



INTRODUCTION TO **FAMILY COUNSELING**

A Case Study Approach

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CHAPTER 10



The Counselor's Experience Working With Families

The majority of this family counseling textbook has focused on the clients who seek family counseling. But what about the family counselors who work with them? Family counselors are also people who participate in relationships with their clients. Family counselors have feelings about their clients, themselves in relationship to their clients, what is happening in their personal and professional lives in addition to counseling a particular family, and the work of family counseling. Family counselors work with multiple clients, have lives and demands made upon them outside of work, and need to find balance between their professional and personal selves as well as practice the self-care necessary to function in multiple settings and avoid unethical behaviors associated with burnout.

In this chapter, we examine what it is like to work with families and what family counselors need to do for themselves in order to work effectively and professionally. This chapter is in no way exhaustive of the topic. Like the rest of this book, it is intended to provide you with an introduction to the concepts, practices, and experiences of family counselors.

THE POWER OF FAMILY SYSTEMS

Just as the family as a system is more powerful than its individual members, so the family system is more powerful than the family counselor as an individual. Some family counselors approach families from a theoretical perspective that views the family counselor as expert authority (Haley, 1963). The family counselor as

expert helps level the playing field when working with a family. Other family counselors embrace a one-down position, using their position to build a healing relationship with the client family and empower its members to participate in their own growth and change (Napier & Whitaker, 1978). Still others view the relationship collaboratively, despite the power of the family system over any one individual including the counselor (Dulwich Centre, 2015).

Whatever theoretical model informs your work as a family counselor, it remains important to be respectful of the power of the family system. As an entity that is greater than the sum of its parts, the family system can be conceptualized as existing somewhat independently of its individual members. Thus, the family counselor's relationships with individual members are insufficient to address the family counselor's relationship with the family as a whole.

Additionally, as we have seen in Chapter 4, family systems strive to maintain equilibrium. So, as unhappy as members may be, change risks destabilizing that equilibrium and members also tend to fear the consequences. Sometimes, in fact, the consequences are devastating. Often, however, they are not, and the fear of change is far worse than the consequences of the change. Working with individuals, a counselor can explain this phenomenon and examine the client's specific fears about changing. The dynamics of the family are usually outside family members' awareness and therefore more difficult to address with them. Yet, as with individuals, nothing will be revealed that wasn't there already. It is simply a matter of making the covert overt (Sager, 1981) and dealing with it so that it stops interfering with both individual and family functioning.

Since this is an abstract way of viewing the family, let us examine a specific example from the Manning-Kelly and Jones families. In Chapter 6, you read transcripts from their first two family counseling sessions. You read about the repetitive arguments between Christina and her mother, Liz, in the first session and saw a glimpse of the repetitive argument between her mother and father, Martin, in the transcript of the second session. These two arguments, being repetitive, are part of the family dynamics, locking members into particular roles. As suggested in Chapter 1, Christina may not be able to decide what she wants to do after high school until she no longer has to defend what may have started as one of several possibilities and then congealed through her response to her mother's response into her position. Similarly, these repetitive fights isolate Liz, because while Christina is supported by her father, stepmother, and to some extent her brother Martin Jr., Liz has no one. Her husband, Mark, is emotionally distant from the family and acknowledges he does not become involved in the specifics of parenting Liz's children. It was not until the family counselor was willing to challenge the effect of the family dynamics that isolate Liz that these two arguments could begin to change.

When the family counselor pointed out Liz's isolation, she was bringing the family dynamics from a covert, unacknowledged position to an overt one that could no longer be ignored (Sager, 1981).

The Manning-Kelly family also illustrates how a family life cycle event can threaten a family system's equilibrium. Christina is preparing to be launched into adulthood, and that change alone will alter the family system. In this case, the repetitive argument between Liz and Christina, like Liz's overinvolvement with Emma's disability, keeps Liz focused away from her husband's drinking and distance. Perhaps the family system is subtly encouraging Christina not to leave, because leaving would result in Emma's development being even more impeded by the family system's need to keep children dependent on Liz so Liz will not confront Mark about his drinking and disengagement from her and the family. In a family in which the marital subsystem is strong, young adult children leaving home may be sad and yet is not threatening to the family system. It is only when children distract their parents from problems within their couple subsystem that family life cycle changes are threatening.

It is not uncommon for repetitive arguments such as those in the Manning-Kelly and Jones families to continue despite the family counselor's intervention. The family system requires members to function in a way that maintains its equilibrium. Additionally, the family is, by definition, stronger than the individual members or the family counselor. Thus, the logic that no one likes the argument is insufficient to stop it. So is suggesting various alternatives to arguing. In sum, it is incredibly difficult for families to change their dynamics, because the system will strive to maintain equilibrium and is also greater than the individuals who comprise it and wish to change it. Family counselors must be able to tolerate frustration and uncertainty about when and under what circumstances the family will be willing to risk disequilibrium in order to attain a new way of interacting. This tolerance for frustration and uncertainty rarely is natural and must be cultivated by the family counselor.

HOW FAMILIES INDUCE FAMILY COUNSELORS INTO THE FAMILY SYSTEM

Because family members usually become used to their distress and on some level accept it as the price they pay for the security of the family system's equilibrium, they not only may be reluctant to change but also feel threatened by the family counselor's attempts to help them change. In other words, the family system may be highly motivated to induce the family counselor into itself so

that she or he will refrain from efforts to place it in disequilibrium. There is usually pressure, often subtle, on the family counselor to accept the status quo even as the family asks the counselor for help changing.

The Manning-Kelly and Jones families provide an excellent example of this phenomenon. Liz was convinced of two things: (1) Christina's eating and cutting behaviors were not as severe as the primary care physician believed them to be, and (2) it was crucial for Christina's future that she first visit and then apply to college for the fall following high school graduation. Christina and the rest of the family agreed with Liz's first belief. However, Christina was as convinced that she needed to experience life, work, and prepare for her role as a stay-at-home mother instead of going directly to college as Liz was that such a course of action would ruin her life. While the family counselor viewed the family's dynamics as the focus for change, the family members would have preferred that she accepted their view that Christina was fine and take sides in the conflict between Liz and Christina about Christina's immediate future. The pull on the family counselor was powerful, and yet succumbing to it would have undermined family counseling by taking the counselor's focus off of changing the family dynamics.

One of the challenges family counselors face is how to decline pressure to be induced into the family system without denying the family's members' reality. If the family counselor ignores the experiences of the individual family members, she or he risks leaving them feeling unheard and, as a result, mistrustful of the family counselor. Unfortunately, there is no simple solution to recommend. At best, family counselors must be alert to both the family system dynamics and the need to empathize with each family member. Unfortunately, the pressure to maintain the family system's equilibrium sometimes undermines family counseling. Inducing the family counselor into the family system is an effective mechanism to protect the system from the disequilibrium that accompanies change while also undermining the desire for change that brought the family to counseling.

An example of induction into the family system involves pressure on the family counselor to agree that the presenting problem resides in the identified patient rather than the family system. Had the family counselor agreed that Christina's eating and cutting disorders or her refusal to explore college as an option for the fall following high school graduation was the problem, there would have been no threat to the equilibrium of the family system. However, by hypothesizing that the family dynamics aimed at avoiding the distress in Liz and Mark's marriage were the true problem, the family counselor threatened the family's equilibrium by engaging in techniques aimed at redefining and addressing the family dynamics. Transcripts in Part II of this book illustrate this point, as do arguments between Liz and the family counselor later in this chapter.

STOP AND THINK:

1. Find specific examples of how the Manning-Kelly and Jones families attempted to engage the family counselor in their view that Christina, the identified patient, was the problem.
2. How, specifically, did the family attempt to induce the family counselor to accept their view?
3. How might you handle the temptation to take sides in the family's situation?

MANAGING MULTIPLE RELATIONSHIPS

When doing individual counseling, there is one relationship to attend to during sessions, the one between the client and the counselor. When doing family counseling, there are multiple relationships to attend to and manage. These include the relationship between the family counselor and each family member, the relationships among the family members with each other, the relationships both within and among various groups (spousal, sibling, parent-child) within the family and between each of these groups and the family counselor, and the relationship between the family as a whole and the family counselor. We have already discussed the power of the family system. In this section, you will become acquainted with the multiple relationships a family counselor must also manage.

Sometimes, these relationships conflict with one another. For example, as already described, the family system maintains its equilibrium by avoiding change, and so, while family members may be unhappy and turn to the counselor for help, the family as a whole may resist the family counselor's efforts to disrupt its equilibrium. Additionally, what is good for one family member may not be good for another member or for the family as a whole. In the Manning-Kelly family, for example, Christina's symptoms and Emma's dependency may both have masked the marital conflict between Liz and Mark and thus served a positive function of maintaining the family's equilibrium. However, anorexia, cutting, and age-inappropriate dependency are not beneficial to Christina and Emma as individuals.

How does a family counselor manage the multiple relationships, their complexity, and the conflicts among them? We have previously discussed this challenge in terms of the family counselor needing to avoid being induced into

the family and taking sides regarding the labeling of the identified patient. It is also important that the family counselor facilitate the family's ability to balance individual and group needs in a way that works best for the family and its members. This not only empowers the family but also allows for cultural and value differences between the family counselor and any particular family.

Even when knowledge of child abuse emerged, the family counselor did not decide what the family needed to do. She did, however, comply with the laws of the state in which she practiced, as specified in her intake forms and took the required step of reporting the abuse. Note that in carrying out her legal obligation, she offered the family options for how she would report the abuse, specifically whether she would report with or without the family present or they would report with her present. It was then up to state officials to decide what happened next.

Being human, family counselors are drawn to some people more than others. So of course we find ourselves sometimes drawn more to some members of a client family than to others. For example, the family counselor found Mark's distance from his family and irritability with her off-putting even before she learned he had been abusing Christina. She also liked Liz and empathized with the many ways she seemed stuck in her position and isolated from her family.

STOP AND THINK:

1. Have you ever read a book or seen a movie that, while well written, was full of characters you disliked? Did you finish reading the book or watching the movie? If you did, how did you cope with your dislike of the characters, and were you tempted to stop reading or watching at any point?
2. Which family member in the Manning-Kelly and Jones families do you feel most drawn to, and why?
3. To whom do you react the most negatively, and why?
4. What can a family counselor do when she or he likes and sympathizes with one family member more than others?
5. What can she or he do when she or he experiences a strong dislike of one of the family members?

Clients may find it difficult to trust someone who does not like them. Similarly, family counselors may find it difficult to do their best for people they dislike. It therefore becomes essential for family counselors to examine their

feelings, both positive and negative, about the members of client families. This involves the family counselor

1. being honest with herself or himself about what she or he likes and dislikes about each family member,
2. examining what those preferences say about her or him, and
3. asking herself or himself what she or he may be overlooking about each family member.

It may be helpful to remember that people tend to do the best they can, given who they are and their circumstances, so that you view characteristics or behaviors you dislike as genuine though ineffective attempts on the part of family members to be likable people.

Family counselors must also manage family members' behaviors toward one another. Some members talk for one another, others interrupt, and some are hostile and challenging to other family members and/or the family counselor.

STOP AND THINK:

1. How might a family counselor set limits on one family member's behavior without intimidating other family members who are behaving respectfully?
2. How might she or he avoid conveying judgment that a family member is rude or mean? In a role-play, practice setting these limits with another classmate.

Family counselors need to be self-aware in order to effectively manage the multiple relationships that the practice of family counseling involves. They need to recognize when they are feeling annoyed or judgmental and quickly soothe themselves. They need to remember that the family requires firm and respectfully conveyed limits from a caring family counselor, and that they are capable of providing that. They need to remind themselves that they can deal with their hurt or outrage or disgust or whatever other negative feelings may arise, though not during the session. This is very similar to what family counselors need to do when clients raise their personal issues:

1. Note it.
2. Avoid allowing it to leak into the work with the client family.
3. Deal with it outside of the time the counselor is working with the family.

As described in the section about avoiding induction into the family system, family counselors also need to avoid accepting the family's views about its members and instead form their own clinical impressions. It is tempting to see Christina's eating and cutting disorders or Liz's repetitious revisiting of the college discussion as the problems. However, viewing Christina as a self-harming and obstinate mess and her mother as a badgering nag would not have been conducive to effectively helping the family. Additionally, neither view was the entire story. What was relevant to the family counselor was that both Christina's and Liz's behaviors were ways of dealing with a family system dynamic that was not working for them as individuals or for the family as a whole, and that neither would be able to change her behavior until that dynamic was addressed. It was the family counselor's job to remind herself that the family had the potential to change in a way that would leave its members more likable.

Finally, one or more family members may remind the family counselor of someone she or he holds negative feelings about. Once again, self-awareness is key. The counselor can use her or his self-awareness to remind herself or himself that the client and the other person are not the same. The family counselor may need to remind herself or himself of this fact repeatedly during sessions.

COMFORT WITH DIVERSITY

STOP AND THINK:

1. What has your experience of diversity been?
2. Were you raised in a multicultural or homogenous community?
3. Were you raised in a multicultural family?
4. What were your parents' and grandparents' attitudes toward people who looked or behaved differently than they did?
5. If you are *not* a White, middle- or upper-class, Christian, straight male, how have you been treated by the dominant society with respect to your "deviant" characteristics (non-White, working poor or impoverished, non-Christian, female or transgendered, gay or lesbian or bisexual), and what are your feelings about that treatment?

6. If you *are* a White, middle- or upper-class Christian, straight male, how has your privileged position in the dominant culture affected how people treat you, and what are your feelings about that treatment?
7. How might your personal and family histories impact your experience working with families who do not share your demographic or cultural background?

Multicultural issues and the need for family counselors to be culturally competent were discussed in Chapter 9, and references were provided for students who wish to learn more about culturally competent counseling than is possible to address in an introductory textbook. This section of this chapter turns the focus to the person of the family counselor experiencing the practice of her or his profession.

Two situations come to mind. In the first, the family counselor is a member of the dominant culture. He has had no personal experience of being discriminated against and is aware that his situation reflects White privilege or freedom from being treated as less-than because of race, ethnicity, socioeconomic status, gender, religion, age, sexual preference, or other characteristics. White women share many of the privileges associated with being White, although there is variation based on other personal and familial characteristics, and both need to assume a non-White family has had a very different and less generally positive experience.

The second situation involves a family counselor of color working with families who are either White or of a different race or ethnicity than the counselor. Differences may include biracial or bicultural families, even though one of the races or cultures is the same as the counselor's.

Diller (2007) and Lum (2007) summarize various approaches to cultural competence, including the contributions of various mental health professions. Although there are many ways to conceptualize and label the essential skill set for culturally competent counseling practice, for purposes of introducing you to the topic, Diller's (2007, p.18) five cultural competent skill areas are included here. These are awareness and acceptance; self-awareness; dynamics of difference; knowledge of client's culture; and adaptation of skills. Awareness and acceptance involve being aware of, valuing, and creatively using cultural differences in one's counseling practice. Self-awareness requires counselors to recognize the potential impact of their own ethnicity and attitudes on their clients and actively working to mitigate it. Dynamics of difference

involves the family counselor being alert to potential miscommunication and misunderstanding because of the cultural differences between counselors and clients and using their clinical skills to resolve them as they arise. Knowledge of client's culture is self-evident. Culturally competent counselors seek information from experts, members of the particular culture, and clients themselves in order to more fully understand the client within her or his cultural context. Finally, adaptation of skills involves adapting counseling theory, assessment, and intervention to account for cultural differences and to more fully serve clients.

Clients differ dramatically in their level of acculturation to the dominant culture, as well as in the ways their own culture and interactions with members of the dominant culture have affected them. Thus, it is as culturally incompetent to apply a one-size-fits-all model to every member of any one cultural or racial group as it is to ignore the impact of culture on the client family. To practice ethically, family counselors need to recognize and respect the uniqueness of each client family and its members while remaining accepting of and adaptable to cultural differences.

Family counselors who are not part of the dominant, White culture are usually far more accustomed to adapting themselves to culturally different individuals, groups, and institutions than White family counselors are. The concept of White privilege specifically refers to the reality that Whites rarely think about racial issues, whereas non-Whites are confronted not only by racism but also by the need to adapt to the dominant culture in order to succeed in it. Thus, the challenges of practicing culturally competent counseling may differ for counselors of different races and ethnicities. Whatever an individual family counselor's challenges are, it remains imperative for her or him to learn to practice in a culturally competent manner.

Culturally competent family counselors also need to recognize the unique needs of bicultural, biracial, multicultural, and multiracial families. As noted in the previous chapter, Diller (2007) also pointed out that racial and ethnic tensions in the larger society are often played out within the family context, and children in biracial families such as the Manning-Kelly family face challenges that children in either Black or White families do not.

An example unrelated to the Manning-Kelly family involves one of the writers' experiences as a preschool teacher in a predominantly Native American prekindergarten setting. A member of the community told her that asking a direct question is indistinguishable from giving an order. Now, when working with Native American clients in her clinical practice, she is careful to word questions in a speculative and indirect manner.

EXPERIENCING THE FAMILY

We all grew up in families. Over the years, we have asked family counseling students to create a genogram (Chapter 3) for their own family. We have also asked family counseling students to apply some of the family concepts we discussed in lecture and this textbook, such as triangles and secrets, to their families. As family counselors learn during training and their work with families, every family has idiosyncrasies. Sometimes, families also exhibit serious dysfunction. It is important for family counselors to learn to distinguish between idiosyncrasy and dysfunction, both in the families with whom they work and in their own families.

Imagine for a moment that you have experienced conflict with your parents about your college major. They think you should choose a major that will prepare you for a high earning profession. You are taking a family counseling class, so unless you intend to use it in a medical school or legal practice, you are likely not headed for a large income. Because this hypothetical version of you has never felt that your family accepted or valued your career choice, you can easily empathize with Christina as her mother insists she choose the path that she, Liz, thinks is best for her, rather than the one she has chosen for herself. As the Manning-Kelly and Jones families' counselor, you would need to bear in mind that Liz is both isolated and defensive about her position that Christina should be preparing to apply to college in a few months, because as a young adult child who has felt the need to defend your right to choose a major and not empathize with your parents' fears for you it would be easy to overlook Liz's perspective. While avoiding empathizing with your own parents may be a coping tool in your interactions with them, avoiding empathizing with Liz would render you ineffective as a family counselor.

Bearing this distinction between your own family and your client families in mind requires you or anyone intending to practice family counseling to establish clear boundaries between your personal and professional lives. Further coursework and structured, frequent supervision during the early years of your work with families will facilitate the creation and maintenance of your boundaries. Additionally, you may decide to work with a counselor to be certain your own personal history does not interfere with your work as a counselor. When and how to decide whether any student of family counseling would benefit from seeking her or his own counseling is beyond the scope of this textbook. Your supervisor will be able to help you draw the line between supervision and your own counseling, and if your issues frequently cross it, that is an indication that going to counseling may be appropriate for you.

Returning to the Manning-Kelly and Jones families, think about what your own reactions might be if you were the family counselor in the following excerpt.

FC: So, Christina, it sounds as though it's important to you to take time after high school before going to college.

Liz: Are you telling her she doesn't need to go to college in the fall? Because it is way over the line for you to intrude in our lives in that way. I'm her mother, and I know what's best for her.

STOP AND THINK:

1. Was it predictable that Liz might view empathy for Christina as undermining her authority as Christina's mother? Explain your answer.
2. If Liz were to confront you and accuse you of undermining her mothering, how might you react? And how might you handle your reaction?

At this point, the family counselor could do one of several things: apologize to Liz, attempt to appease Liz, become defensive, address Liz's anger at her, or address the family dynamics evident in the exchange. We will continue this piece of the family counseling session in all five ways.

Scenario 1: Apologize to Liz

FC: Liz, I'm so sorry. I simply wanted to clarify that I'd heard what Christina said. The last thing in the world I want to do is undermine you.

Liz: Well, I want you to be clear with Christina that you don't support her.

Notice that the family counselor is now trapped. Telling Christina she does not support her is tantamount to saying she does not empathize with her. It will likely undermine any trust Christina has developed for the family counselor and thus the potential for effective intervention with Christina and her family in the future. Additionally, Liz now has the power to undermine the family counselor's interventions whenever she or the family system becomes uncomfortable.

Scenario 2: Appease Liz

FC: I was only clarifying and empathizing. That's my job, and I'm so sorry it upset you.

Liz: Well, I don't think Christina needs your empathy. What she needs is to listen.

Once again, the family counselor has trapped herself. For all practical purposes, she has agreed not to use empathy in her interactions with Christina. And without empathy, it may be difficult if not impossible for Christina to trust the family counselor. Additionally, the family counselor has aligned herself exclusively with Liz.

Scenario 3: Become defensive

FC: No, no. I'm not taking sides in this.

Liz: Really? Because it sounds as though you're telling her she doesn't have to go to college, and I don't appreciate that.

The family counselor has trapped herself for a third time. She now needs to convince Liz that her intention was not to disrupt the mother-daughter relationship, which would have been unethical, rather than continue her efforts to facilitate effective change in the relationship between Liz and Christina and in the family.

Scenario 4: Address Liz's anger at her

FC: You sound really angry at me, Liz, and I think it would be helpful for us to talk about it.

Remember, this is a family that avoids allowing conflict to continue until it resolves. One of the family counselor's goals is to demonstrate continuing conflict long enough to resolve it.

Liz: I'm not angry at you. I do think you should be more careful about your role here, though.

FC: Let's talk about that. When you say careful about my role here, I'm not sure exactly what you would like to be different. Please tell me what you'd like me to do differently.

Liz: I expect you to support my parenting, not undermine it. If you can't do that, then we can't keep seeing you.

FC: I wouldn't want it to come to you stopping counseling. My goal is to support everyone in the family. I'd like to let Christina know I've heard what she's saying while supporting you as her parent. Any suggestions about how I might do that?

Liz: You're the counselor. You tell me.

FC: Let's both think about it.

By avoiding arguing about whether Liz was angry and yet continuing to acknowledge there remained a problem to resolve, the family counselor was able to encourage Liz to engage with her in the process of resolving it. She also avoided becoming defensive in the face of Liz repeatedly challenging her. While they did not resolve their conflict, the family counselor communicated that she believed empathizing with Christina was not mutually exclusive with supporting Liz and modeled both empathetic listening and ways to proceed in the face of conflict. Both are positive; however, neither addresses family dynamics.

Scenario 5: Address the family dynamics

FC: Right now I'm feeling like I need to defend myself. And I'm curious whether that's how you all feel when the arguments about college begin. Martin Jr.?

MJ: Yeah, I guess.

Notice the difference in Scenario 5. In the first four scenarios, the family counselor was induced into the conflict between Liz and Christina. In the fifth, however, she used her experience of the family's attempt to induce her to address a dynamic she had not previously noticed. Liz did not interrupt, and the argument was deflected into the more productive focus on the family dynamic. We will return to how family counselors can use their experience of being induced into the family dynamic to change it later in this chapter.

If the family counselor had been re-experiencing her own conflict with her parents, she might have identified with Christina to the extent that she overlooked the possibility of Scenario 5. And this is the primary reason that, when families raise the family counselor's own issues, the family counselor needs to seek supervision or her own counseling so that her family issues do not interfere with her effectiveness while working with the family.

You may be thinking, most people would not be as hostile to an authority figure or someone from whom they have sought help, like a counselor, as Liz was in these scenarios. While many individuals may be hesitant to confront a counselor, some are quick to react, even if they feel anxiety or remorse about it later, and others do not hesitate to confront a counselor. Additionally, the family system frequently protects its equilibrium (Chapter 4) by covertly appointing one of the members to defend it. Whether that defense is Christina refusing to

go to college or Liz confronting the family counselor is irrelevant from the perspective of the family's dynamics. In the scenarios, Liz was acting as the spokesperson for the Manning-Kelly family and thus protecting the family system as well as herself.

Many family counselors begin their careers feeling intimidated or put off by aggressive adult clients. New family counselors are often younger than the adult members of the families with whom they work and are also not yet secure in their ability to manage a group of people. To further complicate the situation, some family counselors were raised in families in which one or both parents were aggressive, either verbally or physically. And those who are attracted to family counseling as a profession may have been the placaters (Satir, Stachowiak, & Taschman, 1975; Chapter 7), or peace makers in their families, rather than the ones who pushed family members to change. Recognizing one's desire to placate is the first step toward learning to override the temptation when the family needs the family counselor to gently and continuously confront them.

STOP AND THINK:

1. How did you learn to treat authority figures?
2. What was your role in the family in which you were raised?
3. What experience have you had with aggressive adults?
4. How did you react reading the five scenarios of how the family counselor might have approached Liz's anger?
5. How might your family experience affect how you reacted?

As you read this section about experiencing families and responded to the Stop and Think questions, you may have noticed that the work of a family counselor can be emotionally difficult. Two recommendations have been mentioned: supervision and counseling. After describing these, we will turn to a third: self-care.

Supervision can take many forms. All graduate programs require some form of practicum or internship in which students work with clients under the clinical supervision of a licensed professional. State licensing laws include a mandatory minimum number of practice and supervision hours, and graduate training programs are designed to help students meet predegree licensing

requirements in the state in which the graduate program exists. Supervision itself usually occurs at least once a week, although sometimes only once every 2 weeks, and includes one-to-one interactions between the student counselor and her or his supervisor. Some training programs also offer supervision groups of two or more students meeting with the supervisor. Additionally, licensing laws require postdegree experience, again under the supervision of a licensed professional. Clients are told they will be working with a student counselor when they enter counseling and sign a form that allows the student counselor to consult with her or his supervisor. Ultimately, the supervisor is responsible for the clients' welfare and the quality of the student counselor's work.

After becoming fully licensed, counselors often join peer supervision groups. These are groups of professionals who meet regularly to learn about new research and treatment modalities or to provide feedback to one another about their counseling work. Cases are presented, and client confidentiality is carefully protected in peer supervision groups. Although not required, peer supervision helps family counselors with accountability, avoiding isolation, and staying connected with a professional network.

The decision to engage in individual counseling is ultimately a personal one. The writers believe that a willingness to examine one's own issues is crucial to the ethical practice of counseling. Additionally, the experience of being a client gives a counselor tremendous insight into the vulnerability that being a counseling client entails. It is humbling and may circumvent a tendency on the part of some counselors to view themselves as in some way superior to their clients. Such an attitude risks treating clients in a condescending manner. And respect for the client and the client's autonomy is crucial to the ethical practice of counseling.

Self-care is a third component of practicing any form of counseling. You have begun to see how personally challenging family counseling can be. Even when families are not recreating a counselor's issues, revelations and dynamics can be exhausting and lead to burnout. A specific plan for self-care is essential.

Self-care can include anything that restores the well-being of the family counselor. There are daily practices, such as meditation, exercise, and taking a few minutes for oneself in or out of the office before resuming the nonprofessional aspects of one's life. There are also practices that family counselors engage in less frequently, such as attending professional conferences and workshops and going on vacation. As you progress through your training, you can observe yourself, your peers, more seasoned professionals, and eventually your colleagues to learn what might work best for you.

Before we leave the topic of the family counselor's experience working with families, it is important to note that none of us progresses through life without

stress. Sometimes stress is positive, such as weddings and births. Sometimes it is not, for example, when aging parents require additional care and die. And sometimes it occurs when one of our own children or our significant relationship is in distress. At these times it is especially important for the family counselor to both engage in self-care and seek whatever assistance, through supervision or counseling, that facilitates her or his emotional health and personal and professional functioning.

EXPERIENCING THE MANNING-KELLY AND JONES FAMILIES

Bear in mind that the family counselor is, like the Manning-Kelly family, a fictional character loosely based on the writers' experiences working with families and supervising students learning to practice family counseling. Given that both she and the Manning-Kelly family are composites of real people, her experience working with the Manning-Kelly family is hypothetical, as is the family itself.

The family counselor disliked Mark's aloofness from the beginning. She felt he was disengaged, and, as a professional working outside the home and a mother raising children in a two-parent family, she was put off that he seemed to leave parenting entirely to Liz. She was aware that her values about parenting did not need to match her clients' and worked to avoid judging him. The family counselor was also puzzled that he had known his stepchildren as long as he had and yet did not appear to be interested in them or their well-being. He also seemed to avoid interacting with his biological daughter, Emma.

Similarly, the family counselor disliked and was put off by Mark's blaming stance toward his first wife. According to him, he was the passive victim of her and her parents, pushed out of the family and alienated from his children. However, he seemed to overlook his own role, which may have been as simple as acquiescing. However, the family counselor hypothesized that she was seeing something similar in his second marriage and current family. Perhaps his disengagement had led to his first wife, Shoshana, and her parents taking over his role rather than victimizing him. On the other hand, if they had in fact colluded against him then perhaps his current disengagement reflected a reluctance to be rejected again. Clinically, these hypotheses could be helpful to the family.

However, the family counselor had to remain alert to her negative feelings about Mark and attentive to managing them in a way that allowed her to

genuinely convey empathy, support, and openness to her second hypothesis, rather than dislike and blame. She also wondered whether both Shoshana and Liz had felt the same critical dislike of his disengagement, passivity, victim stance, and aloofness she was feeling.

The family counselor also identified with Christina's feelings about being controlled by her mother. The family counselor had grown up in a family in which her mother appeared to dominate the family while her father appeared passive while goading her mother's controlling behavior. The family counselor had recognized this dynamic between her parents as an adult in her own individual counseling. As a child, she had viewed her mother in much the same way Christina viewed hers and her father as a helpless victim of her mother, just as she was. She had since learned no adult really has to be passive, and thus believed both her father and Mark's passivity was by choice. However, she needed to be cautious about conflating Mark with her father. Mark did not appear to goad Liz, though he clearly chose to be a passive, disengaged parent.

As a family counselor, such personal experience with family dynamics underlying unlikeable behavior can be helpful. However, because the family counselor needed to be alert to her reactions to Liz and Mark to avoid treating them as though they were her own parents, she talked about her feelings in her peer supervision group, being careful to protect the privacy of the Manning-Kelly family and maintain the focus on keeping her own issues out of her work. She sought guidance about how to approach Mark from professionals she trusted, who were not emotionally involved in the way she was.

The family counselor's inclination was to protect Christina, to step in and mother her the way Liz seemed unable to do. She also recognized that she did not wish to undermine but rather wanted to strengthen the mother-daughter relationship, guiding them toward a way to communicate that allowed Christina the autonomy appropriate to her stage of development and facilitated resolution of their disagreements.

The family counselor felt much the same way about Emma that she did about Christina. She wanted to lure her away from her mother and demonstrate Emma's ability to be a more autonomous four-year-old. Once again, however, this intervention would have been detrimental to the family and so she talked about and sought suggestions from her peer supervision group.

As you have probably noticed, there were a number of times when Liz was confrontational and even hostile toward the family counselor. And, in Chapter 9, Mark verbally threatened her while standing up, towering over her to further convey power.

STOP AND THINK:

How would you have felt during these events?

The family counselor noticed she felt defensive when Liz confronted her and scared when Mark threatened her. In both situations, she knew she needed to remain calm and soothed herself, both during and after the session, that she would be all right. As a new counselor, she had been intimidated by strong, successful women like Liz. Fortunately, that was no longer the case. However, she continued to experience a desire to defend herself and needed to be aware when that desire arose so she could continue to support Liz while firmly setting boundaries with her.

Her fear of Mark was more difficult to manage. While she knew she needed to maintain her focus on helping the family cope with both the crisis and the need to report his abuse, she was intimidated by the fact that he was an attorney and knew how to cause her a lot of trouble, both in the courts and with her licensing board. While she was confident she was behaving legally and ethically, ethical behavior does not preclude time-consuming and expensive efforts to defend oneself from accusations. She also worried about her reputation if he made his accusations public. Even if he was ultimately convicted of child abuse, the damage to her reputation of any publicity associated with his claims against her, however unfounded, would be difficult to overcome. So she was frightened for her counseling business. Self-awareness of these feelings and self-soothing that she would survive whatever happened allowed her to remain sufficiently focused on the needs of the Manning-Kelly family to complete the session in an ethical manner and as effectively as she did.

Finally, the family counselor was repulsed by Mark's abuse of Christina. She had heard similar stories and was impressed that Liz virtually avoided the temptation to blame the victim in order to hold her marriage together. But no amount of experience with abusive families numbs the horror and disgust one feels when confronted with a situation in which a child who is a dependent and cannot yet leave the family is repeatedly traumatized by helplessness and violation by an abusive adult. The family counselor needed to accept her own feelings and also put them on hold to be dealt with outside of the session, for example, by talking about them in peer supervision where colleagues would validate her reactions and share their own. A family counselor who is numb to the pain and horror that are natural aspects of learning about abuse would need to take action to restore her or his empathy.

SELF-AWARENESS, SELF-CARE, AND ETHICAL PRACTICE

Earlier chapters and sections of this chapter have alluded to the importance of the family counselor's self-awareness in working with the Manning-Kelly family. Had she not been aware of her reaction to Liz, she would have likely followed one of the first four scenarios and been entrapped by the family dynamics, induced into their system, and unable to maintain her counseling role to help them change their dynamics. She may have sided with Christina against Liz, alienated Mark early in counseling, or overlooked the differences between her own ethnic and racial background and those of the biracial family and the impact of these differences on her counseling work.

Self-awareness involves checking in with oneself on a regular and frequent basis. You can begin your practice of self-awareness by noticing what is happening around you at any particular moment and noticing yourself within your context, also at any particular moment. Practice observing, without evaluation or analysis. What does the ice cream in your mouth taste like right now? And then what does it feel like as the cold moves down your throat? Avoid thinking about whether you "should" be eating ice cream or what it might be doing to your weight or cholesterol. Similarly, as you walk across campus, notice the feel of the air on your skin and the smell of the plants around you. Avoid thinking about the work you have to do, the meeting you need to get to quickly after class, or whether you'll have time for lunch. If you are hungry, notice the feeling of hunger in your stomach and then the taste of your lunch and the increasing feeling of fullness as you eat.

Once you begin to notice these daily occurrences, begin noticing your body's reaction to the people in your life. Do you lean toward one friend when she or he is telling you a secret and start thinking about what else you'd like to be doing when another complains about the same thing for the umpteenth time? Do you find it more difficult to concentrate in some classes than in others? Now observe what is happening—the temperature in the room, what students sitting near you are doing, and the tone of the professor's voice—when you notice your concentration has wandered. Finally, ask yourself about the level of your well-being. Again, simply notice, without evaluating or judging.

When one practices self-awareness, one is more likely to recognize both physical and emotional responses that alert one to trouble. The family counselor working with the Manning-Kelly family may have recognized tightness in her shoulders when Liz verbally challenged her and then flagged her body's response as an indication she was feeling the need to protect herself despite the absence of a clear threat. She would thus have been alerted to the need to pay careful attention to her response in order to avoid reacting to Liz in a way

that would convey hostility or defensiveness. Remember that Liz's family members respond to her with hostility and defensiveness, and it would have been tempting for the counselor to have been induced into the family system and responded in similar ways. Without the awareness of what was happening in her body and what it meant, the family counselor would not have been able to successfully avoid a similar reaction.

This level of self-awareness requires careful attention to oneself, how one responds, and where one carries messages from one's mind in one's body when one does not recognize them as thoughts. And the reflection necessary to attain and use this level of self-awareness is simply a matter of practice. Sometimes it also requires input from someone other than the counselor, for example a supervisor, members of a peer supervision group, or the counselor's own counselor.

Self-care is closely associated with self-awareness. Because both self-awareness and the experience of counseling families require concentration, emotional openness to pain, and quickly processing lots of information from lots of people, the work can be exhausting. Many counselors practice self-care to manage all these aspects of their job, as well as demands from their own families and friends. Self-care can include exercise, meditation, rituals like lighting a candle or drinking herbal tea before leaving the office, peer supervision groups, friends and family with whom to unwind, mental health days, and vacations.

Many family counselors rush from their last client of the day to care for their children and, when in the sandwich generation (Chapter 2), their aging parents as well. Sometimes, the people for whom family counselors are responsible in their personal lives seem to appreciate them even less than their clients do. For example, adolescent children may be uncooperative and treat their family counselor parent as though they think she or he is an idiot. Her or his aging parents may resist changing their lives to accommodate the changes in their functioning and blame their adult child family counselor for a situation that is beyond everyone's control. Or, the family counselor may be going through a particularly difficult period with her or his intimate partner. Counselors in private practice may further be tempted to accommodate a client's need to change times at the expense of other important aspects of the counselor's life, such as time with family and friends and self-care, in order to maintain her or his income stream. All of these occurrences require and simultaneously conspire against the family counselor's routine practice of self-care.

Why is self-care important? For the same reason self-awareness is. If a counselor does not practice self-care, she or he is more likely to experience burnout: distraction, lack of empathy, and lack of genuineness that is conveyed when verbal messages conflict with nonverbal messages. When counselors experience burnout their nonverbal messages scream, "I need to get out of here!"

even though the counselor would never dream of uttering those words. When counselors fail to balance their professional and personal lives, they risk their personal issues leaking into and contaminating their professional relationships with their clients.

The Manning-Kelly family was scheduled at the end of one of the family counselor's work days. The family counselor often left sessions with the Manning-Kelly family feeling good about the work she had done and yet sad or anxious. She thought about whether these feelings were reflections of the family's sadness and anxiety, feelings she had had as a child in her own family, or exhaustion from the experience of being with so many distressed families during the day or with this family in particular. She lit a candle, did some deep breathing and muscle relaxation, and then drank a cup of herbal tea while writing case notes for the day. After that, she closed the office, went home, and enjoyed the evening with her family and sometimes also with friends.

You will read about ethics in the next chapter. Some of the most common ethical errors made by family counselors who are not practicing self-awareness and self-care include violating client boundaries by behaving like a friend or family member instead of a counselor and self-revelation that fulfills no clinical purpose. In addition to the ethical violation, such behavior may also leave the already stressed family counselor feeling badly about her or his lack of professional behavior. And a negative spiral can easily follow.

In sum, the practice of family counseling requires that counselors learn and practice self-awareness and self-care in order to avoid burnout and to practice ethically and effectively. The writers advise anyone hoping to become a family counselor to begin a practice of self-awareness and self-care now, so that both are more likely to be habits by the time the student reaches the point in graduate training when she or he will begin to counsel families.

THE SCHOOL COUNSELOR'S EXPERIENCE WITH FAMILIES

In school settings, the counselor serves many roles in addition to counselor. These roles may include consultant, testing coordinator, special program coordinator, student organization advisor, registrar, testing proctor, substitute teacher, witness for disciplinary referrals (these last two are unfortunate and not appropriate for school counselors, but they do happen), and trip chaperone or even talent show judge. Serving in all of these roles can make maintaining boundaries tricky. The counselor-client relationship for school counselors is not confined to the counseling office. School counselors see their clients every

time they walk down the hall, into a classroom, or attend a school event. Many students view their school counselors the same way they view their teachers, in that the ones they really connect with they treat like friends or even extended family. It is not unusual for school counselors to receive gifts, birthday party invitations, and return visits from their former clients after they have graduated from school. While these practices would be strongly discouraged in the mental health agency or private practice setting, they are commonplace in the school counseling world. Managing these boundaries requires careful consideration of what is in the best interest of the client and what is appropriate or inappropriate for the school counselor's role. Therefore, it is important for the school counselor to be familiar with the appropriate code of ethics (see Chapter 11) and to stay abreast of the latest developments in his or her profession. In addition, school counselors should seek supervision when faced with a difficult boundary issue.

School counselors work frequently with their students' families. Oftentimes, the student of concern is in trouble, academically, emotionally, socially, or a combination thereof. For school counselors, having empathy for the students is easy. They chose this profession because they like and understand children and adolescents. Empathizing with the children's parents is not always as easy. When the school counselor meets with the parent or parents, it is important to maintain empathy for them, imagining, or perhaps remembering, what it feels like to be summoned to the school because you or your child is in trouble. Upon entering the school building, many parents are transported through time back to their own childhoods, feeling as though they are being called to the principal's office because they did something wrong. In addition, when parents and teachers have a conflict, territoriality can rear its ugly head. Parents feel as though the quality of their parenting is being questioned, while teachers feel as though their quality of teaching is being questioned. Here again, it is important for the school counselor to remain empathic, validating each person's perspective and expertise related to the child of focus. School counselors are just as susceptible to family induction as counselors in any other setting. The same temptations to side with certain family members (often the child client) can pull at the counselor, just as the same negative feelings toward certain family members may surface. Furthermore, the same self-care practices apply. Finding a supervisor for school counselors maybe a challenge, since there is often only one school counselor in a given school, and sometimes one school counselor serves more than one school. Still, it is important for school counselors to seek supervision with peers in order to protect themselves from burnout. School counselors may connect with counselors from other schools, for individual or group supervision.

CONCLUSION

Family counselors, also being human beings, react to the individuals and family systems with whom they work. The family counselor's awareness of her or his own reactions and how she or he manages them so that they do not disrupt counseling or interfere with what client families need are crucial to the ethical practice of family counseling. Clearly, these counseling tasks must occur simultaneously with assessing the family system and the impact of interventions informed by the family counselor's theoretical approach. Learning to balance all these factors takes time and requires the supervision by an experienced clinician that is part of all graduate programs and required for all licenses.

We will now turn to the ethics of family counseling. Bear in mind that the ethical family counselor is a person like you. In other words, she or he never has all the answers.

Extend Your Learning:

1. What self-care practices are you using now to cope with the stress of being a student?
2. What parts of your self-care routine have you neglected lately? How might you attend to those areas?
3. Most colleges and universities have free counseling services offered for their students. There is no better time than when counseling is free to give counseling for yourself a try. Even if you don't think you have any issues to work through, sitting in the client's seat can be a very helpful experience for counselors-in-training. Honestly, at what other time in your life will there be a person who will give you 50 minutes of uninterrupted attention, to talk about whatever you want to talk about, and for free? As you make plans to see a counselor for the first time, ask yourself and respond in your journal:
 - (a.) Why haven't I done this before?
 - (b.) How do I feel about making the appointment?
 - (c.) Am I nervous? If so, what about?
 - (d.) Am I excited? If so, what about?
 - (e.) After the first session, take note: What surprised you? What did you like about how the counselor worked with you? What did you not like? How did being in the client's seat affect your view of yourself as a future counselor?

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CHAPTER 11



Ethics of Family Counseling

Why do we have ethical codes? Once you have completed your training and pursued and received licensure (if applicable), you will have multiple practice settings to consider as you plan your career. Agencies, schools, hospitals, and private practice are just a few of these options. Because there is such a wide variety of settings and practitioners in the helping professions, and because helping professionals work in a variety of roles with their clients, it is important to have some standards in place in order to ensure that people are receiving the best possible care. Ethical standards are in place to serve as a guide for our behaviors and choices as we work with clients. Simply put, ethical standards are in place to keep us from doing harm. In medicine, the Hippocratic Oath “First Do No Harm” is used frequently in reference to patient welfare. Just as physicians must keep in mind the best interests of their patients, family counselors must be mindful of the best interests of their clients. Ethical standards are also in place because we cannot possibly know all of the potential outcomes of our actions. The ethical codes have resulted from years and years of professional practice and prompt practitioners to consider the implications of their choices when working with clients.

The counseling professions have several ethical codes, depending on what type of training and licensure a professional has. The American Counseling Association (ACA) is for licensed professional counselors, the American Association for Marriage and Family Therapists (AAMFT) is for licensed marriage and family therapists, and the National Organization for Human Services (NOHS) is for professionals who have either an undergraduate or graduate degree in a human services field, and therefore serves a broader population of helping professionals. While there are many more professional organizations

that serve the helping professions, for the purposes of this book, we focus on the three aforementioned organizations.

It is the responsibility of every helping professional to read and be familiar with his or her profession's ethical standards. Students usually read their ethical codes during undergraduate or graduate school, and supervisors typically require their supervisees to read the standards again at the beginning of their supervisory relationship.

PROTECTING CLIENTS

Legal statutes as well as professional ethical codes governing the practice of family counseling have been designed to protect clients. In so far as possible, licensing laws, all of which specify minimum levels of training and postdegree clinical supervision, protect the public from inadequately trained and unscrupulous family counseling practitioners.

Each state has its own licensing requirements and legislated ethical codes governing the practice of family counseling. These include penalties for practicing without a license, misrepresenting one's credentials, working outside what is called one's scope of practice, engaging in any relationship with a client other than counseling during and for some period following the counseling, and reporting suspected abuse or neglect of minor children, the elderly, and the disabled. Scope of practice may be an unfamiliar concept. It simply means that family counselors must be trained and supervised to practice in the areas for which they advertise. So, for example, family counselors cannot give medical advice beyond recommending that a client consult with an appropriate physician. Similarly, a family counselor cannot present as competent to work with domestic violence unless she or he has had specific training and clinical supervision working with families in which domestic violence is an issue.

A third topic that deserves mention involves the differential power of the family counselor and the clients with whom she or he works. Family counselors must recognize that, even if their world view and theoretical orientation involve a collaborative relationship with their clients, they remain the authority on whom the clients depend for mental health care. Family counselors are therefore ethically bound to practice the profession of family counseling in a manner that does no harm, including the harm of abusing the power inherent in being a practitioner of mental health care or ignoring its reality.

Recognition of the potential power of being in the role of family counselor may help you think about some of the other topics addressed in this chapter. For example, if the family counselor is more powerful, then bartering for services,

while potentially of financial benefit to both the counselor and the client, would be biased in favor of the one with more power.

STOP AND THINK:

1. If a client offered to paint your house in exchange for an agreed-upon number of counseling sessions and discovered the house was in such bad condition that painting took two or three times longer than she or he had anticipated, do you think she or he would be reluctant to suggest you renegotiate the arrangement? Why, or why not? And how might her or his trust in you be affected?
2. If you were unsatisfied with the client's painting job, how might that affect your feelings about and work with the client?

Client Rights and Family Counselor Responsibilities

Family counseling clients have rights, and family counselors have certain responsibilities, including protecting those rights. These are specified by both state and federal legal codes. It is beyond the scope of this textbook to detail them all. Following a summary of client rights and family counselor responsibilities, two questions unique to family counseling will be addressed: who is the client? And, what are the boundaries unique to family counseling?

Clients have the right to privacy, and family counselors are responsible for protecting that right in all their dealings with client families. This sometimes raises the question of who is the client, for example, when one family member calls to tell the family counselor something she or he does not want the rest of the family to know. We address this situation further in the next subsection.

Clients also own their medical records. This means that, although it is incumbent on family counselors to maintain detailed records of their contact with client families, the family counselor can be asked to give the family a copy of those records. Again, there are various ways to handle this imperative, including advising the family to read the records in the presence of the family counselor so that she or he can soften the impact of technical jargon and diagnoses.

Finally, family counselors have the responsibility to keep those family members who are dependent on other family members for care safe in so far as possible and to keep the public safe from a family member who the family counselor suspects may harm one or more people outside the family. State statutes and legal precedents such as the *Tarasoff v. Regents* (1976) case specify

when and how a family counselor must report abuse or neglect and when family counselors must turn over medical records to the court or its agent and/or testify. While there are some options, such as the ones the family counselor provided the Manning-Kelly family (Chapter 9), failure to report can leave the family counselor criminally and civilly liable for any harm that is done, and failure to comply with court orders can lead to the charge of contempt of court.

The authors recommend seeking legal counsel when any of these issues arise. If a family counselor's employer does not have an attorney on staff, then the liability insurer that covers the practice will.

Who Is the Client?

When family counselors see more than one family member, the question arises regarding who the client is. Specifically, is the family or one of the individuals in it the client? The answer to this question is especially important with respect to the issue of confidentiality. It also may direct the family counselor to focus on particular assessments and interventions rather than others. Finally, there may be a conflict of interest between the family and one of its members. Deciding who the client is helps the family counselor decide how to resolve such a dilemma.

Consider the initial sessions with the Manning-Kelly family. The family counselor might have concluded that Christina's interests would be best served by helping her identify and resolve her anger at her mother's choices and their impact on her. Such work in counseling might allow her to make decisions about her own future independently of her reactions to Liz. Such an approach would involve individual, rather than family counseling, and the client would be an individual, in this case Christina.

Alternatively, the family counselor might have concluded that the family would best be served by addressing the way Liz and Mark handled the tension between them, as well as any remaining tension between Liz and Martin, and seeking alternatives that did not involve their children. The family counselor who chose this approach would theorize that removing Christina from her position within the marital subsystem would free her to make decisions about her own future independently of her family's needs. And in this case, the family system would be the client.

Deciding whether Christina or the family is the client would help the family counselor to conceptualize the problem, develop a working hypothesis, and choose a theoretical approach to intervention. Either choice would presumably result in greater age-appropriate autonomy for Christina and a resulting

reduction in her symptomatology. Because this is a textbook about family counseling, the second approach has informed the examples throughout the book. However, for the purpose of this discussion about the ethics of family counseling, the critical point is that the answer to the question of who is the client is very different in the two approaches.

None of the ethical codes reviewed for this book address the issue of identifying the client, in other words, whether the client is an individual or the entire family, when counseling client families. Thus, answering the question about who the client is involves ethical decision making. Models of ethical decision making are addressed later in this chapter.

Most ethical codes specify confidentiality requirements when parents ask a family counselor for information about her or his work alone with a minor child. As you continue your training, you will learn to think in an ethical way about what to do if a family member calls between sessions to speak privately with you or when you do sessions with subgroups or individuals within the family in addition to sessions with the entire family. Some family counselors are firm about not seeing individual family members when also seeing their families and instead refer these individual family members to other counselors for individual counseling work. Others believe that individual sessions are sometimes indicated and should not be considered mutually exclusive of working with the family in its entirety. For example, because Christina was 17 years old, and the Manning-Kelly family was about to enter the launching stage of family development, a family counselor might decide to recommend individual sessions with Christina while also seeing the family intermittently. And while a child counselor might also work with a much younger child and only see the parents intermittently, a family counselor would look to the family system as the key to change rather than to the child.

STOP AND THINK:

1. Based on what you have learned, how do you think the outcomes might differ if Christina were seen in individual counseling by a child counselor rather than with her family by a family counselor?
2. If the identified patient was a younger child, what would your answer to question 1 be?
3. Based on what you have learned, do you think one approach might be more effective than the other? Why?

The question of multiple relationships with clients, also referred to as dual relationships in some ethical codes, thus arises when family counselors see entire families and any member or subgroup of the family separately. Dual relationships involve having more than one relationship with a client. Family counselors are prohibited from engaging in dual relationships outside of counseling with clients. This is why family counselors do not barter for services with their clients or engage in social, romantic, or business relationships with clients. Because of the power differential, clients are unable to engage in any of these kinds of relationships as an equal participant with their family counselor.

Are situations in which a family counselor has two counseling relationships with a client dual relationships in the sense of a power differential? Or, because both relationships happen in the context of counseling, are they ethical? If nothing else, this question provides an excellent example of using ethical decision making.

STOP AND THINK:

1. Would seeing Christina both individually and with her family have the potential to harm her? If so, how? If not, what led you to that conclusion?
2. Referring to the section of this chapter about ethical decision making, follow the steps and discuss your conclusions.

Now consider the potential situation in which Mark has been ordered by a court to obtain treatment for his sexual abuse of Christina. The Manning-Kelly family may ask the family counselor to work with Mark individually to fulfill this condition of his obligation to the court. There are many reasons why the family counselor would say no, including that treating sexual abuse is beyond her scope of practice. Another would be the dual relationship she would then have with Mark and the rest of the family. Imagine that she said yes, and then a month later, Liz called to ask how Mark was doing with his individual counseling. Had the family counselor referred Mark to another counselor for treatment, the new counselor could easily explain to Liz that her or his work with Mark was confidential, and she or he was therefore unable to discuss it with Liz. The family counselor, however, already has a counseling relationship with Liz that she is ethically bound to protect. So, while she would have to decline to discuss Mark's individual work with Liz, her choice might be disruptive of her clinical relationship with Liz and thus of her work with the family.

Issues around dual relationships and conflicts of interest extend far beyond what has been covered in this section. If you pursue a graduate degree and licensure in family counseling, you will learn more about these and other specific issues, as well as how to approach them ethically, in your coursework, internship training, and postdegree clinical supervision.

Boundaries and Ethical Behavior

Power was addressed earlier in this section as a way of conceptualizing the client-counselor relationship in an ethical way. Another way to think about these issues involves respecting client boundaries. As defined in Chapter 4, boundaries are physical and emotional spaces that individuals, families, and subsystems within families create around themselves.

Respecting a client family's boundaries involves attention to every level of the family system. Individual boundaries may differ, as may the boundaries among subsystems and between the family as a whole and those external to the family. In the previous chapter, you read about the need for family counselors to avoid being induced into the family system in order to maintain their ability to work on behalf of the family and all its members. Conversely, rigid family boundaries may challenge the family counselor to negotiate sufficient engagement in the family system to form a counseling alliance.

The Manning-Kelly family presents a clear example of respecting boundaries. As an abused member, Christina had received unwanted touching from her stepfather. A family counselor who approached the family from the beginning with respect for boundaries would not have initiated any physical touch with its members. Had the family counselor touched Christina in some way, even if she had intended to convey support, she could have inadvertently traumatized Christina with yet more unwanted touch from an adult. Additionally, and as an aside, touch can easily be misinterpreted by clients, and so the authors do not recommend touching clients. While there may occasionally be exceptions, though never initiated by the counselor, the detailed considerations are beyond the scope of this textbook.

REPORTING LAWS

Client Safety. Every state has laws protecting dependent people from physical and sexual abuse and from neglect by those who are responsible for their care and safety. The protected people include children, the elderly, and people

with disabilities. These laws also require certain professionals, including family counselors, to report suspected abuse or neglect. If you become a licensed or provisionally licensed member of one of the professions required to report abuse, you will need to become familiar with the statutes in the state in which you are licensed in order to learn what the reporting procedures and time frames are for that state. These professions include all mental health practitioners, educators, and physicians.

What does all this mean? First and most importantly, it means family counselors have a legal obligation to use their knowledge, experience, and skills to assess the probable risk or presence of abuse or neglect. Neglect is difficult to define. Physical and sexual abuse are less difficult to define, though the specifics of how to define and assess for them are beyond the scope of this textbook. With respect to sexual abuse, it is important to remember that when someone has power over another, the person of lesser status cannot consent to sex because the option of saying no is unavailable. In other words, if a person does not have the option to say no, then they do not fully have the option to say yes. This is one of several reasons why family counselors and other mental health practitioners, educators, and physicians are prohibited from engaging in romantic or sexual relationships with their clients.

You may have noticed that the criterion for reporting is suspicion of abuse or neglect. It also applies only to dependents, including minor children, the elderly, and the disabled. While a family counselor who engages in a romantic relationship with a client who does not meet these criteria is still in violation of the law, it is assumed that an adult who of reasonable intelligence and physical capacity can refuse to consent or remove herself or himself from contact with the abuser. While in reality this is not always possible—for example, adults can be coerced to remain in abusive relationships—to our knowledge, family counselors do not need to report this kind of domestic violence.

Family counselors reporting abuse of a member of a group legally defined as requiring reporting do not need to be investigators. They do not need to present proof beyond whatever led them to reasonably suspect abuse or neglect, such as what happened during the session discussed in Chapter 9. In other words, counselors need to fully document what has led them to suspect abuse or neglect.

When reporting laws first appeared, many mental health professionals were concerned because reporting was a violation of the client's confidentiality, one that could easily lead to mistrust and the end of the counseling relationship. Some argued that it would be more beneficial to the perpetrator to continue treatment than to become the subject of an investigation. Today, decades after reporting laws became codified in all 50 states, students ask what reporting does to the counseling relationship.

Concerns about trust and future counseling, either with the counselor who reported the abuse or someone else, are reasonable. However, the subject is not available for argument. Rather, the law is very clear that family counselors must report or face charges of being complicit in the abuse. The court considers a mental health professional who fails to report to be behaving like a parent who stands by doing nothing or ignores a child being abused by the other parent, a close friend, neighbor, or relative.

Students also ask about the issue of compliance with reporting laws being a violation of client confidentiality. Family counselors are legally and ethically required to maintain the privacy of what their clients say to them, as well as of the existence of the counseling relationship. This is true whether the client is an individual, a couple, or a family. However, the law also states that a family counselor's suspicion of abuse or neglect overrides legal and ethical prohibitions about revealing client information and requires that the family counselor report to the appropriate agency. The law does not, however, give the family counselor the right to reveal confidential information elsewhere. If a client subsequently sues the family counselor for violating her or his confidentiality, the law protects the counselor from being found guilty so long as the counselor can document reasonable suspicion. Again, maintaining complete records, which all family counselors must do anyway, provides sufficient documentation of reasonable suspicion. The example from the Manning-Kelly family speaks to this point. If, at some point subsequent to the session during which Christina revealed she had been abused by Mark, she said she was lying, the family counselor would still be protected because, based on the information she had at the time and documented in her records, she had reason to suspect. It is, of course, possible that Christina was lying, but the family counselor does not need to serve as investigator and decipher that. There are also reasons other than lying that someone would retract an accusation, for example, fear of what was subsequently happening to the family.

In addition to abuse and neglect of dependents, family counselors also need to protect clients who appear to be a danger to themselves or someone else or who appear unable to accomplish the tasks of daily living. In other words, if a client indicates that she or he intends to kill herself or himself or someone else and has a specific plan to carry out that intention, the family counselor must report it. As with abuse and neglect, the laws of each state specify to whom the report is made. And, although the family counselor needs to be in the room when the report is made, she or he can offer the client the option of making the call herself or himself. We address a family counselor's duty to warn the intended victim in the next section.

Most counselors recommend empowering individuals and families as much as possible under the circumstances when abuse or harm must be reported.

This involves allowing them to choose whether to make the reporting call from the counselor's office, be in the room while the counselor makes the call, or of being absent when the family counselor reports. The Manning-Kelly's family counselor gave them these options in Chapter 9. Once the abuse has been reported, responsibility for what to do with the information rests with the agency to which the report was made.

In cases of intended suicide or homicide, the reporting call must be made promptly. The authors recommend that the family counselor only make the call in the presence of the client or offer the client the option of making it if she or he feels safe revealing to the client that the call must be made.

All mental health professionals include a reference to the circumstances under which they must report suspected abuse or neglect, as well as danger to self or others, in the privacy policy clients sign when they begin counseling. However, clients often skim the materials or forget the content. Part of the family counselor's responsibility is to verify that clients who are old enough to sign consent for treatment are capable of understanding the privacy policy and have the opportunity to ask questions about it.

Some families become enraged by the counselor's decision to report, irrespective of how thorough and careful the family counselor was in explaining the limits of privacy. Mark was angry and threatened the family counselor verbally. Other families appear to have considered the possibility of a report and accept its inevitability. Additionally, some families are able to continue counseling after a counselor has filed a report, while others are not. Reporting suspicion of abuse, neglect, suicide, and so on is very difficult for both clients and family counselors. Situations like these are some of the many reasons supervision needs to be a lifelong process.

Duty to Warn. The California Supreme Court set a precedent almost 50 years ago that has since been upheld. In the *Tarasoff v. Regents* (1976) case, the court held that mental health professionals are responsible for not only reporting homicidal intent to the appropriate authorities but also warning the intended victim of life-threatening harm.

The *Tarasoff v. Regents* (1976) case is complicated and interesting. However, the critical point for family counselors is that if a client threatens to kill someone, the family counselor must not only report this threat to the appropriate law enforcement agency but must also report it to the victim. As such, this is another level of client privacy. Family counselors can be reasonably sure of what may happen when they call the police or sheriff. However, the intended victim can tell anyone she or he wants to that not only is the client threatening her or him but also that the client is working with a family counselor. Again,

the criterion for family counselors involves documenting reasonable suspicion. In the case of a family counselor's duty to warn, it is important to be familiar with the laws of the state in which one practices, as the *Tarasoff v. Regents* (1976) precedent is not federal and thus may not be the standard in all states.

LAW AND ETHICS

What is the difference between law and ethics? Laws are statutes passed by an elected legislative body that govern, among other things, licensure and practice of various professions including family counseling. These laws are reasonably specific, and violation of them results in reasonably predictable consequences.

Ethics are codes of appropriate professional behavior codified in licensing laws and also in professional organizations' codes of ethics. Violations of ethical codes can result in suspension or revocation of one's license to practice counseling. Links to the Codes of Ethics for the American Counseling Association, the American Association for Marriage and Family Therapy, the National Association of Social Workers and the National Organization for Human Services are included at the end of this chapter. When a family counselor applies for licensure in a particular state, she or he is also required to pass an exam that includes statutes governing the practice of marriage and family counseling in that state, including ethics.

A related issue involves the federal government's Health Insurance Portability and Accountability Act (HIPAA) provisions regarding ownership and protection of client information (U.S. Department of Health and Human Services, n.d.). The law was first passed in 1996 and was also known as the Kennedy-Kassenbaum law. Because technology, the storage of medical records, and forms of communication have changed in ways that could not have been anticipated in the 1990s, the law has been and will continue to be updated, as are state laws regarding legal and ethical practice. All family counselors must be in compliance with the HIPAA provisions, which include monitoring changes and adapting one's policies to fit them.

Technology and social networking also have ethical implications for family counselors. For example, neither Facebook nor Skype are HIPAA compliant as of this writing. However, a family counselor can set up a professional page on Facebook, and clients can like it, even though family counselors cannot friend their clients or former clients on Facebook. Additionally, there exist alternatives to Skype that were developed specifically for physicians, are used by clients, and are HIPAA compliant. HIPAA has also been updated to

include specifics regarding record keeping and protection and transmission of electronic records.

Texts and e-mails are now dealt with in ethical codes and statutes to an extent they were not as recently as 10 years before the first edition of this textbook. Family counselors need to inform their clients about the limits of their ability to protect confidential information transmitted through either and are encouraged to ask clients to use them only for business purposes such as scheduling appointments.

Finally, family counselors who agree to accept payments from insurance companies and those who work for agencies or hospitals that accept insurance payments for their family counseling services must be in compliance with laws regulating practitioners doing business with the insurance industry. These also change from time to time, and family counselors who elect to engage in a business relationship with insurance companies must remain familiar with them.

Professional codes of ethics are constantly being revised to keep up with changes and new challenges associated with clinical practice. In the past 2 decades, e-mail, texting, tele-therapy, and social media have arisen. There was no mention of any of these in professional ethical codes in 1990. Yet all of these developments involve issues around protecting the confidentiality of client information and counselor-client interactions. And due to rapid changes in technology, it is impossible for ethical codes to address new issues the moment they arise.

Reading about legal statutes and ethical codes can be intimidating. Additionally, new family counselors often have no idea what to do when faced with a situation with no guidance from a specific clause in her or his professional organization's or licensing law's code of ethics. Gray areas will always exist, and that is one of the many reasons family counselors need to learn ethical decision making as part of their training, carry professional liability insurance, and maintain lifelong supervisory relationships.

REFERRALS

In Chapter 12, we address when and to whom family counselors may need to refer families for additional services. Family counselors may also need to refer individual family members to another counselor for individual counseling. In this section, we address how to make referrals as well as the risks of violating ethical and legal prohibitions against abandonment of clients.

There are many reasons clients are reluctant to accept referrals. Some people do not like to ask for help. Others worry about the expense. Still other people find it difficult to establish trust when meeting a new professional. As a result,

family counselors may be asked by clients to provide services that are outside their scope of practice or involve dual relationships. How the family counselor handles such a request, as well as the entire referral process, is important not only in terms of the outcome of the referral (that it is accepted and needed services are obtained) but also in how it influences the family counselor's continuing professional relationship with the family.

When making a referral, it is important to clarify for the family the reasons why the referral is necessary—for example, the family counselor cannot provide neuropsychological or legal advice for an aging parent—as well as the family counselor's confidence in the people or agencies to whom she or he is referring. The family counselor must do everything possible to inspire confidence within the family about accepting the referral and the importance of acting upon it. Family counselors often follow up during subsequent sessions to learn whether the family has contacted the referrals provided and, if not, what has prevented them from doing so and when they might agree to do it. If the family has not elected to accept the referral, the family counselor may be able to help them address and alter their reluctance or give them an alternative referral.

Sometimes a family needs to address something that is outside the counselor's scope of practice. For example, a family counselor may not have special training and supervision in treating substance abuse or eating disorders. If this is the case, the family counselor is ethically bound to make a referral, explaining to the family that they need someone who knows more about how to help them than she or he does. Again, families may be reluctant to accept a referral. The family counselor can offer to see the family at a future date, after the specialized work is completed, or refer a member for individual counseling while the family counselor continues to work with them on family issues. Alternatively, the family counselor could, if interested, pursue training and supervision in the specialized topic and continue working with the family as part of her or his training if they are amenable.

At other times, family counselors find they do not want to work with a particular family. They may be overwhelmed with difficult cases and started seeing the family thinking it would be less challenging. Or, an issue could arise during family counseling that raises the family counselor's own issues at a time when she or he would prefer not to address them. Sometimes, family counselors simply don't like a family that wants to work with them. Unfortunately, these situations all risk abandonment of the client.

Family counselors are enjoined not to abandon clients. And while referring a family because the family counselor does not possess the training or licensure to help them in a particular way is behaving ethically, referring the family because the family counselor does not want to work with the family constitutes

abandonment. It could be argued that a family counselor who does not want to work with a particular family may not be an appropriate counselor for that family and the family might be better served by working with someone else. And from that perspective, a referral to another family counselor would be ethical. However, ethical codes embedded in statutes would overlook that argument and hold that if the family counselor engaged in a counseling relationship with a client and the services needed by the family remain within her or his scope of practice, referring the family can be construed as abandonment.

Abandonment is different from a situation in which a family counselor is unable to continue seeing the family. Family counselors get sick, change jobs, move, and retire. They may also take a family medical leave to care for a newborn child, an elderly parent, or an ill spouse or life partner. These do not constitute abandonment. However, whenever possible, family counselors need to take time to prepare clients for the transition to a new mental health practitioner. Again, we recommend using ethical decision making or contacting the attorney at your liability insurer if you feel you are in a gray area regarding abandonment.

SELF-CARE

Years ago, one of the authors, who is in private practice, received a call from a physician the week before she was scheduled to go on vacation asking that she see one of the physician's patients. The psychotherapist was exhausted and knew she needed a vacation and told the physician so. The physician responded that this middle-aged patient's father had died recently, and she thought the patient needed someone to talk to about a straight-forward issue of grief. So the therapist agreed to see the patient before she left for vacation. About halfway through that session, the patient said, "There's something else you probably don't want to hear," and the psychotherapist, who very much needed her upcoming vacation, thought, you're right, I don't want to hear it. Because she routinely practiced self-awareness, she noticed the thought, knew it would be unethical to say it aloud, knew also that it was a sign of how burned out she was, and reminded herself of her usual empathy, looked attentive, and said, "Tell me about it." While it would be a violation of the client's confidentiality to repeat what the client then said, it was one of the more painfully awful stories the psychotherapist, who had been in practice for about 15 years at the time, had ever heard. The point, however, is that she was self-aware and practicing self-care sufficiently well to behave ethically with the client in the situation in which they found themselves.

STOP AND THINK:

1. Imagine you have experienced a very painful event and have worked up the courage to seek professional help. Because you know the story may be burdensome to others, you preface it by saying the psychotherapist or counselor probably doesn't want to hear it. How would you feel if she said, "You're right, I don't really want to listen to you talk about something painful today"?
2. Now imagine you are the counselor. You feel as though you will explode or break down and cry if you have to empathize with one more client's pain before you have had time away from your practice, and someone tells you she's about to reveal something awful. How would you feel? Would you want to run from the room, tell her to be quiet, or something else?

Self-awareness and the practice of self-care are both critical to the mental health of family counselors and therefore to their ability to practice ethically. If the psychotherapist had not already known she needed a vacation, one would hope she would have been self-aware enough to recognize that thinking she did not want to hear what a client so obviously needed to say was a clear warning sign that she needed to take better care of herself.

Self-awareness is a lifelong practice required of all mental health professionals. It involves noticing what is happening with oneself. Such noticing includes tension in one's body, thoughts, and feelings. During sessions with clients, mental health professionals use this awareness to inform them of the impact the client and her or his issues are having on both the practitioner and the client. For example, in the scenario above, the psychotherapist noticed her thoughts were unusual for her and not conducive to effective work with the client. She was thus able to shift her focus back to the session, reserving her awareness of how badly she needed a vacation until after the work was finished. And, luckily, she had a vacation scheduled beginning at the end of the following work day.

Other times, mental health practitioners notice they are feeling incompetent or very tense in a certain part of their bodies. Perhaps the client is feeling powerless and saying things that are intentionally designed to disempower the practitioner. When Liz told the family counselor that family counseling was not working for them and making the situation worse, the family counselor began to wonder what she had overlooked and what she could have done differently. She noticed those thoughts, told herself she would address them later, and

refocused on addressing Liz's obvious frustration and being certain she heard what Liz wanted. Without that self-awareness, she might have become defensive, which would likely have worsened Liz's frustration and might have led to the family choosing to stop family counseling.

Self-care is similarly a lifelong practice required of all mental health practitioners. Empathizing with individuals and families who are distressed and in pain, remaining present with them and avoiding defensiveness when they say hurtful things, tolerating the frustration when clients cannot change quickly, and shifting from one client to another throughout the day are emotionally and intellectually exhausting components of the work. Most family counselors also go home to their own families, where they need to be available for their children's and partner's needs, as well as the needs of aging parents, friends, and colleagues. A family counselor whose relationship is going through a difficult time may feel like even more of a failure if her clients' relationships are not solid and thus overlook issues that need addressing to ensure those same relationships continue if possible. Most family counselors discover they become anxious from time to time, feeling that they are seeing the same problems in their own families that their clients have brought to counseling.

Family counselors engage in a number of ways of caring for themselves, and you will need to discover those that work best for you. Possibilities include lighting a candle or incense at the end of the day to cleanse the office, stopping somewhere for a cup of tea before re-engaging in one's personal life, exercise, meditation, creative pursuits, hobbies, lifelong supervision with peers or privately with another professional, a strong social support network, regular vacations, and going to counseling or psychotherapy to address the family counselor's own issues that are raised by clients. Counselors and psychotherapists use specific activities such as gardening, working on cars or motorcycles, chopping wood, taking classes unrelated to their work, bubble baths, massages, and pedicures for self-care. We recommend to students that they ask themselves what they enjoy doing, what helps them relax, and what is reasonable to do on a regular basis given the time and other resource constraints of their lives.

Hopefully, it is obvious why family counselors and other mental health professionals need to practice self-care. Self-care is a way of keeping ourselves from burning out, making careless mistakes, and avoiding the ethical violations inherent in careless mistakes. A family counselor whose relationship with her or his spouse or children is going through a difficult time may turn to her or his clients for comfort, becoming overly involved, subtly and inadvertently asking them to take care of the counselor. Self-awareness allows the family counselor to recognize when these and related problems arise. However, only self-care actually prevents or resolves them.

SCOPE OF PRACTICE

Scope of practice refers to those areas and types of clients that any particular mental health practitioner is competent to see in her or his practice. The most critical question is, what is the scope of the practitioner's license? Each family counselor must be familiar with what her or his license allows her or him to do in the state in which it was issued. For example, family counselors who have not completed medical education and training in psychiatry or psychiatric nursing cannot prescribe medication, even when they think a family member might benefit from it. They must, instead, refer to someone who is licensed to prescribe. In a very small number of states, licensed psychologists who have completed a rigorous training program may become licensed to prescribe psychotropic medication. Violating laws associated with practicing outside one's scope of practice may result in civil and sometimes criminal penalties.

For what a particular family counselor's license allows her or him to practice, she or he must also be able to demonstrate appropriate training, involving both education and clinical supervision. Practicing outside areas of training can lead to sanctions by one's licensing board and professional organization. It can also, as when a counselor presents with competence to give legal or medical advice yet has not been to law or medical school, lead to civil and even criminal punishment. If you practiced law or medicine and then received a family counseling degree and license, you could, in fact, give legal or medical advice as long as you have remained current with legal statutes or remained board certified in medicine. If you have not done all of these things, you can only tell clients that in your professional opinion they might benefit from a legal or medical consultation. You can also provide them with a list of names, usually three, of professionals you have worked with and trust and who are licensed to provide the services the client needs.

The Manning-Kelly family provides an excellent example, as you will see in Chapter 12. If Christina and her family had not been referred by a physician, the family counselor, noting Christina's weight, would have been ethically bound to ask when she had last had a routine medical examination by a primary care physician. She would also have been ethically bound to suggest that Christina see a physician as soon as possible if she were not under the care of one already. Finally, in cases where there are medical issues beyond the family counselor's scope of practice and especially those that can be life-threatening, the family counselor can insist that the client also be in treatment with an appropriate physician as a prerequisite for seeing the client herself or himself. Such insistence actually protects the family counselor from charges that she or he has attempted to treat the medical aspects of anorexia nervosa, for example,

behavior that would be outside her or his scope of practice both legally and ethically. With respect to Christina in particular, the family counselor could, with permission, contact the primary care physician to discuss the possibility that she would benefit from psychotropic medication and whether the primary care physician would prefer the family counselor refer Christina back to her for medication assessment or to a psychiatrist.

SUPERVISION AS A LIFELONG PROCESS

It is a counselor's ethical responsibility to obtain supervision throughout his or her practice with clients. Of course, clinical supervision is required for anyone who is seeking licensure. The number of hours varies from license to license and sometimes from state to state for the same license. Additionally, if a counselor, already licensed in one state moves to a new state, she or he may be required to obtain additional supervision hours prior to being granted licensure.

It should be emphasized, however, that supervision should continue even after licensure has been obtained. Although many professionals in the field do not seek supervision unless there is a problem, we recommend supervision as a lifelong activity. Many practitioners within agencies and hospitals participate in teams that meet regularly to discuss clients and can use those meetings to ask for help with their own reactions to a particular client. Family counselors in private practice usually join a peer supervision group. As long as no identifying information about clients is revealed, peer supervision is entirely ethical. Most peer supervision groups focus on a particular topic or on the counselor's response to clients (see Chapter 10).

As mental health professionals, we run the risk of becoming islands unto ourselves. Seeking supervision throughout the time we practice not only helps us break out of our isolation but also protects us and our clients from the narrowness of any one person's perspective.

ETHICAL DECISION-MAKING MODEL

Laws and ethical codes do not keep up with changes in practice. For example, when Facebook and Skype were introduced, there were no laws or ethical codes covering their use in practice. Now, we know that neither is compliant with federal codes governing the protection of patient information. However, most, if not all, codes of ethics do not specifically address the types of social

media that can and cannot be used in practice. It is up to the family counselor to use what she or he knows along with ethical decision making to determine how to act when, for example, a client “friends” her or him on Facebook or asks for a Skype session while out of town for an extended period of time for work or to care for a family member.

Additionally, ethical decisions are not always clear. Sometimes trying to do the right thing for a client is in direct conflict with what’s best for a counselor’s agency or a third party, such as the client’s spouse. In cases like these, where choices are not clear, it is helpful to have a model in place for making decisions. The following step-by-step ethical decision-making model comes from the work of Corey, Corey, and Callanan (1998):

- Step 1: Identify the problem.
- Step 2: Identify the potential issues involved.
- Step 3: Review relevant ethical guidelines.
- Step 4: Know relevant laws and regulations.
- Step 5: Obtain consultation.
- Step 6: Consider possible and probable courses of action.
- Step 7: List the consequences of the probable courses of action.
- Step 8: Decide on what appears to be the best course of action.

Pay special attention to Step 5. It is important to consult with your supervisor throughout the process.

CONCLUSION

With appropriate coursework and supervision in the principles and practice of family counseling, professionals holding a variety of licenses may practice family counseling. These include psychiatry, psychology, social work, counseling, marriage and family therapy, pastoral counseling, and human services. We have included the ethical codes from the professional organizations responsible for the practices of social workers, counselors, marriage and family therapists, and human services professionals. We recommend that if you pursue one of these professions you also familiarize yourself with the ethical codes codified in the laws of the state in which you practice.

Extend Your Learning:

1. Apply the eight-stage Ethical Decision-Making Model to any ethical questions you may have had about working with the Manning-Kelly family. What is the problem? Which ethical guidelines applied? Which laws applied? What were the possible consequences? What course of action did you decide upon and what are your conclusions after working through the eight steps?
2. Locate other ethical dilemmas or cases online or in other resources, and repeat the activity above with the cases you find.

ETHICAL CODES

American Counseling Association Code of Ethics <http://www.counseling.org/resources/aca-code-of-ethics.pdf>

National Association of Social Workers Code of Ethics <http://www.socialworkers.org/pubs/code/default.asp>

American Association for Marriage and Family Therapy Code of Ethics https://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/code_of_ethics.aspx

National Organization for Human Services Code of Ethics <http://www.nationalhuman-services.org/ethical-standards-for-hs-professionals>

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FOR FURTHER STUDY

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PART IV

Current Trends in Family Counseling

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CHAPTER 12



Issues Requiring Services Beyond the Counselor's Scope of Practice

The Manning-Kelly family is replete with issues that require services that family counselors are not trained to provide. Emma, for example, may require both speech and occupational therapy. And family counselors may facilitate support groups for breast cancer patients, like Barbara, and their families; grief groups for family members following a death; or caretaker support groups for women, like Sally, who are caring for an ailing spouse. However, only a professional with medical training and licensing can diagnose a biomedical problem, prescribe and administer medication, or perform surgery.

Licensing laws and codes of ethics for all counselors and psychotherapists mandate working only within the licensee's scope of practice. This means that unless the counselor or psychotherapist is trained, experienced, and holds a license to practice a particular service, she or he must refer to someone who has these qualifications. Sometimes, even when the need is within the family counselor's scope of practice, she or he must refer to another professional in order to avoid a dual relationship. For example, it might be appropriate to refer Christina to a physician who is licensed to prescribe medication for assessment regarding its potential usefulness. Unless the family therapist also holds a license to prescribe medication (e.g., if she were a licensed psychiatrist who completed family counseling training), she must make this referral because medication assessment and management is outside her scope of practice. Alternatively, following revelation of the abuse, Christina might benefit from individual counseling to deal with its impact on her sexuality, something she might not want to talk about in front of her mother, brother, and half sister. Even if working with abuse survivors is within the family counselor's scope of

practice, she would need to refer Christina because her relationship with the family precludes a second, or dual, relationship with Christina.

Knowing when to refer, to whom to refer, and how to make referrals to maximize the possibility of a good outcome are critical skills for all counselors and psychotherapists. Ethically, family counselors are required to provide a list of at least three professionals when they make a referral, so that the client can choose, in other words, to maximize the client's autonomy. In order to generate these lists, family counselors must get to know other professionals and organizations in their communities and maintain working relationships with the professionals to whom they refer.

In this chapter, we will revisit the eight family issues discussed in Chapter 9 and describe more specific situations in which family counselors may need to refer families for other services. To review, these eight issues are multicultural families, LGBTQIA families, single parent families, blended families, families with aging members, biomedical disease processes in families, mental and substance abuse disorders within families, and domestic violence.

CULTURAL COMPETENCE IN MULTICULTURAL FAMILY COUNSELING

Cultural competence was described in Chapter 9, and the authors recommend you read Diller's (2007) and Lum's (2007) books for more details. Additionally, Ann Fadiman's (1997) book is an excellent case study about the pitfalls of not practicing in a culturally competent way.

Family counselors need not be experts about every culture. It is appropriate to ask clients for information the family counselor does not know about the family's culture. First, even if the family counselor is knowledgeable about the particular culture, she or he has no way of knowing unless she or he asks how enculturated the family is into the dominant culture. And second, there exists tremendous variation among individuals and families within cultures, and thus assuming all families of a particular culture are alike is a form of stereotyping that devalues them.

STOP AND THINK:

1. Do you have parents or grandparents who were born in another country? If not, do you know someone who does?
2. Notice whether and how identification with the traditions of that country's culture have changed or not over the three generations of your family.

When working with bicultural and biracial clients and families, family counselors tend to practice more collaboratively. Clients can easily recognize differences between their own and the family counselor's experiences. These differences are also a factor within biracial and bicultural families. Christina and Martin Jr. did not share the experience of being Black with their mother, which may have impacted their relationship with her. Similarly, they did not share the experience of being White with their father. And neither parent could fully understand their experience of being biracial, because neither parent was.

The writers have speculated that Christina and Martin Jr.'s distance from their parents and half sister could have been a product of the family life cycle stage; how Emma's cerebral palsy had been handled within the family, particularly the extra and possibly unnecessary attention their mother gave her because of it; unresolved tension between their biological parents; or the family's dynamics. A culturally competent counselor would also wonder whether Christina and Martin Jr.'s biracial experience played a role in their relationships with their parents and siblings. Finally, we do not know what their father's, stepmother's, and grandparents' experiences of being Black were, given that they grew up prior to the civil rights movement, when public facilities, including schools, were often segregated and their own parents could not vote.

The family counselor also would not know unless she asked about the impact of cultural differences on Liz and Martin's marriage and how those impacts were managed. She did not know how their extended families reacted to their marriage and how the community in which they lived reacted to them and their biracial children. It is interesting, though perhaps coincidental, that Martin's second marriage was to a Black woman, and Liz's second marriage was to a White man, and it would be appropriate for a family counselor to ask whether their choices were intentional.

The prevalence of eating disorders among White and Black women was addressed briefly in Chapter 9. Irrespective of culture, Christina seems to have learned her concern about weight and appearance from her mother and grandmother, the "White side," as she put it, of her family. It would have been important for the family counselor to ask more about how Martin, Daniella, and their extended families viewed and related to Christina's behavior and attitudes about food and weight.

Jason and Ashley were also bicultural. They were first generation Americans on their mother's side, as she was a Middle Eastern immigrant, and their father and his family are of western European descent. Their family structure was also different than the one in which Christina and Martin Jr. were raised. Their maternal grandparents took a much more active role in daily child care than it appears either Liz's or Martin's parents did. Thus, Jason and Ashley were regularly exposed to their grandparents' cultural attitudes, behaviors, dress,

and other traditions and may have been challenged by their grandparents when they behaved like other children in the dominant culture.

Middle Eastern culture is very different from Black culture, and immigrant parents whose children are born and raised here may be very different from families of the same ethnic or racial origin who have lived here longer. The difference is enculturation, that process by which individuals and families take on aspects of the dominant culture in which they live. Families vary tremendously in terms of how enculturated they become over time. The only way to determine how enculturated or conflicted Jason and Ashley were would have been to ask.

A family counselor cannot generalize that the experiences of being bicultural are identical for these pairs of stepsiblings. And, again, it is beyond the scope of this text to describe in detail culturally competent practice with each of these cultural groups. Rather, the authors encourage counselors to learn from reading, continuing education, supervision, and colleagues; asking their clients questions; and remaining mindful that they cannot make assumptions about any client family's experiences based on either their own or generalized information about another culture.

Since not all members of the same cultural or racial group share identical experiences or values, it is not necessary to refer clients to members of their own racial or ethnic group. What is necessary is to practice in a culturally competent way, respecting the uniqueness of the client family and its members' experiences.

Although it is easier for clients when the family counselor speaks their first language, it is often difficult to find a family counselor who speaks a particular family's first language, when it is not English. Unless a client family is unable to communicate in a language the family counselor speaks, there exists no ethical reason to refer.

LGBTQIA CLIENTS

Christina's cousin, Paul, is gay, and he and his life partner Matthew were in the process of adopting a child. They lived in a state that did not recognize same-sex marriages or domestic partnerships even when the partners are heterosexual. Thus, there were complex legal issues in the adoption process and in protecting the child once adopted that would not have arisen for a couple that was able to marry. Their adoption may have therefore required more involvement by professionals other than family counselors and incurred more expense than it would have if Paul and Matthew's commitment to one another were legally recognized.

Even if they had not been in the process of adopting a child, Paul and Matthew would have faced some of the same issues of being labeled different and devalued that people of color face and that White heterosexual couples do not. Sometimes gay and lesbian partners, as well as transgendered individuals, need to keep the nature of themselves and their relationship hidden from coworkers in order to feel safe in their jobs. Other times, one or more family members may initiate a cutoff with the LGBTQIA family member. And finally, one or both partners may be a member of a cultural group that holds even more negative views of homosexuality than the dominant White community does. LGBTQIA clients who are not White sometimes cannot identify with LGBTQIA groups that ignore the experience of also being an American of color.

Helping Matthew and Paul manage these challenges so that they do not undermine their relationship is within the scope of practice of a family counselor who is culturally competent to work with LGBTQIA couples and families. A family counselor needs to understand Paul and Matthew's unique experiences within their families, professions, cultures, and the larger society in order to be most effective.

There are a variety of issues that also arise in any adoption. These include whether the adoption is of an infant or older child, identified special needs child, domestic or international, or bicultural. Adoption often involves an agency, and the family counselor working with clients who are adopting may be asked for an assessment of the prospective parents' mental health and family stability. The agency wants to ensure that the adopted child will be safe and well cared for, which no family counselor can guarantee. Sometimes prospective parents experience the seemingly endless process of interviews and paperwork as obstructive and become defensive and guarded, and family counselors can support the couple through these hurdles. And finally, adoption always involves an attorney, who may also want information from the counselor and who may become a source of stress for the prospective parents.

SINGLE-PARENT FAMILIES

Family counselors may refer the members of single-parent families to grief or divorce groups in order to adapt to the loss that resulted in becoming a single-parent family. Additionally, a number of legal and financial issues may arise following a divorce or the death of a spouse or parent, requiring the family to seek financial, legal, or court-appointed services.

This is further complicated when a domestic partnership was not legally recognized by the state in which the family resides. If the remaining parent is not biologically related to the children or a parent of record in the adoption, she or he may not have parenting rights, and the deceased or estranged partner or her or his family may attempt to gain custody. She or he also would have no financial rights nor the ability to make decisions for a dying partner.

Sometimes parenting issues also become part of legal proceedings, particularly when there are custody disputes or mutual accusations of incompetence. The family counselor may need to work collaboratively with other professionals, with appropriate consent from the client. Most importantly, the family counselor cannot provide legal or financial advice unless trained and licensed to do so. However, the family counselor can advise clients to seek legal or financial counsel elsewhere and provide a list of professionals.

The majority of single-parent families include a mother and her children. And data indicate that female-headed families are more likely to live in poverty than male-headed families. When family counselors work with families living in poverty, they may need to refer them for support services such as food stamps, subsidized housing, and Medicaid health insurance coverage.

BLENDED FAMILIES

The term *blended family* refers to families in which at least two nuclear families have combined to create a third family. Blended families involve at least one of the spouses having been in a previous relationship that produced at least one child. There are always issues of loss when a family dissolves and, when grief remains unresolved, emotional issues may affect subsequent relationships. Additionally, there are legal issues that may continue into a new relationship, for example managing shared custody or visitation by the noncustodial parent and child support when a relationship has dissolved or inheritance when a parent and partner has died. The family counselor needs to be prepared to refer when emotional issues are beyond his or her scope of practice and when legal issues need to be addressed by an attorney.

There are three blended families in the Manning-Kelly and Jones families that exemplify a range of issues that may require a referral from the family counselor. These were described in detail in Chapter 9 and will be briefly reviewed here.

Sally and Jim's situation is not uncommon. They were both widowed and remarried and had assets from their previous marriages, as well as objects of sentimental value to their adult children. Couples who find themselves in Sally

and Jim's situation may need to be referred for financial and legal consultation in order to protect one another and their own and each other's adult children.

Family counselors need to be aware of tension between the aging parents' biological and stepchildren, as well as tension within each sibling subsystem. As Jim's dementia progresses, his ability to function independently and Sally's ability to care for him will deteriorate, thus incurring decisions about his care and related expenses. Health insurance supplements to Medicare, long-term care insurance, and Medicaid may alleviate some of the financial burden. However, Sally and Jim's adult children may express anger regarding whose money is being spent on whom and who will support Sally living independently after Jim has entered assisted living or depleted their joint resources.

While family counselors cannot advise clients about creating wills and prenuptial agreements, they can recommend that remarrying couples consult with an attorney to create both, as well as health care directives. They can ask remarrying couples how they want to handle their money in the event one of them becomes sick or dies and then recommend that the spouses discuss what they want with an attorney who will use her or his knowledge of the law to create legally binding documents.

A family counselor can recommend counseling with all the adult children together, either with or without their parents present. Helping adult siblings and stepsiblings to see one another as people who care about both parents as well as their own interests can open lines of communication so that the adult children can more effectively deal with issues surrounding their parents' aging, death, and the use and disbursement of resources and assets.

Liz and Mark have also created a blended family, although most of their children live at home, as have Martin and Daniella. While Mark and Liz already had a divorce settlement and child support and custody in place, any conflict around either necessitates a consultation with their attorneys, even though the family counselor can address emotional and family systems aspects of the conflict. It is important for parents to negotiate with each other about alternatives when there is conflict, rather than triangling their children into their conflict. If they cannot, it remains preferable for them to communicate through their attorneys or a mediator. If the family counselor cannot facilitate their communication or they decline his or her help, the family counselor should recommend they seek legal assistance and provide referrals if needed.

Although Mark's children from his first marriage were young adults, he continued to provide financial assistance to them, in part because he believed Shoshana and her parents had disrupted the more nurturing aspects of his relationships with his young adult children. Mark and Liz have argued about his continued support of Jason and Ashley, as described in previous chapters,

and addressing the conflict was within the family counselor's scope of practice. Because Ashley and Jason are no longer legal dependents, there are no legal issues requiring referral to an attorney.

Although Daniella and Martin had created a blended family, she was never married to Jamal's father. From a legal perspective, this means that Martin may have been able to adopt Jamal without Jamal's father's legal relinquishment of parental rights. Laws vary from state to state, and adoption is an issue only an attorney can address. It is not the family counselor's role to suggest adoption but rather to respond if the family brings it up by suggesting and providing a referral. Additionally, if Jamal's father were to become a problem for Daniella and Martin, which appeared unlikely given that he had remained in contact with Jamal, the family counselor could suggest they consult with an attorney if the situation warrants.

As with all families, understanding the issues, dynamics, and pitfalls of blended families and knowing how to intervene effectively does not preclude the need for professionals other than the family counselor to become involved. As part of training and licensing, family counselors learn about their own scope of practice, what additional services to recommend under what circumstances, and how to present referrals to maximize the likelihood the family will follow through with them.

FAMILIES WITH AGING MEMBERS

As the U.S. population ages, there is an increasing need for family counselors with gerontology experience to deliver counseling and other services to the elderly and their families. In Chapter 9, the authors described issues relating to aging family members that counselors can manage. To review, these include clients facing physical and mental decline, loss of independence, and impending mortality; adult siblings disagreeing about how to distribute caretaking responsibilities; and aging spouses balancing one's need for care with the toll giving the care is taking on the other's biomedical and mental health. Although family counselors can provide services such as grief and caretaker support groups, there remain other services family counselors must refer to other professionals.

Family counselors may need to be part of a team of in- and out-patient medical staff, extended care facility staff, hospice staff, and physical, occupational, and speech therapists. Coordinating legal services for health care power of attorney, living wills, and do not resuscitate documents may also be a part of the job, although family counselors cannot provide the actual legal services.

Finally, in some settings, family counselors may be called upon to coordinate in-home services, such as home health care, transportation to and from medical and senior citizens' facilities, and meals on wheels delivery. The cost of care may also be an issue, and family counselors can help connect family members to the various financial services available in their community.

Both Liz and Mark were facing issues around their parents' aging process that may have required services beyond the family counselor's scope of practice. Liz's stepfather's decline was clear to his children and stepchildren. Additionally, its toll on Sally's health concerned them.

Family counselors are often asked to see aging couples who are in situations similar to Sally and Jim's and are expected to help the adult children convince the parents that the patient requires a higher level of care or help the parents convince the children more care is unnecessary, depending on who arranged the appointment. While making the kinds of life-changing decisions Sally and Jim faced was not part of a family counselor's role, family counselors can help family members clarify their thoughts and more effectively communicate with each other so that everyone's perspective is heard and considered. Family counselors can also provide referrals to support services within the community, such as senior centers, adult day care, home health services, and experts at county departments of aging.

As noted in previous chapters, all states have reporting laws which include a family counselor's duty to report a reasonable suspicion that someone is a danger to self, others, or unable to care for himself or herself. If, in the family counselor's professional opinion, Jim's rage and forgetfulness posed a danger to Sally or his wandering put him at risk, he or she would have to report the concerns to the appropriate legal or social service agency. You will need to be familiar with the laws of the state in which you practice to know to whom to report concerns. You can also make an anonymous call to ask whether the situation requires reporting, if you are uncertain.

If Jim and Sally decided to pursue an assisted living facility for him, the adult children could help them research and visit facilities that might be a good fit for him. The diagnosing physician would also need to be involved in the referral process. Additionally, there may be legal and financial decisions, including whether Jim was mentally competent, whether the cost of maintaining a home for Sally while Jim was in assisted living was feasible, and the impact of maintaining separate domiciles on Sally's financial security. While family counselors cannot provide any of these related services, we can explain the process as well as make referrals, when necessary. For example, because Jim's dementia could be at least in part a result of the traumatic brain injury (TBI) he sustained in combat during the Korean War, he may have been eligible for Veteran's

benefits that would have deferred some or all of the additional expenses for his care. Alerting the family to this possibility and either suggesting they contact the local Veterans' Affairs office or providing them with a phone number and perhaps a contact person are within the family counselor's scope of practice.

Because Jim and Sally have created a blended family, the legal and financial considerations might be complicated by disagreements among the stepchildren. Sally's children were protective of both her health and her financial security, whereas Jim's children contended that since Jim was better off financially when they married, much of the money was not Sally's to use. The legal aspects of this conflict would have been much simpler if Jim and Sally had specified how their assets would be used during their lifetimes and distributed after their deaths in a prenuptial agreement prior to their marriage. While a family counselor cannot write such a prenuptial document, she or he can suggest a remarrying couple do so with an attorney.

Helping adult children cope with the emotional repercussions of being told by an attorney that what one thought was one's mother's money was not her own falls within the scope of practice of a family counselor. These emotions may include anger, anxiety, hopelessness, and incredulity, which is more often referred to as denial. In Sally and Jim's situation, they were legitimate feelings, and family members needed to acknowledge them, accept them, and do what needed to be done to protect Sally while getting both her and Jim the services they needed.

Mark's parents, Emily and Bryan, presented a different set of challenges, as noted in Chapter 9. Aging family members like Emily and Bryan do not have a compelling need for the types of services Jim did. So a family counselor's approach to Mark's concerns about their health and well-being and to their upset that their son was pushing them to move would not be considered issues of safety. The family counselor could focus exclusively on the dynamics of the parent-son relationship, the family's realistic assessment of the pros and cons of Emily and Bryan remaining in their home, and then guide the family through the decision-making process. A family counselor's familiarity with services available in Emily and Bryan's community and the mechanism for determining whether they qualified for any would be helpful. However, because this family counselor was not in the state where Mark's parents lived, she might not have been familiar with services and qualification requirements in their state and could have instead suggested they or Mark call their state or county department of aging for suggestions.

Emily and Bryan needed to consider the relative costs of staying in their home or moving, as well as their ability to maintain their home. Pragmatics and emotions can be difficult to balance, especially when aging family members

equate moving from their home with losing their independence. If they decided to move, they would also need to decide whether to remain in the city where they currently lived and presumably had a social support network or move closer to Mark so he could be more involved with obtaining and monitoring care and other services as they continued to age. These were difficult decisions, with multiple factors in favor of each option. A family counselor can help with some but not all of them; for example, she or he cannot advise the family about the financial consequences of their decisions.

Martin's parents were both in their mid-60s and were the center of Martin's extended family, which included his siblings and their children. Martin's father's health was excellent, but his mother had suffered mild cardiac (heart related) problems for a number of years. She became very ill about the time her youngest child left for college, which may have affected her daughter's adjustment to living away from home. Since then, her condition had been well managed, and she was active and independent. At the time the family was in family counseling, she only needed routine medical care to monitor her health. The family counselor would have no role in referring her for services unless she needed to find a new cardiologist or primary care physician.

FAMILIES WITH BIOMEDICAL CONDITION

While biomedical diseases require diagnosis, intervention, and ongoing care by physicians and allied health personnel, family counselors can help patients, caretakers, and the entire family adapt to the changes, emotions, and demands brought about by ongoing, or chronic, diseases. We discussed the biomedical diagnoses present in the Manning-Kelly and Jones families in Chapter 9 and those related to aging in a previous section. In this section, we review the need to refer for medical and allied health services.

We have already discussed some of the issues associated with Jim's Alzheimer's. Additionally, the medical team that treats an Alzheimer's patient will explain to the family the associated health consequences, which include infections associated with decreased functioning as the brain deteriorates. The family counselor may benefit from conversations with the medical team, so that she or he can determine, for example, whether a family's anxiety is medically warranted.

Family counselors may be called upon to help the family understand the full meaning of a diagnosis and prognosis, find ways to cope with the patient and her or his disease, and make decisions about when the patient requires more care than the family can provide at home, as recommended by the medical team.

As patients lose independence and function, their reactions may add another level of difficulty for the rest of the family. For example, when patients with dementia or circulatory disease are no longer able to drive, they may rage and manipulate family members, and these relatives may find it difficult to say no even when they know that the patient's driving is unsafe. Physicians can be helpful in deciding when it is no longer safe for the patient to drive, and family counselors can be helpful to family members in learning to assert themselves despite their complex feelings about the patient's deterioration and the patient's reaction to losing independence. Family counselors can also encourage family members to seek further information from the medical team when questions arise that are beyond the counselor's knowledge or scope of practice.

At the other end of the life cycle, 4-year-old Emma experienced brain trauma during delivery and had been diagnosed with cerebral palsy. While cerebral palsy is not a progressive disease, it cannot be cured, and so the patient and her family need to adapt to her special needs and the impact of these needs and the diagnosis itself on the patient and family. Depending on the severity of diagnosis, Emma may be unable to reach her full intellectual or physical potential. That she walked and communicated verbally with Liz and attended preschool suggested that she will become fully independent as an adult.

As mentioned in Chapter 9, one hears both verbal and nonverbal messages that suggest Liz may be overly involved with Emma in transcripts of family counseling sessions. A family counselor could, with permission, communicate with the medical team and then, if appropriate, help redirect Liz's attention to include the developmental needs of her older children, who needed a mother to whom they felt important. However, only the medical team could advise the family about what the family could expect for Emma and how much parental attention her disabilities required. Similarly, if she were to need care after Liz and Mark died, an attorney would need to help them make arrangements for her.

As discussed in Chapter 9, when a child is born with special needs or becomes chronically ill, each of her or his parents may cope differently. The family counselor can assess the adaptability of the marital relationship and facilitate prevention or treatment of marital deterioration secondary to how the parents cope. However, if the marriage does not survive the stress of a special needs child, the family counselor can refer both partners to attorneys.

When Emma was diagnosed with cerebral palsy, Liz was distraught. Mark understood that the doctor did not yet know how severe her disability would be and decided to defer being upset until they knew with what they were coping. He also thought Liz was overly emotional and that it might have helped her if he remained calm. So he showed virtually no emotion following the diagnosis. Liz interpreted his behavior as lack of empathy or attachment to her or

their daughter. Mark was confused and hurt by her lack of appreciation for his strong demeanor. Perhaps these discrepant ways of coping and related misunderstanding were the origin of Liz's overinvolvement with Emma. And perhaps they were also the beginning of the deterioration of Liz and Mark's marriage.

Barbara's breast cancer was in remission and also a factor in the lives of the Manning-Kelly family members. Unless there was a compelling reason for the family counselor to include Barbara in family counseling, there would be no need for her to speak to Barbara's medical team. However, if a member of the immediate family had cancer, even if it were in remission, the family counselor would be well advised to consult with someone from the medical team. Family challenges with which the family counselor can be helpful were described in Chapter 9.

Returning to the identified patient, Christina, it was also important for the family counselor to know whether there were biomedical consequences of her eating disorder. These may include cessation of menstruation, damage to bones, and consequences for heart, kidney, liver, and immune system functioning. When weight loss is extreme, death may occur, and anorexic patients are usually admitted to hospitals when their weight drops below a certain percent of their ideal body weight. When self-induced vomiting occurs with bulimia, glandular, dental, and esophageal damage may occur. Although the literature does not mention damage to the pancreas, anecdotal observation suggests that family counselors need to assess whether there is a history of an eating disorder when clients in their 20s present with diabetes and no other health or family risk factors, as eating disorders can disrupt treatment for diabetes.

Family counselors need to be sure that clients presenting with either anorexia or bulimia are also under the care of a physician. Monitoring weight is beyond the scope of a family counselor's practice. In addition, it may place her or him in the role of a controlling parent, and anorexia is sometimes a way of telling an overcontrolling parent that the patient cannot be fully controlled. Replicating that dynamic in the client-counselor relationship could undermine the healing potential of the counseling relationship. Minuchin, whose theory of structural family therapy was described in Chapter 6, would tell the mothers of hospitalized anorexic patients to force them to eat. This intervention was aimed at highlighting the battle for control over the client's body.

Increasingly, eating disorders are being treated with psychotropic medication, particularly antidepressants. While there is some indication that seizures can be triggered when patients with a history of bulimia take certain antidepressants, there is also evidence that some antidepressants stimulate appetite in anorexic patients. If you are counseling a client with an eating disorder, it is important to ask whether she or he has been assessed for medication and

request permission to exchange information with the prescribing practitioner if she or he is taking medication.

Clients are best served when family counselors work with their physicians, irrespective of the biomedical or mental health diagnosis. You must obtain written permission to exchange information with the specific physicians and allied health professionals involved in the patient's care prior to sharing information about the client, even if the information might be helpful to the physician with her or him. If a client declines permission, it may be helpful to explore her or his concerns.

There are a number of in-patient treatment programs for patients with eating disorders throughout the United States. Best practices include a family counseling component. Because of the way medical costs are reimbursed, eating disordered patients may need to leave treatment before they are stabilized. For example, a client with whom one of the authors recently worked learned how to eat to gain a normal weight, but then funding for her care ran out before she achieved her target weight and learned how to maintain it. Family counselors can suggest clients in similar situations ask their physicians about the availability of nutrition counseling and obtain permission to communicate with both the physician and nutritionist in order to best coordinate care.

Christina's uncle, David, suffered from metabolic syndrome. This diagnosis refers to a combination of type II diabetes, high blood pressure, and high cholesterol. Prolonged substance abuse can compromise a variety of organ systems, and metabolic disease is also related to obesity. If David were a part of the family system in your office, it would be helpful for you to obtain permission to talk to his physician. Depending on the specifics of David's health and history, the physician would be able to provide information about prioritizing weight loss and treatment for substance abuse. Because David had been abusing substances for an extended period of time, his treatment would most likely begin in an in-patient program and your work would involve assessing for relapses, monitoring his compliance with out-patient treatment recommendations, and working with the family to change the family dynamics that may have contributed to his tendency to abuse substances. For weight loss, you would likely also want a specialist in diet and exercise for people with compromised cardiovascular functioning involved in his care.

It is not unusual for caretakers to exhaust themselves and become ill caring for a patient to the exclusion of themselves. Sally's blood pressure and sleeplessness, while possibly secondary to the stress of caring for Jim, required medical assessment. Family counselors who work with physicians can help clients manage stress while the physicians monitor the health consequences and biomedical symptoms.

FAMILIES COPING WITH MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS

Mental Illness. As family counselors, our job is to diagnose and treat mental illness from the perspective of the family's impact. So you may wonder why you are reading a section about mental illness. There are two reasons. First, diagnosis and treatment of the mental disorder itself may not be within the scope of practice for all family counselors. Some states preclude family counselors who are not also psychologists or psychiatrists from doing some kinds of diagnostic work, such as psychological testing. And all states preclude family counselors from engaging in medication management, brain scanning, and interpretation of the results of biomedical tests. Additionally, your training may not include work with certain patient populations, such as substance abusers or psychotic patients, and so you cannot engage in work with them without more specific training and supervision.

The second reason to include a section on mental illness is that some patients require services that your agency or practice may not be able to provide. These include, but are not limited to, substance abuse programs, in-patient treatment, day treatment, sheltered living situations, and assessment of cognitive impairment. However, if you continue your training in family counseling, you may be able to provide support services for the families of these patients and referrals for the patients themselves.

The Manning-Kelly family contained at least four members with diagnosable mental disorders and a fifth who potentially did: Liz and Christina both evidenced eating disorders; David had a history of bipolar disorder complicated by his polysubstance abuse; and Jim suffered from dementia, which is an organic mental disorder. It is also possible that Emma had developmental delays associated with her cerebral palsy. Each of these would have been addressed, as well as the client and family's need for services beyond family counseling.

Eating disorders are, in part, a disturbed relationship with food. As such, they often reflect or serve as metaphors for disturbed relationships in other parts of the client's life. For example, induced vomiting has been viewed as a metaphor for spewing anger and overeating for stuffing down unwanted emotions. In either case, anger and other feelings that might be productively dealt with within the client or her or his relationships are avoided and thus remain unresolved.

In many cases, eating disorders can be treated with out-patient psychotherapy. Family counselors may require additional training and supervision, depending on what the program from which they graduated and their postdegree supervision

provided. Eating disorders are complex, usually involving internalized cultural beliefs about attractiveness and health, individual and family histories, family dynamics that subtly support the eating disorder or prevent change, trauma, and entrenched beliefs about perfection, control, goodness, comfort, and food. Clients who present with eating disorders may also engage in other dissociative self-harm, such as cutting. A family counselor working effectively with eating disordered clients must be able to diagnose and treat trauma, psychodynamic processes, and family systems processes, as well as the behaviors apparent in the disorder's symptom picture. For all of these reasons, family counselors must know when to refer a client with a diagnosed eating disorder to another mental health professional, as well as to a physician.

Eating disorders can be life-threatening. Anorexia, which involves restricting caloric intake and overexercising, can cause bone, cardiovascular, reproductive, and brain damage. Bulimia adds the potential of esophageal, glandular, and dental damage to the mix. As when treating any mental disorder, family counselors must prioritize addressing life-threatening and other self-destructive behaviors and use whatever supports are available, including assessment for in-patient admission and referral to a psychiatrist for medication assessment and management, when necessary. For most patients with bulimic symptoms, interventions that facilitate bingeing without purging reduce the immediate risks.

Some clients with eating disorders have been hospitalized at least once for the disorder. Some have been in residential treatment programs, either in or out of a hospital facility. Any client with an eating disorder is best served when under the simultaneous care of a physician with whom the mental health professional has a good working relationship. The physician can monitor weight and health sequelae, or consequences, as well as assess and prescribe psychotropic medication. And, although nutritionists cannot change disordered eating, working with a nutritionist can help clients identify what they need to eat to regain and then maintain a healthy weight.

Because Christina was referred by her primary care physician, the family counselor could assume her weight did not suggest a need for immediate medical intervention. However, it would have been helpful for the family counselor to obtain consent to exchange information with that physician so that the two could work together to be sure Christina got the care she needed. Given Christina's age, a family counselor who works with eating disorders might either schedule an individual session to more fully assess Christina's disorder and then make recommendations for treatment or refer her to someone who was not concurrently seeing the family. The family counselor might also discuss the value of a referral for nutritional counseling with the physician, if she or he had

not, either now or at some point in the future when Christina was more willing to change her eating behavior. It is beyond the scope of this text to describe how the family counselor might facilitate Christina's progress to that point. As with many clients, Christina was in a situation in which other people thought her eating was problematic, and she had not yet endorsed it as an issue for her. This stance complicated and extended treatment.

Given what you have learned about family systems, it may not surprise you that Liz had also struggled with an eating disorder, as has her sister Barbara. A family counselor would ask Liz about the history of her eating disorder, when it began, what she thought triggered it, and how she managed it. The family counselor, whether seeing Christina individually or within the context of her family, would focus on the family dynamics and intergenerational messages that support eating disorders and prevent change. Some clients model their parents' relationship with food. Others find that their problem serves a function in maintaining family system homeostasis (see Chapter 4). For example, Christina's symptoms may have distracted her parents from emotional pain and conflict, and so she may have experienced subtle pressure to continue. Unfortunately, family dynamics usually reside below the level of family members' awareness, and family members do not comprehend an intellectual description of the pressures the client experiences to remain the same.

Imagine saying to Liz and Martin or to Liz and Mark, "I think Christina can't stop starving herself because she's afraid you'll fight more." Some family counselors would say exactly that (see Chapter 7). However they would say it to "gently perturb the system" and not because they expected the family to intellectually grasp the concept. Had the counselor said that in the first or second session, Liz and both Mark and Martin would likely have become so defensive that they would have left counseling. So family counselors work to change the dynamics, based on the assumption that changing the dynamics will remove impediments to client change.

If you are interested in working with families in which a member has an eating disorder or individually with eating disordered clients, who are often affected by the dynamics of the families in which they grew up or with whom they live, then you need specific training and supervision in diagnosing and treating eating disorders on both individual and family system levels. You also need to form and maintain both referral and working relationships with physicians, psychiatrists when medication is needed or the client arrives from the hospital already taking medication, and nutritionists.

Liz's brother, David, exhibited symptoms of bipolar disorder, although it was complicated by his polysubstance abuse. His substance abuse will be addressed in the next section of this chapter.

Bipolar disorder usually involves at least one hospitalization, depending on the age of the patient, and on-going care by a psychiatrist to manage the regular use of psychotropic medication. However, manic episodes are often ego-syntonic, meaning the patient views them as pleasurable while they are happening. Therefore, many bipolar patients do not take prescribed medication regularly.

Based on the information we have about David's history, he may have needed a number of services, including individual psychotherapy, medication management, medication oversight, substance abuse treatment in- and/or out-patient, sheltered living, and perhaps legal services for questions of child support and competence. We do not know much about his divorce, alienation from his son, or his inability to support himself. We also do not know whether he has had legal issues resulting from his polysubstance abuse. All may be related to one of his two mental disorders, bipolar disorder and polysubstance abuse.

Family counseling for David, his son, and his extended family may have been helpful, not in changing David but in changing the family dynamics that may have supported his symptoms. Just as eating disorders can serve as the mechanism that keeps the family system in equilibrium, David's inability to achieve financial and behavioral independence and fulfill his role as a father may serve a function in the family dynamics.

Jim's dementia was yet another example of a mental disorder requiring services beyond family counseling. Dementia is an example of an organic mental disorder, meaning it is a biomedical brain process. Because of the biomedical aspects of the disease, all dementia patients require medical care from both a specialist and their primary care physician. They may benefit from medication, again necessitating a physician to prescribe and manage. Early in the dementia process, Jim may have benefited from counseling, either individual or family, to cope with the enormity of the diagnosis and make some anticipatory decisions while he remained competent.

Decision making for Jim may have included what is termed a *living will* and a DNR, or do not resuscitate directive. While no one can fully anticipate the disease process, Jim could let his family know his wishes and codify them legally.

Sally, her children, and Jim's children may have benefited from family counseling around managing the emotions, tasks, and decisions related to Jim's care. If there was tension among the siblings about who was responsible for what and how Jim's disease should be managed, family counseling could help to both alter current interactions and heal old wounds that may have been exacerbated by the present circumstances. Some of these issues pertain to blended families and were discussed in an earlier section of this chapter. These issues may also arise in caring for an aging parent whose mental functioning is declining.

Sally, as primary caretaker, may have also benefited from a caretaker support group. It is very easy for caretakers to overlook their own needs and become physically and emotionally depleted. Because of the emotional and behavioral changes that occur in dementia patients, Sally will gradually lose the Jim she loves and be left with all of the challenges of caring for a difficult patient without the benefits of their loving relationship. How much she does or does not rely on her daughters for emotional support is a decision that could be addressed in either a support group or family counseling with her daughters. A family counselor can obtain permission to exchange information with her physician and alert her or him to any biomedical symptoms she or he notices.

Liz and Barbara were in what has been termed the “sandwich” generation. They were both busy with their own families of procreation, yet were bound to their families of origin. Liz had three children at home, one quite young and with special needs. She also had two stepchildren. Although Barbara's children were both grown, she had a grandchild, a husband, and her own health problems with which to cope.

Both Liz and Barbara may have wanted or felt obligated to help their mother as Jim's disease progressed. Yet both had competing demands on their time and energy. A family counselor could help them explore ways to achieve balance in their lives, set reasonable limits on what others could expect of them, manage their own feelings about what was happening to their mother and Jim, and refer for other support services such as Meals on Wheels. Sometimes dementia treatment centers provide family support groups, but that is not always financially feasible.

Finally, Emma may have had developmental delays associated with her cerebral palsy. As with Jim, these would be organic in nature. In other words, neither individual nor family counseling could change them. However, there are a variety of services available for children with developmental delays, including speech, occupational, and physical therapies and academic tutoring. A family counselor could intervene to help the Manning-Kelly family cope with grief around Emma's limitations and also ensure that the two older children were receiving the attention they needed as adolescents. Given Christina's eating disorder, it may have been important to test the hypothesis that the family dynamics around coping with Emma's cerebral palsy had not been totally effective. Additionally, any serious diagnosis for a child may be associated with marital distress, and a family counselor could intervene to help the parents avoid such dynamics as mutual blame, reduced empathy for how the other copes, and the sense that the other is not doing enough as a product of there being simply too much to do rather than the other's unwillingness to contribute.

When a family enters family counseling, it is not unusual for one or more members to be taking psychotropic medication. Whether the prescription is written by a psychiatrist, neurologist, or primary care physician, it is useful for the family counselor to obtain permission to exchange information with the physician. The family counselor often sees the family more regularly than the physician does and is therefore able to communicate timely information, for example, about compliance or effectiveness of medication, that the physician might not otherwise learn until a routine follow-up a month or more later.

Family counselors are also in a position to refer one or more family members for a medication evaluation. It is useful to have a list of at least three psychiatrists who the family counselor trusts and with whom she or he has good working relationships to provide clients who may require medication. As with legal and other referrals, family counselors are not in a position to provide medical, legal, or other specialist advice. However, they can tell clients they recommend consultation with the appropriate professional and explain why.

Substance Abuse. Substance abuse is a mental health issue and yet also has unique physiological components associated with addiction. These were described in detail in Chapter 9.

Addiction adds a second layer to substance abuse. Clients suffering from addiction have developed a physiological or psychological dependence on the substance. Physiological addiction involves tolerance for the substance they are abusing. Tolerance means that they require more and more of the substance to achieve the same physiological reaction and suffer negative symptoms when they do not ingest the substance in that quantity. These clients cannot stop using the substance or substances they are abusing without risk of physical consequences, some of which may be life threatening. If they do decide to change their substance abuse, a physician may recommend they do so in an in-patient treatment facility where the potentially life-threatening consequences of stopping use can be treated as effectively as possible.

Clients with substance abuse disorders may require in-patient detoxification for their physical safety, residential out-patient treatment, or a 12-step group. Ideally, family counseling will be made available in any treatment program, and many 12-step programs offer groups for family members, though groups for partners and children may be separate from each other and from the abuser, rather than the conjoint family counseling you have been learning about throughout this textbook.

The Manning-Kelly family's only member with an obvious substance abuse disorder was Liz's brother, David. The information available indicates that David suffered from polysubstance abuse, meaning that he abused more than

one substance. We do not know whether he was addicted and would likely have referred him to a physician to diagnose addiction and prescribe appropriate treatment.

Family counselors sometimes learn about client drug seeking, which refers to visiting several physicians for medications and then filling prescriptions at several pharmacies so that no one tracks how much medication the patient is taking. Electronic medical records somewhat alleviate this problem. However, when a family counselor is concerned about substance abuse and has consent to speak to the primary care physician about the family, it may be helpful to inform the physician about what the family counselor knows about prescriptions from other physicians.

DOMESTIC VIOLENCE

How family counselors are expected to respond when they learn of domestic violence is codified in legal statutes in all states. To review, all states require family counselors to report suspected abuse of dependents: children, the elderly, and those with disabilities. In other words, when someone is unable to get away from the abuser, the state takes over the protection of that individual.

Domestic violence between adult partners who are physically able to remove themselves is more complicated, as the abused partner is expected to remove herself or himself when physically able in terms of the law. However, in many instances, there is dependence or coercion that interferes with the victim's physical ability to leave, including the abuser manipulating or threatening the abused. Family counselors can address financial and emotional dependence, as well as the dynamics between partners that lead to manipulation and violence. It is beyond the scope of this textbook to provide a review of the various perspectives on treating domestic partner abuse. However, it is important to remember that such treatment must be within your scope of practice as a family counselor if you engage in it. If it is not, then you must ethically refer the family to someone who works with domestic violence.

Families experiencing domestic violence may need legal counsel. There are also support groups in many communities, as well as women's shelters. Partner violence directed at men is not uncommon, though it tends to be even more underreported than violence against women and so there are less resources for male victims of domestic violence. Additionally, police departments may have a domestic violence unit, which includes support for avoiding violence and not simply apprehending perpetrators of domestic violence.

Following the revelation that Mark had sexually abused Christina, the Manning-Kelly family would need legal counsel. Mark would need an attorney to guide him through the investigation that was likely to occur and to defend him if the investigation resulted in criminal charges. Liz would need counsel if she decided to terminate the marriage or in the event she was charged as a colluder in the abuse. The family and the family counselor would interact with the child protective agency in their jurisdiction. Liz and the children may also have needed legal advice or police protection if Mark refused to leave the family home.

CONCLUSION

We have reviewed eight family issues that may require services beyond a family counselor's scope of practice. These are multicultural families, LGBTQIA families, single-parent families, blended families, families with aging members, biomedical disease processes in families, mental and substance abuse disorders within families, and domestic violence. We have also surveyed some of the services with which family counselors must be familiar so that they can make appropriate referrals. We will now turn to a more specific review of resources other than family counseling that are available to families with whom family counselors also work.

Extend Your Learning:

1. Choose among the following films about families. Watch individually, as a small group, or as a class. Discuss the main issues presented. How might you work with this family? Who would you need to refer for treatment elsewhere? Why?

Rachel Getting Married

Ordinary People

When a Man Loves a Woman

The Kids Are All Right

The Incredibles

2. Consult the phonebook or other local directory in your community. What populations appear to be served by the agencies listed? What populations are clearly missing? How would you direct a client with an issue beyond the scope of your practice in a community with limited resources?

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FOR FURTHER STUDY

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