ASSOCIATION OF FAMILY THERAPISTS OF NORTHERN CALIFORNIA NEWSLETTER

JULY 2010

EXPANDING THE AFTNC AND CREATING SUSTAINABILITY

President's Corner

It has been another productive six months with the Council working hard for the AFTNC membership. We've updated our bylaws, our operations manual, increased the membership, have been hosting numerous events, and expanding the organization. With all the changes that are going on in the organization, my focus this past several months has been on sustainability and accountability.

The AFTNC is expanding. The membership is steadily increasing, our events are being well attended, and we've discussed increasing the number of events we offer. Our audience varies widely with seasoned family therapists, students, early career clinicians, and non-family therapists attending events due to interest in general topics, interest in working with families, and interest in working with couples. We've begun talking about having a cou-

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W. Keith Sutton

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EDITOR'S COLUMN

The AFTNC is happy to re-introduce the printed newsletter to our membership. We initially were very excited about the new website and listserv so we established a paper-less newsletter. Then we became concerned that our readership decreased and a vital avenue for communication with our membership was being under-utilized. So, we're back in print and we would like your input and feedback about how we can continue to improve our use of the newsletter to communicate with our membership. Please make sure that we have your preferred mailing address so you can get the printed newsletters that we will be sending out twice per year– in January and July. Also consider submitting articles, introductions, reviews of AFTNC events, and anything else that you think would be of interest to our membership. We would love to hear from you! Contact me at: newsletter@aftnc.com.The AFTNC has been undergoing some rapid changes over the past six months. In this issue, President Keith Sutton has outlined many of his contributions to the structure of the organization and the ideas he is making efforts to infuse into the AFTNC council. His column found on page 1, this page, and continued on page 17 is a great overview of the ideas in the works for the AFTNC council and the organization at large. We also have 2 new columns that are going to be recurring in our bi-annual newsletter. Fran Wickner is going to continue to provide highly valuable information on growing your practice. She is inviting our members to pose questions for her to answer in her column, so take advantage of her coveted advice because she knows what she's talking about. Her column is found on page 3 of this issue. Past President Terry Patterson is also providing a stimulating column where he encourages the membership to engage in a dialogue about legal and ethical issues in clinical practice. He contributed a thoughtful article on page 13 where he asks: Why should we do what's best? There's lots of great articles in here so keep on reading!

Alena Schabes

President's Corner

ples therapy workshop series and a child/adolescent workshop series. In our two hour free workshops, we've decided to encourage our speakers to cater to both the students/beginner audience who may need practical tools to use with their clients as well as provide time for discussion as many of the members attending workshops are very experienced family and/or couples therapists that are more interested in deeper discussion. We've also talked about starting a grand rounds series where members present cases and have other AFNTC members be discussants. The case would be discussed and the audience would participate in a case consultation. We've got so much wonderful experience in our membership that would be great to utilize in discussing cases and it would provide some intriguing dialogue among AFTNC members.

With all the changes we've been making, my focus has been on ensuring that this expansion is sustainable. Reviewing the bylaws has given us a chance to take a systemic look at the organization of the AFTNC and make changes to ensure that we've got a sustainable system in place. I found that much of the organization was dependent on the president, so we discussed changing the organization of the Council so that committees were more organized and have clear leadership within each committee. In the past, much of the council activities were organized by the president, thus causing major changes from presidency to presidency. We have now made a shift so that three main Council members are overseeing the various activities of the Council. The Treasurer will oversee the Membership Committee; the President Elect will oversee the Programs Committee, Conference Committee, and Video Library; and the Secretary will oversee the Communications Committee, which includes the Website Committee and Newsletter Committee. The president will oversee these three officers as well as oversee and mentor the Student Reps. The Past President will be available to consult with the current President in supporting the various Council members and committees. We have also updated the Operations Manual so that roles, responsibilities, and timelines are clear to Council members. It is our hope that this new organizational structure will provide a model for our organization to sustain its expansion.

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MARKETING FOR THERAPISTS: ADVICE FOR GROWING YOUR PRACTICE BY DR. FRAN WICKNER

My practice is low right now. I know I need to market but I don't want to spend a lot of money. Are there ways to market without spending much money?

Yes, there are many ways to promote your practice without spending lots of money. In my workshops and individual consultations, I tend to emphasize practice building ideas that are free or low cost. The one practice building suggestion I'll focus on here is NETWORKING. In order to have a full practice, clients need to know about you, and networking is one way to do this. Networking is low cost or free. Here are some ways to network and get new clients.

1. Go to clinical workshops and network with other therapists. I've found that by going to smaller group trainings in your area, you have more opportunities to connect with therapists than going to the large convention-like workshops. There will be other local clinicians there you can talk to, and you might even run into an old colleague, someone you went to graduate school with, etc. Go to the training early and talk to the other participants. Stay afterwards and have informal discussions about the presentation. Trade business cards, make a coffee date, check out their website.

2. Join professional associations. Go to their meetings and better still– get on the board, it will get your name out. Most professional associations have networking lunches; as with the CEU workshops, go early and stay a little later to talk to the therapists you meet.

3. Always carry business cards. You never know when the other carpool mom would be a good referral source, or the friend you run into at the grocery store, or the person in line for the baseball game, etc. I've found that lots of people are really interested in our work and happy to take your card. Having business cards are useless unless you actually use them.

4. Do "coffee" once a week. Invite out another therapist who you might be able to cross refer to, or health practitioner, or a teacher, or business person, or financial person, etc.

5. With all of the above, follow-up is as important as the initial contact, so make sure it is an integral part of any marketing plan you do.

I'm thinking about getting on insurance panels because I'd like to have more clients, but I've heard that all insurance panels are closed, and that it's not even worth it to apply, that I'm too late. Is that true?

No, it's not true that all the panels are closed, or even that the "big" panels stopped accepting therapists. There are many reasons why even panels that have been closed for years may now have openings.

1. The managed care or EAP company may be trying to get a new contract and need therapists. For example, maybe UBH is trying to insure Company X in San Francisco. They say to UBH "We need 100 therapists within 20 miles of our headquarters". If UBH doesn't have that many clinicians within 20 miles of Company X, they need to add more right away in order to be considered for the contract.

2. Maybe a group practice got off the insurance panel, so they need to add more clinicians.

3. You might have something they need, i.e. an expertise in couples counseling or addictions or geriatrics or adolescents, or ?; maybe you are bi-cultural, LGBT, have an office in a certain zip code, or can do testing etc.

Even if the insurance panel is full right now, apply in case any of the above occur. And make sure you send in your managed care resume/cover letter at least once a year.

Where would be the best place to have a private practice?

I often get this question; the answer depends on your particular desires and needs. With regards to where you'll get the most clients, unless you are willing to move to a rural area with no other therapists, it won't matter if you are in a city or a suburb. Instead, use the checklist below to narrow down your choices.

-Rent. How much are you willing to pay?
-Location. Do you want your office to be close to your home (advantages are an easy commute, familiarity with the area, the ability to do household business during work hours) or do you want to rent away from your neighborhood (advantage is that you can clearly separate work and home life)? When you take a break, do you

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Marketing for therapists: Advice for growing your practice by Fran Wickner

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want to be near restaurants, stores, etc.? Or would you rather be in a residential area?
-Terms of rental. Do you want a full-time rental or do you want a part-time sublet? If part-time, are you negotiable on the days/hours? What is the maximum amount of time you want to pay for? The minimum you need? Do you want a furnished or unfurnished office?
-Appearance. Do you need a sunny space? A quiet space? Are stairs okay or not?
-Size. Will you be running groups? Seeing families? Children? Do you need a storage area?
-Proximity/contact with colleagues. Do you want to be in an office with other therapists? If yes, do you want an office where the clinicians meet regularly?
-Security. If you see clients in the evenings, does the office feel safe?
-Parking. Is it adequate for your needs? Your clients' needs?
-Professionalism. Does the office look professional enough for the clients you see?

Just as in any other major financial commitment (i.e. buying a car, a house), some of the above issues will be negotiable and some will not. Be clear what is not negotiable so you can screen the rentals on the phone and only visit the ones that sound promising. Try to visit the office during the daytime and again in the evening so you can get a better idea what it would be like to work there. And of course get a lease/sublet contract in writing.

Have a question about practice building that you'd like answered in our newsletter? E-mail your questions to Alena Schabes, the AFTNC newsletter editor, at newsletter@aftnc.com

Fran Wickner, Ph.D., MFT has been a licensed Marriage and Family Therapist since 1983. In addition to seeing clients in her Albany, CA office, Dr. Wickner is a practice building consultant and offers individual consultations and workshops (regularly scheduled as well as availability to speak to your consult group or professional association) on all aspects of building and expanding your private practice. For more information: www.franwickner.com, franwickner@hotmail.com, 510-527-4011.

THE AFTNC MENTOR PROGRAM

The AFTNC's mentor program has been running for the past four years. Recently, the council has renewed its commitment toward this program. The program provides an avenue for students to become involved with the organization and to find guidance in their development as family therapists. At the same time, it's a great way for more experienced members to give back and get inspired by their mentee's excitement about the field. The mentor program is like a buddy system where students are connected with licensed professionals. Together, mentor and mentee decide the frequency and type of contact together ranging from occasional phone or e-mail contact, to meeting for lunch or coffee every few months, to more frequent meetings. If you're interested in getting involved in this exciting program as either a mentor or a mentee, send an e-mail to the student representative coordinating the mentor program, Tom Wooldridge, at tw@gmail.com.

VIDEO LIBRARY

One of the unique benefits of being an AFTNC member is the ability to borrow over 100 therapy tapes and DVDs from our extensive collection at no cost, and it's easy! Most videos are still in VHS format, although we're in the process of transferring them to DVD. You can pick up the tapes personally if you wish, or have them sent to you for a two week period. The success of the library relies both on our responsiveness and your promptness in paying the mailing fees and returning the video promptly. You will normally receive it about one week after you call (pickups are faster). To check out a video, just follow these steps:

- Search the video library at AFTNC.com
- Contact Randy Wyatt video@aftnc.com and arrange for pickup or mailing
- Return the video no later than two weeks after receiving it.

2010 AFTNC Annual Conference Interview with Presenter Celia Falicov, PhD by Leticia Manzanares

Celia J. Falicov, Ph.D. is a clinical professor in the Department of Psychiatry at the University of California San Diego. Dr. Falicov pioneered writings on family transitions, migration and cultural perspectives in family therapy training and has a practice. Her publications include two edited books: Family Transitions (Guilford) and Cultural Perspective in Family Therapy (Aspen). Her Multisystemic Ecological Comparative Approach (MECA) model integrates cultural and sociopolitical similarities and differences across cultural groups. This model plus learning new family therapy concepts and interventions applicable to families in cultural transitions will be presented at this year's 2010 AFTNC Annual conference.

Dr. Falicov, as I read the preface from your book, *Latino Families in Therapy*, I felt myself pulled back to my own upbringing in this country and the challenges I personally faced as I learned to live between two cultures. I thought my personal experiences would give me an advantage in working with a diverse population; however, early in my counseling career, I made a mistake working with a diverse client. This mistake taught me to step back and reassess my cultural knowledge. Knowing that clinicians will fail at early attempts to be culturally sensitive in the beginning of their careers, what would you want a beginning therapist or an intern to understand in terms of working with a person from culture that is different from theirs? Is there a single most important idea to keep in mind when starting out?

Yes, examine the cultural ideas implicit in your theory and techniques and consider their cultural relativity. It is the first step to understand that as human beings we are always creating belief systems, assumptions that are culturally based. Culture is in all of us, not just in our multicultural clients.

In your book, you claimed refusing to learn to speak Yiddish. Did you reclaim your language? In addition, how many languages do you fluently speak and practice in?

Leticia Manzanares

No, I never learned Yiddish except for a few words that I understand and some simple words I can write like mother and father. Yiddish was the language of my maternal grandparents; my mother stopped using it except when she did not want the children to understand her, and she increasingly favored Spanish, the language of Argentina where I was born. I speak Spanish, English, a bit of Italian and French, the latter two not sufficient to read or write acceptably.

Carl Rogers stressed the importance of being congruent

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2010 AFTNC ANNUAL CONFERENCE INTERVIEW WITH PRESENTER CELIA FALICOV, PHD BY LETICIA MANZANARES

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with the client to build a successful alliance. How would you define being "culturally congruent?" and what are the barriers that clinicians experience that prevent them from experiencing this alliance?

I think it is like being culturally "attuned" to some broad features of the culture of the client that may be different than one's own. It means an openness to asking and waiting to learn instead of making stereotypical assumptions. It does not mean knowing a lot about the client's culture. The latter can become an obstacle to an alliance if the therapist is more intent on finding cultural features than to hearing the client's individuality. Language barriers and negative preconceptions can create distance instead of alliance.

Do you remember excluding others based on culture or gender? What did you learn in the process as you developed your professional career as a therapist and on a personal level?

Yes, it is painful to recognize that I have some barely conscious ethnic or racial or gender prejudices. Some experiences led me to be alert to those hidden societal folds and make efforts to confront them in my work through a variety of ways that fit the situation at hand, not really a set formula.

As an author and international speaker, what is the best/worst thing about introducing your work in other countries?

I preface all my work in other countries by telling them that my work comes from the U.S. and therefore it is not universal. I talk about the unwitting cultural colonization that occurs when people take work from America as entirely applicable to their own contexts. The best experiences are to witness young professionals' enthusiasm when I encourage a discussion on grass roots, nation based intellectual production based on work in their countries. When I use this approach the bad part for me is when I return, I get flooded by emails that ask me for feedback on papers and dissertations.

When we initially spoke, you informed me that you were working on a current book. Can you briefly share your new project?

It is not a new project. I am engaged in writing the 2nd edition of Latinos in Family Therapy: A Guide to Multicultural Practice. It will be 35-40% different and updated from the first edition.

Whose work currently excites you?

Because of my interest in migration, what is being written in migration studies about transnational families is of great interest. I am also fascinated by the proliferation of binational studies that compare the immigrants who left with those who stayed from the same villages and families in a number of issues that range from health outcomes to gen-

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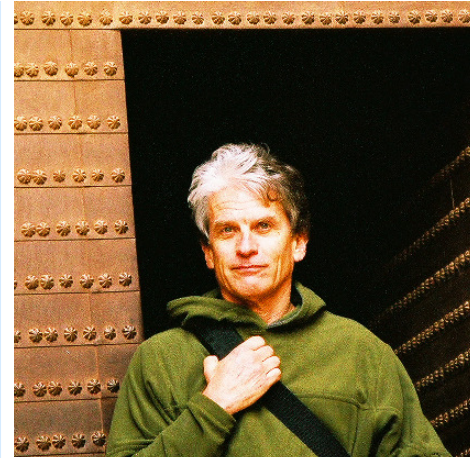
REFLECTIONS ON AFTNC'S JUNE 4TH MEETING BY ROGER LAKE

In the more than quarter century that I've been going to AFTNC presentations, I can't remember a meeting where the substantial majority of attendees were people of color… until tonight. I just got home from the June 4th event:

The Psychological Residuals of Slavery for Black and White America: Implications for Our Clinical Work

Like all of our meetings, this one included a snafu with the media. Somehow, the projector didn't make it to the meeting, so the powerpoint had to be read from the handouts. And there was some question about the video: could we get the TV in the Kaiser conference room to work well enough so that the basic text of the conversation, Ken Hardy's 1995 video, The Psychological Residuals of Slavery, would be viewable. Fortunately, our incoming president, Shawn Giammettei, has a knack for making tech stuff happen, so the video worked, and the stage was set for a presentation about what some of us seem to think is the hardest conversation in America: an inclusive narrative of chattel slavery.

AFTNC members Susan Wilkens and Theopia Jackson, clinical psychologists in the Psychiatry department of Oakland's Children's Hospital are remarkable sisters in this work of creating a dialogue that informs and makes accessible the mechanisms of oppression that for so long colluded in the practices of subjugation known as "american slavery." For those of you who don't know them, Theopia is African American, and Susan is what most of us call White. The serious point that they made is the obvious one: that slavery represents a relational world organized and informed by a variety of narratives that describe a made up world in which domination and privilege are romanticized in ways that preserved the economic utility of the institution of slavery despite the moral imperatives of those not subjugated. In fact, they maintain that the work they are exploring is the work of making the narratives stand up to the historical experiences of African Americans. These sorts of dialogues are important because they are capable of creating empathic channels of new experiencing and authenticity in real relationships between those of us who are native speakers in worlds of "black" and "white." Aside from their co-presentation of the information and ideas, their dialogue was a demonstration of the process of self contained willingness to see the world of others more deeply and to experience the personal narratives we all have in new ways brought to



Roger Lake

mind through the dialogue. They gave several examples from their experiences supervising trainees at Children's Hospital.

The implications of this kind of self exploration for informed clinical practice seem straightforward. Part of how therapy works is through the therapist's uncovering of the stories that describe the client's abilities to access the world and accomplish life tasks. The moral dilemma of slavery and the ubiquity of the racist frame for understanding self and other continues to disturb our thinking about that as it constrains our imaginations and prejudices our questions in ways that quite obviously undermine trust and openness in the therapeutic relationship.

For me, a white man born in 1946 and raised in the MidWest and the

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WHY AREN'T MORE THERAPISTS DOING FAMILY THERAPY? AND WHAT TO DO ABOUT IT!

BY RANDALL C. WYATT, PHD AND W. KEITH SUTTON, PSYD

Last summer, the two authors of this article met for lunch in San Francisco and continued a conversation that was started at the AFTNC Teaching Family Therapy event several months earlier. We kept coming back to the same question: "Why aren't more therapists doing family therapy?" And why are so few students in practicum and internships doing family therapy or seeing parents while they see children? As the training director for the California School of Professional Psychology in San Francisco, Randy is very interested about the barriers for trainees as well as practicing clinicians to working systemically and engaging parents in the work with their children. Keith has heard a number of therapists in private practice who have said, "I used to do family therapy, but it's too hard in private practice." Many clinics and agencies say they do family therapy and work closely with the parents of children in therapy, but over and over again we found colleagues and students reporting the same thing: even when clinics saw children in therapy, the parents and family as a whole were rarely an integral part of the treatment.

We came up with a list of possible reasons why people avoid working systemically and engaging families in therapy. We hoped that by discussing each issue and discussing ways to overcome this issue, it might help teachers, students, supervisors, and practicing therapists begin to think: how can I help support systemic work in my own practice, in the practice of my students with whom I work, and in the systems I'm involved with? Just as important as the necessity of working with parents in family therapy for the betterment of their children and the parents themselves. Below are eight of the ideas we came up with.

#1 Fear

Fear is certainly a factor that plays into whether a student in training uses family therapy or a licensed therapist begins working with families. Many therapists are fearful of having more than one person in the room. There's a fear that they won't be able to handle it if there is a fight among family members or if the family or couple turns on the therapist.

In speaking on the topic of family therapy with adolescents who are dealing with substance abuse/dependence to groups of interns, Keith asks how many interns are doing family therapy? Usually one or two hands go up. When asked who would like to be doing family therapy, one more hand might go up. When asked who is afraid to do family therapy, almost all hands go up. This is a common experience that must be acknowledged and worked through to help the students and new family therapists managed their fears and develop the skills for doing this work.

One way is to acknowledge it, dialogue about it, and prepare for it. At the Teaching Family Therapy event, Bart Rubin, PhD, Director of the Family Institute of Pinole, and long time professor of the Family Systems course at Alliant and now at the Wright Institute said he felt the most important part of his class is the role plays where students are able to face their fears of being a family therapist and begin to feel more competent. Acknowledging this fear of working with families

Randall Wyatt

and role playing in supervision are great ways to help students get over their fear. Of course fears of families or couples arguing and getting upset are real and must not be minimized. Also, it is important to know that it is natural to have a fear of working with families and realize that fear may be shared by the family coming in for therapy. People training in family and couples therapy should also be taught how to manage high conflict families by being assertive, centering themselves, using the physical space to relocate individuals in the room, using one's tone of voice to slow down the process, or explaining to clients the benefit of sitting and listening to the other for a moment. This can often be difficult for a therapist who has difficulty being direct or assertive, but these techniques can be learned in ways that that fit with the therapist's personality and style.

#2 It's Hard

It takes a lot of work to do family therapy.

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WHY AREN'T MORE THERAPISTS DOING FAMILY THERAPY?

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It takes work to get a family to come in to the session and reframe a problem as being systemic while at the same time acknowledging the identified patient and not pathologizing the family. It takes a lot of coordination to get everyone in the office with schedules, transportation, and differing levels of motivation. It is true that often times the path of least resistance for the therapist is to just have the parent drop the child off and see them individually for an hour. Many therapists have had a parent bring her child in to therapy and leave saying "he is your problem now" as she scurries out the door. Also, if we're getting the whole family in, we're often working late in the evening or on the weekends.

We have found that being both flexible in scheduling and flexible in the concept of family therapy is crucial to its success. We certainly know that some family theories suggest that having the whole family in each session is the most effective and at times it certainly is. However, we have found that being flexible in being able to see the whole family every few sessions with visits with subsystems or individuals in between is often more doable for families. A therapist can work systemically whether the entire family is in the office or not. Home visits, weekend appointments, and sessions shorter or longer than 50 minutes are also great ways to be flexible for the family you're working with. Other ways to involve the systems are through phone calls and using speaker phone in the session, using Skype to bring family who are not in the area into the session, using letters or emails in the session, or having the parent(s) come in at the beginning or last part of the session.

Also, it's important to reach out to fathers. Sometimes they're left out because of scheduling problems or by the partner's report that they're either not willing to come in or inappropriate to participate. Reaching out to the father and letting him know how important his involvement is can get him engaged. In terms of mothers, it is key to realize that often mothers come in fearing that they will be blamed for the child's problems. While each family member may have a role in the problem, offering support and encouragement for each parent is key in building alliances.

We think it is important that we ask ourselves whether we believe that family or couples therapy could be helpful in a particular case (we don't believe every issue has to be treated by family or couples therapy) and if so, are we short changing our clients because it is easier for us to not see them as a family? Is the reason we're not doing family therapy because it's not indicated or because it is too inconvenient or difficult for the therapist? If it's too inconvenient for the therapist, then maybe it warrants a referral to someone who can work with the family.

#3 It's Difficult to Juggle Rapport with Multiple Clients

It's hard to maintain rapport with every person in the family or couple especially when they have competing goals. This is very challenging when working with defiant teenagers. It is difficult to both build rapport with a teen who doesn't want to be in therapy since the therapy jeopardizes their power in the system. At the same time, you have to juggle the parent's rapport and be careful to make sure they don't feel blamed or pathologized, that you're on the child's side, or that you're not "doing anything" because the child isn't changing fast enough.

Couples therapy is another situation where juggling rapport can be very difficult. Sue Johnson, Ph.D., developer of Emotionally Focused Couples Therapy, described it as standing on a highway with two Mack trucks coming at you, and this applies to family work as well.

One of the biggest reasons that therapists give for not doing family therapy with a child is the fear that it would jeopardize their rapport with the child. In that situation, the relationship between the child and therapist is raised above the relationship between the child and family. Of course, the therapist will not always be there for the child, but the parents hopefully will be. A recent study of Multidimentional Family Therapy (MDFT) compared it to Cognitive Behavioral Therapy for the treatment of teenagers with drug and alcohol problems (Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008). Both treatments significantly decreased teenagers' drug use. There was no difference between treatment effectiveness at the end of treatment, but follow up studies found that MDFT was significantly more effective at preventing relapse than CBT. In a study of CBT with children with anxiety disorders, they also found that adding a family component provided a significant difference in treatment outcomes at the end of treatment as well as follow up (Barrett, Dadds, & Rapee, 1996). It is this systemic change that leads to lasting and pervasive changes.

The way to developing rapport with multiple family members is not to just be neutral toward all clients where no one feels understood or validated; rather, as Dan Wile, PhD developer of Collaborative

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WHY AREN'T MORE THERAPISTS DOING FAMILY THERAPY?

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Couples Therapy (www.danwile.com) suggested, the therapist's role is to find what makes sense in both partner's stories or with each family member. This focus on what is sensible, logical or emotionally resonating can be bonding and reassuring for each family member. Another way to build and maintain rapport with all members of the family is to have a reframe that explains how the treatment is meeting all of their goals, showing each person that you understand and empathize with their situation and that you don't pathologize them. You can get feedback to gauge the level of rapport with each individual and spend extra time building rapport by using individual sessions between sessions, phone calls, emails, or other contacts. There is a lot of juggling involved, but done well, these ideas can increase the alliance and allow for good work that produces lasting change.

#4 Believing that the Parents are "Too Disturbed"

We have often heard therapists explain the reason that they are not doing family therapy is because the parent is "too disturbed." One therapist Keith spoke with made a sweeping statement that she didn't do family therapy because most of the parents of the children she worked with were Borderline. Again, this speaks to the difficulty of family therapy where we generally see parents when there is a problem and the parents may be at their worst. It takes a lot of work to both treat a relational problem while also working on individual psychopathology, but often that individual psychopathology is related to elements of the family system.

We have found that it is not uncommon for therapists to become triangulated between the child and parent. For example, the child begins to have strong positive transference for the therapist that triggers the parents' attachment anxieties and their real and perceived experience of being blamed by the therapist. This can result in a difficult relationship between the therapist and parent thus leading to the therapist pathologizing the parent as "too disturbed" to work with. The therapist, in frustration, then excludes the parent and works primarily with the child or adolescent.

Of course, while parents can have as much pathology as anyone, it is not standard practice to blame clients in individual therapy where empathy and support are key to rapport and progress. Why then, is it so common for therapists to pathologize and attack parents? This may be due to any number of reasons including: therapists seeking to protect the child from the parent's problems, therapists' own buttons being pushed and reacting as if they are protecting themselves, or the real need to protect the child via generally ineffective critiques of the parent. In these situations, it is helpful to have the therapist see this not as a personality trait of the parent, but as symptoms arising from the context needing to be addressed in family therapy. It is important to focus on building rapport, looking for qualities that the therapist can appreciate about the client, and realizing that the parent is usually doing the best they can to take care of their child.

Alfred Adler emphasized that the therapist must work from a position of seeing the best in the parent, and using support and encouragement to form a working relationship. Seeing the best in the parent and emphasizing their love for their child builds rapport while also making it more likely that the parent will accept suggestions or ideas the therapist has. The opposite, seeing the worst in the parent, seeing only their conflict with their child and troubling parenting behavior, leads to poor rapport and poor clinical outcomes. As in Motivational Interviewing, resistance is a sign for the therapist to readdress their approach, think systemically, and understand the relational dynamics that may be contributing to the behavior being labeled as "too disturbed."

#5 It Would Be Harmful to the Child

Another common reason given for not doing family therapy is the fear that it would be harmful to the child if there was an argument or if the parent said something hurtful in front of the child. There is a lot of unpredictability in a family session because the therapist cannot carefully control interactions to the extent they can when working individually. What we know as family therapists is that this is part of the process and sadly, if it happens in the therapy session, it is most likely happening in the home. Many therapists who don't do family therapy are scared that if the family gets in a fight and has a negative experience that it is their fault rather than understanding that this may be part of the family's process. It is likely that the family is acting out even more when the therapist is not there.

This brings up the issue that the family may feel embarrassed for having an argument in the therapy office. The therapist needs to provide reassurance that it is actually helpful to see what happens at home in the session so it can be worked on and changed. Indeed, the therapist must work in a solution focused way when noting

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WHY AREN'T MORE THERAPISTS DOING FAMILY THERAPY?

(Continued from page 10)

these problems in the session and avoid jumping on the family member that is most troublesome in the moment. Of course, boundary setting is important, but supporting the setting of boundaries can be emphasized instead of merely telling people how bad their boundaries are.

Family therapy can be difficult and at times the room can get heated. Meeting with subsystems in addition to individual work can help repair relationships after difficult sessions and can also help to prepare individuals for difficult family sessions.

Of course we don't want the family session to merely be a repeat of conflictual patterns outside the session and if some basic safety, trust, and de-escalation cannot be developed, it is best to go on to working with subsystems and/or individuals until family sessions can be workable and helpful.

#6 It Goes Against My Theoretical Orientation

This is one of the most difficult reasons therapists give for not doing family therapy. Unfortunately, some theories are interpreted as not allowing for family therapy or working with the parents of children directly or in an in-depth way. It also connects to another reason that is the feeling that family therapy wouldn't add to the treatment the therapist is already providing. Fortunately, much of the current research is finding that family therapy, couples therapy, or at least family involvement in the therapy has significant lasting effects.

Working with families is not the purview of family therapy theory. Indeed, many research protocol treatments from a Cognitive Behavioral Therapy perspective encourage having a session with the family or partner early in the therapy to explain the treatment and gain family support. There are also psychodynamic family therapies that work extensively with family involvement and go beyond basic parent consultation. Novick and Novick (2005) expressed the importance of family work in the title of their book, *Working with Parents Makes Therapy Work*. An active parent consultation model that happens routinely can achieve significant parental involvement with check-ins with parent-child dyads and negotiating between children and parents. This type of engaged family work by dynamic therapists resembles much of what family oriented therapists do with families.

For many therapists, their theoretical orientation is related to their personality characteristics. Family therapy often is viewed as directive, requiring being assertive, and thinking quickly and creatively. However, there are also ways to do family therapy that do not require being so overtly directive such as Narrative Therapy or Solution Focused approaches where the therapists facilitates the family's solution building process. Family therapists don't have to be extroverted dramatists, but can also work in quiet ways that fit their own style.

Another subtle but just as troubling problem is when a clinic purports to do family therapy but all the policies of the agency and supervision of the agency discourage working with families and parents. This places the trainee or clinician in a bind and how to deal with this might be the subject of further study.

#7 The Trainee is Young (or not) and Identifies with the Child

Another factor that can cause a trainee to have anxiety about doing family therapy and pathologize the parent is because many of the trainees are young or are not parents themselves yet. There is the fear that the parent will say, "Well, do you have children?" and the trainee will feel like they can't provide guidance without the experience. Many young trainees may identify with their child clients and project their own issues with their family of origin onto the parent of their client. Interns can try to become of aware of this tendency and discuss it with supervisors and colleagues to overcome fears and develop ways to deal with these reactions.

Indeed, most of us feel challenged and stressed by difficult families, but once the therapist joins with the family, shows commitment to helping the family, and shows initial competence in exploring problems and solutions, most families soon begin treating the intern or young therapist as the person they trust and seek help from.

#8 Not Enough Training

Many therapists explain that they were never trained in family therapy, thus they don't feel competent enough to use it and it feels too difficult to obtain training once licensed. This does not seem to be the case in couples therapy as many therapists report not being trained in couples therapy in graduate school or in internship, yet many practice it once they go into private practice. The fact that many training programs don't provide training in family therapy is unfortunate, since the opportunities for in depth training post-graduation

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WHY AREN'T MORE THERAPISTS DOING FAMILY THERAPY?

(Continued from page 11)

are small. Unfortunately, many clinicians go on to expand their competencies without getting proper training and supervision, which sometimes has a negative effect on clients and a negative effect on their feelings about couples or family therapy. One therapist started seeing couples because her individual clients began dragging their partners in, so she learned on the spot.

To deal with the issue of there not being enough family therapy training, we encourage practitioners to research effective forms of couple and family therapy and go to workshops, get consultation, and if possible, participate in live supervision. We see the issue of there not being enough training as a central part of why practicing clinicians are not providing family therapy. The AFTNC is dealing with these issues in multiple ways including placing a page on aftnc.com with training programs that are providing family therapy training to both students and licensed clinicians. AFTNC has also increased the number of free workshops offered in order to increase the availability of training. Lastly, AFTNC is reaching out to students in training, developing a family therapy speaker's bureau, holding events for family therapy instructors to learn from each other, and offering a family therapy law and ethics and supervision workshop to help support the systems that launch new therapists into the professional community. It is hoped that by providing training opportunities, more clinicians and student therapist will apply family therapy effectively with competence and confidence.

As family therapy is gaining more researched credibility, there are beginning to be systemic changes. Locally, Marin County is requiring that any child being seen using MediCal insurance be participating in family therapy. Also, the Juvenile Justice system is having each county choose either MultiDimensional Family Therapy, MultiSystemic Family Therapy, Functional Family Therapy, or Brief Strategic Family Therapy to help kids involved with probation to prevent being sent to detention centers. Also, various Kaisers are utilizing family therapy such as the Mosley Method for eating disorder at Kaiser Redwood City or Brief Strategic Family Therapy at Kaiser Santa Rosa. These are just a few of the local positive trends in working with families in the San Francisco Bay Area.

We are very aware that there are valid reasons to not work with the entire family or the parents; central among them are the need for individuation between child and parents, particular skill work with the child, working on adolescent identity issues, intrusive parents, safety concerns, among others, but these don't always obviate the need for family and or parent work.

In a recent workshop, family therapist Pamela Parkinson, LCSW, PhD outlined eight reasons why clinicians don't do family therapy: there is "no family"; there is a sexual offender; there has been "abuse" and we don't want to retraumatize the victim; the child doesn't want it; adolescents are too old to benefit from family therapy and they are "emancipating" anyway; the parents/caregivers have mental health issues; safety issues; when the therapist does not know how to work with families and parents; and when there is so much counter-transference that they can't be therapeutic. While each of these reasons has varying degrees of valid concerns within them, each should be considered thoughtfully by the therapist to discern whether or not to work with the family system and what can be most beneficial for the child and the family.

Family therapy and working with parents of children in therapy is often difficult and anxiety provoking for beginners. Training opportunities for family therapy can be scarce, but we know from clinical experience and family research that it makes sense and is valuable in the lives of children and families. It is also an exceptionally rewarding experience for well trained family therapists who can then contribute to and witness the meaningful changes in the lives of families.

Unfortunately, the general public's concept of therapy is often that of individual therapy, but by educating our clients, using our skills to show how family therapy is meeting everyone's goals, supporting their best and avoiding pathologizing, and by seeing the family as a resource that enables success, we can provide effective interventions that work for families. Instead of asking "Should we see the family?" or "Should we see parents when a child is in therapy?" We should first ask, "How can we best work with the children and parents?" and "How can we competently work with families who seek out our help?"

Randall C. Wyatt, PhD is a an Associate Professor in the Clinical Psychology doctoral program at the California School of Professional Psychology, San Francisco where he is also Director of Training. He teachers brief therapy, practice management and dissertation proposal. Dr. Wyatt practices psychotherapy and consultation in Oakland and Dublin with an emphasis on couples therapy, PTSD, and family therapy, as well as individual psychotherapy. He serves on the AFTNC Council as Video Librarian.

ETHICS AND MINDFULNESS: WHY SHOULD WE DO WHAT'S BEST?

A COLUMN BY TERRY PATTERSON

At a recent ethics forum I was asked "What really makes the difference between those who do what's best in clinical practice and those who just do what's necessary to get by?" Stated differently: What makes a person consistently strive to adhere to the highest standards as opposed to just staying out of trouble? We know that the *APA Ethical Principles and Code of Conduct* (APA, 2002) includes the highest standards psychologists are advised to follow as well as the enforceable ones for which members can be sanctioned for violating. Other ethics codes (e.g., AMFT, CAMFT, ACA, NASW) offer single standards that involve a range of both optimal and enforceable practices.

Ask yourself this question for a moment: Where would I place my practice on an ethical scale of 1-5? Most of us, and if we ask colleagues as well, would say that we would be: at a 3 or 4 out of 5 (best), and believe we follow both ethical and legal standards equal to or better than most other practitioners. But what if we answer the questions on the following checklist candidly?

✓ Do we always provide a written informed consent and make sure that clients understand the details accurately?

✓ Do we make a thorough record entry each session according to clinical and legal guidelines?

✓ Do we keep separate records for each member of a couple or family when we conduct individual interviews with family members?

✓ Do we have a process for determining when clients have reached maximum benefit?

✓ Do we consult with experts when we have clinical, ethical, or legal dilemmas?

✓ Are we familiar with relevant guidelines in specialty areas?

✓ Can we demonstrate relevant training and experience for specialties that we engage in?

Terry Patterson

✓ Do we have balance in our lives so that we can attend to clients and other duties carefully?

✓ Have we provided access to other professionals to review our records and contact our clients in case we are suddenly unable to practice?

✓ Do we regularly schedule phone sessions or conduct sessions outside of the office primarily for our own convenience?

You may think of these as routine matters and have them all well in hand, or you may consider them nitpicking and that you do things well enough and know your clients so that there will never be a problem. So I would like to raise the question asked at the beginning: What makes the difference? Without sounding simplistic, I believe that it is

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on ethics…

by Terry Patterson

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generally based on how we organize, structure, and remain mindful about our lives in general. As an example, I recently attended a lecture by a psychologist on achieving one's full potential, and heard of a client who not only made a list of activities each evening for the following day, but to counteract his tendency to be off-task, he scheduled important tasks beginning first thing in the morning and allowed a specific time for each before moving on to the next task. This may seem compulsive, but it illustrates the importance of: first, accepting his tendency to be unfocused and determining to change; second, structuring his time with a detailed plan; third, not relying on the common, but presumptuous self-appraisal that "I'm ok the way I am and I'll just do what comes naturally." This type of notion in professional practice can lead to a slippery slope involving impulsivity, self-deception, and self-proclaimed competence leading to mediocrity and ethical and legal violations.

So please consider these aspects of ethical practice and send comments and issues you would like to have addressed to *pattersont@usfca.edu*. I hope to make this column a dynamic, practical dialogue and forum that allows us to learn from each other and to do our best consistently in the interests of those we are privileged to serve.

Recommended Reading

American Psychological Association (2002). *Ethical principles of psychologists and code of conduct.* Washington, DC: APA.

Patterson, T.E. (2009). Ethical issues in family psychology: The special issue of competence. In Bray & Stanton, *Handbook of family psychology.* Oxford: Blackwood Publishing.

Patterson, T.E. & Gottlieb, M. (2002). Ethical issues in cognitive-behavioral therapy. In F. W. Kaslow & T. Patterson (Eds.), *Comprehensive handbook of psychotherapy: Vol. 2. Cognitive-behavioral approaches.* New York: John Wiley & Sons.

Patterson, T.E. (2001). Does anybody know a good couple therapist? *Behavior Therapist, 24* (4), 85-88.

Stanton, M. & Welsh, R. (in press). Specialty competencies in couple and family psychology. In A.M. Nezu & C.M. Nezu (Eds.), *Oxford University Press series on specialty competencies in professional psychology.* New York: Oxford University Press.

Terry Patterson is Professor of Counseling Psychology at the University of San Francisco where he teaches Ethics and Family Psychology, and is in independent practice in San Francisco and is Board-certified (ABPP) in Couple & Family Psychology. He is past President of AFTNC and the APA Society of Family Psychology and a member of the CPA ethics committee. His column will be featured regularly, and he hopes to have an ongoing dialogue with members. Please contact him with comments and questions at pattersont@usfca.edu

Cultural Accountability in Schools

By Lucy Ferguson, PhD

I have been reflecting on the close of the past year in the public schools in my immediate area - west Contra Costa County and Berkeley. For a number of years, I have been providing pro bono supervision for students from local doctoral programs in clinical psychology. They are usually second year students placed in their first practicum through BACR (Bay Area Community Resources). For these students defined as trainee "counselors", this is a useful and often challenging placement. Many have little or no prior training working with children in a mental health capacity. Their last experience in an elementary or secondary school was as teenagers themselves. Learning to negotiate the administrative complexities of the public schools, and even more so the occasional charter school, may present difficulties. Their role is not always clearly understood by school personnel. It usually takes some time before they can fit in as colleagues and even consultants rather than as babysitters to whom the most troublesome kids in a classroom can be referred.

"Cultural diversity", i.e. the mix of pupils from different language, national, ethnic, racial, economic and educational backgrounds, presents additional opportunities and challenges. Obviously, fluency in Spanish will be a great asset for a trainee placed in a school with a large Hispanic population. Pupils and families from a variety of Asian countries provide additional complications. Few graduate students can be expected to master such a range of languages. Even more basic is an appreciation of family culture, which may itself be mixed. The primary language of parents from the Philippines may be Tagalog, Spanish or both depending on their educational background. Other examples abound. These days graduate programs make more or less successful attempts to inculcate some knowledge and appreciation of cultural diversity. One hopes this exposure "takes". My own sense is that the cultural sensitivity students bring to their programs as a result of prior life experiences is the most important factor.

So far I am preaching to the choir. Even more if I emphasize the importance of the cognitive paradigm shift to thinking and planning in systems terms. Clinical programs usually include such courses these days, but usually too late in the curriculum to help students to recognize the nature of the ecosystem of school, family and larger community in which the referred children are embedded. It makes a great difference in their lives if one or both parents live under threat of deportation, or if family members have been the victims of drive-by shooting. Such children may be exhibiting symptoms of deep trauma or prolonged stress, not just chronic trouble-making that easily earns them a DSM label in the eyes of a graduate student just being introduced to psychopathology.

The final point I would like to make is one that has come home to me recently with increasing force. Those of us who grew up and went to school, and eventually gained advance degrees before the present electronic age of TV and telecommunication were usually competent if not addicted READERS. We are all aware that reading is the primary academic skill underlying most academic difficulties that emerge in the primary grades along with impaired capacity for sustained attention and focused reasoning. Many creative and successful programs have been introduced to prevent and remediate early reading problems. Unfortunately, such programs are often among the first victims of budget cuts. But what I notice is how relatively little time is spent either in school or at home reading WITH children.

In this the parents in highly educated families, even more than school personnel enamored of technology, may be the chief offenders. When both parents in traditional or even multigenerational families are working multiple jobs in an attempt to maintain a middle class lifestyle, it is tempting to feel that limiting kids to a couple of hours of educational TV and stressing homework does the job. In how many families do we still sit down with toddlers and read picture books with them gradually attracting their notice to the written story line as they get older? Story hour in preschool or kindergarten or the local library is very fine, but it has to have something to build on. And if the primary language at home is Spanish, or creole French, or Chinese or Japanese, or from India or southeast Asia, I am sure that children's books exist in those languages too.

I am curious what other members of AFTNC think. Does this suggest the possibility of some relatively simple interventions? Or am I just hopelessly old-fashioned? Maybe after over fifty years of teaching and practice, that's OK.

Lucy Ferguson no longer has an active practice. She provides supervision and brief consultation on a variety of issues involving children and families including foster, adoptive and stepfamilies.

UPCOMING AFTNC EVENTS

GO TO AFTNC.COM FOR MORE INFORMATION ABOUT THESE AND OTHER EVENTS

Saturday July 24th

HELPING CLIENTS "WIRED DIFFERENTLY": A SYSTEMIC APPROACH

With
MärRem Remington LMFT

Friday August 6th

AN INTRODUCTION TO PARENT-CHILD INTERACTION TRAINING

With
Dedalus Hyde, PsyD and Karen Godfredson, PsyD

Saturday August 28th

TEACHING FAMILY SYSTEMS: A Collaboration of Local AFTNC and AFTA Members Who Teach Family Therapy

FIRST ANNUAL AFTNC MEMBERS FAMILY BBQ IN THE PARK

WITH ALL OF US AND OUR FAMILIES

With all the talk about professional things, the time for fun and socializing has now arrived. AFTNC will provide basic BBQ goodies and beverages, and of course you can bring your own as well. We probably won't discuss health care reform, evidence based family therapies, advances in couples therapy research, advocacy, or DSM-V issues. Instead, we've decided to put on an event that advocates fun and good times. Bring your family, a blanket and enjoy the sun. We look forward to seeing a good turnout on a warm and sunny day in July.

When: Saturday July 31, 2010
11am-2pm

Where: Tilden Park
Carousel Picnic Area

Cost: FREE

RSVP: Contact Shawn Giammattei,
drshawn@questfamilies.com
(415) 722-7134

PRESIDENT'S CORNER

(continued from page 2)

In the last newsletter, I discussed AFTNC's efforts to make our organization more accountable to our members. I wanted to give an update on the Cultural Accountability Committee (CAC). The CAC developed to a point where we needed direction from the Council, which was a major focus of this year's annual retreat. It was decided that since we only have four two hour Council meetings per year, we often can not give enough time and attention to the issues of cultural accountability. The CAC will be a separate committee made up of at least three Council members who will meet at least twice a year for two hour meetings to discuss the issues of cultural accountability in our organization and provide feedback and recommendations to the Council. In addition to having three Council members making up the CAC, it will be open to the full membership who can be ongoing members of the committee. The CAC meetings will also serve as a venue for members to drop in to discuss their ideas or concerns and those ideas can be taken back to the Council. The Council also decided to include this description of the CAC in the updated bylaws to be voted on in April and to update the organization's mission statement by changing the AFTNC's purpose to say, "to promote the science and art of family therapy in a multicultural context by such means as…" The addition of "in a multicultural context" was felt by the Council to succinctly incorporate these values into the most significant part of our bylaws, which is our mission statement. So far, the CAC has met quarterly and has been a wonderful addition to our Council process.

Additional changes in our organization have happened in a short time. We are going back to a printed newsletter and are adding a few continuous columns such as a question and answer column with Fran Wickner, MFT, PhD on practice management. We will also have a law and ethics question and answer column with Terry Patterson, PhD. We also aim to have a committee member interview a AFTNC member for each newsletter issue. We encourage all our members to write articles about topics of your choice, reflections on AFTNC events, introductions of yourself to the membership, or anything else you'd like to write about.

We've been planning our conferences further in advance by having our 2010 and 2011 conferences already scheduled and we are in the process of scheduling the 2012 conference. This way we can have the continuity of having our conference at Westerbeke Ranch and not have to end up with the situation we had last year where we were unable to have our conference at our preferred location in Sonoma.

Lastly, our student representative, Tom Wooldridge, has revitalized the mentor program by connecting mentors and mentees. Mentorship is such an important part of our organization. It is a way of helping our students get connected to professionals providing family therapy and be welcomed into our organization. Unfortunately, there are a number of student interested in family therapy that don't have much support in their school or training sites, so our mentor program supports these students as they make their way through their training. Mentorship and supporting our student members is an important part of our organization and a great way to support the practice of family therapy.

This has been another busy and productive six months for the Council. I have been honored to be working with such hard working, dedicated therapists who are passionate about family therapy. We're steadily expanding the organization to better serve our members and the community at large. We've focused on making this expansion sustainable and are attempting to assure accountability so that we are there for our members. As always, your Council is working for you, so please share your thoughts, suggestions, recommendations for changes, and anything that you might think would be helpful to improving our organization. Feel free to call or email me or any of the AFTNC Council members. Also, we're always looking for more members who want to be involved, so if you're interested in helping out, please contact us. It's great to have you all participate.

Keith

REFLECTIONS ON AFTNC'S JUNE 4TH MEETING

BY ROGER LAKE *(continued from page 6)*

West, racism was in the air I breathed. Though I lived in a suburb of Chicago, there were no people of color in my school experience until I went to high school, a township school that included a sizable African American community. We had no aquatic sports at that school even though we had a full sized indoor pool because…Well, because our parents apparently didn't think we should swim together?? But Lee Brown, my first (I would have said "Negro" at that time) friend sat next to me in band, and our lockers were next to each other on the football team. WTF? Did we talk about any of that? Not really. We just didn't. And we weren't hanging out after school either. Our world's only overlapped in the tiny space of music and sports, not including swimming.

When my family moved to Spokane in 1962, there was one African American kid at my high school, and his dad played shortstop for the Dodgers. That's all I really knew about him. Then, the next summer, the March on Washington captured my attention, and I began to realize that this way we had in America was just wrong, and many people thought so. And then, the shit hit the fan. In the summer of 1965, I'm a third class midshipman on a bus in LA, late at night, trying to get back to my ship after visiting family friends in Pasadena. It dawns on me at one point that I'm the ONLY person on this bus that looks like me, and I get that I'm not regarded as a patriotic young serviceman, which is how I think about myself. Within weeks, that section of LA explodes in the Watts riot. Life just got more weird as the 60's shook everything to the core, and I advanced to take my place as an officer and gentleman in the United States Navy, a profoundly racist organization in those days. The war in Viet Nam brought my familiarity with racial hatred front and center in incident after incident, as I came to realize the political dimension of these issues and began to distance myself from the culture of domination in that I'd been born.

I mention all of this because I understand that my personal journey through this miasma of confusion and unquestioned assumptions has been an important part of my growth as a man of my time and as psychotherapist with a systemic perspective intent on finding ways to create alliances for change, but particularly for liberation from the kinds of oppression I have felt as my own personal legacy of racial domination and privilege.

I have much more work to do on this, and I have found some places to do this work. I am strongly of the view that some of my colleagues in psychotherapy are struggling with this, and that our graduate schools are for the most part not able to provide much in the way of a supportive structure for this form of self-exploration. I was glad to see all the people of color at this meeting, but I would have been even more pleased to see those of us who carry white privilege come in solidarity with this work. I understand that this is not easy, but I am encouraged by the increasing willingness I see in our younger generation, and I am proud of Family Therapy for stepping into this space. I want to credit the presenters for bringing this powerful issue to our attention and I want to call on all of us in AFTNC to TALK ABOUT this. We do not become culturally competent by reading about culture; we do so in conversations where we have our own experience at the center while we hold the experience of the other with openheartedness.

Roger Lake, MFT is in private practice in San Francisco. He is a past president of AFTNC and currently serves on the Council as a member-at-large.

2010 AFTNC Annual Conference Interview with Presenter Celia Falicov, PhD

By Leticia Manzanares *(continued from page 6)*

der renegotiations. Many sociologists and anthropologists are working on these topics Robert Smith, Jennifer Hirsch, Gloria Gonzalez-Lopez in ways that are helpful to family therapists

In a profession with a great deal of abstract and subjective context, a condensed framework or guide that can inspire how we work with clients seems ultimately helpful. How was it taking up the challenging task of creating a framework? Where did you start?

It was not challenging. I have always been interested in qualitative analysis and finding common themes in human experience. When I first became interested in culture in family therapy, I had objections to having to learn a number of distinctive discrete themes for a variety of ethnic groups. Instead, I wanted to concentrate on similarities rather than differences and came up with four parameters that it seemed to me I was always taking into account implicitly or explicitly in assessments and in therapy. I realized too that my clients were saying things that I could also place in the same framework; they were filling out the blanks for me in those generic parameters that I use in MECA.

What are some key points our members and students can take with them and begin to practice?

Acknowledge that therapy is a multicultural encounter; be culturally attuned and culturally humble. I question the idea of cultural competence; it is very top down and may send the message from the expert: "I know a lot about your culture".

What considerations would you like our members attending the conference to contemplate as a means to facilitate a dialogue for a successful workshop?

Think about the cultural strands in your training and in your personal life and come prepared for dialogue about your cultural dilemmas with clients.

Is there anything you would like the association to know that I did not include about you, your culture or professional career?

No, this is sufficient for now. I look forward to stimulating discussions in October.

2010 AFTNC ANNUAL CONFERENCE

OCTOBER 15-17

SONOMA, CA

Conference information and Registration forms on the following pages

2010 AFTNC Annual Conference

One Size Doesn't Fit All:

Working with Latino Families and Other Cultures with the Multisystemic Ecological Comparative Approach

Featuring **Celia J. Falicov, Ph.D,** internationally renowned family therapist and author of *Latino Families in Therapy: A Guide to Multicultural Practice.*

October 15-17 at Westerbeke Ranch, in Sonoma, CA

Traditional clinical concepts do not necessarily fit every client. Unlike an earlier generation of therapists, who believed the goal of therapy was to help clients acculturate, today's therapists need to practice the art of "cultural humility" by becoming aware of the personal and cultural biases that they bring to the therapeutic encounter. Therefore, in today's diverse society therapists are invited to modify traditional clinical concepts to help clients reconcile, learn to live in the dominant society and constructively challenge social and cultural disjunctions in their lives.

In this workshop, *a generalist framework* called MECA (Multisystemic Ecological Comparative Approach) will be offered for integrating in the therapeutic conversations issues of cultural diversity, the stresses of race, conflicts with institutions and social class locations and the resources of religion and spirituality. Attention will be paid to important cultural differences in family organizations and in how the family life cycle is constructed and experienced. Furthermore, therapists will learn to ask relevant questions that elicit information about significant cultural conflicts, including the therapist's own cultural preferences. Participants will learn new family therapy concepts and interventions applicable to families in cultural transition. Techniques that fall into "therapeutic rituals" (odd days/even days; catching-up life narratives; rebalancing contracts and others) can be used to deal with the ambiguous losses of migration; or to intervene in generational conflicts between parents and adolescents or gender conflicts between husband and wife. This multicultural roadmap and clinical illustrations relevant to assessment, goal setting and interventions will be useful for working with a wide variety of cultural groups rather than becoming competent with one ethnic group.

Celia J. Falicov, Ph.D. is a clinical professor in the Department of Psychiatry at the University of California-San Diego. Dr. Falicov pioneered writings on family transitions, migration and cultural perspectives in family therapy training and practice. Her Multisystemic Ecological Comparative Approach (MECA) Model integrates cultural and sociopolitical similarities and differences across cultural groups. Her publications include two edited books: *Family Transitions* (Guilford) and *Cultural Perspectives in Family Therapy* (Aspen). Dr. Falicov's book, *Latino Families in Therapy: A Guide to Multicultural Practice*, provides a new model for both trainees and experienced therapists.

This conference is intended for licensed mental health professionals, residents, interns, and students in training.

CEUs are provided by **The Spiritual Competency Resource Center** who is co-sponsoring this program and is approved by the American Psychological Association to sponsor continuing education for psychologists. SCRC maintains responsibility for the program and content. SCRC is a California Board of Registered Nursing Provider (BRN) and a Board of Behavioral Sciences Provider (BBS). For questions about ce contact David Lukoff, PhD at (707) 763-3576.

2010 AFTNC Annual Conference

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Featuring **Celia J. Falicov, Ph.D,** internationally renowned family therapist and author of *Latino Families in Therapy: A Guide to Multicultural Practice.*

Registration Due by Friday, September 10, 2010

All postmark or email registration received after September 10, 2010 will be considered late.

********In order to register for the Conference, the Release and Waiver Form from Westerbeke must be completed and returned with your registration information. To download this form visit: http://www.westranch.com/pdfs/ReleaseAndWaiver.pdf Please also download Guest Guidelines http://www.westranch.com/pdfs/GuidelinesForRanchGuests.pdf and Travel Directions http://www.westranch.com/pdfs/WesterbekeRanchDirections.pdf**

Program: Friday October 15- Sunday October 17, 2010
Location: Westerbeke Ranch 2300 Grove Street Sonoma, CA 95476
(707) 996-7546 www.westranch.com

Meet and Greet with presenter, Celia Falicov, PhD. Friday evening at 6pm

Schedule:

Friday October 15	Saturday October 16	Sunday October 17
	Session A: 9:00 am – 12:30 pm	Session C: 9:00 am – 12:30 pm
	Lunch: 12:30 pm - 2:30 pm Student Meet & Greet with Celia: 1:30-2:30	Lunch: 12:30 pm – 1:30 pm
Dinner with the Presenter	Session B: 2:30 pm – 4:30 pm	Session D: 1:30 pm – 3:30 pm
Meet and Greet with Presenter	Dinner: 6:00 pm Charades: 9:00 pm	Adjourn 3:30 pm

AFTNC 2010 ANNUAL CONFERENCE REGISTRATION FORM

Please complete this form and email or send it to: Lisa Anderson Shaffer: lisaandersonshaffer@gmail.com

Lisa Anderson Shaffer, MFT: 870 Market Street, Suite 1101, San Francisco, CA 94102

Payment can be made online at www.aftnc.com or by check payable to AFTNC and send to Lisa Anderson Shaffer

Please contact Conference Co-Chairs with any questions you may have regarding the conference.

Lisa Anderson Shaffer: lisaandersonshaffer@gmail.com & Leticia Manzanares: lmanzana1@yahoo.com

To apply for the Ram Gokul scholarship fund, please email Lisa Anderson: lisaandersonshaffer@gmail.com

Name:________________________ **AFTNC Member: Yes No**

License#/Type:________________________ **Email:**________________

Address:____

Telephone: (Home)____________________**(Work)**____________________

Roommate Preference (if applicable):________________________

Meal Choice (circle one): Vegan Vegetarian Regular

Conference and Lodging Option:(ex: member 2 night early =$480)________________

CEU add $15________________________________

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Conference and Lodging Costs: Late Registration is after Friday, September, 10 2010

Options	Member Early	Member Late	Non Member Early	Non Member Late
2 Nights	$480	$555	$540	$615
1 Night	$350	$425	$410	$485
Conference Daytime Only	$290	$365	$350	$425
Student 2 Night	$350	$425	$410	$485
Student 1 Night	$258	$333	$318	$398
Student Day Only	$187	$232	$337	$292
CEU	$15	$15	$15	$15

Cancellation Policy: Please contact Lisa before September 29, 2010 to receive your full refund less $35.00 administration fee if you cannot attend the conference. September 29, 2010 will be the last day the conference and food fee will be refunded (lodging is no longer refunded) less $35.00 administration fee.
Auxiliary Requests: Please email Leticia Manzanares: lmanzana1@yahoo.com if you need auxiliary aids or services to assist you during the conference. We will make every effort to accommodate your requests.
Above costs include: Shared cabins with baths, daily use fees at Westerbeke Ranch, Friday night dinner, Saturday and Sunday breakfast, lunch & dinner (No dinner Sunday).
Ram Gokul Scholarship Fund ~ AFTNC has created a scholarship fund in honor of the late Ram Gokul to help support members committed to family therapy who otherwise would not be able to afford to attend the conference. If you are interested in applying for the scholarship fund, please contact Lisa Anderson Shaffer at lisaandersonshaffer@gmail.com

aftnc

THE ASSOCIATION OF FAMILY THERAPISTS OF NORTHERN CALIFORNIA

ASSOCIATION OF FAMILY THERAPISTS OF NORTHERN CALIFORNIA

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WE'RE ON THE WEB!

WWW.AFTNC.COM

WHO WE ARE

Founded in 1963, AFTNC is the nation's oldest professional association devoted to promoting family therapy. Our goal is to advance the theory and practice of family therapy while fostering collegial relationships among family therapists. AFTNC is a group of experienced mental health and social service professionals committed to providing quality services to families, couples, and individuals in private and public settings. Our multi-disciplinary, multi-cultural membership includes MFTs, PhDs, PsyDs, MDs, LCSWs and advanced graduate students.

RAM GOKUL MEMORIAL SCHOLARSHIP FUND

PROVIDING SCHOLARSHIPS FOR AFTNC'S ANNUAL CONFERENCE

The Ram Gokul memorial scholarship fund was established by the AFTNC council in 2005. For the past several years, the council has worked to incorporate cultural perspectives into the training and practice of family therapy in our region. We have attempted to put these issues at the top of our agenda, particularly in choosing presenters for the Fall Conference. Ram, our friend and colleague, was an inspiration to many of us in that regard. Having come to the United States from Guyana as a young man, he trained in the Bay Area at a time when few men of color were entering our field. His life and work embodied respect for cultural diversity. When he passed away last summer, we were all caught by surprise, and sought to memorialize his life and promote our interest in culturally sensitive mental health services by establishing a scholarship in his name to support the goal of broadening participation in our Fall Conference, thereby creating a more respectful community of understanding and justice.