.

Jeff Bennion, LAMFT, is a part-time therapist and has been a member of the Reconciliation and Growth project since the spring of 2018. He notes (personal communication, October 12, 2021): *My work with RGP has helped me immensely as a clinician. It has helped me see where my blind spots and biases might be potentially harmful. As therapists, we all come with blind spots, and these can end up harming clients. Being in a constructive dialogue with people with dramatically different values, backgrounds, and life experiences has helped me see some of my own blind spots and helped me avoid harming certain clients. This is important to me, because I often see clients who are harmed by therapists who tell them, for example, they can never be happy in a traditional religion, or that it is fruitless to remain heterosexually married because it is an inauthentic and unsustainable life path. My own experience, and many others, have taught me that this is not always the case. They are truly harmed by this because this course of their life has meaning, and as we know from the Four Options Survey results, there are many who find living this way satisfying and personally meaningful.*

Two core principles, “doing no harm” and “facilitate self-determination” were the foundation for the work RGP has done. The guidelines provide context and a rationale for each principle. For example, clinicians may unintentionally do harm such as by reinforcing “a belief that either identifying as religious or as lesbian, gay, bisexual, or transgender (LGBT) must be avoided” and promoting restriction from “education or exploration regarding a wide range of options” (personal communication, September 21, 2021). The guidelines also provide practical ways that clinicians can prioritize their client’s right to self-determination. “Understand and respect the importance of religion and spirituality in the lives of clients, to provide/offer meaning, tradition, culture, identity, community, health, satisfaction, and diversity” (RGP, 2017, p. 18).

These two core principles are fascinating to me. I do not disagree with these principles at all—just the opposite—I find them to be a clear and succinct statement of what is most important when working with this population. To me, the reason why these core principles are so fascinating is that these two groups from opposing world views shared the belief that these fundamental principles are important.

One of the consequences of the divisive and polarizing discourse that seems to dominate our social, academic, and political narrative, is that it creates artificial barriers to find common ground, and mutually shared principles. It is so easy to vilify and demonize an opposing group, without being able to recognize any common or shared values.

It is completely isomorphic with the high conflict couple, who can't seem to understand each other, even the most important and cherished values or memories, because their conflict is getting in the way.

RGP decided to focus on what they could agree on, instead of what they disagree on. This was key and allowed them to discover that they shared a lot in common with each other. They found these two core principles as the foundation for their work, to be able to create their guidelines for ethical and professional conduct with this population. They also found they agreed upon recommendations for the main overarching goal of therapy: "All sexual orientations, gender identities, and religious/spiritual and other ideological values have the potential to be lived in healthy and unhealthy ways. The focus should be on improving functioning and changing unhealthy expressions" (RGP, 2017, p. 9).

In my opinion, finding common ground is RGP's biggest success. The guidelines are a tremendous milestone and an important guide for clinicians, policy makers and licensing boards. But for me, even more importantly, is that this diverse group has been able to engage in meaningful and respectful dialogue. They have provided an example of not only what can be done, but what needs to be done, for individuals, couples, families, and communities to move forward in finding solutions to the host of complex challenges that we all face. Not only can we not do it alone, there is tremendous strength in finding unity amidst diversity.

Bennion remarked (personal communication, October 12, 2021): *At times, the process has been personal and painful. We have had our share of hurt feelings, and even tears. But as each of us has committed to work through these feelings, and following our protocols for understanding and managing emotionally strong disagreements, we have grown much closer in trust and mutual affection. As we have recognized each other's mutual humanity, we have managed to find common ground, and hopefully this is also improving the profession as a whole; much more common ground than was initially apparent. And all of us were able to do this without having to surrender the values and beliefs that are important to us, and over which we still fundamentally disagree.*

Make no mistake, creating a safe environment and engaging in respectful dialogue is no easy task. Members of RGP openly share how difficult the experience of participation has been. These are passionate professionals who care not only for their clients and communities, but also are personally living amidst the socio-political clash of values regarding these issues. It is easy to be triggered and become flooded with emotion. It requires tremendous courage to be vulnerable and reach out to someone else for mutual understanding.

As trailblazers, RGP has been innovative in finding ways to be able to come together and find mutual understanding discussing emotional and polarizing topics. In order to help, RGP has created some protocols to help facilitate similar discussions. They have outlined "peacemaking protocol," designed to teach and model the principles and skills used to bring about respectful dialogue. The peacemaking protocols use various principles and practices, such as: how to create safety, inclusion vs. exclusion, steps to explore differences, debate vs. dialogue, and how to seek a win-win outcome, to name just a few. It is hoped that others can use these same tools to help create similar experiences regarding a variety of difficult topics.

It is refreshing to see a diverse group of people be able to come together and find common ground. While divisive contention and polarization permeates our society, we can rise above it and engage life in a similar way we help our clients do so; with respect, curiosity, and understanding. This doesn't mean we have to agree with others—but we can disagree without being disagreeable. In order to move forward and find better solutions to the host of problems and issues that face us, more respectful dialogue will go a long way to help us find mutual support, understanding and cooperation. RGP provides an important example we can all follow.

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All RGP documents and other information can be found at **reconciliationandgrowth.org**.

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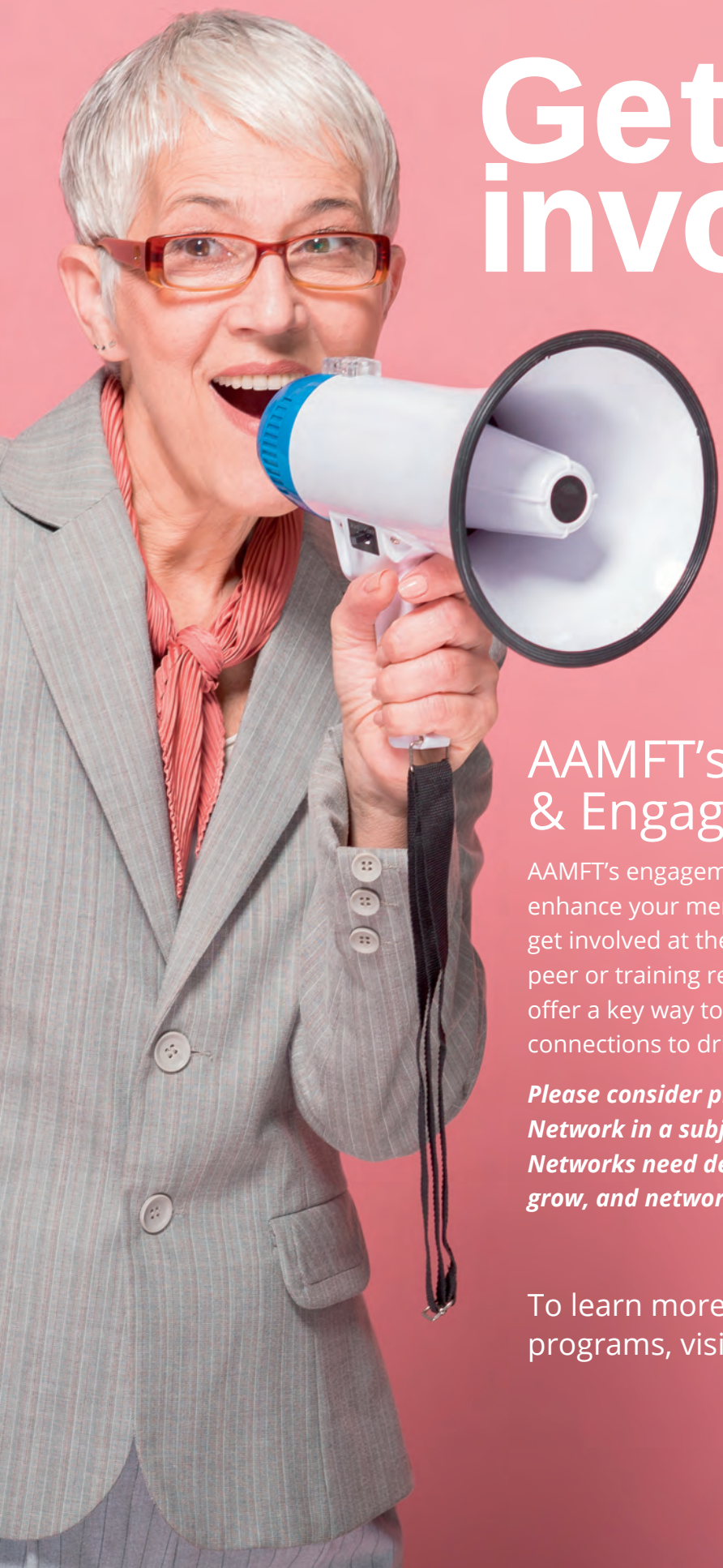

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# Healing Systems: Therapy with Mandated Clients

Mandated clients are often navigating many systems at once. These systems include their families, their schools, the Department of Juvenile Justice (DJJ)/Juvenile Services Department (JSD), etc. In addition to navigating multiple systems, mandated clients may be experiencing levels of trauma (or Adverse Childhood Experiences – "ACEs"), individually or within the family system.

These traumatic experiences may contribute to barriers that may impede the therapy process and the effectiveness of treatment. Given these barriers to treatment, and the potential for complex trauma histories, it is critical to approach therapy through a systemic and trauma-informed care perspective when treating this population. Assessment and coordinating appropriate services can provide a useful tool, as well as incorporating a trauma-informed care (TIC) lens.

**Healing systems: Therapy with mandated clients**

My colleague and I, Franchesca Meyers, have worked in the field for over seven years in different capacities. As registered marriage and family therapy interns in South Florida, we have worked in different settings providing direct services (outpatient, in-home, telehealth, etc.) to children and their families, either within the DJJ/JSD or dependency (foster care) system. Most of our clients include mandated youth between the ages of 4-19. Although from different backgrounds, there is a common thread—mandated clients are all individuals navigating the system in hopes of moving forward with their lives.

In a typical setting, these are individuals who would never seek services of their own volition—mandated—who also have committed a crime—offenders (Reddick, 2004). Realizing that these are individuals who do not have the luxury of exploring various therapists for the right fit and would not typically seek services, it must be taken into consideration that our standard approach to clients may differ.

**Mandated clients**

Mandated clients are required by the courts—through a post-release diversion program—to attend some sort of mental health or substance abuse service. Their cases range from substance abuse to grand theft auto. We have had the privilege of being our client's mentor, case manager (at times), as well as their therapist. According to the Florida Department of Juvenile Justice (2020):

Between 2018-2019, 54,827 juveniles (aged 10-17) were arrested in the state of Florida. Of that number, 11,181 were sent to diversion programs, and 11,549 were placed on probation. When broken down by race, Black juveniles made up 49.9% of the total

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number and White juveniles made up 33.2%, with 16.4% as others. In terms of diversion programs, Black juveniles were diverted at 39.5%, while White juveniles were diverted at 42%.

Children—or even adults—who may or may not have any insight into their problems, or have not had the chance to process the trauma they have experienced in their household(s), are often faced with meeting many of our colleagues within these various systems. Oftentimes, mandated clients may show "resistance" when they are required to attend outside services. This increases the urgency for us to discuss and understand the importance of our roles as clinicians as well as the system as a whole. As systemic thinkers, it can often become difficult to navigate within systems that tend to ignore trauma when assigning mandated clients to mandated treatment. These issues, and many more, affect our communities in more ways than we often think.

**Therapeutic alliance**

Children within the DJJ/JSD system are often required to participate in post-release services. Services include individual or family therapy, rehabilitation care (for substance/alcohol use), and so forth. Within the systems we are working, the relationships we are working to maintain with our clients can be crucial to their growth and longevity. Research has consistently shown that the therapeutic alliance is the strongest predictor of whether or not therapy will be successful (Knobloch-Fedders, 2008).

It is essential to understand how the mandated therapy relationship differs from traditional voluntary therapy relationships in working with mandated clients. Hachtel, Vogel, and Huber (2019), state "while mandated therapy provides external motivation to attend treatment, voluntary clients are normally believed to be intrinsically motivated" (p.1). The literature suggests that mandated clients are more resistant than voluntary clients (Hachtel et al., 2019). However, research has shown that court-mandated clients have expressed gaining something valuable from therapy, citing that the experience was more enjoyable than anticipated (Forte, 2018; Mee-Lee, 2017). The quality of the therapeutic relationship (provider-client relationship) is as important, if not more, than specific psychotherapy techniques applied (Hatchel et al., 2019). This also speaks to the effectiveness of treatment and barriers that prevent treatment from being provided and/or effective.

**Barriers to treatment**

While examining and exploring the effectiveness of treatment, it is important to explore the barriers to treatment that include family dysfunction, trauma (that manifests itself as maladaptive behaviors), and lack of access to resources. The family unit (and family dysfunction) can be seen as a crucial part when exploring the root cause of what is happening with clients. Papero (2017) refers to systemic dysfunction as "a deterioration in the process of coping with adversity that promotes the maintenance of the family's ability to meet the needs of its members" (p. 584). When the equilibrium is unbalanced, the family system is often responding to internal and external pressures; external pressures mirror a need for the family to respond to conditions that are changing and challenge the family's capacity to maintain its lifestyle and ways of functioning (Papero, 2017).

This barrier, or wall, can be seen as resistance. These walls are often a manifestation of the traumatic experiences they have experienced, as well as a system that has not often afforded them the opportunity to explore some of that hidden trauma. Being exposed to trauma can present itself as many symptoms. Ford, Chapman, Hawke, and Albert (2007) posit that this includes "not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior" (p. 1). Trauma can impede a child's thinking and learning, as well as interfere with the levels of development (Ford et al., 2007).

Racial disparities also exist amongst minorities within the community. Mcguire and Miranda (2008) note "As documented in Mental Health: A Report of the Surgeon General and its supplement, Mental Health, Culture, Race and Ethnicity, racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated" (p. 3). Moreover, in the United States, minorities are most likely to not seek, or wait, for services (Mcguire & Miranda, 2008). Understanding the complexities that exist in our client's lives and allowing for open exploration of proper, achievable goals is important even in the midst of constraints that exist in everyday life.

**Setting goals**

When working with mandated clients, it is imperative to establish a unified goal outside of the goal that the referring system has for them, meaning that although mandated clients can appear resistant to changing or uninterested in therapy, they are in an action stage for something they may want (Mee-Lee, 2017). Some of the actions may include "staying out of jail; getting people off their back; getting housing or a job, or getting their children back" (Mee-Lee, 2017, p.3).

In finding a common treatment goal, it is best to meet the client where they are. Clients may not always acknowledge the circumstances that have led to them being in their current position. In these situations, ask them how they would like to spend their time here, or variations of this question. Forte (2018) highlighted that by giving mandated clients the ability to identify the goals they want to focus on, their motivations go from being solely externally motivated by the legal system to internally motivated.

From here, there is the ability to eventually tie the goals they have come up with to changes in their behaviors and how they make decisions. An aspect of leading from behind, utilizing our role as a systemic therapist, is to discover an area where we can combine what is essential to the client and the referral source. In considering our roles as therapists with mandated clients, there is the need to highlight the differences in our role as their therapist in comparison to their probation officer, or even the judge. Forte (2019) stated "my job is not to 'catch' them if they mess up. Our role is to help them make better

## 6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL, & GENDER ISSUES

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

decisions so that they do not mess up in the first place, and to support them and help them learn from any mistakes they might make" (p. 4).

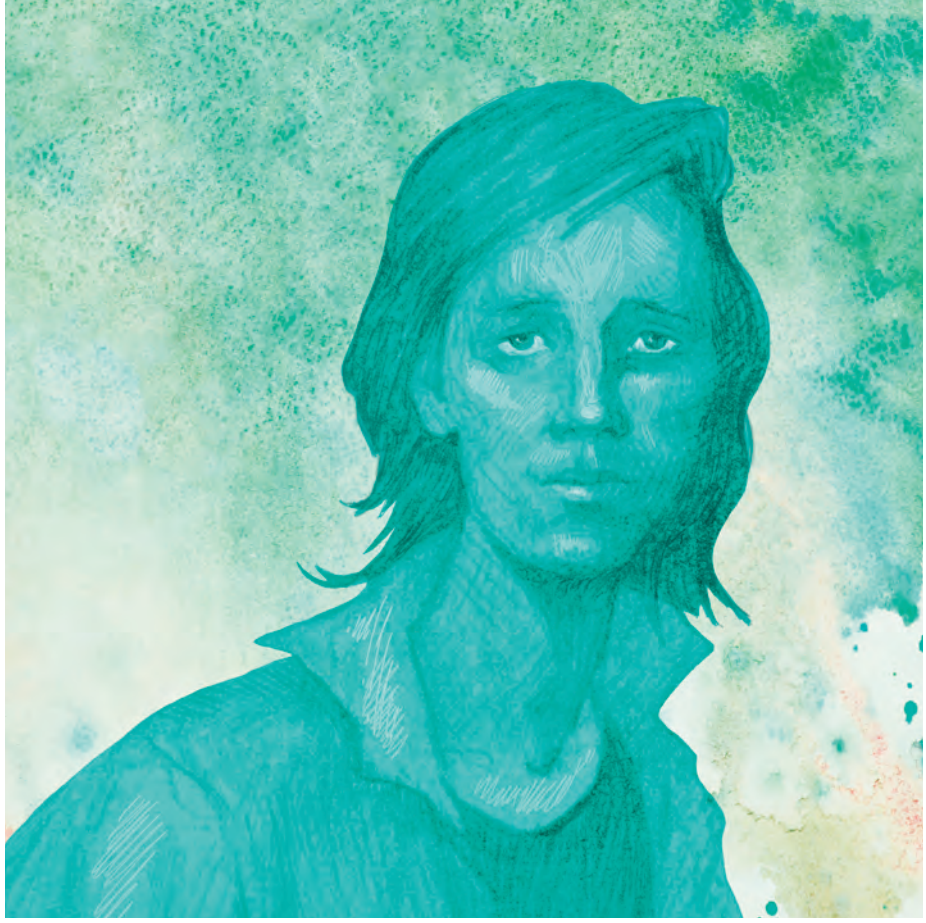
**Systemic framework**

By using a systemic framework, we have shifted our thinking from the "individual unit" to the larger system that allows us to focus on "facts" instead of "cause and effect" (Bowen, 1978, p. 416). Thinking systemically opens the door for clinicians to explore the family unit as a whole, while simultaneously considering each person's individual differences. Spronck and Compernolle (1997) write "Thinking 'systemic' means that one is willing to take into account information about the other levels, the higher as well as the lower ones" (p. 153). Bowen (1978) posits that the function of any system is dependent on the functioning of larger systems of which it is a part, and also on its subsystems. Systemic framework pulls from culture when working with families (Spronck & Compernolle, 1997). In certain cultures, there are conversations that many may not want to have within their family unit. This can bring on shame, guilt, or even regret.

**Trauma-informed care**

The National Child Traumatic Stress Network (NCTSN; 2021) defines trauma-informed care as a system where everyone involved in working with children, caregivers, and so forth, is capable of recognizing and responding to the impact of traumatic stress. Many times, the first line of contact with clients who clinicians work with are police officers (POs) and/or probation officers (JPOs). The continuation of care and concern can often go unexpressed if JPOs are unaware of a youth's previous mental health disorders and/or trauma that a youth has experienced.

It could be noted that a youth needs mental healthcare, while not having enough information about how to refer out accordingly based upon



It is important to take into consideration the complexities of adolescence and teen years.

the displayed symptoms. Holloway, Brown, Suman, and Aalsma (2013) state that "although POs may be more sensitized to mental health, they may be less sensitive to specific subsets of mental health care" (p. 372). JPOs/POs are often seen as the "gateway" to mental health services for this population (Holloway et al., 2013). As mentioned, with JPOs/POs oftentimes being the first line of contact, a trauma-informed care approach may also provide an added layer of comfort for youth that offers the opportunity to allow for care and concern.

In healthcare settings, healthcare providers and staff are trained to be aware that trauma can be hard on individuals with whom they come in contact (Koetting, 2016). Utilizing the 6-key principles of trauma-informed care (See figure 1.1): 1. Safety, 2. Trustworthiness and transparency, 3. Peer support, 4. Collaboration and mutuality, 5. Empowerment, voice, and choice, 6. Recognition of cultural, historical, and gender issues, individuals in all settings (not just the healthcare systems) can incorporate an environment with the "goal to guide patients from a state of trauma to one of healing…" (Koetting, 2016, p. 212).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA; 2021), "A trauma-informed approach to services or intervention acknowledges the prevalence and impact of trauma and attempts to create a sense of safety for all participants, whether or not they have a trauma-related diagnosis" (p. 1). When an agency or system utilizes trauma-informed care, it can help to assist with re-examining policies that would not offer individuals the feeling of comfort as well as re-examining the training of the staff. One of the main goals of trauma-informed care is to avoid re-traumatization, as well as provide a welcoming environment for individuals who may or may not be experiencing trauma.

Mandated clients are often viewed as harder to work with, at times. This population faces several barriers that range from familial stress to trauma. As we continue to explore, and literature continues to emerge, it is important to take into consideration the complexities of adolescence and teen years. It is highly encouraged that we consider the severity of trauma when working with this population, as well as provide the necessary best course of treatment that would provide the youth with the needed services. Our role as clinicians is often seen as an important part of many of our clients' lives.

Our role within these family systems offers us the opportunity to explore their worlds and work to process the trauma or life stressors for which they may, or may not, have had the opportunity. It is through the work we do that we can fully grasp the understanding of systems and acknowledge the importance of support, guidance, and homeostasis. Ford et al. (2007) notes "traumatic stress symptoms may worsen as a result of juvenile justice system involvement" (p. 3).

From our experience, the relationships with voluntary clients differ from the relationships with mandated clients. We may find ourselves spending an extensive amount of time in the joining stage, figuring out ways to gain these individuals' trust, and letting them know we are here for them, to help them, as they navigate their time within the system to move on with their lives. Work with mandated clients is not a walk in the park; there is navigating and balancing work with the client and the referral source, in many cases, the probation officers. But, through it all, there are significant rewards related to the work. These rewards come in the form of a meaningful career, inherent challenges of the field, and standing up for the underdog.

The awareness of the therapeutic relationship is important for many reasons. One of these motives is the increase in the recommendation of mandatory services for clients, as many judiciary systems are noting that psychotherapy is a more practical approach to rehabilitation than incarceration (Razzhavaikina, 2007). As there is an increase in mental health services being recommended by the judiciary system, there is an expectation of positive outcomes for those clients and/or cases.

Research has shown a correlation between successful therapy and the therapeutic relationship; it is no different in the case of therapy with mandated clients. Ultimately, the therapeutic "relationship has been conceptualized as a working alliance, founded on trust, openness, genuineness, and congruence" (Honea-Boles & Griffin 2001, p. 150). As cited by Razzhavaikina (2007), the therapeutic relationship awareness can be beneficial in effective … interventions with mandated clients (p. 4).

A court mandate can alter the therapeutic relationship. Focus on that relationship. Maintaining it is of great importance.

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