



NEJRSP

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The New England Journal of Relational and Systemic Practice (NEJRSP) is a regional journal that disseminates pertinent relational and systemic information, giving mental health professionals the knowledge and expertise to enhance their practice.

***The New England Journal of Relational and Systemic Practice* publishes both innovations for practice and new developments, and practical information that trains current and future practitioners. We publish quarterly, and would love to present your writing.**

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NEJRSP

NEW ENGLAND JOURNAL OF
RELATIONAL & SYSTEMIC PRACTICE

The New England Journal for Relational and Systemic Practice is a production of the New England Association for Family and Systemic Therapy (NEAFAST).

NEAFAST is the professional home for family and systemic therapists in Massachusetts and surrounding states. NEAFAST is a membership organization of professionals dedicated to the advancement of family and systemic therapy through advocacy, networking, and education.

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EDITORIAL: PARENTS, ESSENTIAL WORKERS, AND CONTINUING MENTAL HEALTH DISPARITIES

STEPHEN DUCLOS, MEd

Editorial Team – *New England Journal of Relational and Systemic Practice*

During the first week of December, 78 people died of COVID-19 in Massachusetts alone (Kaufman, 2022). This is an increase from about 50 per week in the preceding three months. We are pretending to be in a post-COVID ecology, just as we are pretending to address mental health disparities. Respiratory ailments are also very high, causing difficulties in families, and interrupting work and respite for parents. Essential workers, such as teachers, truck drivers, nurses, therapists, and warehouse workers, among others, have seen small gains in income wiped out by inflation.

Mental health workers continue to be underpaid and overworked, with little thought or resources directed toward developing more structural change. As indicated in prior editions of this journal, therapists, social workers, and psychologists are leaving the field in waves that are not replaceable. Anxiety is higher now than ever before, leading to alarming climbs in depression and suicide. Suicide rates in 2022, according to the CDC, continue to climb, with rates in New England ranging from 16.4 citizens per 100,000 per year dying from suicide in Maine and New Hampshire, to 8.4 per 100,00 in Massachusetts.

This does not take into account the peripheral damage of suicide to families and friends. Nor does it take into account the unmediated damage to others. Commuter rail train engineers *frequently* have to endure persons running across the tracks with the intent to die. Some engineers have had this occur more than *three or four* times in the last several years. In every case, the totality of response by the managing company, Keolis Commuter Services, is 3 days off with no mandated mental health counseling.

This industrial response is a metaphor for what is occurring more systemically, not only in other industries and occupational groups, but in the entire population. The suicide rate for police officers is higher than any other vocational group. And the suicide rate for Black men is higher than any other citizen group. From 2014 to 2017, death rates from overdoses of synthetic opioids in majority-Black urban areas increased 818% (Farahmand, et al, 2020).

This is a journal for those family, relational, and systemic therapists who are battling the effects of dysfunctional systems. In working with families and parents, we are attempting to counterbalance the effects of racism, homophobia and transphobia, ableism, sexism, misogyny, and ageism, one session at a time.

In this edition of the journal, we focus on parenting. Parents are under stress from every direction, from the randomness of serious illness to themselves and their children, to increasing occupational and economic instability, from everyday racism, to a profound lack of support from a crumbling mental health system.

We seek to uncover the voices of New England therapists and are soliciting ideas for interviews, articles, and journalism from this local ecology.

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CoPAFS: A COPARENTING TOOL FOR ASSESSING AND CLINICAL INTERVENING

MARSHA KLINE PRUETT, PhD, MSL, ABPP
Smith College for Social Work

JESSICA PARDIM ARAUJO
Smith College

Coparenting is a concept defined as two or more adults in any family structure engaging in the shared activities and responsibilities of raising a child (McHale & Lindahl, 2011). The coparenting subsystem of the family is distinct from the marital relationship, the parent-child relationship, and the family system as a whole (Kerig, 2019; Teubert & Pinquart, 2010). Through many studies, including meta-analyses, we have come to appreciate its power for promoting children's and families' well-being. Researchers have repeatedly found coparenting to be a predictor of parenting quality and family stability (e.g., Cabrera et al., 2012; Feinberg et al., 2016; 2022) across family structures (e.g. living together and separated), including sexually and gender-diverse families (Farr et al., 2019; Johnson et al., 2016). Through dedicated coparenting, even parents in conflict can nevertheless parent their child(ren) competently and effectively (Pruett et al., 2017; 2019).

One of its superpowers is that positive coparenting optimizes parenting: positive coparenting is associated with better mother-child and father-child relationships in both middle-class and low-income families (Doss et al., 2014; Feinberg et al., 2016). In married couples, lower marital satisfaction is related to poorer coparenting (Christopher et al., 2015), while coparenting quality may be associated with parenting quality even more closely than marital satisfaction (Feinberg et al., 2010). Coparenting predicts parenting quality, especially for mothers (Le et al., 2016), and positive father involvement, especially among fathers (Pruett et al., 2017; Pruett & Pruett, 2020). Moreover, healthier coparenting is related to better child outcomes in heterosexual and same-sex families (Farr et al., 2019; McConnell & Kerig, 2002; Neppl et al., 2019; Stright & Neitzel, 2003). Supportive coparenting can directly serve as a buffer against the transmission of negative effects to children from depressed and anxious parents (Feinberg et al., 2016).

Components of Coparenting

With all of this research supporting the importance of coparenting, there is still much to be learned about the construct in order to harness its positive effects for the benefit of families. Significant heterogeneity exists across studies of the various constructs of coparenting, although most studies have identified two high-order dimensions, conflict and support, and several lower-order dimensions, including triangulation (parent-child coalitions that undermine the other parent and blur parent-child boundaries; Margolin et al., 2001); coparenting alliance (Hock & Mooradian, 2012; 2013; Van Egeren & Hawkins, 2004); childrearing agreement; division of labor in childrearing; support and undermining actions between co-parents; and joint family management of interactions (Feinberg, 2003; McHale & Irace, 2011).

In separated families, developing cooperative coparenting is considered an optimal goal to facilitate post-divorce/separation parenting and child adjustment. For these couples, conflict is the central theme in a number of conceptually overlapping instruments. Other primary indices in these various measures include communication, hostility, triangulation, cooperation, respect for the other parent, gatekeeping, support, and cohesion (see Saini et al., 2019; Saini et al., 2022 for summaries). Boundary ambiguity (Beckmeyer et al., 2021; Pruett & Donsky, 2011) and a drop off in coparenting support (Malette et al., 2020) also are identified in separated families.

Assessing Coparenting

While there are measures with adequate psychometric properties available for assessing both intact and separated coparenting (Feinberg et al., 2012; McHale et al., 2008; Teubert & Pinquart, 2011), there are no validated measures reliably capable of capturing the salient dimensions of the construct of coparenting across intact and separated coparenting configurations (Molla Cusí et al., 2020). Furthermore, psychological research has lagged behind social changes regarding intact and separated sexually and gender diverse coparents (Johnson et al., 2016), and there is not yet a questionnaire assessing coparenting relationships within these various parenting constellations. For example Johnson and O'Connor (2002) found that lesbian couples who were coparenting performed as well or better on measures of family relationship quality and parental attitude variables than heterosexual couple coparenting counterparts. However, further research is needed to consider the implications of coparenting among sexually and gender-diverse parents living in different family structures.

Need for an Integrative, Simple-to-Use Tool

Within most western cultures, parents can be single, married or separated; sexually and gender diverse; an adoptive or step-parent; and are influenced by multicultural influences on how their parenting promotes children's emotional development and well-being. Despite the various coparenting measures that have been developed for specific research purposes or populations (married, separated, never married), none exist as a tool widely applicable across family structures and free of gender-role assumptions for researchers as well as agencies and programs to use.

In this context, we aimed to design a tool that could be accessible, cost-free and could capture the most important underlying factors of the complex construct of coparenting. To move away from siloed assessment tools, we aimed to develop an instrument that could be valid with families in which the parents live together and those that live separated, for whatever reason and in any configuration. We also wanted to recognize that couples move between these structures over time. Additionally, we aim to be more inclusive than previous research has tested for in terms of sexually and gender-diverse families.

Development of CoPAFS

The Coparenting Across Family Structures (CoPAFS) is still in a development phase, as we are finding it to be reliable and valid, but still have much work to do on validating it across diverse samples. To date, we have collected and analyzed two samples and are in the process of analyzing a larger, more diverse group of parents. The first sample consisted of 252 parents. The inclusion criteria were: (1) being a parent with a child under the age of 18 at the time of completing the survey; (2) being a parent who shares parenting in some capacity with at least one other parent; and (3) being a parent who is able to read English in order to provide informed consent and complete the survey.

We began with a review of the literature and an analysis of coparenting measures, resulting in a 56-item Coparenting Across Family Structures Scale (CoPAFS) (Saini et al., 2019). The scale captured nine dimensions of coparenting identified in the literature: (1) Communication; (2) Sharing; (3) Anger; (4) Restrictive coparenting; (5) Facilitative coparenting; (6) Respect; (7) Trust; (8) Conflict; and (9) Valuing the involvement of the other coparent. Parents broadly recruited online from organizations identified as interested in parenting intervention were asked to complete the online coparenting survey on SurveyMonkey (<https://www.surveymonkey.com>). For each of the scale's 56 items, respondents were asked to rate their agreement (ranging from 1—strongly agree—to 5—strongly disagree) with a statement concerning their coparenting relationship. Examples of the items in the scale are: “I usually just give in to the other parent so we do not argue”; “We can usually find solutions about parenting that we are both happy with”; “I get annoyed easily about the mistakes that the other parent makes with our child”; “The other parent undercuts my decisions”; “We have similar hopes and dreams for our child”; “We generally agree on how to discipline our child”; or “Although we don't always agree, we respect each other's differences as parents.”

This pilot test assessed the psychometric properties (stability, reliability, and internal consistency) of the CoPAFS to determine whether the measure could be useful for evaluating the core dimensions of coparenting. The initial pilot and validation study of the 56-item CoPAFS scale demonstrated the scale's reliability and overall strong psychometric properties (Saini et al., 2019). However, in spite of our efforts to recruit a diverse sample, the majority of the participants self-identified as female (81.7%), Caucasian (71.8%), highly educated (64.3% completed schooling beyond college), employed full-time (70.2%), and reported annual incomes

over \$80,000 (73%). There was diversity in living status – married, separated, or never together. Over half of the participants were living together with the other parent, either married or in a common-law relationship, a third identified as separated or divorced, and the rest reported living together but neither married nor in a common-law relationship.

Next, we added a second sample of 329 parents and conducted a confirmatory factor analysis. These analyses reduced the 56-item CoPAFS scale to a 5-component scale of 27 items which included Respect, Trust, Valuing the other parent, Communication, and Hostility. This short form (27 items) again used items measured by a 5-point Likert-scale ranging from 1 = Strongly Disagree via 3 = Neutral to 5 = Strongly Agree. Examples of items include: “It is important that my child loves both parents”; “I value the other parent’s parenting skills”; “I work well with the other parent when decisions need to be made about our child”; and “I find it difficult to support the other parent’s relationship with our child.”

The second sample was recruited through an invitation to answer an online survey on coparenting and COVID-19 related stressors, which was circulated in multiple online parenting groups on Facebook. The inclusion criteria for participation in the survey were the same as the first sample. Participants were not compensated for participating in the survey. The final sample consisted of 329 participants. The sample again was predominantly mothers (82.1%), overwhelmingly White (81.8%), with far fewer parents identifying as black (4.3%), Latinx (6.1%), Asian (3.3%), or indigenous/Native Americans (1.8%). More than half of the parents (54.4%) had a university degree or above, 29.2% had some post-secondary education and 11.5% had a high school diploma or less. The sample was significantly lower income than the first sample, with nearly half the sample reporting lower average incomes (<\$59,000). A majority of parents (60%) were separated, with proportions of parents never married/living together and/or married/cohabiting.

These limitations notwithstanding, the results of this study provide promising evidence for the strong psychometric properties of the short-form 27-item CoPAFS scale for this homogeneous sample. The short-form scale was very strongly correlated with the 56-item CoPAFS scale (Pearson correlation = 0.98), as were the intercorrelations between the 5 subconstructs—which were all significant and ranged between 0.763 and 0.914. The internal consistency of the short-form scale was excellent (Cronbach’s alpha = 0.96). The confirmatory factor analysis for the 27-item CoPAFS scale measurement model showed good model fit indices, and all estimates for the five subconstructs were significant, ranged between 0.82 and 0.96, and explained between 67% and 92% of the variation on the short form scale. In the transition from a 9-subconstruct model to a 5-subconstruct model, Anger and Conflict were found to be better conceptualized from a practice perspective as a single factor—Hostility.

Consistent with family systems theory, the five dimensions of the short form CoPAFS foreground the conditions that foster autonomous, considerate, and coordinated parenting by

coparents. The pivotal roles of trust and respect are especially supported by family systems considerations, given that these two dimensions constitute the conditions of possibility for accepting and supporting each coparent relationship with each child.

Translated into Six Languages

As we continue to collect data, the CoPAFS was translated into five additional languages: Mandarin, French, Spanish, Arabic, and Hebrew. An Italian version also is being used autonomously. For each language version, the survey was translated alongside colleagues we identified whose primary language was the one being translated. Typically, the colleagues included clinicians and/or academics in a country that spoke the language of interest, such that North America was not the major collection point across languages. Based on local expert feedback, we made edits in the surveys to be consistent with the meanings attributed to the items in the culture being studied. For example, questions about sexual orientation, the meaning of sharing childrearing, and family structure (living together or apart) held different valances in different cultures. The survey is being collected not only in different languages but in different countries, expanding the cultural differences we can examine.

To date, we have collected another several hundred English surveys, and over 900 Mandarin surveys – almost all of which are a married sample from parents living in China. About 600 of those surveys are being analyzed by Smith College student Tianmei Zhu, comparing English and Mandarin-speaking samples, for mothers and fathers, to learn more about coparenting in two different cultural frames.

We are also making efforts to collect more data from fathers, in particular, from various ethnic and racial groups, and at diverse economic and education levels.

Ways CoPAFS Can Be Used in Practice

In the meantime, colleagues have used CoPAFS on their own or through parenting education or intervention programs underway. The tool is free-of-charge, accessible, and quick. That makes it easy to obtain and use. Although there are not yet normed data from which to interpret or categorize, the tool can be used qualitatively and interpretively. Moreover, you can compare individually collected data to information collected by the researchers on a larger scale if the individual/group demographics are similar to those currently available. Such comparisons must be made with care and great conservatism, but they can provide some generic information. Here are some ways the tool is being used.

*Collect the tool with couples or parents who are clients in clinical practice to assess the extent to which coparenting is operating as a positive aspect of their lives, as well as to identify the specific subconstructs in need of attention. The tool is used to understand how similarly or differently the parents assess their coparenting and which factors are least correlated or most in agreement to identify strengths and areas for focus.

*Have parents talk specifically about the meaning of the five factors in their life as coparents: where are they a strong team, what do they need to work on, and how do they see their progress or lack of it affecting their children?

*Without trust and respect, it is difficult to enhance communication, cooperation, or reduce hostility. Therapists can focus on how they are working to increase trust and respect between parents. Where are the “sore points” in this regard that hamper intervention focused more behaviorally? Families who struggle with issues of trust may benefit from a different approach than families whose main challenge is with issues of communication. We believe that laying this groundwork in assessment and other forms of clinical intervention, including couples therapy, support groups, etc., may provide the basis for more productive work.

*CoPAFS can provide information about coparenting that can be integrated into court-interventions. It can be used to identify court-involved families at risk of conflict escalation.

*The CoPAFS is being used to examine which aspects of coparenting are changing as a result of parenting education. Such information can inform the development of better parenting classes or interventions.

*Correlations between child outcome information and CoPAFS factors may offer clues about which components of coparenting can create significant change, and in which circumstances.

*With coparenting heralded as an important component of parenting and reduced stress (e.g. in response to COVID) (Pruett et al., 2019), developing better and more universal assessment tools is a priority in family research.

Give it a try!!

Join our team of data collectors. Attached is a flyer with a link to the survey in different languages. Use it through research, couples and family work, student projects, or for your own interest. We look forward to working with anyone who wants to help us collect more diverse data – especially relevant to education and income levels, gender inclusion, race, etc. The development of this tool will be ongoing for some time to come; we will continue to improve upon the tool and share uses for it in clinical work and study.

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SMITH COLLEGE
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CO-PARENTING SURVEY INVITATION



The survey is available in 6 languages:

Arabic: bit.ly/copafsArabic

English: bit.ly/copafs27

French: bit.ly/copafsFrench

Hebrew: bit.ly/copafsHebrew

Mandarin: bit.ly/copafsMandarin

Spanish: bit.ly/copafsSpanish

About The Survey

We are a team of researchers involved in supporting parents' involvement in the raising of their children.

Complete an online survey, 15 minutes to complete. You will be asked questions about co-parenting and some basic informational questions.

Your information is completely anonymous.

Please Participate If:

- 01 You are a parent of a child under 18 years old
- 02 You are married, divorced, separated, or never lived with the other parent
- 03 You are both involved with your child

For questions, please contact one of the researchers:

Marsha Kline Pruett, Ph.D., M.S.L., ABPP
Smith College School for Social Work
mpruett@smith.edu

Jonathan Alschech Ph.D.
Assistant Professor
Smith College School for Social Work
Jalschech@smith.edu

Michael Saini, Ph.D.
University of Toronto
Factor Inwentash School Of Social Work
Michael.Saini@Utoronto.ca

This research has been approved by the Smith College Institutional Review Board.
Thank you for your participation.



SUPPORTING PARENTS OF NEURODIVERSE CHILDREN: AN INTERVIEW WITH CORNELIA ELWOOD

JACQUELINE GAGLIARDI, MeD

Editorial Team – *New England Journal of Relational and Systemic Practice*

*Cornelia Elwood is a parent support specialist at Mass General Hospital, where she provides trainings for parents of individuals on the autism spectrum. She is the co-author of the book *Take Charge of Treatment for Your Child with Asperger's (ASD)*. NEJRSP editor Jackie Gagliardi interviews her about ways that the family therapists can support parents of neurodiverse children.*

Jackie Gagliardi: Hi Cornelia. Welcome and thank you for agreeing to participate in this interview.

Cornelia Elwood: Thanks so much for the invitation to participate in the interview! I am excited about it!

JG: I am curious about how you became interested in specializing in work with individuals and parents of children on the spectrum.

CE: Most of the experiences of my adult personal and professional life have led to my interest in specializing in work with individuals and parents of children on the autism spectrum. I have always been interested in supporting people. As a young professional, I took a two-year life coach training and loved the work. My oldest son, Alexander, was born 22 years ago, and he was diagnosed with Asperger's Syndrome (now known as autism spectrum disorder) when he was four.

I felt that I was ineffective at my most primal and important job...parenting. I was very humbled by the process of parenting and found that typical parenting techniques, such as time outs or getting on Alexander's level to talk through struggles empathically, were ineffective and ultimately led to greater escalation and emotional chaos in our home. I desperately sought strategies to support myself and our family because parenting and home, school, and community life were complex. My search for ways to support Alexander and our family led me to many professionals, including psychologists, speech and language pathologists, occupational therapists, psychiatrists, and educational consultants who understood autism. When Alexander was ten,

I enrolled in a certificate program for autism spectrum disorders to try to make sense of my son's complex profile and to bring greater harmony to our home. Finally, I understood autism and felt empowered to make a difference for Alexander and our family.

For an assignment for one of my classes, I created a parenting guide for home, school, and the community. My guide served as a case management road map for me, an instruction booklet for Alexander, and a collaboration toolbox for the professionals supporting Alexander. I shared this guide with Alexander's educational consultant and the Executive Director of MGH Aspire, Dr. Scott McLeod, and we decided to use the contents to create a book, *Take Charge of Treatment for Your Child with Asperger's (ASD)*, to support other parents. I developed a corresponding training, using the book as the curriculum, and facilitated it a number of times. Supporting parents of autistic children became my mission.

My book trainings helped me realize that I wanted to take my clinical skills to a different level, and I applied to William James College for the clinical mental health counseling program with a concentration in couples and family therapy. My interest in serving this population remained, and I became an ASD specialist for Riverside Community Care and am currently the parent support specialist at MGH Aspire. My life experience shaped my passion for working with autistic individuals and their parents.

JG: So interesting and admirable how you were able to utilize all you learned and researched as a parent, and then write a book for parents, so that they had information at hand. As a clinician who specializes in this area, I am wondering what advice or information you can provide to clinicians who are working with individuals on the spectrum and their families.

CE: Thanks, Jackie. I could go on and on about this topic, but the three points that I will discuss are: 1. Understand the ASD profile and know corresponding strategies that support each feature and associated feature; 2. Make therapy accessible; 3. Know ASD-specific resources to recommend to clients.

Understand the ASD Profile

First, Autism Spectrum Disorder profiles are complex, and it helps to understand the features and associated features of Autism Spectrum Disorders and the corresponding strategies that support individuals with this profile. The features are social differences, communication differences, restricted and repetitive patterns, interests, and behaviors, and sensory differences. The associated features are motor differences, cognitive differences, and emotional vulnerability. It helps to understand how these features and associated features uniquely present in your clients.

An example of pairing a strategy with a feature or associated feature is working with an individual who struggles with communication and supporting their communication by role-playing, rehearsing, miming to teach non-verbal communication, video-modeling, and in the

moment coaching. You can explain that conversations are like a ping-pong game where you can respond to a question and keep the conversation going by asking a related question back to the conversation partner. The key is to know what strategies are ASD-informed.

Making Therapy Accessible

Here are seven strategies that therapists can utilize with these families.

1) Provide structure. Have a visual agenda for the therapy session. I worked for several years with a wonderful eight-year-old boy with an Asperger / autism profile. Every session, we took the first few minutes to preview what we would do during our hour together. Every week, we kept the agenda fairly consistent. I used a time timer to visually show him where we were in each segment of the session. For example:

- Build agenda – 3 minutes
- Check in – 10 minutes
- Discuss topic / practice a skill related to check in – 20 minutes
- Discuss child’s special interest – 5 minutes
- Play game – 5 minutes
- Talk with mom – 7 minutes

2) Delineate behavioral expectations. Individuals on the autism spectrum can miss the hidden rules of different environments. It is helpful to proactively explain what the expectations are in writing. For example, therapy lasts 50 minutes. We will not use screens unless for a therapeutic purpose. If using screens for a therapeutic purpose, we will use the center’s computer. It is helpful to clearly establish, particularly for family therapy, that when one person speaks, allow them to complete without interruption. Individuals benefit from therapists clarifying what their role / job is and what the client’s job is in therapy. This explicit information can set the autistic client up for success in participating in the session.

3) Preview. Transitions and changes are hallmark challenges for individuals on the autism spectrum. Autistic clients benefit from previews about changes, such as changes in schedule, meeting times, or meeting location. One time I was working with a client, and every week we met in a particular meeting room. One week, after many months, the room was not available and this client and I had to meet in another room. The change in room without sufficient preview made the client very anxious. From that point forward, I reached out to the client, prior to the session, whenever there was a change.

4) Be sensitive to sensory struggles. Autistic individuals might have an over- or under-reactive response to sensory stimulation. As a clinician, it is helpful to understand your client’s sensory profile and support accordingly. For example, if your client has a sensory over-reactive response to touch, it is helpful to ensure that you do not touch your client. For sensory

over-reactivity to smell, it is helpful to refrain from wearing scents. If your client is over-responsive to noise, it is helpful to preview loud noises and make sure that the noise in your office is tolerable. If an individual has an under-reactive sensory response to touch, it might be helpful to have fidgets available that can provide tactile input.

5) Engage through special interests. Engaging with special interests can be exceptionally rewarding, fun, engaging, and stress reducing for individuals on the autism spectrum. My son's therapist was able to talk about extremely important topics with my son, such as sex, drugs, alcoholism, and relationships by looking at clips of a show, *Bojack Horseman*, which was his special interest. They would watch clips during their session, which addressed these themes and more, and use them as a way for him to access psychoeducation. I have connected with many clients through their special interests. This strategy can lead to engagement and connection with therapist and therapy. That said, it is important to know that transitioning from special interests can be difficult, so make sure that you preview the schedule and support this transition.

6) Use visual supports. As mentioned before, it is helpful to have a visual agenda, behavioral expectations list, and previews. In fact, I make as much about the session as visual as I can. For example, when I work with clients virtually. I will often share my screen as take notes on the key take aways from the session and send the list to my clients, so they can review it as often as they would like.

7) Collaborate with parents and other service providers. Autistic individuals often benefit from having coordinated support in every environment...home, school or work, and the community. Also, this approach helps individuals generalize skills from environment to environment. When Alexander was younger, his therapist, special educator, speech and language pathologist, and I often worked on developing the same skill, such as whole body listening or using "I-statements" simultaneously in each environment.

ASD-Specific Resources

It is helpful for clinicians to understand what services and resources that are available for individuals on the autism spectrum and their parents. Three that I most recommend are:

1) MGH Aspire which provides year-round programming for individuals aged 5 years to adult, including:

- Social groups
- Summer camp
- School vacation camp
- Work-related support
 - Internship program
 - One-on-one career coaching
 - Skill-building workshops

- School consultation
- Corporate neurodiversity trainings and workshops
- Parent and caregiver trainings, workshops, and coaching

2) MGH Lurie Center which provides the following services for children and adults:

- Neurology evaluations and services
- Psychiatry evaluations and services
- Gastroenterology evaluations and services
- Psychology and educational evaluations and services
- Behavioral consultation and training services
- Speech-language therapy
- Occupational Therapy
- Physical therapy
- Family support services
- MGH Aspire
- Primary care services

3) Asperger / Autism Network which provides the following services:

- Information and referral calls
- Coaching for parents
- LifeMap coaching for teens and adults
- Neurodiverse couples
- Coaching in Spanish
- IEP support
- Support groups
- Social events
- Training and education – conference
- LifeNet – Independent living support

JG: Thank you for such a detailed response. I am wondering what the impact of Covid had on this population!

CE: I did research on this and provided a webinar for parents of children in Aspire programs. There were vulnerabilities and strengths for individuals and families entering the pandemic. The vulnerabilities included:

- Potential for exacerbations of symptoms due to all of the changes and transitions
- Limited access to therapy
- Overwhelming responsibility for caregivers

That said, families of children with ASD are more skillful in adapting to unusual conditions, so they showed resiliency.

There were variable responses to the Pandemic. The benefits for some children with autism profiles included being able to be at home where they were comfortable. They could engage in self-regulating activities without negative social consequences and enjoy a break from social obligations and expectations. The pandemic birthed new ways of communicating, virtual

communication, that favored people with autism. The impact of these benefits included reduced stress, positive learning impact, less over-stimulation, less need to mask, more remote social outreach, and a more equal playing field because everyone was awkward remotely.

Some autistic individuals were challenged by the lockdown due to changes in the routines, environments, expectations, and services. Some homes were small, so people had less physical space. Small environments could lead to greater sensory issues. For example, it might be noisier or smells were more present in the space. These challenges led to increased stress, ineffective engagement virtually, regression of communication and self-management skills.

Parents were overwhelmed. They had to be both full-time caregivers and educators. They had to manage and structure daily activities and support their children's therapeutic needs without support or with less professional support. Managing their own jobs became problematic in some cases, and they had to take leave or quit their jobs to manage home demands. Many were contending with potential health threats, social isolation, mounting financial pressures.

Families experienced benefits and difficulties from the pandemic. One significant benefit for the family was increased family time. Many children's verbal behaviors increased due to this increased family interactions. Also, families shared responsibilities more. The difficulties included great stress. Some parents had more conflict with their child. Mental health struggles became greater; at the same time families experienced delays in seeking and receiving care.

As children went back to school and to their extracurricular activities, anxiety heightened in many cases due to the transition and the expectations to refocus on social performance. Many children exhibited increases in externalizing behaviors associated with anxiety, including aggression and defiance. Profile-specific challenges were exacerbated.

JG: Thank you, Cornelia, for this wealth of information. If readers would like more information can they reach out to you.

CE: Yes, my email is cpelwood@yahoo.com. Please also check out the resources listed above.

Resources

- Beatriz, E., Guarino, A., Beatriz, P.V., (2021, June). *Covid-19 Community Impact Survey: Parents & Families*. Massachusetts Department of Public Health. doc/ccis-webinar-parents-and-families/download
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- Hurwitz, S., Garman-McClaine, B., Carlock K. (2021). Special education for students with autism during the COVID-19 pandemic: "Each day brings new challenges." *Autism : the international journal of research and practice*, 1-11.
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PRIVILEGE AWARENESS FOR COUPLE AND FAMILY THERAPISTS: A MODEL FOR TRAINING AND SUPERVISION

JAMES BRIDGES, PhD

This Space Between, LLC

CARMEN GRAY, PhD

Kansas State University

Abstract

The purpose of this paper is to propose a privilege awareness model. This model considers multiple identities of privilege, and answers the following questions: (1) How do supervisors guide clinicians through privilege awareness raising? (2) What role do supervisors play as clinical trainees experience discomfort from this process? And (3) how can clinical faculty and supervisors facilitate privilege awareness with some level of consistency? This model has been adapted from the framework of multicultural education (Ortiz & Rhoads, 2011). The model provides a guide for therapists who may find it difficult to challenge dominant cultural narratives in themselves and in society—narratives perpetuated by cultures of privilege. Research suggests the privilege awareness process influences the therapeutic approach for clinicians in ways that increase multicultural competency in positive ways. This model can aid in the facilitation of that awareness raising.

Privilege is here defined as greater access to unearned resources, largely due to certain identities being deemed more superior than others by dominant groups in society (Black & Stone, 2005). Educators and clinical scholars have found that the process of privilege awareness leaves people feeling a large range of emotions, including defensiveness, empathy, sadness, shame, compassion, and feeling personally attacked (Bridges et al., 2022a, Boatright-Horowitz, Marraccini, & Harps-Logan, 2012; DiAngelo, 2019). Educators and clinical scholars find that as awareness of privilege increases, negative biases and stereotypes about marginalized groups are reduced (Bridges et al., 2022b; Case, 2013; Nunn & Bolt, 2015).

Research indicates that clinicians who are more aware of the privilege they hold may be more likely to assess the impacts of marginalization for minority clients, and monitor their own language for microaggressions (Case, 2015; Chan, Cor & Band, 2018; Bridges et al., 2022b; Davis, 2014). When therapists are unaware of privileges they hold, they may be more likely to avoid conversations about identity, less likely to discuss and consider the influence of discrimination for

for clients, and more likely to hold stereotypes (Case, 2015).

The purpose of this paper is to propose a privilege awareness model (PAM), which considers multiple identities of privilege, and answers the following questions: (1) How do supervisors guide clinicians through privilege awareness raising? (2) What role do supervisors play as clinical trainees experience discomfort from this process? And (3) how can clinical faculty and supervisors facilitate privilege awareness with some level of consistency?

Privilege Awareness

While privilege highlights the unearned advantages that come with certain social identities (McIntosh, 1988), we understand oppression as discrimination and lack of access to resources. Intersectionality takes a closer look at overlapping oppressed identities. The model here proposed focuses on privilege, and thus does not rely on intersectionality as a theoretical lens. The purpose of this is to not misrepresent the origins of intersectionality, which specifically centered women of color (Crenshaw, 1989).

Privilege Awareness for the Therapist

Drawing from literature in education and counseling fields, some consistent themes emerge about the privilege awareness process (Bridges et al., 2022a; Bridges et al., 2022b; DiAngelo, 2019; Combs, 2019; McGeorge & Carlson, 2011).

Growing awareness of privilege can lead to feelings of guilt, shame, denial, and avoidance (Boatright-Horowitz et al., 2012; Bridges et al., 2022a). Moreover, in counselor training, Walls and colleagues (2009) discovered that when therapists in training were exposed to material on heterosexual privilege and encouraged to complete exercises, this resulted in several reactions. It was not uncommon for students to feel anger and shame increase as awareness grew (Walls et al., 2009).

McGeorge and Carlson (2010) found that students relied on critical reflection to process their own positionality. Additionally, Bridges and colleagues (2022a) found that it was important for therapists to organize previous experiences or mistakes, including microaggressions or periods of ignorance. Experiences of oppression also acted as a catalyst to privilege awareness. Therapists holding marginalized identities described experiences of oppression that sensitized them early in life to the larger societal structures of power, privilege, and oppression (Bridges et al., 2022a).

Some scholars have recognized the crucial role of relational safety in clinical training around issues related to power, privilege, and oppression (Hernández & McDowell, 2010). Similarly, Bridges and colleagues (2022a) found that close relationships were one of the most positive influences for privilege awareness in therapists.

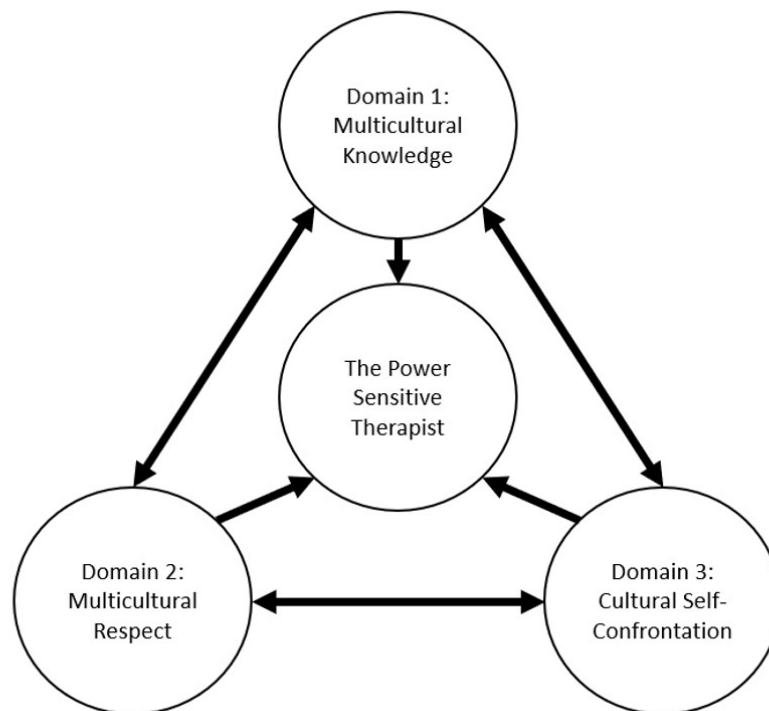
Privilege Awareness and the Clinical Process

When clinicians acknowledge privileges they hold, they may be more likely to assess the impacts of marginalization experienced by minority clients, monitor their selves for microaggressions, and adjust treatment to fit the unique needs of minority clients (Bridges, 2022b; Case, 2015; Chan et al. 2018). Awareness can also lead to creating a safer space for clients by demonstrating a warmer, more curious, and inviting stance (Bridges, 2022b). Therapists also credit their own privilege awareness to making policy and procedural changes in their clinical practices, including providing pro-bono work, and adjusting therapeutic contracts to represent diverse identities and family formations (Bridges, 2022b).

Privilege Awareness Model Theoretical Construction

The PAM (See Figure 1) here proposed, has been adapted from Ortiz and Rhoads' (2011) framework of multicultural education. The model provides a guide for therapists who may find it difficult to challenge dominant cultural narratives in them and in society—narratives perpetuated by cultures of privilege, including but not limited to the cultures of race/whiteness, patriarchy, heteronormativity, cisnormativity, monogamy, colonization, citizenship, English speaking/language, religious affiliation, being able-bodied, classism and capitalism. Before engaging supervisees or students in the process of privilege awareness, it is important to first consider the self-work required for this kind of clinical development.

Figure 1: Privilege Awareness Model



Supervision Working Alliance

The PAM encourages the supervisor or the instructor to develop awareness of their own social identities and understand how these identities influence their instructor, clinical, and/or supervisory roles (Aponte & Kissil, 2016). Adapted from the working alliance between therapist and client, Bordin (1983) proposed a very similar framework for the alliance between supervisor and supervisee, including 3 main components: (1) the bond between supervisor and supervisee, (2) agreed upon goals that guide supervision, and (3) tasks that are collaboratively established to reach those goals.

Incorporating privilege awareness in supervision requires relational safety (Hernández & McDowell, 2010). Developing a safe relationship within supervision can increase the likelihood that supervisees will engage in reflective practice, self-confront their own privileged identities, and self-confront the influence of these identities in their clinical practice.

As the one in the evaluative role, the supervisor has responsibility for making sure that goals, tasks, and overall expectations of the supervisory processes are clear. A privilege aware approach can sensitize the instructor or supervisor to power differentials existing between the supervisor and supervisee, especially when they hold a set of diverse social identities related to privilege and oppression (Hernández & McDowell, 2010). The degree to which this power differential is made transparent by the supervisor can act as a modeling intervention of self-confrontation and intentionality in clinical practice.

The Privilege Awareness Model

As supervisors and faculty engage in their own self work and as the alliance in supervision grows, the supervisory environment allows for self-confrontation. Facilitating privilege awareness relies on supervisees building a sense of awareness of culture in their environment, in themselves, and the dynamic relationship between the two.

Domain 1

Multicultural knowledge. This domain encourages couple and family therapists (CFT) to develop a systemic understanding of culture that considers groups, resources, and societal narratives as interconnected and dynamic. CFTs move from seeing culture as created by society to an understanding that they both influence culture and are influenced by it. Activities in this step can include learning about culture from an academic perspective, identifying culture in their own life, and observing it in the lives of others. This domain can be accomplished through several activities in formal and informal educational settings (assignments, readings, guest speakers, attending cultural events, and engaging in social media in more intentional ways).

Domain 2

Multicultural Respect. This domain encourages CFTs to move past the belief of one common culture, and advance in their understanding to acknowledge the existence of many cultures with equal value (Ortiz & Rhoads, 2011). This requires making space for different culturally informed beliefs, values, and paradigms. This can be accomplished in class, clinical and supervision settings. Assignments that ask students to attempt to step into the felt and lived experience of others can help build this kind of respect. Supervisors can also ask supervisees to consider the lived experiences of their clients and make explicit connections between presenting problems, systemic barriers to well-being, and resources of resilience within cultural identities.

Domain 3

Cultural Self-Confrontation. This domain encourages CFTs to develop an understanding of how privileged cultures are universalized as the norm in society, and that CFTs have the choice to invest or divest from them. The goal in this domain is to help students and supervisees understand that culture is something we all have, and some cultural values are believed to be superior or inferior in society based on historically perpetuated structures of inequality (Ortiz & Rhoads, 2011). This step can best be addressed in classes that emphasize multicultural competency and humility, but can also be addressed with assigned literature, supplemental reading, and conversations with others who have been disenfranchised or who have acknowledged their own privilege.

The Power Sensitive Therapist

Developing a power-sensitive clinical identity is placed at the center of the privilege awareness model. The main goal of the PAM is for CFTs to better understand the ways power, privilege, and oppression organize the experiences and access to resources for individuals, families, and communities. The power sensitive therapist allows their professional role to be directly influenced by their growing understanding and awareness of power, privilege, and oppression they become aware of in their personal life. Domains 1, 2, and 3 directly contribute to becoming a power sensitive therapist and can be developed by continuing education, like resources emphasizing queer-informed, anti-racist, and trauma-informed approaches. This development can also occur by expanding the professional role to address larger structural changes in the community, field, and society that help to remove barriers to well-being for communities and groups who have historically experienced marginalization.

Autoethnographic Application**Positionality (James Bridges, he/they)**

As an individual holding mostly privileged identities, the process of privilege awareness takes on personal significance for me in my personal life and in my professional role as a clinician. I identify as a white, masculine-presenting, gender queer, polyamorous, academically educated, able-bodied, English speaking US citizen of colonizing-settler ancestry.

Model Application (James Bridges, he/they)***Domain 1***

As a child and teen I didn't have language for what culture was, how it developed, and what role I had in the creation of it. I had experiences in childhood, adolescents, and young adulthood that would be considered multicultural experiences. The following are examples that would later influence how I made sense of culture: having a mother who spoke with a French accent, and received her citizenship while I was young; being active members of the Unification Church (or Moonies) until I was 6-7 years old; work trips with my father to New York City; having a best friend who immigrated to the United States from Japan; visiting France and Japan during high school; growing up in a very homogenous, white rural town in the northeast region of the United States; and growing up in a working class home.

My graduate degrees provided me with more cultural exposure through reading, assignments, instructional resources, and clinical training experience. In my master's degree I was introduced to literature that taught me about general characteristics of ethnic groups throughout the United States and the world. I also was introduced to clients who held identities that I had never had proximity to in childhood and adolescence. During my clinical training in community mental health, I had exposure to people recently incarcerated, individuals who identified as polyamorous, and queer folks of color in queer relationships living in conservative communities. All these experiences were new to me, and this feeling of newness was in large part due to my upbringing in a very homogenous rural town. It wasn't until I was in my clinical training that I could reflectively look back on these experiences and settings and make sense of it through a cultural lens, noting how I was being influenced by culture, and influencing my environment in return.

Domain 2

My default coping mechanism to this cultural existential frustration was to emphasize sameness. This paradigm led me to believe opportunity was shaped by action, rather than how people looked or identified. On the other hand, it was blinding me to the act of minimizing the differences between myself and others, which invalidated the experiences that opportunity is often given based on identity and culture.

Multicultural respect started to grow when I started to see and reflect on injustice and marginalization experienced by others. I understood cultural difference were not only defined by different practices, values, foods, identities, but also included the ways cultural groups have been considered more inferior or superior throughout history. For example, when immigration issues became more publicized in my young adult years, I observed negative stereotypes and false narratives about Arab nations and Central and South Americans. As I learned more about the history of marginalization for these groups, I started feeling empathy for their position, and also felt anger for the unjust ways they continued to be treated with regards to United States' policies on immigration.

Domain 3

A more intentional form of my own privilege awareness started during my graduate education and was facilitated by exposure to diverse populations as a therapist. This is when my belief of being cultureless was challenged the most. I began to see my privilege and what that privilege gave me. Literature, clinical experiences, faculty instruction, self-reflective exercises, and research invited me to confront my culture of whiteness, of masculine presenting privilege, and the culture of my English-speaking US citizen identity. As my own empathy grew for marginalized groups, I was increasingly more willing to reflect on what role I played in the power imbalances I saw in society. I considered how my socialization may have resulted in me holding beliefs that were sexist, homophobic, transphobic, ableist, classist, or xenophobic (to name a few). As an ongoing participant in society and culture, I also realized I would have to continue doing this work throughout my life.

Developing A Power-Sensitive Clinical Identity

My own recognition and deconstruction of privilege gave me the tools to start developing a power-sensitive clinical identity. I noticed that I was initially intimidated by clients who held identities that I had little exposure to. For example, I remember feeling anxiety at the thought of seeing an African American, lesbian couple in therapy because I believed I would not be equipped to help them. As power sensitivity increases, I have noticed that any apprehension or anxiety I have about client identities can lead me to a reflective process where I attempt to identify how these feelings are associated with my socialization in cultures of privilege. For me, a power-sensitive clinical identity has meant an increased sensitivity to the social contexts of my clients. I consider more frequently how the presenting issues clients report may be associated with marginalization or some form of disenfranchisement because of the identities they hold. Another result of my own privilege awareness has been increased transparency that I give to clients about the clinical process and the therapeutic relationship I am developing with them.

Positionality (Carmen Gray, she/they)

My awareness of both my privileged and marginalized identities have heavily influenced and shaped who I am as a clinician. I identify as a Black, Queer, able-bodied, masculine-presenting cisgender woman from a southern, Christian, middle-class upbringing. I am also an English-speaking American who has had the privilege of pursuing higher education and earning a graduate degree. As a feminist informed contextual family therapist, recognizing power structures and how they affect me and my clients is essential to understanding my clients' full context, and it gives me the information I need in order to help my clients develop ethical and just intra and interpersonal relationships.

My experience with privilege awareness has shown me that on an individual level, power dynamics shift depending on who is in the room and what identities they carry. Whenever I happen to be the most powerful in a space, my goal is to consider issues of access to avoid othering, and delegate power to those sharing the space with me to close the power differential and make our interactions

more equitable and collaborative when possible. I understand that privilege awareness is a continual process, and I hope to continue growing and broadening my approach as my awareness on this topic expands.

Model Application (Carmen Gray, she/they)

Domain 1

Growing up Black in the South, I became aware of differing cultures based on race and ethnicity quite young. My mother hails from Tuskegee, Alabama, a predominately Black town, home to Tuskegee University, one of the country's most prominent historically Black universities, where her parents met and graduated. Because of this, her Blackness was something that she was taught to love and revere. She and my father passed along that sense of racial pride in me and my brothers by surrounding us in our culture. From the church we attended to the organizations we joined, my parents were intentional about affirming our racial identity by putting us in spaces that were created to center and celebrate Black culture.

However, they also made it a point to educate my siblings and me about the different standards held for us and our white counterparts. The schools I attended as a child had mixed racial demographics including Black, Latino, Asian, and white students, but were largely staffed and led by white teachers and administrators. Because of this power dynamic, my mother made sure I understood that I could not “do everything they [white children] do” at school because my actions would not be given the same benefit of the doubt. Knowing that there were different expectations for me did not make me think white culture was superior or that my own was second-rate. Although, it did make me question what cultural messages white people received about their identity that led to this double standard. I also wondered how other people of color fit into the picture. The power dynamic between Black culture and white culture was always clearly laid out and defined, but there was little discussion about people who did not identify with either of these cultures. Not knowing much about these other cultures pushed me to ask more questions to explore what made them different.

Domain 2

Since I understood that my culture was not the dominant culture in America, and I was constantly exposed to mainstream white society through media and education from an early age, I never really questioned whether other cultures were legitimate. Other cultures simply existed like mine did. I understood what made my culture unique and worth celebrating as a Black person, so I figured this extended to other cultures as well. Plus, as a descendent of the African diaspora I would never deny people from other cultures their traditions to try and get them to conform to mine because I know what it is like to feel as if part of your history, customs, and language is lost due to assimilation.

Domain 3

I did not begin to really understand my privileged identities until I attended college and began meeting people from differing backgrounds. I saw how my class, education, religion, citizen

status, able-bodiedness, and cisgender identities gave me access to things or simply allowed me to avoid feeling othered in certain situations. My first major realizations about my privilege happened with class. While my family was not very wealthy, I was able to be comfortable and not worry about things like school supplies, food, clothes, or any other necessities because I knew I could count on my family to help me when I needed them. In theory, I knew that people struggled more financially than my family did, but I never really occupied the same spaces as people who experienced poverty until college. I met students who were working three jobs to make ends meet, getting emergency food from food banks, and struggling with how to pay rent or their tuition. I saw the stress that they were under and thought about how that affected their performance in class. College was already hard without having to worry about having your basic needs met.

From that point on, I started noticing other issues concerning access. During my undergraduate years, transgender and non-binary rights were becoming more of a national conversation. As a resident assistant working in housing, I saw how transgender students were treated when it came to room assignments which were based on sex and not gender identity. This was especially problematic in the community style residence halls where students could be discriminated against for choosing the bathroom that matched their gender identity. I also became very aware of my able-bodiedness in college because I had a friend who used a wheelchair as his primary means of travel. I did not consider how different it was for him to navigate the world until I saw him take an alternate route to our destination or not go at all because the space was wheelchair inaccessible. Before I became friends with him, I did not think of how exclusionary the world could be when it came to physical spaces and structures or even how temporary the state of able-bodiedness is.

After having these realizations about my privileges, I noticed the recurring theme of access being the issue for all these situations. It made me think about what I could do to address these access inequalities because I saw how much it affected people's quality of life. My sense of empathy was triggered because while I may not have known what it was like to struggle with finances, being misgendered, or mobility issues I knew what it felt like to be excluded because of the other marginalized identities I had. These realizations caused a real shift in my life because I recognized that even though I was only an individual there were things I could do to help balance the scales. I made the choice to actively invest my time and effort to shift the culture by joining political advocacy groups and volunteer organizations that focused on addressing accessibility issues in their many forms. My realizations were also what led to me to choose to become a marriage and family therapist over other mental health fields. I valued the focus that marriage and family therapists (MFT) put on systems in both the family and broader social context which would allow me to address issues of power, privilege, and oppression as a part of the therapeutic process.

Developing A Power-Sensitive Clinical Identity

As I mentioned before, I was drawn to MFT because I wanted to address issues of privilege and oppression in my therapeutic practice, so I sought out a master's program that offered a social

justice-oriented experience. I received my training as an MFT in a rural mountain town in western North Carolina. My clinical internship was at a local community mental health center working with a population that was largely white, heterosexual, less formally educated, and from a lower socioeconomic status. Because I have a mixture of privileged and marginalized identities, my development of a power-sensitive clinical identity was and still is an interesting balancing act.

In my experience at my master's internship, I found that I need to leverage my privileged and marginalized identities differently depending on the identities of my clients when developing a therapeutic relationship. For example, if I have white or male clients who question my authority as the professional in the room based on my race and/or gender, then I must lean into my educational background to address the behavior and even out the power differential. When I am working with clients who are Black or another person of color, I do not have to use my education as a tool to garner respect nearly as often. Usually, I am more concerned with delegating power and making sure that they understand that our relationship is collaborative, so they are comfortable opening-up to me. Regarding accessibility of services, I try to meet each individual clients' needs as best as I can. I recognize that it is my responsibility to remove as many barriers as possible that are within my power, so I adjust things like my language, interventions, cost, and availability to meet my clients where they are.

Training Implications

The model can be utilized in clinical training programs, especially in courses where multicultural competencies and multicultural humility is developed, and in clinical supervision. Faculty and supervisors can assess to what degree students and clinicians have self-confronted their own privileged identities. Additionally, faculty and supervisors should be conscious of the influence marginalization has on clinicians. It is possible that the experience of oppression results in meaning making for privilege that is very different than individuals who have experienced little to no identity-based discrimination.

Conclusion

The model proposed here is based on a small base of clinically focused literature. More research is needed in this area to better understand this developmental process. The argument that this process improves therapeutic outcomes is based on theory and clinician self-report. The PAM model here outlined provides the field of CFT with a map for clinicians, clinical training faculty, and supervisors interested in the work of privilege awareness. Research suggests the privilege awareness process influences the therapeutic approach for clinicians in ways that increase multicultural competency in positive ways. This model aids in the facilitation of that awareness raising and should be as accessible as possible.

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COLLABORATIVE POSITIVE INTERVENTION IN AN INPATIENT SETTING: A CASE STUDY

ALEJANDRA SANCHEZ, MA
William James College

Abstract

This article entails a case study of integrating Positive Psychology theoretically framed interventions to a non-binary white adolescent with chronic suicidality in an inpatient setting. The article follows the clinicians first-hand experience of developing and implementing collaborative positive interventions as well as the learning process of both the clinician and patient on how effective treatment can present. The step by step incorporation of Martin Seligman's Positive Psychology concepts including PERMA to clinical treatment is highlighted throughout the case study. Patient feedback and shift in symptom presentation is included to note the likelihood of the treatment efficacy. Barriers to treatment due to setting is addressed and exploration into how future studies can explore these barriers as well as considerations for how to work around such limitations. The clinician's reflections regarding the implementation process as well as take away learning points are included to serve as an example of how strength's based relational interventions impact therapeutic relationships and result in shifts of patient autonomy, motivation, and engagement.

After approximately two years into the COVID-19 Pandemic as a Clinical Psychology Psy.D. student, it had become apparent through my clinical training that my priorities as a clinician had transitioned towards one of treating children and adolescents who were in chronic states of traumatic stress and presenting with increasing suicidal ideation. As a psychology extern at child and adolescent inpatient units in the Greater Boston Area for the past two years, I had grown accustomed to adolescents presenting with depression, suicidality, and self-harm that they reported were exacerbated by the pandemic through the real and perceived loss of hobbies, friends, and socialization with others. So when I was assigned by my professors during my Spring Semester of 2022 to select a patient in which I could create a treatment plan and implement a course of treatment utilizing a Positive Psychology theoretical framework and interventions, I was highly skeptical of the likelihood of meaningful outcomes.

When the time came for me to select which of my individual patients I would create the treatment plan for, I gravitated towards the patient that I felt the most stuck with. I had spent a little more than 6 months treating this patient, dedicated the majority of my supervision time to discussing them, and still felt just as lost regarding treatment trajectory as I had the first day I met with them. For the purpose of this article and to maintain patient confidentiality, I will refer to my patient as M. M was an 18 year old non-binary (they/them) adolescent who had a longstanding history of frequent inpatient unit admittance since they were 13 years old. After the pandemic began, M was psychiatrically admitted in May 2020 and later transferred to a long term inpatient unit, where I worked together with them. M's presentation included chronic suicidal ideation and suicidal gestures including significant self-harm and multiple attempts of self-strangulation. Throughout the year long hospitalization prior to my work with M, their presentation had remained acutely suicidal and at high risk for suicidal behaviors, requiring one-to-one monitoring and multiple clothing and item restrictions for months at a time.

Upon starting our therapeutic relationship, my naïve confidence as a fourth year doctoral student who was envisioning a career of specializing in treating high-risk adolescents was quickly challenged. M presented highly treatment resistant for our first two months of meeting for individual sessions. I processed my failures endlessly through consultation and supervision, and found myself feeling helpless, unintelligent, and lost. My countertransference and perception that I could provide no help to M, and that they required clinical expertise far greater than I had acquired in my training, began to make me wonder how M must have perceived themselves, as possibly someone who was beyond helping and lost. Therefore, after six months of working individually with M, and still not yet having a clear picture of what intervention style fit their needs best, I jumped at the opportunity to incorporate Positive Psychology into our work together.

When I presented the possibility of integrating Positive Psychology Interventions into our individual sessions, M presented excited and engaged for the first time and expressed a strong desire to move away from processing their suicidality. M began to speak about how treatment had “always” focused on processing their self-harm and that treatment was often oriented towards chain analyses of past experiences of suicidal ideation and assessing current risk. I noticed that M's treatment thus far hadn't addressed ways to live a life above zero, a concept from Seligman's Theory of Well-Being that I incorporated throughout our intervention. (Seligman, 2011). I began the Positive Psychology intervention by asking C if they wanted to start focusing treatment on ways to live a life above zero. I used this wording as a way to describe the overarching theme of Positive Psychology and as an introduction to what our intervention will be focused on.

After I posed this question to M, they responded by saying that having something to look forward to would give them a break from having to constantly think about their depression and suicidal urges. M and I worked collaboratively to find out ways we can focus on the flourishing aspect of life and in a future oriented manner, instead of hyper focusing on decreasing their pain and suffering. I began by introducing Well-Being Theory and together we discussed what a

strengths-based intervention might entail. We discussed how often times treatment focuses on labeling and identifying problems or symptoms. We further explored how this labeling can overcome a client, and through this totalizing experience, they lose sight of where the label ends and the human self begins. I introduced the concept of positive labeling to M, explaining that it can serve as a motivator to shift how people perceive themselves (Niemic, 2018). Together we practiced strength-spotting, by noticing and labeling character strengths in each other. I knew from their large pile of once used yet forgotten art supplies, M was creative and loved using their imagination to create art. M showed some discomfort when I strength spotted this skill of theirs because they perceived it as a compliment. However, despite the discomfort, they agreed with me. This response led me to incorporate the intervention to focus on the empirically supported elements of PERMA. I described to M that the construct of well-being required five measurable elements: positive emotion, engagement, relationships, meaning, and accomplishment (Niemic, 2018).

After reviewing aspects of PERMA together, M expressed that creating art brought about Positive Emotion. At the time, M was only able to draw a connection between positive emotion and art and we were willing to explore together how our art activities may foster more connections to the other elements of PERMA. I gave M the opportunity to choose an activity and they described wanting to create their own sneakers, by drawing designs on white Vans that they had. During the first week of practicing the intervention, there became an apparent behavioral shift in M, yet I felt our discussions in session were still lacking content. M began to wake up early for school every day of the week, perform their ADLS, attend school, and return to the unit asking to meet with me so that we can continue to work on the sneakers. They gradually began to eat more consistently throughout the day and treatment members noted that this shift was strongly correlated to their engagement in our art activity. Most specifically, a clinical social worker stated that M had shared their intentions to eat in order to increase their energy so that they may be awake and able to engage in our art sessions in the late afternoon. M also connected that their increased eating came with greater ease than in the past because they were socializing with others about art or interests during meal times which shifted their mind from perseverating on calories and the amount of food they were consuming.

However, during our sessions, M would often remain quiet and focus on the art without connecting their experience verbally to PERMA or Positive Psychology and I wasn't getting much feedback around how the intervention was working from their perspective. To address this unknowing, I gave M an open ended question of what they would like to do after the sneakers are finished. They described a recent reconnection with an old friend and a desire to create 4 portraits of their friend to give as a gift. This prompted our discussion around the relationships element of PERMA and further rooted our intervention in an empirically supported practice that doing a kindness to others produces the single most reliable momentary increase in well-being than any exercise tested (Seligman, 2011). Throughout approximately 9 consistent sessions, M and I continued to create art and discuss how the intervention impacted M's well-being. At this point,

M's restrictions on the unit lessened and they reached a great accomplishment of being safe enough to be allowed to go on walks with family members off the unit and outside of the hospital grounds. Through supervision, I was able to process how the relational nature of our work and the collaborative standpoint that I took fostered self-confidence that M might not have experienced before. I further understood that this relational experience did not always contain verbal discussion in sessions. M's ability to utilize their strength by connecting to peers on the unit through their art was a strong example of how the process of our sessions promoted their confidence to connect with others outside of session.

However, there are notable drawbacks to implementing such interventions in an inpatient setting. The systemic barriers of a highly restrictive hospital setting were apparent in each session. For example, requirements ranged from which type of paintbrushes were used to ensure that no "sharp" object was admitted to only having 30 minutes or sometimes less to meet for session due to the highly structured nature of the unit's schedule. Specifically for high-risk cases such as M, it was difficult to shift to a strength-based mind set when they have experienced years of inpatient level of care, and consistent messages from clinicians that they were not safe enough to return home. To me, a large part of the positive intervention focused on the shared experience of collaborating on a strength and giving the patient a voice to express their thoughts and contribute as an equal part to that collaboration. Therefore, it was a conflicting message to encourage autonomy yet simultaneously have to deny M multiple different art modalities that they were interested in because of the hospital safety precautions. For future implementations, I find it necessary to compensate for aspects of the intervention that cannot be designed to the patient's desires by validating those frustrations and seeking alternative ways that the patient's voice can be heard.

Overall, M and I learned a lot about Positive Psychology together. I learned that giving M's decision making freedom over our activity allowed them to embrace their autonomy and further bolstered their confidence to design something they were passionate about. I also learned of the distinction between this personal autonomy and collaboration, and how being figuratively and literally side by side with M highlighted the importance of their role in treatment. M and I explored the efficacy of this approach and how the positive interventions took away their perceived pressures of being "tested" on the application of intervention skills, a stress they often felt with Dialectical Behavioral Therapy.

M learned of the different PERMA elements and further connected how PERMA can be translated into other activities they engage with. I think this new experience for M and myself taught us both that interventions aren't required to follow a scripted manual and we were able to witness over time how consistent application of a strengths-based intervention gradually impacted one's presentation. Also, M and I appreciated that using the activity as a sort of time keeper allowed us to look back after an activity was finished and see how much they have accomplished since the beginning of the project. While M and I continued to work individually together through

my training year, we incorporated art into all of our sessions, and created a list of individuals to whom M plans to gift their art. During our termination sessions, and as I transitioned out of the training year, M and I were able to reflect on their flourishing process and how both our perceptions of treatment modality efficacy drastically shifted towards one of a collaborative and relational nature.

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PEER CONSULTATION GROUPS: THE FUTURE OF CONTINUING EDUCATION?

JEREMIAH GIBSON, MMFT

Editorial Team – New England Journal of Relational and Systemic Practice

An ongoing requirement for mental health clinicians is to receive continuing education. The American Association for Marriage and Family Therapy, like many professional organizations, includes this as an expectation in their codes of ethics: “Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.” (AAMFT, 2015). In this paper, “continuing education” speaks to the accrual of ongoing education, training, and/or supervised experience.

Mental health clinicians are by no means the only profession that requires continuing education. The systems and constituents that many professions serve evolve over time, and new short-term and longitudinal research studies provide feedback as to how to most effectively meet the needs of consumers. Continuing education requirements invite professionals to hone their skills, adapt to the needs of clientele, and reflect on how professional work impacts the professional individual and community at large.

The Oversight of Continuing Education

Continuing education is one of many strategies by which the public are protected from receiving services from ill-prepared, uninformed, and/or unethical individuals and companies. In the United States, the oversight of professional development, which includes regulations, consumer protection practices, and continuing education requirements, happens on a state level. Massachusetts professions are shepherded by the Division of Occupational Licensure, “an agency within the Office of Consumer Affairs and Business Regulation, is responsible for oversight of 32 boards of registration.” (Commonwealth of Massachusetts, 2022). These 32 boards of registration are responsible for providing licensure—an educational and occupational process by which individuals are deemed to be effective for serving the public—and regulatory standards for almost 600,000 professionals in over 150 professions in our state.

One of the 32 boards of registration is the Board of Registration of Allied Mental Health and Human Services Professionals, which oversees regulations for marriage and family therapists, mental health counselors, behavioral analysts, educational psychologists, and rehabilitation counselors. (Note: On January 1, 2023, the Board of Allied Mental Health will be overseen by the Department of Public Health.)

The development of a bureaucratic system to oversee licensure requirements created a marketplace for individuals and businesses to administer continuing education; these individuals and businesses, as a representation of the capitalistic elements of continuing education, are referred to as “vendors”. Vendors submit outlines of continuing education programs to bureaucratically-approved oversight organizations (NEAFAST for licensed marriage and family therapists) to vet and ensure that the content of said continuing education events match the standards for best practices of the profession that the oversight organization serves. In general, there are four types of vendors.

For some context, in 1994 the Board of Allied Mental Health enlisted the help of separate entities that would be responsible for certifying continuing education activities acceptable to meet license renewal requirements, which included that LMFTs and LMHCs receive 30 hours of continuing education every two years. The Massachusetts Association for Marriage & Family Therapy was chosen as the entity for MFT’s. MAMFT published a request for proposals to subcontract the administration of its CE program. FDA/CE Certifications, directed by Michael Vickers was chosen by MAMFT to design and implement the CE program. In December 2018, upon the retirement of Michael Vickers, the Board of Registration directly authorized the New England Association for Family and Systemic Therapy, NEAFAST, the successor organization to MAMFT, to continue its LMFT certification program.

NEAFAST chose to continue the same regulatory guidelines that FDA/CE had proposed, including the criteria for approving continuing education programs, forms for CE vendors to apply for approved CEs for LMFTs, and processes for granting CE credits to participants (Gibson & Kobel, 2018).

NEAFAST evaluates continuing education programs along the rubric of three content categories and its connectedness to the practice of family and systemic therapy:

- 1) Professional practice activities, education events that engage within the legal, economic, regulatory environments, as well as self-of-therapist exploration.
- 2) Family and systemic therapy activities, which includes education that addresses the methods, theory, research, training, and supervision of couples, family, and systemic therapy.
- 3) Other relevant clinical activities. This includes a wide diversity of specific content areas, such as mood disorders, anxiety and PTSD, and a host of family and relational processes.

In order to meet the variety of professional needs of marriage and family therapists, including the acknowledgment that many MFTs in our state work largely and specifically with individuals, these three categories are broadly and loosely defined.

NEAFAST has developed processes to meet the standard established by the Board of Allied Mental Health, which is similar to most statewide regulatory boards. We are collaborating with more vendors to ensure that a wider variety of continuing education options are approved for LMFTs in Massachusetts, as shown by our quantitative and financial growth of our continuing education program in 2022.

But are we, or any of the thousands of organizations in our position, actually enhancing the practice of family and systemic psychotherapy with our current continuing education structures?

How do we know that continuing education is effective, both for the development of the professional and, more importantly, for the complex needs of the families and systems that we serve?

Do our current continuing education structures meet these needs? And if not, what are characteristics of continuing education programs that lead to second-order change: in the case of our profession, the ability for clinicians to ethically and effectively implement the materials they learn into their therapeutic practice?

What is Effective Continuing Education?

There are a myriad of theories that describe factors to effective continuing education. For instance, Chickering and Gamson (1987) propose seven features of effective learning, including encouraging collaboration between students, giving meaningful and timely feedback, and communicating high expectations. Ajzen (1991) and Sniehotta (2009) describe the theory of planned behavior as a way to assess intentions, attitudes and bias, and perceived behavioral control of the learner. According to this theory, an effective educational event would enhance positive attitudes toward the subject matter, the ethical implementation of the skills learned within the professional practice, and the overall process of learning and continuing education and implementing, as well as a subjective feeling of mastery of content. Michie, van Stralen, and West (2011) designed the behavioral change wheel, which suggests that capability, the “psychological and physical capacity to engage in the activity concerned”, and opportunity impact motivation, which leads to behavioral change, creating a feedback loop where the behavioral change leads to more capability, motivation, and opportunity.

Assessing the effectiveness of continuing education is complicated research; while educational theories are important, there are numerous variables that might disrupt the data, including, but

not limited to the stage of professional development of the learner, the financial and temporal limitations of the learner, and the numerous ways that a learner may integrate new information into their larger body of knowledge.

Louise Forsetlund and colleagues (2021) evaluated 200 worldwide studies, involving over 28,000 healthcare professionals, that discuss the effectiveness of continuing education programs. These programs had a high variety in terms of content, number of participants, length and frequency of meetings, the type of interaction between educator and learner, and education practices. The studies in the literature review also communicated a high variance in effectiveness. They suggest the following:

- 1) Continuing education programs that have strictly didactic practices, where there's a clear delineation between presenter (or lecturer) and learner, are typically not effective.
- 2) One-time educational meetings are unlikely to improve practice for "highly complex behaviors"; the utilization of systems theory into our psychotherapeutic perspective automatically adds complexity to our work.
- 3) Programs that have fewer participants, more sessions over a longer duration of time, a shorter time for follow-up may have larger effects.
- 4) Experiential trainings, where learning objectives and interventions are practiced as part of the learning experience, may have larger effects.

One of the primary sources that Forsetlund and colleagues use is Mansouri and Lockyer's 2007 evaluation of continuing education in medical professions, which used a similar process as Forsetlund, but had fewer studies. Mansouri and Lockyer categorized continuing education events by type of education event (workshop, lecture, small group activity, etc.), participant numbers, length, both of the continuing education event and the time between events, and the number of sessions. They assessed for three markers of success: physician knowledge, physician performance, and patient outcome. They determined:

- 1) Case-based training, long-term workshops where the content progresses over the duration, and interactive small groups have the highest success rate, while auditing, workshops, and detailed comments in written feedback, had the lowest success rate.
- 2) The only successful strategy that improved physician performance was individual training; NEAFAST will produce an entirely separate article about the necessity for better supervision practices in a future journal issue.
- 3) Interactive small groups were the only continuing education model that improved patient outcome.

How can NEAFAST use this research to design continuing education for the psychotherapy community in New England that leads to more effective learning experiences?

Peer Consultation Groups: The Future of Continuing Education

Assessing ongoing therapist competency is a challenging process. While we are grateful for the existence of regulatory boards, especially as they protect the public from people unethically practicing therapy, the quantification of biannual continuing education hours (30 CEs every two years for LMFTs in Massachusetts) has created an industry that's invested in producing a high volume of continuing education events, often with characteristics that the research suggests doesn't lead to effective outcomes, such as one-time, 1-3 hour training events, didactic learning, large audiences, and minimal followup. Evaluation forms commonly assess the performance of the presenter at the expense of exploring how the learner might implement the educational experience into their ongoing practice. These characteristics reinforce the power differential between educator and learner; virtual platforms have contributed to the likelihood of the disengaged learner.

NEAFAST is responsible not just for ensuring that the continuing education programs submitted to us meet appropriate content standards; we are also responsible to develop continuing education that is informed by research, which suggests that small groups meeting over extended amounts of time and discussing, in an egalitarian manner, the intricacies and challenges of our profession, are the most effective strategies. NEAFAST has revamped its mission statement to reflect this position: *NEAFAST provides stewardship for the art and science of systemic psychotherapy practice in New England by investing in supportive creative programming using collaborative platforms for cooperative grassroots professional development.*

While at this stage we cannot inform regulatory standards, we can begin to explore alternative designs that are informed by research, as well as by the interest of practitioners.

In good news, these systems already exist: peer consultation groups, defined by Miu, et al (2022) as goal directed group of professionals that “receive guidance on problematic cases, discuss ethical and professional issues, and process countertransference concerns” were a much more common form of continuing education (Miu, et al, 2022).

Quite a bit has been written about the effectiveness of peer consultation groups. Nobler (1980) writes that peer consultation groups have similar developments as therapy groups, moving from discomfort and uncertainty about the function and role of the group, to a greater willingness to take risks, and ultimately, a greater sense of intimacy. Counselman and Weber (2004) define ten important characteristics of effective peer consultation groups:

- 1) The tasks of leadership are shared, so that everyone has equal responsibility for the group.
 - 2) A directional, goal-oriented focus that finds the balance that focuses as equally as possible content and process.
 - 3) A clear contract of expectations, understood by all participants, and a discussion about
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contract violations

4) A culture of respect, openness, and curiosity that capably addresses emotional processes around shame, competition, avoidance, and aggressiveness.

5) Attendance to present, in-the-moment responses and interactions.

In the last two years, NEAFAST has developed three peer support groups—Moving Toward Antiracism, Next Steps Toward Antiracism, and Stop, Breathe, Write. However, these groups have addressed exclusively to self-of-therapist and self-care issues.

In 2023, NEAFAST will add two six-month peer consultation groups as continuing education programs to join our Moving Toward Antiracism groups. These groups will be closed, semi-structured, content and process-oriented, and ongoing, and will offer continuing education units for participants.

Couples Therapy 101, facilitated by Jeremiah Gibson, LMFT, will explore Karl Tomm's *Patterns in Interpersonal Interactions* as a strategy to help couples therapists focus exclusively on the process of the relational dynamic. Participants will learn from the wisdom of Tomm and his collaborators at the Calgary Family Therapy Centre, the experiences of each participant in practicing the model in the consultation group, and case studies that participants process with the group.

Family Therapy with Young Children, facilitated by Howard Wolfe, LMFT, will intersect the work of Rudolf Dreikurs, rooted in Adlerian Family Therapy, with Stanley Greenspan's *Floortime Approach*. Participants will be invited to share cases that encourage learners to invite parents and others in adult subsystems to be agents of change through their transmission of values, and explore transference and countertransference issues that arise throughout the family therapy process.

The leadership team of Skeetz Edinger, Ike Gallinsky, Miranda Hughes, Katherine Manners, David Wood have met with me and Howard for the last several months to discuss how NEAFAST can develop processes for peer consultation groups to be successful, with this research in mind. We are eager to write more about how these structures and future peer consultation groups can help therapists engage in their professional development in a more holistic way so that we can have a deeper understanding of how to navigate the complex systems that we address in systems therapy, explore self-of-therapist issues and biases in safe, supportive structures, and build more collaborative relationships with other professionals and, most importantly, the populations we serve.

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