MAY // JUNE 2015

FAMILY THERAPY

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

FAMILY THERAPY IN THE AGE OF TRANSNATIONALISM

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Strengths, obstacles, and common themes relevant in therapy

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Family therapy around the world:
See what systemic therapy is like in Brazil, India, Norway, Sweden, Germany, and China

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"Should we encourage or guide clients towards a utopian state of marital fulfillment, or encourage clients to find whatever works best for them?"

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LETTERS TO THE EDITOR

We encourage members' feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

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TRANSNATIONALISM: "A New Way of Thinking About Relationships Between Cultures"

THE TOPIC OF THIS ISSUE of *Family Therapy* reminded me of an old text I still have in my office. Edited by Florence Kaslow, *The International Book of Family Therapy* was published in 1983, just a couple of years after I graduated from my doctoral program. I pulled it off the shelf and flipped through the chapters and was reminded of the excitement and passion of the early days of family therapy (the book contains a brief history). I was also reminded of brilliant and passionate family systems thinkers from around the world who were making an impact on how we thought about and worked with people and families. Work in the field of family therapy is still going on around the world.

It is also true that a lot of grad students come to the United States to study, with plans to return to their home countries to work in their chosen fields. Did you know that 886,052 international students were enrolled in U.S. institutions of higher education in 2013-2014 (Institute of International Education, 2014)? That number represents an increase of 8 percent over the number enrolled 2012-2013, and a growth of 72 percent since 2000. Nearly 90,000 of the international students studying in the U.S. during 2013-2014 were graduate students. While the number of international students in mental health disciplines in the U.S. is small in comparison with those in the sciences, math, and business, those students are an important part of both the educational and the future professional landscape of the field. Given that many international students intend to return to their countries of origin to work, and that U.S.-born graduate students may wish to work abroad, it is critically important to consider the impact of our programs and practices in the U.S. on those who will work outside the U.S. at some point in their professional lives.

One of my responsibilities as a faculty member is to serve on dissertation committees. One of the most rewarding and fun (for me) dissertations I have ever chaired was written by a woman who had spent several years living in Hawai'i. She also, interestingly enough, had an undergraduate degree in anthropology. Her curiosity about other cultures was and is strong, and the friendships she still maintains from her time in Hawai'i only honed her desire to understand people and the cultures in which they live. She developed a particular interest in Japanese culture and, during her time in the doctoral program where I teach, she also sharpened her interest in how international students who study in the United States and then return to their home countries adapt what they have learned in the U.S. to their work there. Her dissertation, *The Transcultural Application of Western Counseling in Japan: A Grounded Theory* (Freeman, 2009), was the result of her curiosity, sound research skills, ability to recognize and set aside her own cultural assumptions and "knowing," and willingness to listen and try to deeply understand what "others" say about themselves and their worlds.

As a faculty member and proud dissertation chair, it was delightful to watch the unfolding of Dr. Freeman's ideas and understanding. It was amazing and a bit humbling to track her progress as she traveled to Japan to talk face-to-face with clinicians who trained in the U.S., but then returned home to Japan to practice with individuals, couples, and families. It was enlightening to read the co-researcher/participant's own words and descriptions of the processes they went through and to read Dr. Freeman's careful consideration of what she learned. It was downright fun to look at the oversized drawings and figures she made as we taped

them to my bookshelves and talked through the theory that was emerging from her work. And it helped to enhance my sensitivity to international students and the additional layers of consideration they have to give to what they are learning—especially if they are returning to their home countries to work—an especially important piece for me since we have a number of international students in our program.

As a clinician and systemic thinker, it was something else entirely. It was a challenge to think more deeply about my training and the context in which I received it. It encouraged me to remain curious and to remember that my research skills are as important in the room with clients as they are on campus. It reminded me to always question what I think I know and to recognize and, where necessary, set aside my own assumptions that are part and parcel of the culture in which I have lived. Perhaps more than anything, it was a reminder to always—always—listen deeply for context and meaning. I found myself wondering about what it would be like to practice therapy in an entirely different part of the world, where ideas about how individuals, couples, and families "work" might be very different than those embedded in me. Naturally, I had attended workshops about cultural competence, diversity, and the like, and had read about others who worked in cultures vastly different from their own. But somehow, watching my (now) former student conduct her research and entering more closely the world of the clinicians she interviewed, reached me at a different level. Reflecting back, I think it was the personal connection with her and her personal connection with her co-researcher/participants that made it a powerful process for me even at a step or two away.

I hope the contents of this month's *Family Therapy Magazine* reach you at a level that is meaningful for you!

—Marvarene Oliver, EdD, LMFT, LPC

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corrections

AAMFT Organizational Restructuring 2015 Booklet: On page 69 of the printed version, the report listed four provinces in Canada as having divisions. This should read that there are six Canadian provinces with divisions. We apologize for the error.

Page 11 of the March/April issue of this magazine noted that 18% of MFP Fellows are male and 71% are females. These should have been noted as total quantities rather than percentages. FTM regrets the error.

Leadership Symposium: Building a Bridge to the Future

On March 19-21, AAMFT held its inaugural Leadership Symposium in Arlington, Virginia. Welcoming nearly 150 attendees—ranging from established leaders in the field looking for opportunities to continue to grow and diversify, to new and emerging leaders eager to find their voice and help shape the future—the energy in the Symposium was electric.

Through a mix of keynotes, breakouts, and workshops, attendees were asked to challenge themselves with introspection and interaction. By thinking about their future roles in not only their own careers, but in their contributions to advancing the profession as a leader, visions were shaped for what could be for the future.

I am glad that issues for minority women were explicitly explored.

Kudos for presenting and executing an exciting new format for the leadership symposium. I'm excited to be part of the future of this organization.

This was an excellent experience for me. It was useful to network with other professionals and gather ideas to push the profession further.

An amazing opportunity to network and better understand the field/community.

I think this was a great launch!! The focus was well defined, the messages consistent; well organized. Enjoyed seeing a variety of presenters and appreciated the professionalism throughout.

Good content and presenters. Great opportunity to reflect and develop both personally and professionally.

This was an excellent experience for me. It was useful to network with other professionals and gather ideas to push the profession further.

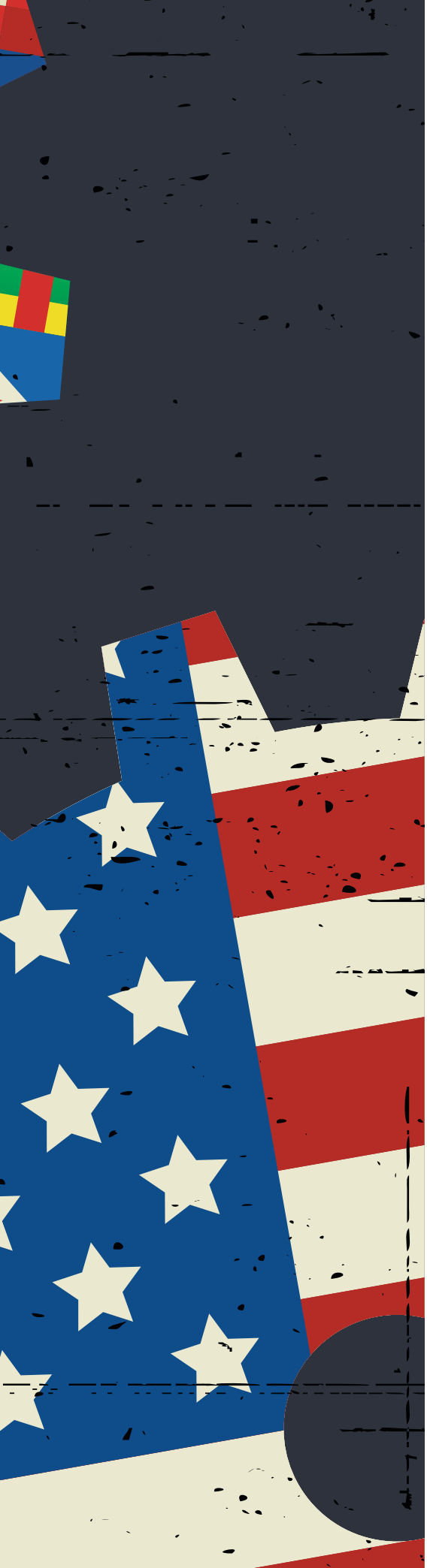
Great forum to discuss leadership and encourage our field to promote profession. Great speakers with enthusiasm.

Enjoyed the new style—presenters were high quality. Content was well done, impressed with diversity of attendees (age, race, and ethnicity).

Save the date for the 2016 AAMFT Leadership Symposium from March 3 – 5, 2016 in Santa Fe, New Mexico!

An Exchange of Wisdom:

THE GLOBAL EDUCATION OF MARRIAGE AND FAMILY THERAPISTS



The United States has witnessed an enormous influx of immigrants into the country, now totaling 39.9 million people, up from 9.6 million in 1970 (U.S. Census Bureau, 2010). During 2000 to 2010 alone, nearly 14 million immigrants made the United States their home. The leading countries-of-origin of immigrants in the United States include Mexico, China, India and the Philippines, according to a survey in Immigration Worldwide (Segal, Elliott, & Mayadas, 2010). These individuals speak dozens of languages and bring with them a wide variety of distinctive cultures, behaviors and values. For couples and family therapists who work with multi-cultural families, these statistics become vital as we attempt to understand the nuances that exist within diverse cultures, and how these cultural differences impact family systems.

Frank M. Dattilio, PhD

Differences in attitudes, beliefs and behaviors that U.S. marriage and family therapists need to be particularly sensitive about include:

- boundaries between individuals, especially family members
- power and control in couple and family relationships
- views of gender
- expression of affection
- handling issues with a significant emotional component, including loss, conflict, homosexuality and intermarriage, and
- dealing with mental illness.

We must become particularly sensitive to the issue of mental illness and how people of different cultures express and communicate this distress. This includes views on institutionalization as opposed to caring for one in the home or the community as well as how the stress of mental illness is dealt with.

Some excellent research is currently underway that indicates the need to incorporate a more individualized understanding of cultural differences among families and developing culturally competent interventions, research and practice. Steven Lopez, PhD (as cited in DeAngelis, 2015), a cross-cultural psychological researcher at the University of Southern California, and Stanley Sue, PhD, a distinguished professor of clinical psychology at Palo Alto University, have emphasized the importance of understanding specific factors that inform an individual or families' presenting problems as opposed to generic research wisdom about their ethnic group as a whole.

Certain treatment approaches, among them systemic approaches, have also been studied to assess how they may be more effective with various cultures. For example, a cognitive-behavioral approach that accommodates various cultural schemas into the treatment process. The need to tailor treatment to an individual's or family's cultural values, beliefs, habits and customs has been borne out by meta-analytic studies. Overall, research that has focused on both experimental and quasi-experimental studies reveal that culturally-adaptive treatments are more effective than conventional therapy (Smith, Rodriguez & Bernal, 2011; Benish, Quintana & Wampold, 2011).

Tori DeAngelis has written a very interesting article in the March 2015 issue of the American Psychological Association's *Monitor on Psychology*, which discusses the notion that effective treatment of people in diverse cultures requires solid research on cultural adaptations of proven treatments. She persuasively argues that as we work with family systems, we need to develop the ability to understand, appreciate and interact with people from cultures or belief systems that are different from our own. In her article, DeAngelis gives an excellent example of Mexican-Americans with serious mental illness, suggesting that clients tend to relapse when they return to family members who are inclined toward emotional over-involvement. By contrast, studies of European-Americans show that their condition tends to worsen when they return to homes high in criticism. In DeAngelis' article, cross-cultural

According to the 2010 Census, the U.S. population included **39.9 MILLION IMMIGRANTS**

Don't miss Frank Dattilio's keynote address, **EXPANDING THE HORIZON OF MFTS GLOBALLY**, on Friday, September 4, 2015 from 4:30-6:00 p.m. in Austin, Texas.

researcher Steve Lopez argues that it is important to assess individual families and determine what the likely predictors for relapse might be for that particular family. Partnering with Mexican or European colleagues can help us to better understand the dynamics of families of these cultures and how we can most effectively work with them here in the United States and Canada.

In short, we have a lot to learn about cultural sensitivities if we are going to achieve effective therapy with immigrant clients in the U.S. The good news is that there is a large and thriving non-American MFT world out there—a world that can teach us a tremendous amount about effective ways to work with clients from other countries. The ongoing barrier, however, is that American MFTs in the U.S. do not always seem to recognize these international sources of information and wisdom. There is a perception that we have been happy to export our way of doing therapy to others around the globe, but less interested in learning from the worldwide marriage and family therapy community.

Unfortunately, very little has been published as to whether or not immigrants feel well served by American therapists due to their lack of knowledge about cultural differences. Nor is there much literature concerning how MFT practitioners around the world perceive American marriage and family therapists. As a first step in trying to remedy this privation, during the course of my preparation for my keynote address for the 2015 annual conference of the American Association for Marriage and Family Therapy, I conducted a survey of marriage and family therapists worldwide in an attempt to understand how we could better serve each other's needs, and what each of us has to contribute regarding the global impact of marriage and family therapy. The results of the survey were quite surprising, and many interesting insights were gleaned. I will be discussing the results and what I discovered during my keynote in Austin this September. It is my hope that my keynote will offer useful ideas and spark a productive discussion about how members of AAMFT can facilitate a balanced collegial exchange with colleagues throughout the world in order to help us all grow to better serve our worldwide community. A special addition will include comments beamed in from MFTs around the world.

It is my impression that we American marriage and family therapists need to modify our thinking if we wish to establish better relationships with colleagues across the globe. We need to show our international counterparts that we understand—and truly believe—that they are an invaluable source of information, experience and wisdom to us as we strive to help immigrant families and grow in our knowledge and development as MFTs. It is my belief we can best achieve this goal by actively engaging in a mutual collaborative relationship with our worldwide counterparts on an ongoing basis.

Frank M. Dattilio, PhD, ABPP, is one of the leading couple and family therapists in the world and is specifically known for his development of the Cognitive-Behavior Therapy model of treatment. He currently holds part-time faculty positions with the Department of Psychiatry at Harvard Medical School and the University of Pennsylvania Perelman School of Medicine. He has published close to 300 professional publications and 20 books in the areas of couple and family therapy and psychological disorders. To date, his works have been translated into 30 languages. Dattilio has lectured on just about every continent in the world and his works are used in over 80 countries. He is a Clinical Fellow of AAMFT and currently serves on the editorial boards of a number of professional refereed journals including *The Journal of Marital and Family Therapy*, *Contemporary Family Therapy*, and *Couple and Family Psychology: Research and Practice*. Dattilio has been the recipient of numerous awards for outstanding achievement in the fields of psychology and psychotherapy. He is also the 2010 winner of the Pennsylvania Association of Marriage and Family Therapist of the Year Award, as well as the recipient of the 2013 Outstanding Contribution to Marriage and Family Therapy Award through the American Association for Marriage and Family Therapy.

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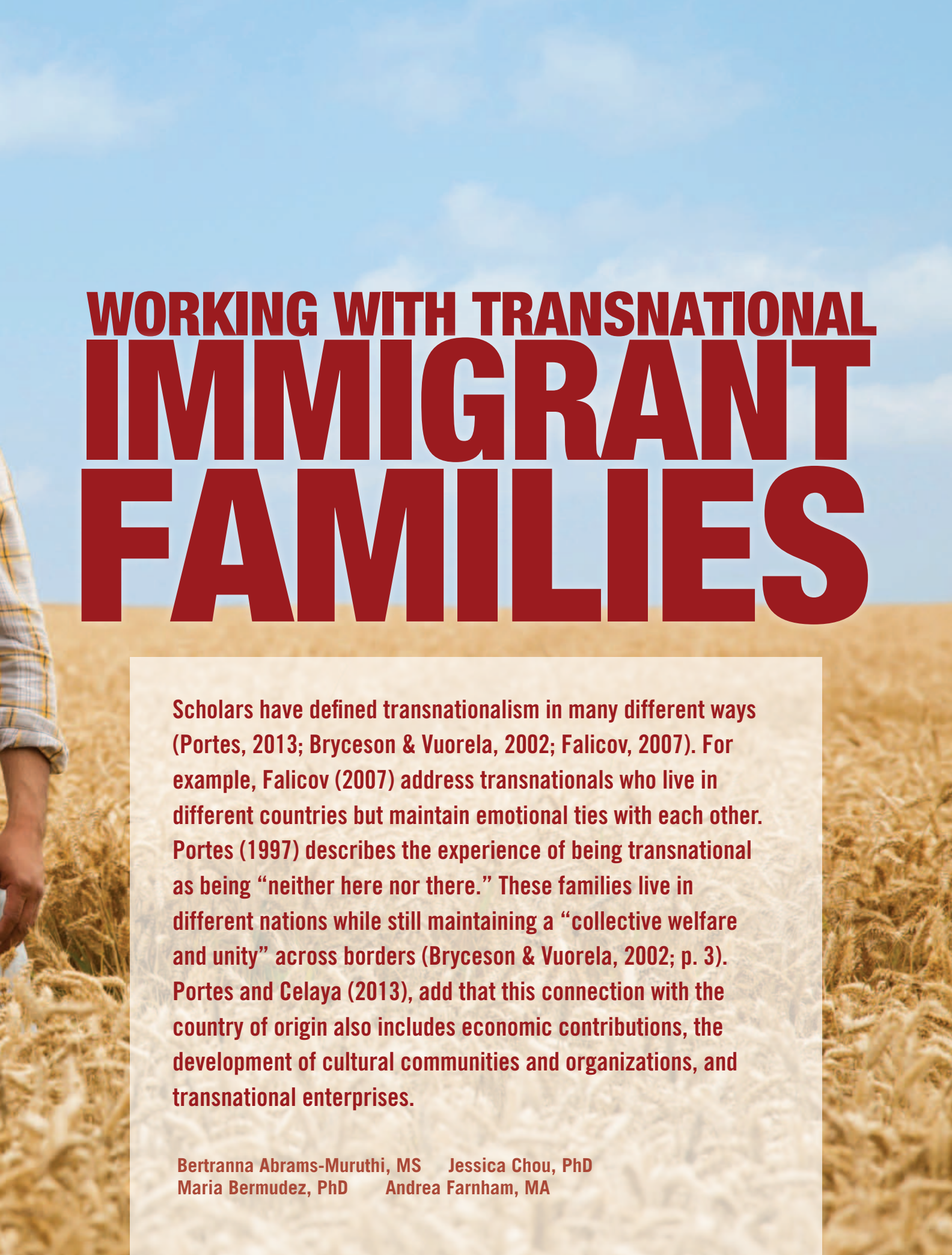


WORKING WITH TRANSNATIONAL IMMIGRANT FAMILIES

Scholars have defined transnationalism in many different ways (Portes, 2013; Bryceson & Vuorela, 2002; Falicov, 2007). For example, Falicov (2007) address transnationals who live in different countries but maintain emotional ties with each other. Portes (1997) describes the experience of being transnational as being "neither here nor there." These families live in different nations while still maintaining a "collective welfare and unity" across borders (Bryceson & Vuorela, 2002; p. 3). Portes and Celaya (2013), add that this connection with the country of origin also includes economic contributions, the development of cultural communities and organizations, and transnational enterprises.

Bertranna Abrams-Muruthi, MS Jessica Chou, PhD
Maria Bermudez, PhD Andrea Farnham, MA

This can create complexities in immigrant cultural adaptation, as transnationals bring values and beliefs across national borders (Osirim, 2008; Guarnizo, Portes, & Haller, 2003). Although transnational immigrants have a multitude of strengths, our intention is to help couple and family therapists become aware of some common themes that are relevant to transnational families in therapy.

Insight into experiences of transnational living

The concept of transnational families is not a new phenomenon; however, there are notable reasons why transnationalism has become more relevant for marriage and family therapists. As globalization has become the norm, culturally-aware family scholars and practitioners are beginning to understand the significance of transnationalism for the families we see in therapy. Their family dynamics are unique and fluid, and their identities and ways of "doing family" must be better understood in multiple contexts. Specifically, we must re-examine our Westernized views and cultural norms that assume that stable families have a stationary "home base." Although there are a myriad of topics to address when working with transnational families, we chose to address the most common themes most salient in the social science literature and those that we have encountered during our own clinical work with transnational families; acculturation processes, economic responsibilities, change in the family structure, and parent-child separation.

Acculturation processes

Stress from migration and transnational living for a family is inevitable and must be considered (Falicov, 2007). Transnational individuals visit the host nation frequently while continuing to practice native cultural beliefs and behaviors (Reynolds, 2005; Chioneso, 2008). Although maintaining contact with heritage culture is valuable, these behaviors have three main effects on their acculturation process in host nations. First, constantly re-living native practices as one is living in a host country can increase ambiguity regarding processes of acculturation. Secondly, the tendency to hold on to native-culture practices impacts sociocultural beliefs and practices of host societies. And thirdly, the dynamic nature of such cultural practices creates a shift in the structure and roles of the family. These effects on the processes of acculturation bring to light factors that contribute to the ambiguity of what is considered home. As families try to navigate the processes of adaptation for the individual(s) who are migrating, it is necessary to consider how complex acculturation processes affect and create changes for a family unit.

Economic responsibility

The process of immigration and traveling back and forth can be costly, but migration often serves as a means for economic stability for the migrant and their family members left in sending nations (Bradatan, Melton & Popan, 2010). As these immigrants become more established in the host country and are more economically stable, they make more financial contributions and increase their investment in their home country (Portes & Celaya, 2013). Immigrants often send a significant portion of their income to relatives in their native countries. These monetary remittances are determined by 1) the composition of the family at home and abroad, 2) the level of disposable income (wages), 3) the income differentials and 4) the anticipated length of stay in the host country (Sampson & Branch-Vital, 2013). Remittances have also been noted to have a positive effect on the growth of a country because it helps reduce poverty, ease consumption and lessen the financial struggles of the poor (Nwaogu & Ryan, 2015; Sampson & Branch-Vital, 2013). Although transnational obligations can be beneficial to the receiving family members, it can also create financial strain for the family member who is trying to maintain multiple households in host and native countries on little income. This can create dissonance between family members in the country of origin and the individual abroad. For example, families in the native country may not understand the financial struggles of the individual in the host country, especially if these individuals live in poverty in the U.S. and appear financially stable in their country of origin.

Transnational obligations can create financial strain for the family member who is trying to maintain multiple households in host and native countries on little income.

Gender role expectation

Gender scripts and family roles often shift within a transnational family context. Families with scarce resources view immigration as a "bottom-line survival strategy" (Antrobus & Deere, 1990). Such families migrate in search for better economic opportunities, which could guarantee better social status and upward mobility, however, these families might face separation

at the time of immigration because limited resources do not allow for migration as a family unit (Antrobus & Deere, 1990; Chioneso, 2008). This process results in a stage migration, where family members migrate when others are settled and gain citizenship or residency in the host country (Landale, Thomas & Van Hook, 2011). It has been noted that the feminization of the service industry has an impact on migration because it is easier for women than men to qualify for labor certification largely due to the demand for domestic work in American cities (Foner, 2009; Cortes, 2015). Hoang & Yeoh (2011) found that this feminization creates the new position of women as breadwinner and provider for the left-behind family, a role that many traditional immigrant families ascribe to men.

This shift of gender roles can be understood in the context of transnationalism because constructions of gender differ from country to country. For example, transnational women in the U.S. may enjoy more rights and privileges and can be forced to revert to hegemonic gender expectations when they travel to their native countries. The pressure to conform to different cultural expectations may trigger acculturative stress in those who are more assimilated to U.S. norms (Cooper, Linstroth, & Chaitin, 2009). Once women gain residency or citizenship, they may send for a spouse who may react to this by asserting old patterns of traditional role scripts, which can lead to couple conflict and/or marital dissolution (Falicov, 2007).

When children join their parents in the host country, parents expect gratitude, but children sometimes express feelings of ambivalence, resentment, or indifference.

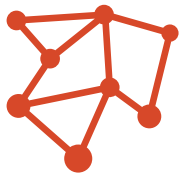
Parent-child separation

Family forms can shift as family members live in a transnational context. Children are often left with extended family members or a remaining parent in the native country who takes care of them. Parents often make strong efforts to maintain contact with their children, and for many, their primary goal is to contribute to their child's material well-being (Suarez-Orozco, Hee, & Ha, 2011). What can complicate matters is that although parents are familiar with the host country, children continue to age, develop, and learn different values and customs that may create gaps in the growth of their relationship with their parent (Sciarra, 1999; Suárez-Orozco,Bang, Kim, 2011). For example, Falicov (2007) found that when children join their parents in the host country, parents expect gratitude, but children sometimes express feelings of ambivalence, resentment, or indifference. In a study done by Suárez-Orozco, Bang, and Kim (2011), children reported missing their parent(s) living in the homeland, but when separations were for extended periods of time, they reported feeling like they were meeting a stranger or a distant relative.

Clinical considerations

Following are a few points to consider when working with transnational families in therapy or when conducting outreach in other contexts.

- Broaden your assumptions about transnational families. When most people hear the words "transnational families," they assume these families are immigrants. While it is true that some are immigrants, many are not. Military families may fall into this category and other situations can create reasons why families have to live apart and go back and forth from country to country. For example, people work abroad for extended periods of time and their family members might stay in the homeland and only visit when possible. Another point to consider is that many families do not self-define as being transnational (Bradatan, Popan, & Melton, 2010). This may be a new term to them and it may or may not be helpful for them to define themselves in this way.



Transnationality does not just refer to having family in two nations, but may involve having family in multiple countries.

- Expand your definition of family well-being and stability. As MFTs, we are often trapped by Westernized and rigid views about what is normative. Transnational families present with many family forms with their own unique benefits and challenges. Though this article focuses more on nuclear family perspectives, transnationality can exist among extended and other family relationships. For example, collectivist cultures value the importance of the extended family network and may have obligations to take care of their needs.
- There are varying degrees of transnational mobility for families. A family's legal and socioeconomic status will strongly dictate their ability to go back and forth. Those who are legal residents have more freedom to travel compared to those who risk their lives to illegally cross borders to see their children or other family members. Also, transnationality does not just refer to having family in two nations, but may involve having family in multiple countries. According to Goulbourne (2010), this multifaceted definition of a transnational family suggests a need for a more nuanced definition of this migration phenomenon.
- Expand therapeutic role to that of a cultural broker. As a starting point,

therapists should consider their role of connecting clients to community resources that will support the continued transitions the client is experiencing. When the client is in a marginalized position, they need an advocate, and the therapist can be the bridge between the clients' needs and navigating the dominant culture. If therapists are not familiar with the clients' cultural context, we should make efforts to learn, and connect the client to a community that can further support and offer insight from a lived perspective.

- Help clients expand their social support network. Once the connection with the homeland changes through migration, it can be difficult to define new relationships in the host country (Bradatan, Popan & Melton, 2010). In the absence of family members, clinicians can help immigrant families solicit support from different surrogate kin networks (Baptiste, 1987). Surrogate networks can be churches, social service agencies, and other social affiliations that can serve as a support for the family (Baptiste, Hardy, Lewis, 1997).
- Assess psychosomatic symptoms and their meanings. When individuals have limited access to family support, this can lead to increased risks of developing somatic complications and illnesses (Reynolds, 2005). Be aware that clients who experience pain related to anxiety, or other symptoms related to depression, may be referred to therapy by a doctor. Therapists and clients can explore the psychosomatic symptoms in the context and the feeling of cultural ambiguity.

Given the heightened awareness of transnational families as a unique family form, it is important for family therapists to consider the complexities of cultural adaptation within these families. By re-examining Western views of a "home base," therapists can better meet the needs of clients through understanding experiences of: acculturation processes, economic responsibilities, change in the family structure, and parent-child separation. In order for best practice, family therapists must stay culturally sensitive and well informed when addressing the ambiguous nature of transnational living.

Bertranna Abrams-Muruthi, MS, is a doctoral candidate in the MFT program at the University of Georgia. She is also an AAMFT Minority Fellowship Dissertation Fellow. Her research centers on developing culturally responsive intervention and prevention programming for immigrant families. Abrams-Muruthi is a Student member of AAMFT.

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THE MFT PROFESSION ABROAD

I (DS) recently attended a paper session entitled "Do MFT Models Travel Well Internationally?" (Wang & Glebova, 2015). In my experience, marriage and family therapy (MFT) models travel as well as the MFT practitioner, scholar, researcher, and trainer: Are we willing to adapt to and embrace other people, values, and ways of being, to learn from indigenous cultures, to be responsive to systemic needs, and to be culturally humble and gracious travelers?

Desiree M. Seponski, PhD **Charity Somo, MEd**

Globally, MFT is a fairly new commercialized profession, as recent as the late 1970s in non-Western countries (Ng, 2005; Kaslow, 2000), and there has been a growing, expressed need for MFT in many parts of the world (i.e., East Asia, Africa). This emergence has resulted in unique approaches, successes, and challenges in practice, supervision, and training. MFT is practiced differently and distinctively across and within nations, and MFTs are making incredible steps toward establishing marriage and family therapy as a respectable and independent profession in their local countries.

With our experiences as an MFT assistant professor (DS) who trains, supervises, researches, collaborates, and co-learns in Southeast Asia, and an international student (CS) who is studying in the U.S., we share our experiences of international applications of MFT.

SOUTH AFRICA: OVER THE LAST 20 YEARS, EXISTING MFTS IN SOUTH AFRICA HAVE BEEN WORKING ON ESTABLISHING MARRIAGE AND FAMILY THERAPY AS AN INDEPENDENT PRACTICE AND THESE EFFORTS ARE STILL IN PROGRESS.

The training for MFTs varies by country. For example, in East Asia and Sub-Saharan Africa, MFT training is offered as part of another mental health profession such as social work or psychiatry (Nwoye 2001; Ng, 2005). This training is often limited to a few credit course or workshop series (Ng, 2005); in Southeast Asia, trainings are often conducted as one-day seminars or weekend intensives by visiting scholars. In South Africa, a training certificate in MFT is offered for mental health professionals, such as counseling psychologists and educational psychologists. Training in MFT is offered in various professional and educational settings, such as national institutes for mental health or medical schools, and as part of professional development (Ng, 2005).

Many non-Western countries do not offer graduate training in the MFT field. As a result, most professionals who have studied or study overseas (America, Canada, Australia) often "run into or accidentally come across" MFT (Dupree, Pierce, Luthra, Huff, Green, & Dupree, 2012, p. 314). I (CS) came across family counseling in my master's course in educational psychology at a University in South Africa. During my training, we had to take a course in family systems theory so that we would be able to intervene with children at the family level; we were told that we could not call ourselves family therapists unless we sought additional training in family therapy through a locally offered certificate in MFT. Following my interest in helping children with special needs at family levels, I began to explore international training opportunities in family therapy, and realized that family therapy is not offered without the inclusion of marriage counseling. It was at this point that I discovered MFT. Before this I had never heard of it. Because there is little to no formal training in MFT outside Western countries, most licensed MFTs in these countries carry a Western qualification and licensure.

THE REGISTRATION AND LICENSURE PROCESS in non-Western countries mirrors the training process. Some countries, i.e., India, have recently established regulations boards for the practice of marriage and family therapy (Ng, 2005). In South Africa, you may attach your MFT qualification as part of your formal registration in another mental health profession. Before you can practice as an MFT, you must be a registered and practicing professional in another mental health profession that is recognized by the Health Professions Board of South Africa (HPCSA), such as counseling psychology or educational psychology; you are not able to register with the HPCSA as an MFT. Existing MFTs in South Africa have been working on establishing marriage and family therapy as an independent practice and these efforts are still in progress (Ng, 2005). Still, other countries do not have a regulations board for the practice of marriage and family therapy, and no standardized procedures that regulate the practice of MFT exist (Ng, 2005); many of these countries do not have regulatory boards for mental health practices in general.

As a result of a shortage in formal training and limited professional licensure, **professional supervision and mentorship opportunities a**re scant. Practitioners in East Asia report that there is no formal supervision available for practicing therapists (or those who desire to enter the profession) and that it is through informal peer case consultation that they receive mentorship and professional development (Ng, 2005). I (DS) have observed many of my newly graduated MS students in Cambodia go straight into supervisory and administrative roles, as opposed to clinical practice, because they are needed to supervise bachelor's-

BECAUSE THERE IS LITTLE TO NO FORMAL TRAINING IN MFT OUTSIDE WESTERN COUNTRIES, MOST LICENSED MFTS IN THESE COUNTRIES CARRY A WESTERN QUALIFICATION AND LICENSURE.

level clinicians. They often express feeling challenged to provide supervision with limited personal clinical experience and no supervisory mentorship or guidelines. Along the same lines, MFTs who are trained overseas typically take academic positions overseas or practice privately in their home countries therefore perpetuating the shortage in academic faculty, practice supervisors, as well as peer mentors for those who are training locally (Rastogi, Natrajan & Thomas, 2005).

Most MFTs have the desire to increase their training and have **theoretically sound practices,** especially in marriage and family therapy-specific theories (Rastogi, Natrajan & Thomas, 2005). Because MFT training is nested within formal training in other qualifications, these practitioners find themselves applying theories from other mental health models such as Rogerian and psychodynamic schools of thought (Rastogi, Natrajan & Thomas, 2005; Nwoye, 2001). Many of these practitioners are often not able to expend the repertoire of skills in MFT because they do not have sufficient time to pursue additional intensive self-study and/or workshops on MFT-related skills and topics. Additionally, while some countries such as South Africa are able to host numerous workshops annually and sometimes invite notable MFT scholars, other countries do not have the financial resources to host such conferences (Nwoye, 2001; Ng, 2005). The result of a shortage in supervision and mentorship leads to the practice of MFT to be based on professional "instinct" (Rastogi, Natrajan & Thomas, 2005, p. 462). Due to the expressed desire to increase the practice of theoretically-informed MFT in their own countries, many countries **collaborate** with Western professionals, regulation boards, and institutions on professional development efforts. This collaboration has been beneficial in exposing

INDIA: INDIA HAS RECENTLY ESTABLISHED REGULATIONS BOARDS FOR THE PRACTICE OF MARRIAGE AND FAMILY THERAPY

therapists to more theories, case work experiences, and international perspective, but can be challenging when the presenters are not culturally responsive to the native context, such as being responsive to local values of well-being, addressing needs as understood by the local population, considering and incorporating indigenous healing practices, and understanding how the family and its systems are conceptualized.

CAMBODIA: MANY NEWLY GRADUATED MS STUDENTS IN CAMBODIA GO STRAIGHT INTO SUPERVISORY AND ADMINISTRATIVE ROLES, AS OPPOSED TO CLINICAL PRACTICE, BECAUSE THEY ARE NEEDED TO SUPERVISE BACHELOR'S-LEVEL CLINICIANS.

In principle, the practice of marriage and family therapy can be helpful for families globally. Consider **cultural values** that exist in non-Western cultures that are consistent with the practice of MFT—many African cultures are collectivist in nature, resulting in an individual's commitment for the greater good of the family and the community. This commitment to the collective lends itself to the ideal that families would be open to interventions that would benefit the family systematically. What tends to be different is the approach of these interventions. In South Africa, systematic family interventions are common, as an entire immediate and extended family system comes together to share problems, solutions, and resources in order to address family issues. These interventions are often led by family members through meetings, planned initiations, implementations and follow-ups, as opposed to being facilitated by an external agent such as a therapist.

Although the systems-oriented principles of Western-based MFT theories resonate with many non-Western cultures, MFT approaches need to be evaluated for fit between model and context before being applied cross-culturally (Epstein, Berger, Fang, Messina, Smith, Lloyd, & Liu, 2012). Cultures vary in terms of individualism vs. collectivism, egalitarian vs. hierarchical relations, talking vs. doing, and high vs. low context (Wang & Glebova, 2015). Privileging Western values when disseminating MFT models can be colonizing, patholgizing, and harmful to native therapists and clients (Wang & Glebova, 2015; Seponski & Jordan, 2015). To increase the global usefulness of marriage and family therapy, it is crucial to be culturally responsive, relying on local knowledge and values to inform each aspect of the training, practice, supervision, and research (Seponski, Bermudez, & Lewis, 2013).

Overall, little **empirical research** has been published on the use of marriage and family therapy theories and models internationally. Existing non-Western MFT research publications are essays written on the experiences of the authors or reports of the state of MFT in different countries. Authors of these studies are often local therapists trained at overseas institutions and expand on certain MFT topics through

CULTURES VARY IN TERMS OF INDIVIDUALISM VS. COLLECTIVISM, EGALITARIAN VS. HIERARCHICAL RELATIONS, TALKING VS. DOING, AND HIGH VS. LOW CONTEXT

articles from research dissertation and/or parallel studies. However, the lack of evidence-based research should not be misconstrued that MFT is not "successful," but perhaps that scholars have limited access to publication venues or their jobs do not emphasize/require this dissemination process. For example, several studies presented at international conferences suggest that MFT models and theories are being adapted and implemented with success (Piyavhatkul & Arunpongpaisal, 2015; Low, 2015).

Overall, the international recognition of the profession and use of MFT models is exciting and promising. Despite the slow progress in MFT growth globally, Nyowe (2001) reported that the **future of MFT i**n Africa is bright, as many African nations consider marriage and family therapy an essential practice with the growing needs of African families. Likewise, MFT practitioners in other parts of the world, such as Brazil, are hopeful that the profession is growing (DuPree et al., 2012). Such growth promotes co-learning and collaboration on how we conceptualize, implement, and evaluate MFT abroad and in our native countries.

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HOW DOES MARRIAGE AND FAMILY THERAPY LOOK AROUND THE WORLD?

THE FIELD OF MARRIAGE AND FAMILY THERAPY (MFT) is growing and gaining acceptance in the United States at a very fast pace. The U.S. Bureau of Labor Statistics (BLS) has projected employment in the field to grow by 31 percent during the 2012-2022 decade (U.S. Department of Labor, 2014; Learn.org, 2015). In addition, the BLS noted that 37,800 professionals were employed as marriage and family therapists in 2012, and this number is expected to grow to 49,400 by the year 2022. The American Association for Marriage and Family Therapy (AAMFT) reports that there are over 50,000 professional therapists counseling couples and families throughout the country (AAMFT, 2015). Further, *U.S. News & World Report* ranks the field number 35 on their top 100 list of best jobs in 2015.

No doubt, the field is growing in recognition and popularity in the states—but how does the field look in other countries? I decided to reach out to some colleagues and friends around the globe to find out.

Lisa Reynolds, PhD

BRAZIL

I BEGAN A DIALOGUE with psychologist Bianca Welikson Vasconcellos a few years ago (personal communication, February 10, 2015). She had contacted me after coming across a divorce and parenting book I had written that had been translated into Portuguese. She was interested in bringing training on best practices in parenting during divorce to Brazil. I recently contacted her for feedback on how the field of marriage and family is progressing there.

Bianca practices privately in Brazil, and sees clients at a medical clinic, as well. She says that the divorce rate is on the rise there. In fact, the number of Brazilians getting divorces is at a record high, according to the South American Nation's Brazilian Census (IBGE) statistics, as reported in *Huffington Post* (2012). More than 350,000 divorces occurred in 2011. That's up 46 percent from just the year before. This is due in large part to Congress enacting a law that makes it quicker and easier to get a divorce in the most populous Catholic nation on earth, with no waiting period. Additionally, in the same year, the Supreme Federal Court voted in favor of allowing same-sex couples the same 112 legal rights as married couples. According to the *Guinness Book of World Records*, the São Paulo Gay Pride Parade is the world's largest LGBT Pride celebration, with 4 million people attending in 2009 (Wikipedia, 2015). Brazil has 60,002 same-sex couples living in the same home (*LGBT Weekly*, 2011). Indeed, this makes for a very "ripe" population of potential consumers of marriage and family therapy.

Brazil still lags behind in assisting residents in consuming family therapy services.

Accordingly, Bianca has found an increase in both the utilization and social acceptance of marital and family therapies offered in her country. She has seen a marked increase in families looking for help. However, she also feels that Brazil still lags behind in being able to assist residents in consuming these services. First, insurance pays very little for marital or family counseling. Therefore, therapists must often collect much of the fee from the clients themselves. Such financial burdens often keep them from seeking out the services that could help them. Rates for services vary greatly, largely depending on *where* the practice is located and how *well* the therapist is known.

Bianca, and many others, complete a psychology degree at a university, and then have the option of taking training courses on a variety of topics and specialties, including systemic methods. She describes there being "many different models of therapy being practiced here," and feels that this is a good thing because, "There is no way people will not be able to find a therapist they like." However, she hopes that she can bring even more cutting-edge programs and trainings to therapists and clients in Brazil. For example, despite the variety of continuing education courses available, Bianca has struggled to find specific training on best practices for helping couples' navigate the process of divorce and the subsequent task of effective co-parenting.

INDIA

FATHER TOMICHAN MOONNANAPPILLIL (Fr. Tom) is a practicing Catholic priest from India, who is just finishing up his master's in MFT at a college outside New York City. I interviewed him about his experience with marriage and family therapy in his country.

Fr. Tom reports that, outside the biggest cities, there are very few therapy practices or clinical opportunities for residents throughout much of India (personal communication, February 17, 2015). He describes the Indian people as being very private. Traditionally, people there share the cultural view that families should settle their own issues amongst themselves. They very rarely go outside their family system for help in dealing with problems, and if they do so, it is often to an extended family member only. In fact, he claims that it is not uncommon for members of a family system to step into each other's business, and intervene in interpersonal issues or disagreements. Not only is this acceptable, but is largely expected within Indian families. Therefore, he has experienced there being great stigma attached to going to family therapy. Also, as a patriarchal society (one where the values uphold the dominance of men in positions of power and control), he believes that males in India feel even more besmirched by the prospect of seeking out therapy.

Traditionally, people share the cultural view that families should settle their own issues amongst themselves.

India has enjoyed one of the most historically low rates of divorce in the world. Traditional standards of remaining married, and strong religious influence have likely

supported this. However, those numbers are changing, especially in more urban areas of the country. According to Fr. Tom, despite a growing divorce rate, seeking out marital counseling, or help with separation, is very rare. Further, most therapy costs must be paid out of pocket by consumers. The United Nations reports that one-third of the world's 1.2 billion "extreme poor" live in India alone (2014). Clearly, this further complicates residents being able to access the help that might assist them with family stressors and issues.

Fr. Tom has found, however, that utilizing one's priest or religious leader to assist with personal or family issues is far more acceptable than seeking out marital or family therapy. He has found far more success being "accepted" as a helper into family systems by being a priest than a marriage and family therapist. Therefore, he believes that it is important for these religious figures to be trained in, and to provide systemic views and support, for the individuals and families they may see.

SCANDINAVIA

I INTERVIEWED TWO RESIDENTS who utilized MFT services in Scandinavia, one from Sweden, "Freja," and "Lise" from Norway, as well as one therapist, "Brigit" (names have been changed for anonymity), who works at a public clinic in Sweden. Additionally, I gleaned information from Dr. Barry Duncan, a prominent and well-respected MFT leader in the U.S., who has served as an experienced consultant and trainer in Scandinavian countries since 1999.

Freja and Lise both sought out marital counseling in the past two years (personal communication, February 22, 2015). They reported similar experiences, despite living in two different countries. Both had their sessions at government-supported clinics, and both saw therapists who reported specialized training in systems work and couples counseling. They agreed that there is far less stigma associated with marital or family issues, especially when it comes to separation or divorce, than in many other countries. Freja and Lise each shared their gratitude that the government subsidized their sessions, so there was no out-of-pocket expense. They believe this financial support is what makes it possible for so many people to get the help they need. "Without it [the government funding], my partner and I would likely not have done couples counseling, and perhaps we would not still be together two years later," Lise offered.

Freja expressed having no hesitation or embarrassment about seeking out marital counseling. However, she described Swedes as being "very private people," and so she found it rare that she or any of her friends or family discussed if they had been to therapy, despite the fact that she knew a few of them had. She also credits the great influence of Public Service Television in Sweden, and feels it was a very powerful statement when they aired a documentary in 2012, entitled *Par i Terapi* (roughly translated to "Couples in Therapy"), that followed six couples through their marital counseling experience.

Freja also believes that family therapy will be even more needed in the future, as she sees the younger generations developing more conservative "core family values." "They will need help in keeping their families together. The older generations were more casual about multiple relationships yielding children, but the new generation seems to be adopting more traditional marriages." Indeed, a quick internet search turns up more than a handful of challengers to the popular belief that marriage is a dying institution in Scandinavian countries.

"They will need help in keeping their families together. The older generations were more casual about multiple relationships yielding children, but the new generation seems to be adopting more traditional marriages."

The Swedish therapist, Brigit, agrees that "times are changing" [with younger generations] and believes that family therapy will continue to be a growing field there (personal communication, February 22, 2015). She reports that, if anything is an obstacle, the occasional waiting lists that occur when providers are full with cases may be an impediment for treatment. However, she has not found that discomfort, embarrassment or stigma have been issues responsible for people not seeking family mental health services. She shares that there are many opportunities for training and workshops in systemic work, but she does not believe there are adequate "degreed programs like there are in the [United] States."

Lise, in Norway, also reported that she and her partner attended the country's mandatory mediation session with a family therapist prior to finalizing their divorce. She said that this meeting is required by every set of divorcing parents who have minor children together. However, she was disappointed that only one session was required, and believes that it would be better to mandate more sessions for parents. "If they are only forced to go to one, then the

onus falls to the parents to pursue further counseling, and in this case, many may not follow through."

After sharing some of the content from these interviews with Dr. Duncan, he was not surprised by much of the feedback. He agrees that the government subsidizing therapy sessions in both private and public (clinical) sectors enables almost anyone who wishes to receive treatment the opportunity to do so. Additionally, he shared that mental health treatment is separated into two distinct systems—traditional, diagnostic-based psychiatric treatment for children and adults, much like the U.S., and a more systemic alternative providing couple and family counseling that does not require diagnosis. Perhaps the lack of diagnoses translates into less stigma regarding seeking help for couple or family issues. Imagine what it would be like to never again agonize over the least-pathologizing diagnosis to give a client who presents for therapy with family disaccord as the primary issue!

Dr. Duncan's experience with these countries over the years is that they are very systems-thinking savvy, and are very progressive in their training and adoption of cutting-edge family therapy concepts. They are big fans of solution-focused, narrative, and language-based family therapy models. Anker, Duncan and Sparks (2009) demonstrated the benefits of client feedback with couples in a Norwegian setting, as well as ongoing training there instrumental to the national implementation of Partners for Change Outcome Management System (PCOMS), a client-based feedback system in Norway's couple and family therapy centers.

It seems that Scandinavian countries enjoy a far more supportive and accepting environment for utilization of MFT services than many others. The government subsidy of treatment seems to be a large part of the acceptance, availability, and better utilization of mental health services. Additionally, although the respondents described privacy as being important in their cultures, there seems to be a wider acceptance of family issues, marital disruption, and a general tolerance for a broad range of family constellations.

GERMANY

FAMILY THERAPY IN GERMANY has a distinguished history. Helm Stierlin, MD, studied in the 1960s-1970s in the U.S. (with Minuchin, Haley, Weakland, Milton and Erikson), and held positions in National Institute of Mental Health. He founded the Family Therapy Institute in Heidelberg, Germany, which to this day trains family therapists and provides research in systemic approaches.

I interviewed Dr. Ingeborg Haug, long-time professor of MFT in Connecticut, distinguished clinician and supervisor, and author of countless publications. She is originally from Germany, returns there regularly, and continues to be updated and involved in the field of MFT there.

As in several of the countries discussed in this issue, Germany does not grant graduate degrees (as in the U.S.) in MFT, but offers psychologists specialized post-graduate training in systems work and family therapy at freestanding institutes across the country. Until several years ago, MFT was seen as a sort of "fringe treatment" in Germany. However, in recent years, the field has finally succeeded in being recognized as a specialty that is now reimbursable. This development has obviously made family therapists far more able to survive in practice. In fact, during her own recent exploration of how she might be able to become "licensed" in Germany, Dr. Haug discovered just how difficult and rigorous the standards have become for a person to obtain that standing (personal communication, March 5, 2015).

People in Germany value privacy, and do not generally discuss going to therapy.

Dr. Haug echoes the sentiments of other interviewees in that people in Germany value privacy, and do not generally discuss going to therapy. Family therapy appears to be more socially acceptable than marriage counseling, and treatment for children is perhaps the most accepted form of treatment. She also reports that there is a fairly strong stigma attached to seeking out family or marital counseling in Germany. Despite this lingering view, the country continues to progress in the field of MFT. Although systemic therapy in Germany "seems to be more didactic and has an intellectual feel," according to Dr. Haug, this type of therapy is gaining interest and acceptance, albeit slowly. There are two major MFT organizations in the country, and several Germans clinicians have spoken at AAMFT conferences. Systemic therapists there are researching and publishing, and helping to hone clinicians' skills with a variety of interesting and cutting-edge course offerings.

CHINA

Dr. John Miller, professor of MFT at Nova Southeastern University, also director of the Sino-American Family Therapy Institute, and winner of the Fulbright Senior Research Scholar Award in 2009, lived and conducted research in Beijing, China. He has been a visiting faculty lecturer at several top psychology programs in China and Southeast Asia, and is actively engaged in scholarly training projects there.

Dr. Miller described his experiences with MFT in his work and travels across Asia (personal communication, March 11, 2015). Chinese mental health has historically been ruled by psychiatry, with little room for other types of therapy. In the last decade, however, things have changed dramatically. With growing social problems emerging, there is a call for a broadened offering of different types of mental health services in the Chinese context.

During these last 10 years, Dr. Miller described the changes he has seen: more agencies have been created and opened; there has been more collaboration between mental health providers; and there is a marked increase in university-based training programs in MFT methods. There are many new clinical models of therapy that are amalgamations of Western and Eastern models, and some that have been created anew by leading Chinese therapists.

Although systemic thinking seems like an ideal fit for the Chinese people (given their collectivist culture, and how life and experience is largely organized around the family), it may not be utilized as fully as it could be. Many Chinese have a strong sense of "saving face." That is, they feel compelled to keep a stoic, private, and proud stance on struggles or personal issues. However, Dr. Miller has found that many people in China are willing to share if there is an environment of trust and positive relationship with the therapist. The World Health Organization (WHO) has identified "stigma" as one of the main barriers to mental health service worldwide (2003). Overcoming this barrier is one of the main challenges facing the next generation of therapists in China.

Dr. Miller shared a couple of topics that he has experienced as being very powerful to the Chinese people. First, we cannot underestimate the importance of the "one-child policy" that has existed there for many years. One possible unintended consequence of the only-child-policy involves the increased pressure an only child (or grandchild) may feel in terms of his or her family's hopes and expectations. Likewise, a parent or grandparent may recognize that this child is their "one shot," and unintentionally project their anxiety and desperation on the child. They may not hold back on making these intentions overt, and may be unable to hide the disappointment or shame they feel with any failures the child has in succeeding to meet the expectations set for him or her. There is the potential to create a multigenerational phenomenon that will likely be the focus of future research regarding Chinese family process.

Rapid economic development and the increasing influence of Western media and culture have had an impact on Chinese families. As Western influences (like fast food and media) have grown there, so have certain other issues. While some things "exported" from the West may be beneficial, others may create unforeseen problems. Depression, anxiety, and eating disorders are on the rise. As these issues continue to be more common occurrences, it is important that mental health offerings reflect the current needs of the Chinese people. This will involve being sensitive about the possible negative consequences of transplanting Western methods to the Chinese context without being sensitive to how well they fit the culture.

We cannot underestimate the importance of the "one-child policy" that has existed there for many years.

Perhaps the most important bit of wisdom Dr. Miller bestowed was of his strong belief of the importance of students and clinicians having an international experience. Even the best U.S. schools and MFT training programs are capable of giving only a glimpse into the experience of the people in other cultures. "Western media is not always accurate," he offers, and shared that his own travels and experiences in Asia and other countries have given him knowledge that he believes would have been impossible for him to have discovered otherwise.

There are several themes that seem to run through, and connect, many of the stories of how family therapy looks across the globe. It is vital that our field continues to focus on, and dialogue about, how to better serve those who need our services most. First, the stigmatization of those who seek out mental health services appears to still exist in many places. This may prevent potential clients in need from seeking out family therapy. Second, there should be concern for the lack of funding for these services in many countries, and the financial hardship this puts on potential users of mental health counseling. Third, becoming more culturally sensitive to the unique views, traditions, and beliefs that each family has regarding their system, and the possible

To learn more about Bianca's work in Brazil, visit **www.biancawelikson.com.**

For more information about Dr. Duncan's work in Norway, PCOMS, or his Heart and Soul of Change Project, visit **https://heartandsoulofchange.com.**

Dr. Miller can be contacted at **jm2790@nova.edu** about his work abroad or regarding interest in student training trips.

discomfort with, and distrust of, outsiders assisting them with issues should be explored. Systemic therapies should be fitting for all families, regardless of cultural differences. However, understanding and being sensitive to the particular nuances of each family is vital.

Although it may seem that the U.S. is a "hotbed" of growth and activity on the MFT front, we must be careful with both our assumptions, and with the thought that we should go into other territories to make them more like us. Dr. Haug agrees that, "We cannot go out internationally and attempt to colonize others. We need to go in as learners and conversationalists, rather than simply as teachers." She also so wisely stated, "You never know where the next Milan or narrative model will come from." Perhaps the best efforts will come from global education, and international experience and dialogue.

Lisa Rene Reynolds, PhD, is a licensed marriage and family therapist in private practice in Connecticut. She is a Clinical Fellow of AAMFT, and an adjunct professor in the psychology department of Western Connecticut State University. Reynolds is the author of several non-fiction books, including *Parenting Through Divorce: Helping Your Kids Thrive During and After the Split.*

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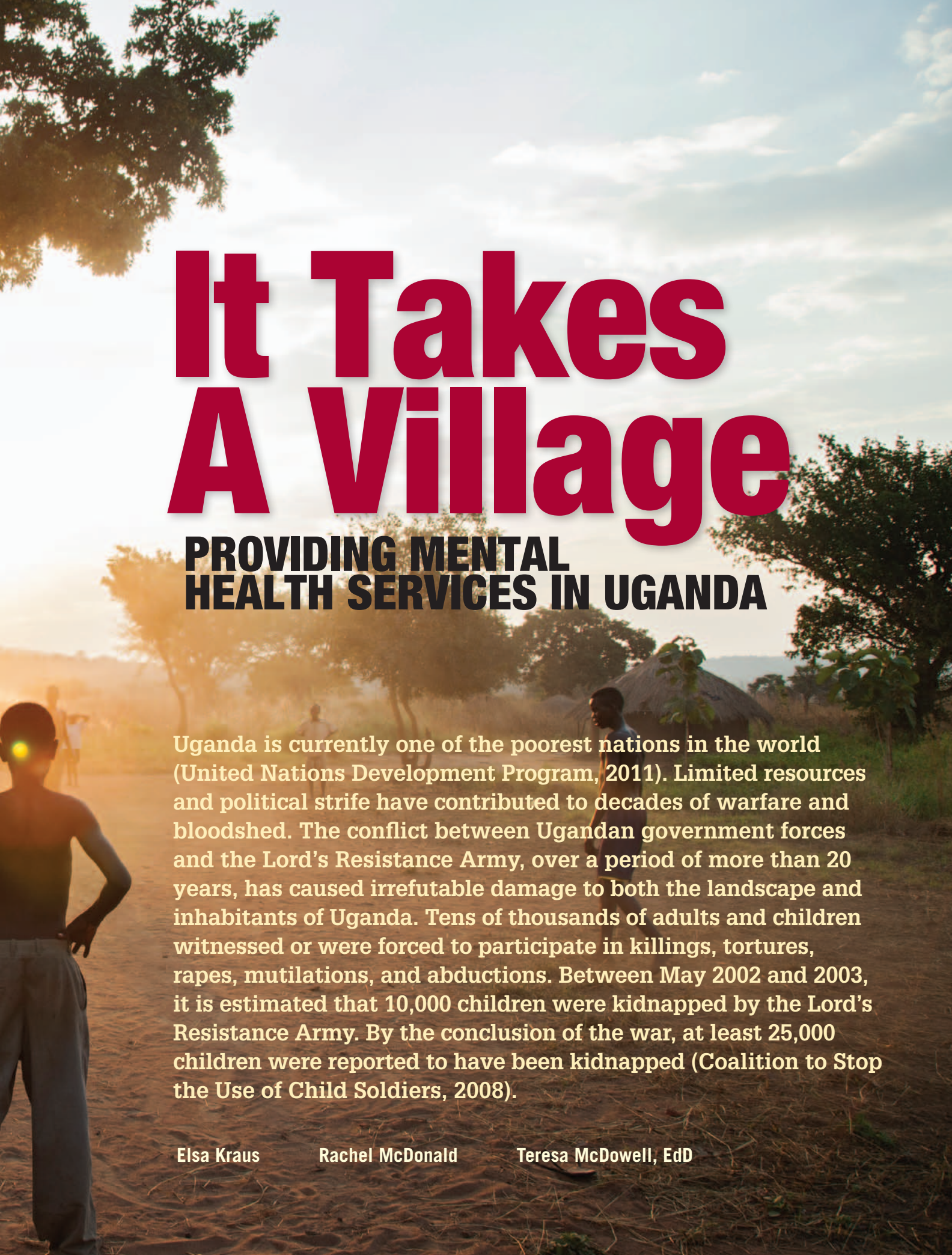

It Takes A Village

PROVIDING MENTAL HEALTH SERVICES IN UGANDA

Uganda is currently one of the poorest nations in the world (United Nations Development Program, 2011). Limited resources and political strife have contributed to decades of warfare and bloodshed. The conflict between Ugandan government forces and the Lord's Resistance Army, over a period of more than 20 years, has caused irrefutable damage to both the landscape and inhabitants of Uganda. Tens of thousands of adults and children witnessed or were forced to participate in killings, tortures, rapes, mutilations, and abductions. Between May 2002 and 2003, it is estimated that 10,000 children were kidnapped by the Lord's Resistance Army. By the conclusion of the war, at least 25,000 children were reported to have been kidnapped (Coalition to Stop the Use of Child Soldiers, 2008).

Elsa Kraus Rachel McDonald Teresa McDowell, EdD

Multiple traumas, mental health concerns, as well as communities' difficulties accepting and reintegrating abducted peoples have made healing from these human rights violations deeply challenging (Klasen, Oettingenm, Daniels, & Adam, 2010; Bannink-Mbazzi & Lorschiedter, 2009). These challenges specific to Uganda are deepened by the universal struggles perpetuated by oppressive-gendered, socio-economic frameworks. Ugandans, like all world citizens, fight against domestic violence, sexual abuse, and child neglect. Research has shown that these problems can get significantly worse with poverty. Currently 38 percent of Ugandans live on less than $1.25 a day (UNICEF, 2015).

In Uganda, adolescents account for almost 25 percent of the total population, with 2,700,000 of those children being labeled as orphans (UNICEF, 2015). That is the approximate population of Chicago, Illinois, the third largest city in the United States. These children often live with relatives or in group homes. The social impacts from the spread of HIV/AIDS and related deaths have dramatically shifted how families and communities are organized. Child-headed families have become commonplace. Parents and relatives suffering from HIV/AIDS are often unable to care for or provide for their children. As of 2013, over seven percent of the adult population is estimated to be HIV positive (UNICEF, 2015).

This reality has a significant impact on children's education, safety, nutrition, material necessities, community relationships, and emotional needs (Kipp, Satzinger, Alibhai, & Rubaale, 2010). While evaluating an assistance program for families who are caring for orphaned children, Roby & Shaw (2008) found that 78 percent of the orphaned children's mothers and 65 percent of the orphaned children's fathers died from AIDS. Addressing the psychological, social, and emotional needs of the orphaned children and their foster families is important for overall well-being, but is lacking due to limited resources (Kipp et al., 2010). The results of these statistics are many child-headed households and children working to support their families (Bolton & Wilk, 2004; Kipp et al., 2010). Past traumas of a war-torn country ravaged by disease have perpetuated a pattern of poverty and continued colonization, and exacerbated mental and physical strife throughout Uganda.

When these conditions caught the world's attention, Western Eurocentric mental health ideas and practices soon followed. The association between mental health assistance and having HIV/AIDS stigmatized the field. This pattern has been exaggerated by well-intentioned interventions from outside Uganda that have unwittingly served as yet another colonizing force. Providing mental health interventions without being a cultural insider, who can bridge Western practices with local healing practices, can yield results that are ineffective, at best. Ugandan counselors are, however, rising to the challenge—working diligently to combat the damaging psychological effects of war, HIV/AIDS, and colonization to restore their communities. Driven by the struggle and suffering around them and equipped with first-hand knowledge of what their communities need, Ugandan counselors give their time and money to seek higher education in the counseling profession and provide help in their communities.

Despite the immense need for mental healthcare, there is only one accredited counselor training center in the Fort Portal region of Uganda: Bishop Magambo Counselor Training Institute (BMCTI) founded by Dr. Paschal Kabura. Here, counselors develop the necessary skills to serve the communities they know best. Their work is not without challenges; cultural stigma prevents counseling from being treated as a profession and there is very little funding available for training or practice. At present, the field of counseling in Uganda is not fully recognized by the government as a profession and Ugandan counselors face an uphill battle because of the context surrounding how professional counseling first came to their country. It is a risk for people who choose to enter the field of because they will spend money on a degree that may not bring them a sustainable income upon completion. Very few Ugandan

ADOLESCENTS ACCOUNT FOR ALMOST 25% OF THE TOTAL POPULATION, WITH 2,700,000 OF THOSE CHILDREN BEING LABELED AS ORPHANS

Clockwise from top left: BMCTI front gate, collaborative workshop, outdoor classroom, BMCTI workshop participants

counselors express receiving a livable wage for the services they offer. Many report having two professions, such as teaching and counseling, or nursing and counseling. It is the commitment to healing and witnessing the transformative power of counseling that fuels Ugandan counselors to keep doing what they do.

It Takes a Village Uganda (ITV Uganda, 2014) began as a result of a two-week workshop hosted in Fort Portal at the Bishop Magambo Counsellor Training Institute (BMCTI), in 2014. Family therapists and counselors from both BMCTI and the Marriage, Couple and Family Therapy program at Lewis & Clark College Graduate School of Education and Counseling (located in Portland, Oregon) had the opportunity to exchange knowledge and practices that are most prevalent within their cultural contexts. Participants from both countries collaborated on topics that are universally relevant and exchanged information about how culturally-specific contexts influence the ways healing can be facilitated. ITV Uganda emerged from this ongoing collaboration between family therapists and counselors in Uganda and the U.S.

ITV Uganda supports access to mental health education, training, and community outreach in Fort Portal, Uganda and the surrounding region. We are dedicated to ending the cycles of violence, poverty, and colonization that have historically disempowered Ugandans. We provide financial and other much needed resources to help Ugandan counselors create positive change in their own communities. ITV Uganda believes that Ugandan counselors are most knowledgeable about what is needed to promote greater well-being in their own country. ITV Uganda works to share power and resources in order

190,000 CHILDREN UNDER THE AGE OF 18 ARE LIVING WITH HIV IN UGANDA.

to promote local knowledge and counseling practices that come from Ugandans. Our collaborative work also provides opportunities to examine how family therapy knowledge and counseling practices transfer across borders.

At BMCTI, counselors have the opportunity to work towards certificates in HIV/AIDS counseling and child and adolescent counseling, as well as Diplomas, including bachelor's and master's degrees in counseling psychology. Many students who receive a degree from BMCTI go on to teach courses at the institution and practice in their local communities, while maintaining other jobs. Many of these trained counselors came to the field because people were coming to them naturally for advice and they saw the need to develop better skills to help their neighbors. They address issues of school problems, parental disagreements, spousal distress and abuse, and are many times looking for resources to help alleviate the symptoms of poverty. Many of the trained counselors do extensive community outreach projects to extend a helping hand to rural regions. These projects include counseling at prisons, counseling in orphan group homes, and hosting empowerment groups for vulnerable populations. Equipped with local knowledge, thorough training, and modest financial resources, these dedicated professionals can make an enormous impact.

Concepta, a teacher and counselor at BMCTI, facilitates an outreach program with teenage mothers who are also survivors of sexual abuse, domestic violence, and childhood neglect. Through this program, she strives to provide young mothers with adequate skills to support themselves and their babies. Concepta teaches them about physical and emotional health and hygiene, as well as skills that will disrupt the cycle of poverty like sewing, weaving, or baking. She undertakes these efforts without additional compensation and often the cost for her supplies, such as the gas to travel to the women and hygienic supplies such as toothbrushes or soap, are taken from an extremely stretched supplementary fund at BMCTI.

A student, currently working on her bachelor's degree from BMCTI, works specifically with homeless, HIV positive children who are placed in orphanages. As of 2013, it is estimated that 190,000 children under the age of 18 are living with HIV in Uganda (UNICEF, 2015). She shared that these children face ridicule from their peers and caregivers as a result of their HIV status. Her work centers around reducing the child's shame and depression from their HIV status, breaking misinterpretations about HIV-positive status with peers and guardians, as well as instilling hope in the children. This student's spiritual beliefs help her inspire and empower the children to see beyond their current circumstances and pain.

Another instructor and counselor named Martha, who holds an MS in counseling, is passionate about teaching experiential therapy. Martha trains students to use indigenous materials when practicing art therapy techniques. She has found that using readily available materials such as soil, leaves, and sticks to help a child or family express something painful can be beneficial. Though it may seem helpful from a Western perspective to send crayons, markers, paper, and other art supplies to support the experiential work this counselor is doing, it is also imposing the Western belief that using crayons, markers, and paper is better than using sand, soil, and leaves.

These examples highlight universal concepts of therapy that when paired with invaluable local knowledge and cultural considerations are promoting mental health in Ugandan communities. These examples provide a mere glimpse into the positive work that is being done on a daily basis by Ugandan counselors. Their work is inhibited by severely limited resources. It is with this knowledge in mind that ITV Uganda strives to: 1) supplement staff salaries and continuing education to maintain and expand the local and regional impact of BMCTI; 2) supplement scholarship opportunities for community members to develop knowledge and skills needed to make a real difference; and 3) to provide on-the-ground resources for community outreach efforts.

ITV Uganda collaborates with Ugandan counselors to identify what is truly best for Ugandans. Sharing successful

theories, methods, and practices provides insight not only into the development of mental healthcare in Uganda, but the development of counselor and family therapy training and practice throughout the world. ITV Uganda provides the opportunity to learn from our Ugandan sisters and brothers in ways that resist replicating the colonizing relationship that has hurt so many African countries. By ITV Uganda supporting local counseling practices, creating space for shared knowledge, and redistributing economic resources, we can offer a helping hand to Ugandan counselors as they cultivate healing and empowerment in their communities.

Rachel McDonald is a Master's of Art candidate at the Lewis and Clark Graduate School of Education and Counseling. She is specializing in international family therapy in the Marriage, Couple, and Family Therapy program. She is currently a graduate assistant at Lewis and Clark Problem Gambling Services, where she provides counseling and facilitates psychoeducation classes. McDonald is a Student Member of AAMFT.

Elsa Kraus is a Master's of Science candidate at Lewis and Clark Graduate School of Education and Counseling, studying marriage, couple, and family therapy. She is specializing in international family therapy and working towards becoming a certified problem gambling counselor. Kraus is currently a graduate assistant at Lewis and Clark Problem Gambling Services. She is interested in the transferability of MFT knowledge and practice on the global level in relation to power. She is also interested in how the development of a critical consciousness influences best practices, and can better serve under-resourced/marginalized populations. Kraus is a Student Member of AAMFT.

Teresa McDowell, EdD, is a Clinical Fellow and Approved Supervisor of AAMFT. She is the department chair and professor at Lewis and Clark Graduate School of Education and Counseling. McDowell currently is working on expanding critical multiculturalism in the field of MFT. Much of her work facilitates students' development in order to address power inequities that are behind many relational and mental health problems. Her current research strives to integrate critical social theory into the practice and education of MFT.

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For more information on how you can get involved in ITV Uganda and how you can support Ugandan counselors, email itvuganda@gmail.com or visit www.itvuganda.org. ITV Uganda offers an easy way to support continuing education for Ugandan counselors and scholarships for interested community members at BMCTI with our "Lifting as We Climb" program. One-hundred percent of donations go directly towards a Ugandan gaining counseling skills, knowledge, and experience to heal and empower their communities.

Couples Therapy Revisited

Alev Ates-Barlas, MAMFT

SIX MILLION YEARS OF EVOLUTION has equipped humankind with an immense capacity for survival. What has also evolved is the concept of survival itself as it went from the primitive bacterial cells' symbiosis to early hominid's insistence on persevering in the primeval landscape, perhaps facing a saber tooth with a rock in hand. The concrete nature of survival prior to modern times seems to be disappearing more and more each day; at least in the clinical environment the family therapist encounters.

As family therapists, we interact with the ever-evolving survival endeavors of relationships and systems in the abstract jungles of our modern times. The size or the shape of the threat is ever-changing and never stable. So, when that initially faceless, sizeless, volumeless predator enters my office with the couple whose relationship it is threatening, I find myself yearning for the "simple" fight of the early hominid with the saber tooth, whose presence can never be denied, neither can there be any misapprehensions as to what it actually is.

Working with couples, therefore, might require the therapist to think in more abstract and evolved ways. But how are we to do that, despite the years of exposure to our respective dominant discourses about what marriage is and what it cannot be?

I would like to explore this matter by elaborating on two themes: Marriage (or any other long-term committed relationship) and the therapist. Let us take marriage as a contract and look at it through the concept of regulation in economics. Regulation, in economics, gets in the way of contracting between parties (Coase, 1960; Smith, 2010). Yet, some degree of regulation is necessary to

make sure that people don't get cheated (Pigou, 2013). This kind of regulation can be reached by the safe space that can be provided by the therapist. Anything that goes beyond that, such as to the promotion of a particular kind of a relationship dynamic, is excess regulation that can prevent people from exploring the open contract space between themselves. The therapist, along with the pressure of social norms, individual expectations, etc., can in fact become a force for distortion rather than clarification. Take two concepts that are parts of a relationship: love and commitment. The dominant discourse that surrounds us teaches us to think of these two terms interchangeably, as a result of which the quality of good marriages/relationships is measured by schemas such as commitment is the ultimate form of love. When this is the case, is anyone, including the therapist, allowed to think that "Love is not a commitment. Love is not a relationship. Love is not a responsibility" (Gordon, 1993, p. 28)?

Lori Gordon furthers her argument, in a spirit of defiance of such dominant discourses, that love is but a feeling that is bound to wax and wane like all other feelings and that "the only promise that we can make and keep is to create an atmosphere between us that allows for feelings of love to continue to flow between us" (Gordon, 2001, p. 28). In the absence of such an insight, the process of healing/recontracting can be hindered by excess regulation that assumes any discrepancy in commitment to be a reflection of either presence, absence, or even the quality of love. In such circumstances, the only clarity that the therapist should be providing is the light that allows the clients to explore and negotiate the space between them, rather than how they may or may not fit in the schemas of dominant discourses.

When contracts fail, there are two approaches to help the contracting parties come to terms: (a) a regulatory approach, in which we either force or nudge the parties towards satisfying certain conditions; and (b) a deregulated approach, in which we facilitate the parties' exploration of a solution space to the failed contract. As marriage and family therapists, we are supposed to take approach "b," to help marriages in crisis. However, in both practice and theory, we are often at risk of taking approach "a."

My clinical work with struggling couples begins from the premise that there is no normative solution that does not come from the parties themselves. Of course, couples carry others' expectations into therapy; they carry parental, social, religious, and other kinds of ledgers. However, the most important stakeholders in this process are the partners themselves. One of the therapist's main purposes is to help them interact with each other, and with the relationship itself, with a kind of authenticity that is unburdened by the expectations of others including the therapists'.

Ideally, the therapist should help couples in a struggling relationship to discover, express, and act on this authenticity. What happens, though, when the therapist also projects expectations onto a relationship? Such expectations are informed by the therapist's own schema of a good relationship, which can prevent the couple from developing their own schema as part of the recontracting process; the couple's "mutual inability to define the relationship" (Karpel, 1994, p. 87) is perpetuated under this kind of stress.

Marriages can work, or fail to work, in innumerable ways. We should not take a standardized, check-listed approach in which a good marriage is reduced to a shortlist of desiderata prized in the dominant discourse. Of course, some marriages/relationships might possess each of these desiderata, but what should we do when we encounter a marriage/relationship that lacks or has lost various items on the checklist? Should we encourage or guide clients towards a utopian state of marital fulfillment, or encourage clients to find whatever works best for them?

As time goes on, fewer Americans are marrying. If people in struggling marriages feel that working on a marriage means to return to or build an ideal state of bliss, the pressure to drop out of a marriage is greater than if partners are encouraged to explore unconventional, but nonetheless, mutually satisfying contract renewals. As marriage and family therapists, we cannot let the great become the enemy of the good. Continuing to promote or use utopian models of marital repair can drive couples to prematurely give up on marriage altogether, instead of reaping the benefits that can come with redefining their marriage. Never mind what we think of good marriages, it is our duty to be aware of our own schemas for marriage, prevent these schemas from entering the room, and let clients define the marriage contract for themselves. To return to the metaphor of regulation, we need to do a better job of creating safe, deregulated spaces for couples to renegotiate their marriage contracts, as free as possible from therapeutic pressure.

Alev Ates-Barlas holds an MS in communications and an MA in marriage and family therapy. She is currently practicing as a family therapist at a not-for-profit, multi-service agency in Upstate, NY. Ates-Barlas is a Pre-Clinical Fellow of AAMFT.

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Ethics Report

Members of the AAMFT in all membership categories, AAMFT Approved Supervisors, and applicants for membership and the Approved Supervisor designation are bound by the AAMFT Code of Ethics. Allegations of code violations are investigated by the Ethics Committee according to the AAMFT Procedures for Handling Ethical Matters. Members found in violation may appeal the Ethics Committee's findings and recommended actions to the Judicial Committee. The possible outcomes of an ethics complaint include: a finding of no violation; finding a violation and recommending a mutual agreement with the member (e.g., supervision, education, therapy, community service, suspension of membership and/or the Approved Supervisor designation); or termination of AAMFT membership. Termination is a permanent bar to readmission. In general, only terminations are published.

- Effective December 1, 2014, the membership of Scott E. Bair, a resident of Burlington, Iowa, was terminated with a permanent bar to readmission to the Association for violating Subprinciples 3.15(a) and 3.15(e) of the AAMFT Code of Ethics.

The current AAMFT Code of Ethics is available online at: http://www.aamft.org/code-of-ethics. The Ethics Committee can be reached at ethics@aamft.org.

Twitter Chats

First Wednesday of each month. 3:00 p.m. EST
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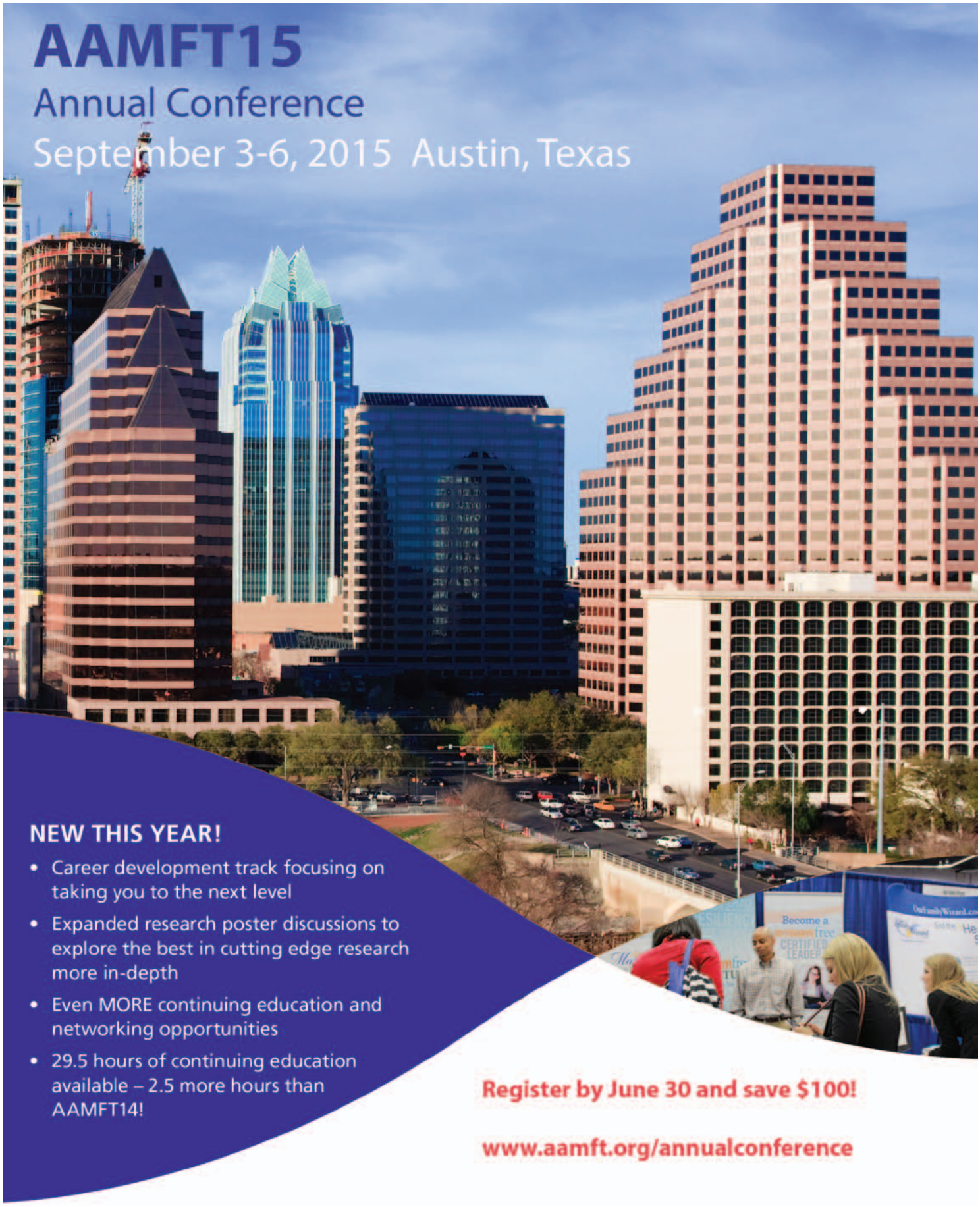
June: Developing a Clinical Specialty: What should you consider?

July: Licensing Exam Preparation

August: AAMFT Member Benefits: What would you like to see?

To follow and/or participate in the Twitter Chat, follow Tracy Todd on Twitter @TToddMFT (www.twitter.com/TToddMFT) and include #AAMFT_Chat in your tweets. Participation in the chats will require access to Twitter and a Twitter account, however you do not need a Twitter account to follow along. To follow AAMFT Executive Director Tracy Todd's messages/tweets, visit www.twitter.com/TToddMFT.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