Dan's Talking Points Memo **Ch. 4**

Wilcoxon, Remley, and Gladding; Chapter 4
For discussion on Week 5: February 15, 2018 -- *TWO THIS WEEK*

Unique Ethical Considerations in Marriage and Family Therapy: Principle Distinctions

1. The authors delve into "multiple patient considerations." Working with families is quite different than working with individuals. Here we have to consider whether helping one will negatively affect another, or whether the general good of the family might be harmful to one member. There are considerations that we rarely ponder on an ongoing basis in individual work (pp. 72-73).

2. Family secrets are of three varieties (per Karpel, 1980, p. 74); 1) shared by all (gramps is an alcoholic), 2) secrets known and shared by some family members (Brenda has a different father), and 3) secrets known and kept by individual members (Sally's son is gay). What is the difference between confidences and secrets and how do they apply the therapeutic progress?

3. What do you think about the position by Margolin (1982, pp. 74-75) that as far as confidences are concerned, each family member needs to be treated like an individual patient? What are the benefits of non-secrecy to the process of family therapy? What are the benefits of a midpoint stance on secrecy?

4. Per Karpel, what is the difference between *secrecy* and *privacy*? (p. 75)

5. Have an understanding of the importance of "informed consent" and how it will protect both therapist and patient form misunderstandings that could lead to problems.

6. Privileged Communication in Marriage and Family Therapy. We will have a lot to say about this legal concept, but the list by Gumper and Sprenkle (1981, pp. 77-78) does a great job of posing suggestions to therapists to manage Family Therapy/ Privilege issues. We will go over each of these in class …

    1) Whatever their credentials, therapist should acquaint themselves with privilege provisions in their state.
    2) MFTs who deal with divorce issues might obtain a written agreement from all parties NOT to seek therapeutic disclosures of therapy communications. You may NOT, however, state in your Informed Consent that you do not deal with court mandates. Everybody has to deal with court mandates!
    3) Demand that all requests for information be accompanied by a written release from the patient. I go so far as to demand that it be in blue ink (to assure that the release is an ORIGINAL and pertains to THIS INFORMATION).
    4) Assert privilege in a calm, but assertive manner.
    5) Handle subpoenas correctly (I'll teach you all about that subject!).

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6) Have your own legal counsel (and this begins with your CAMFT membership; you are provided some essential legal guidance that can save your bacon.

7. I really like the Nichols (2008, p. 79) statement on establishing goals for therapy as the *beginning* of the therapy process, **not** a *prelude* to the process. This will serve you well.

8. How is the identified patient (IP) in family therapy selected? What do you think about the idea that therapists assume the right to define the patient's problems in terms of their own therapeutic orientation? (p. 80)

9. Is it beginning to look like individual therapists want the patient to define the problem from patient's perspective, and family therapists want to define the problem from the therapist's perspective? Explain this …

10. For those of you just now transitioning from individual psychotherapy to family psychotherapy, the case of "Mahesh's First Practicum Session" (p. 82) will give you a glimpse of what is ahead for you. Terrifying, huh?

11. On page 84, the authors introduce "the feminist critique of family systems." This is adjunct to and expands the central view of systemic therapy, but in a very helpful way. See if you can get the gist of what is meant by "the feminist critique of family systems." It addresses "institutional inequities" that we (yes, therapists) too often take for granted.

12. Triangulation (p. 85). This has been a topic of general interest to family therapists for years, and is at the core of Murray Bowen's theoretical approach. Be aware that a dyadic unit is typically unstable, and dyads oftentimes seek stability through triangulation (e.g., unstable newlyweds seek stability by having a baby, hence forming a triangle). We need to talk about our being triangled-in by our clients, and becoming duped into serving as agents of dysfunctional systems. Please note inset on page 85.

13. **ETHICS ALERT:** Most of your reading, and surely all of your professors, will argue the negatives of triangulation, as well as the negatives of creating a dependency relationship with your patients. The new MFT training guidelines from the Board of Behavioral Sciences (BBS) requires instruction on "The Recovery Model," which has these elements at its philosophical base. What are we to do?