St. George, S. Evolution of family therapy in the United States and Canada. *Counselling, Psychotherapy, and Health*, 4(1), Counselling in the Asia Pacific Rim: A coming Together of Neighbours Special Issue, 64-77.

Evolution of Family Therapy in the United States and Canada

Paper Presented on 11-July-2008
Sally A. St. George
University of Calgary
Calgary, Alberta, Canada T2N 1N4
sstgeor@ucalgary.ca

Abstract

The evolution of family therapy in the United States and in Canada has many similarities and some distinctions. Based on my own experiences, many conversations with my professional colleagues/friends, and an overview of the flagship publications, I look back over the recent past to address leadership in the field, economics, science, politics, education, and the future. These are areas that are part of a field and profession that I think, in developmental terms, has reached adulthood.

Evolution of Family Practice in the United States & Canada

The evolution of family practices in the United States and in Canada has many similarities and some distinctions. In both countries there have been struggles with issues around professional identity, legislative strategizing, theoretical and paradigmatic development and change, payment for service, educational standards, research-based evidence for practice, and working collaterally with other professionals. Dealing with each of these struggles has members of the profession discussing, debating, and making decisions about professional survival, validation, and distinction. Though family therapists are facilitators of change, organizational change within the profession is challenging and difficult, but nonetheless inevitable. The commitment to persevere and evolve continues to make these two North American countries leaders in the field of working therapeutically with families.

The purpose of this paper is to outline the more recent developments in the professional practice of marriage and family therapy in the United States and Canada. This is accomplished through a blend of my personal reflections as a family therapist/educator, with information gleaned from family therapy journal articles, current websites, publications from the Association of Marital and Family Therapy, and current textbooks.

My Context

Acknowledging the crucial family therapy perspective of understanding the family's context, I offer readers contextualization of my involvement in the field as revealed through my experiences, observations, and conversations. The information contained in this paper has been accumulated and filtered through my particular lens of having entered the family therapy field in the early 1990s, being a White woman (with four grandchildren), grounding my thought in social constructionism, being married to Dan Wulff (who is also my colleague), actively practicing therapy, and teaching within a Faculty of Social Work. In addition, my outlook and path in this field have been shaped by the professional friends that I keep—you will hear the voices of my professional "cuddle group" mingling with mine. Furthermore, I have lived in the United States until this last year when I moved to Calgary, Alberta, Canada. With this background I provide you my perspective and outlook regarding what is transpiring in the field and profession of MFT in two countries that are neighbors, in two countries that have given me much opportunity, privilege, and possibility.

Lynn Hoffman has written wonderful texts on the development of the field of family therapy (1981, 2002). Since she knew most of the major contributors within the field first-hand, I refer you to her writing for a more expansive historical perspective. In this paper, I will cover a more contemporary view, a lived perspective that is quite recent. The major areas that will be addressed include: leadership in the field, the economic context of MFT, the role of science, reflections on the politics of the field, education, and some predictions about the future. These are important facets of a field/profession that I think, in developmental terms, has reached adulthood.

Leadership

National MFT conferences in the United States over the years have been great learning experiences for practitioners who could hear first-hand developing ideas from the prolific writers and practitioners in the field. These key leaders have influenced many and the legacy of their writings in the body of literature on MFT and video recordings live on in personal and university libraries.

The last 3 years have been monumental in terms of key figures lost. While not all of the leading figures in family therapy came from the United States and Canada, a significant number have and they spent a great deal of time in both countries conducting workshops, consulting, supervising, and collaborating. In 2005, Steve deShazer died, and in 2007, we received notices of the deaths of five other greats: Paul Watzlawick, Insoo Kim Berg, Lyman Wynne, Ivan Boszormenyi-Nagy, Jay Haley, and Tom Andersen. Just recently we were shocked by the news of Michael White's death. Each of these innovators was a creative and prominent figure in the field; each has left big shoes to fill and questions that linger. In listening to conversations among MFTs one can often hear worries about who will lead the field now. What will happen to the continuing development of the postmodern approaches to therapy? Who will create new practices, paradigms, theories, creative shifts?

Diverging for a moment to look back at history, we can see that the field of MFT had an interesting beginning (Becvar & Becvar, 2009). There was a restlessness that was driven by a rebellious need to put forth new principles, theories, and practices designed to successfully understand and work with families. Conceptualizing a family's dilemmas systemically took center stage and using relational language became a hallmark of working with a family. The MFT giants of the early days came together at conferences to demonstrate their latest ideas and to debate and sharpen their arguments with each other. The story that is often told of the history of MFT is a story of boldness and pioneering—one that privileged the generation of theoretical and practical ideas of better and more effective ways to help families.

In some ways a portion of that spirit seems to have shifted in recent times to matters that focus more on preserving the profession and its vested interests. The economic well-being of family therapy practitioners has become increasingly important. It is my observation that the influence of economics has increased in shaping the direction that the profession is heading. Theoretical innovation has given way to practical issues of reimbursement and the related aspects of credentialing and liability.

Economics

Reflecting on conversations with colleagues, it seems that very often working in one's preferred ways and making a living by being an MFT have been placed in competition. Reliance upon third party payment is the primary means by which MFTs are paid for services in the United States and Canada and is therefore extremely influential in the decisions a practitioner makes about the therapeutic process (Becvar & Becvar, 2009).

Economics is a prime focus in two ways. First, in the United States, third party payments that are part of a process referred to as managed health care are crucial to the livelihood of many family therapy practitioners. Whether families seek treatment from a private practitioner or a mental health center, the bill is usually paid by a person's insurance company, that is, if the client has that benefit, or a federal or state plan such as Medicaid or universal health care.

However, insurance companies are becoming more particular about the kinds (and length) of services they will pay for—family therapy is a service that is often not paid for by insurers or is paid at a rate lower than what a practitioner normally would charge. The majority of the mental health services that are paid for by these third parties require that a designated person/patient is given a diagnosis using the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). For example, if a child is diagnosed with oppositional defiant disorder, then the insurance company will pay for services for the child and possibly for the child's family, and the diagnosis prescribes the payment, the authorized forms of treatment, and oftentimes the number of sessions. Philosophically and theoretically this protocol of diagnosing and treating the individual patient does not easily fit within a systemic or relational conceptualization of a child who is misbehaving or having some sort of trouble (Strong, 1993; Tomm, 1991).

There has been a second change in service delivery that has been initiated by economics. That is the prevalence of MFTs who are becoming specialists in some area of treatment (e.g., eating disorders, substance abuse, attachment, health issues), generally an area that fits into one of the psychiatric diagnostic categories. Following the tradition of medical specialization, MFTs are constructing their professional practices by becoming experts within a narrow range of client problems (Crane, 1995b). The economics of creating a successful practice for an MFT are well-served by focusing his/her training and client caseloads around a specified problem area (diagnostic area). Tailoring one's MFT practice to be in accord with medical/psychiatric structures, conceptualizations, and protocols can seriously dilute or alter the practitioner's focus on relational work, thereby potentially changing the fundamental nature of the profession and its practices.

In Canada the economic squeeze is not quite as pronounced, but it shows signs of moving that way. Family therapy is paid for by the health care system. At the Calgary Family Therapy Centre where I see a caseload of families, families are seen at no cost to them and with no restrictions on the number of sessions. The payment for services to the Centre is made by the Health Region. However, there is some movement afoot to privatize health care in Canada—so the system could one day change to an individual/personal insurance system.

At the annual Association for Marriage and Family Therapy (AAMFT)[i] conferences, participants can select from an array of sessions that directly address the economic side of surviving in the professional world. On the AAMFT website there is a section devoted to resources for practitioners. A good number of them concern finances:

- Therapists Transform Mental Health Services in wake of Managed Care Survey
- Follow Payment Policies to Avoid Collection Woes

- Managed Care Treatment and Provider Guidelines
- A Managed Care Bibliography for Therapists
- Glossary of Managed Behavioral Health Market Terms

In addition, an entire issue of AAMFT's *Family Therapy Magazine* (Bowers & Gautney, 2007b) featured articles on insurance and managed care issues. However, economics is not an independent issue—it is intimately tied to what we consider to be legitimate knowledge and how this knowledge is most appropriately used. The economics of the profession are linked to certain preferred ways of understanding families and that is entwined with the issue of what is considered to be legitimate evidence.

Science

Utilizing sound principles of scientific thinking is an important part of responsible and effective delivery of MFT. Science in the field of family practice/therapy here is defined as the systematic study of families dynamics/relationships and the integration of that knowledge into therapy practice. At the University of Calgary, Dan Wulff, Karl Tomm, Tom Strong, and myself are incorporating scientific principles/practices into clinical work through a developing process called "research as daily practice" a process that is systematic and an integral part of daily clinical work. In MFT the use of science holds great potential for essential and generative development within the field.

Science is influencing MFT in the United States in two major ways. The first is through the introduction of evidence-based practice (EBP) and the second is through a greater emphasis for including biological factors in conceptualizing family problems. Evidence-based practice is a way of providing the best and most cost-effective practice available by looking at the intersection of what research says is effective, what clients say works, and what practitioners say is successful in working with client problems (Gambrill, 2006; Gilgun, 2005). Theoretically, it makes good sense to take all of the perspectives into consideration in order to create a unique and tailored experience for families in clinical work. What also makes EBP a good practice is that multiple viewpoints are evenly taken into consideration as to what constitutes a "best practice." One of the advantages with EBP is that scientists, researchers, and practitioners diligently attend to the rigor in their studies/practices and build confidence in consumers of research by utilizing systematic and grounded methods (Sprenkle, 2002; Sprenkle & Piercy, 2005). Ironically, from 2003-2007 only 11 articles out of 809 submitted to *Journal of Marital and Family Therapy* (*JMFT)*[ii] centered on EBP. Most of the talk about EBP that I hear is in conversations among practitioners working in agencies and academics in universities. The talk is frequently tied to funding—an agency or program's funding may hinge on their degree of adherence to EBP in the services they provide.

However, concerns about EBP have also been appearing. One of the greatest concerns is that research credibility has been unnecessarily limited to randomized clinical trials and research conducted using any other method is often viewed as inferior and therefore discounted. As a consequence, a narrow band of scientific practice is privileged, leaving other forms of evidence such as that found in qualitative research and non-randomized studies as underutilized and undervalued sources of knowledge. Another concern with

EBP is that the "hard" research evidence is often given greater valence than the evidence provided from clinical wisdom/experience or from the clients themselves. The three sources of evidence (Gilgun, 2005) become reduced to one—double-blind randomized clinical trials—thereby narrowing our potential for understanding clinical situations and their array of remedies and oftentimes creating manualized or standardized treatments. For example, workers in mental health agencies dependent upon external funding have reported that if there is a diagnosis of ADHD in a child, the corresponding treatment that will be paid for is cognitive-behavioral therapy (CBT) because the randomized clinical trials have suggested CBT is the best practice. Some other forms of treatment (e.g., narrative therapy or solution-focused therapy) have not been so studied, so they are considered inappropriate therapies to use.

One of the responses to the privileged status of clinical trial studies has been to utilize empirical scientific approaches to study the effectiveness of MFT in order to demonstrate that MFT interventions should be considered as credible as other interventions and should therefore be acknowledged and paid for by managed health care plans. During the 2003 publication year, each issue of the *JMFT* contained a special section of research results demonstrating the effectiveness of MFT practice in treating issues such as spouse abuse, substance abuse, and childhood behavioral disorders. *Family Process*, over the last 5 years, has published research pertaining to special issues in working with families and research on training programs. Using science to make MFT credible (and monetarily worthy) is ongoing work conducted primarily by academics.

The second way that science is appearing in MFT is in a new appreciation and attention to the biological part of bio-psycho-social explanations for problematic behaviors in families. Brain science and genomic explanations (Bowers & Gautney, 2003b, 2004)[iii] are endorsed by some avid proponents in MFT. Advancements in understanding how the brain works and how genetic transmittal works have energized some in the MFT field to find applications in the family arena. For example, there is attention to the social construction of mind and body, that genetics are not determinative, and that the brain is a social organ (personal communication, C. Knudsen-Martin, May 28, 2008). This trend has also brought with it a stronger link between delivering therapy and the use of medications (Bowers, & Gautney, 2003a).

Canada is affected by the professional trends/movements in the United States. The members of the provincial divisions of AAMFT are full members of AAMFT and receive all of that organization's publications. Since the funding processes are different, as explained earlier, the push for using science as the primary basis for therapeutic decisions does not yet hold as primary a position within the daily conversations or practice protocols of the MFT practice community in Canada, but there is a clear trend moving in that direction.

Research effectiveness is not just about clinical improvements and the economics of practice. It also impacts the politics of professional helping by providing a basis of legitimation for a profession amongst other helping professions and within the public's mind (Doherty & Simmons, 1996).

Politics

Politics are inevitable when people work together. MFT in the United States has fully entered the arena of state politics, as currently only two states do not have licensure for MFTs (Bowers, 2007). Licensure was sought to give greater credibility to therapists in the eyes of the public as well as to protect the public from working with those who are not competent or legitimate practitioners. To achieve this reputation much effort, time, and money have been expended in writing legislation that will guarantee therapists a place in the spectrum of paid helping professionals "Licensure or certification laws for marriage and family therapists (MFTs) provide a mechanism for the public and third-party payors to identify qualified practitioners of marriage and family therapy" (see http://www.aamft.org/resources/Online_Directories/boardcontacts.asp).

One of the downsides to this licensure and legislative focus has been the increasing occurrences of, and worry about, litigation. With increased safeguards and guarantees, more scrutiny is authorized to insure that these policies are followed. This enforcement component necessitates that MFTs protect their practices by purchasing increased levels of liability insurance. This all occurs in a United States context that has generally become a more litigious society, more prone to suing for compensation and damages than ever before.

In Canada, Ontario and Quebec have regulated MFTs while three other provinces are taking steps to achieve licensing for MFTs (Bowers & Gautney, 2007a). At this time in Alberta, the official and legitimating designation for MFTs comes from a registry, a regulatory board who oversees that MFTs have the proper qualifications to call themselves marriage and family therapists. The purpose of such regulation through registries and licensure boards is to legitimate the educational standards of MFTs vis-a-vis those of psychiatrists and psychologists. The increase in malpractice litigation and the associated fears in Canada seem to be less at the present time than in the United States. MFTs still purchase malpractice insurance, but many of the conversations concerning therapeutic decisions do not seem to be so focused on worries about being sued.

Politics at the state (in the United States) and provincial (in Canada) levels are closely tied to higher education—institutions are preparing therapists for work in the field and must have an eye toward what state and provinces require. Interestingly, it is also the case that institutions of higher education are also preparing those people who will eventually serve on the various legislative committees that influence state and provincial professional standards.

Education

Education is an area in which I have much knowledge and direct experience. In the United States I was a co-director (with my husband) of a program that was housed within a school of social work. We developed a highly integrated program that joined what we thought of as the strengths of social work with the strengths of MFT. This was unusual given the political antagonisms between the two professions. In spite of those

professional turf battles that were being played out in the States, we persisted with our university program, accreditation and all.

Many programs in the United States—counseling, pastoral counseling, social work—make the claim that they teach family therapy and they do. However, the higher credibility usually belongs to the programs that have rigorously conducted self-studies and site visits to obtain accreditation from the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE), AAMFT's stamp of approval (see http://www.aamft.org/about/COAMFTE/AboutCOAMFTE.asp). In the last few years, the accreditation commission has undergone major revision, switching from an input-based system for making curricular decisions to that of an outcome-based system. As a result of this change, the personnel in each program decide the best routes (e.g., course offerings, practicum and supervision hour requirements) to demonstrate the ways in which core competencies (which were developed by the AAMFT) are demonstrated and measured, thus providing evidence of the program's high standards.

This shift maximizes the freedom that programs have in making those curricular decisions—it has also put at risk some of the educational practices that made accredited programs stellar. For example, with the former standards of what a program should include, it was necessary to maintain a ratio of one supervisor for every six students with a minimal number of supervision hours prescribed. Under the new set of standards each program can decide for itself what is a good ratio and frequency for the supervision component. How this ties to costs can easily be seen—more supervision is more costly in terms of money and better for the preparation of master's level practitioners, but reduced levels of supervision can save money. Tough choices!
Programs in the United States are also under pressure to prepare practitioners for the local work forces and health care changes (Crane, 1995a)—therefore, local agency or institutional requirements to use EBP and the medical model are being integrated into educational programs (Patterson & Scherger, 1995) and other curricular components less necessary to actual employment activities/duties are being excluded. Part of that is survival for programs. More tough choices!

The year 2005 was a banner year in terms of publications regarding core competencies in family therapy academic programs and institutes. The September 2005 issue of *Family Process* published a special issue on the State of the Art of Systemic Training, and four articles discussing core competencies appeared in the *Family Therapy Magazine* (Miller, 2005; Nelson, 2005; Northey, 2005; Rambo, Hibel, Green, & Cole, 2005). Then in 2007, more was written on the development of core competencies in *JMFT* (Nelson, Chenail, Alexander, Crane, Johnson, & Schwallie, 2007)

In Canada there has been some support for importing the accreditation processes from AAMFT, but for the most part that has been resisted. There are so many ways that Canada is influenced by US policies and practices, and this is one in which universities have found no value added for the monetary cost and time required. Results of an informal survey of several Canadian MFTs have indicated that if Canadians decide to initiate accreditation for MFT studies, the policies and procedures should be tailored for

Canada (and not become just another extension of the US system). For example, at the University of Calgary, MFT is being integrated with social work through courses and a specialized practicum, but there are no current efforts to pursue COAMFTE accreditation.

The Future

At a recent meeting of the Taos Institute, Ken Gergen (personal communication, June 10, 2008) talked about the recent death of Michael White. He asked who we thought the next "MFT gurus" might be. And then he asked if we even needed gurus. I wonder if the field is beyond the point of centering its thinking and identity around key individuals. Good food for thought.

A few years ago at the Family Therapy Program at the University of Louisville, there were concerted and diligent efforts to create an "inter-professional"—a professional who integrated skills and knowledges from two professional sets. Students from that program were tired of being asked if they were social workers *or* MFTs and to set the record straight one student said, "from social work we get the gumption, and from MFT, we get the swagger," meaning social work provided the energy to make bold changes in the world while MFT provided important interpersonal skills to work relationally. At the University of Calgary, a frequent conversation among faculty, administrators, and students concerns interdisciplinary preparation and inter-professional certificates. As more and more MFTs add specialty credentials and as other professionals work with families and larger groups systemically, it may be that the new MFTs will become professional hybrids and that the answer to Ken Gergen's question is that the field will not need gurus or "rock stars." That is not to say that there is not development of new ideas and approaches--just that we may be less dependent upon a few singular leaders in the field.

Actually, there are many ideas growing all over the world and some very exciting new generative thought is emerging. The last 5 years has seen a continued emphasis on special populations and special problems. *Family Process, JMFT,* the *Journal of Systemic Therapies,* and the *Family Therapy Magazine* are filled with research studies and clinical techniques for greater effectiveness with respect to special problems (e.g., substance abuse, domestic violence, suicide, divorce, sexuality, etc.) and populations (e.g., couples, blended families, single-parent families, same-sex couples, immigrants, etc.). Focus on how problems and populations are unique is very likely to endure as clinicians see families in a variety of new living arrangements and who suffer many life dilemmas.

What is remarkable is the appearance of some approaches and understandings that seem to contain both a local and global perspective and that have MFTs moving into some new directions that are designed to address larger social conditions in which our families are living (Almeida, Dolan-Del Vecchio, & Parker, 2008; Almeida, Woods, Messineo, & Font, 1998; Hernandez, Siegel, & Almeida, 2009; Waldegrave, 1990). There seem to be no large-scale movements to name or the identification of the next approach to family

therapy, but there are those out there "moving and shaking" and inviting others to join them as they articulate their current work.

One of the most exciting developments is the greater attention given to social issues within intra-family work. For example, community has become an additional theme and focus in MFT circles. In the United States, Dr. William Doherty from the University of Minnesota has been blending MFT with community building in his "citizen model." As a professional he assists groups to see themselves as citizens with the power to join and take collective action on their own behalf that better children and families (Doherty & Beaton, 2000; Doherty & Carroll, 2002). He was also instrumental in organizing a special section in the March 2004 issue of *Family Process* that described the intersections of family and community work.

In New York City, Salvador Minuchin has begun a new center dedicated to "working with couples and families that are marginalized due to racism, socio-economic conditions and/or sexual orientation" (see http://minuchincenter.org/), operating from the premise that intra-family problems can often be attributed to the family's relationship within the broader community.

Another developing theme is that of our participation as global citizens. Jill Freedman from the Evanston Family Therapy Center in Illinois joined with the Dulwich Centre to support and train workers in Rwanda to assist genocide survivors. An additional global perspective at this time comes from Mishka Lysack, from the University of Calgary as he is joining his background in social work and MFT to advocate for changes in the efforts to preserve our earth's environment, understanding the deleterious climate changes as matters of fairness and justice to all people (tune into Ecological Grief, http://www.cbc.ca/wildrosecountry/research.html). Spoiling the environment has serious social consequences which all-too-often fall disproportionately on the poor and disenfranchised.

Ron Chenail's continuing contributions to the world of MFT research cannot be underestimated or appreciated nearly enough. He continues pioneering efforts to make qualitative research valid and credible in MFT inquiry through his gentle and masterful editorships for *JMFT* and *The Qualitative Report* (see http://www.nova.edu/ssss/QR/). Ron also speaks of the technological advances that are influential in the creation of new clinical problems (e.g., online addictions, cyber–sex) and that are making possible virtual learning environments, swift and extensive retrieval of the most current research, online therapy, and supervision from a distance (personal communication, R. Chenail, May 26, 2008).

US and Canadian practitioners who believe that MFT practitioners have a greater responsibility to social change efforts continue to be strongly influenced by the Just Therapy Team from New Zealand (see http://www.familycentre.org.nz/) and their unique approach to therapeutic practice and research in order to enact social policy change at local and national levels (Waldegrave, 2000).

Extending her practices beyond the therapy room, Harlene Anderson (1997) inspires us with her message of working collaboratively in partnership across the world, across individuals, in families, and in organizations (also see Anderson & Gehart, 2007). In her work she always makes sure that all participants are given time and space for their voices to be heard and their contributions to conversations valued (http://www.harleneanderson.org/). Another generative development in the field comes from Lynn Hoffman and Christopher Kinman who have been speaking and writing about the "rhizome" as a metaphor for the enduring and intricate nature of relationships and their endless array of non-stop alterations (see http://www.christopherkinman.com/experiments.php).

Now I would like to talk about my own work in its current context and the future possibilities. In Kentucky, the caseloads that Dan, our students, and I carried were filled with families who were suffering from ills that the traditionally-practiced approaches of MFT did not effectively address. We worked with families facing the challenges of a single mom diagnosed with AIDS, families with special needs children who were living in abject poverty and gang-infested neighborhoods, families struggling with a return to drugs and alcohol, families in which a member was imprisoned, biracial families who were experiencing racial discriminations, couples who had histories of domestic violence, and couples facing the unknown territory of cyber infidelities. Most families face problems that come in complex combinations—there are no truly "single" issues out there. At the Calgary Family Therapy Centre, we work with many families who are vexed and stuck by 8-10 year-old "tyrants" and those with serious diagnoses, or adolescents who threaten and make good on their threats of cutting, running away, engaging in promiscuity, stealing, or children who refuse to go to school or work or to do anything that is not deemed fun, or parents who are floundering in parenting claiming that nothing works. Long gone are the days of "our child is not doing his/her homework" or "he/she is not keeping his/her room clean," or "my child is not obeying curfews."

In answer to these serious problems we are taking what we call a *community-minded* approach to therapy (St. George & Wulff, 2008) in which we examine the large social narratives that work invisibly to keep problems in families alive and well. We are looking at the ways in which all of us, families and helpers alike, are hypnotized by those narratives and therefore implicated in their continuance. We are finding that when we look at them in relation to our families' lives and our work with them that we can create new dialogue and action that at once hold possibilities for change within our families *and* changing the social narrative.

In addition to our community-minded approach, we are using some of the principles and strategies of non-violent resistance as set forth by Omer (2001) and Weinblatt and Omer (2008). As we add these new ideas to our clinical work, we are simultaneously studying them. Using qualitative inquiry methods that have been adapted to be in line with our daily clinical practices (such as Adele Clarke's *Situational Analysis*, 2005) we together with Karl Tomm and Tom Strong, are looking at the "pathologizing interpersonal patterns" (PIPs) within family systems that pair with larger narratives in our effort to develop better treatment dialogues and strategies. After running a pilot project this past

year, we are finding that parents are lost and uncertain, that there are strong mandates about their duties in responsible parenting, but confusing and conflicting messages about how best to be responsible and effective parents.

MFTs continue to create and develop in the quest to find ever-more effective ways to help families and the worlds in which they live. There is no shortage of work that needs to be done. We are called and challenged to look along a continuum of practice from helping those who continue to suffer from the sociopolitical conditions to reevaluating our ethical principles and reexamining our theoretical stances and fidelity to those stances (Becvar & Becvar, 2009). May our courage remain high and our dedication to a global evolution of practice drive our profession.

[i] The American Association for Marriage and Family Therapy (AAMFT) is the primary professional organization for academics and practitioners in the United States (see http://www.aamft.org/about/Aboutaamft.asp).
[ii] *JMFT* is the flagship professional journal produced by AAMFT.
[iii] The *Family Therapy Magazine* is a bi-monthly publication provided to all AAMFT members.

References

Almeida, R., Woods, R., Messineo, T., & Font, R. (1998). The Cultural Context Model: An overview. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 414-431). New York: The Guilford Press.

Almeida, R. V., Dolan-Del Vecchio, K., & Parker, L. (2008). *Transformative family therapy: Just families in a just society.* Boston: Pearson.

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy.* New York: Basic.

Anderson, H., & Gehart, D. (Eds.). (2007). *Collaborative therapy: Relationships and conversations that make a difference.* New York: Routledge.

Becvar, D. S., & Becvar, R. J. (2009). *Family therapy: A systemic integration* (7th ed.). Boston: Pearson.

Bowers, M. (2007, July/August). Making of the MFT profession: Standards, regulation, and the AAMFT. *Family Therapy Magazine, 6*(4), 12-18.

Bowers, M., & Gautney, K. (Eds.). (2003a, March/April). MFT & medications [Special issue]. *Family Therapy Magazine, 2*(2).

Bowers, M., & Gautney, K. (Eds.). (2003b, May/June). Genomics: Changing the future of families [Special issue]. *Family Therapy Magazine, 2*(3).

Bowers, M., & Gautney, K. (Eds.). (2004, July/August). The brain [Special issue]. *Family Therapy Magazine, 3*(4).

Bowers, M., & Gautney, K. (Eds.). (2007a, July/August). Regulation of the MFT profession. [Special issue]. *Family Therapy Magazine, 6*(4), 19.

Bowers, M., & Gautney, K. (Eds.). (2007b, September/October). Reimbursement [Special issue]. *Family Therapy Magazine, 6*(5).

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn.* Thousand Oaks, CA: Sage.

Crane, D. R. (1995a). Health care reform in the United States: Implications for training and practice in marriage and family therapy. *Journal of Marital and Family Therapy, 21,* 115-125.

Crane, D. R. (1995b). Marriage and family therapy in health care reform: A response to Patterson and Scherger. *Journal of Marital and Family Therapy, 21,* 137-140.

Doherty, W. J., & Beaton, J. M. (2000). Family therapists, community, and civic renewal. *Family Process, 39*(2), 149-161.

Doherty, W. J., & Carroll, J. S. (2002). The Families and Democracy Project. *Family Process, 41*(4), 579-589.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy, 22,* 9-25.

Gambrill, E. (2006). *Social work practice: A critical thinker's guide* (2nd ed.). New York: Oxford University Press.

Gilgun, J. F. (2005). The four cornerstones of evidence-based practice in social work. *Research on Social Work Practice, 15*(1), 52-61.

Hernández, P., Siegel, A., & Almeida, R. (2009). The Cultural Context Model: How does it facilitate couples' therapeutic change? *Journal of Marital & Family Therapy, 35*(1), 97-110).

Hoffman, L. (1981). *Foundations of family therapy: A conceptual framework or systems change.* New York: Basic Books.

Hoffman, L. (2002). *Family therapy: An intimate history.* New York: Norton.

Miller, J. K. (2005, July/August). The question of competence. *Family Therapy Magazine, 4*(4), 28-31.

Nelson, T. S. (2005, July/August). Core competencies and MFT education. *Family Therapy Magazine, 4*(4), 20-23.

Nelson, T. S., Chenail, R. J., Alexander, J. F., Crane, D. R., Johnson, S. M., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital and Family Therapy, 33*(4), 417-438.

Northey, W. F. (2005, July/August). Are you competent to practice marriage and family therapy? *Family Therapy Magazine, 4*(4), 10-13.

Omer, H. (2001). Helping parents deal with children's acute disciplinary problems without escalation: The principle of nonviolent resistance. *Family Process, 40*(1), 53-66.

Patterson, J., & Scherger, J. E. (1995). A critique of health care reform in the United States: Implications for the training and practice of marriage and family therapy. *Journal of Marital and Family Therapy, 21*, 127-135.

Rambo, A., Hibel, J., Green, S., & Cole, P. (2005, July/August). New ventures in syllabi writing. *Family Therapy Magazine, 4*(4), 19.

Sprenkle, D. H. (Ed.). (2002). *Effectiveness research in marriage and family therapy.* Alexandria, VA: AAMFT.

Sprenkle, D. H., & Piercy, F. P. (Eds.). (2005). *Research methods in family therapy* (2nd ed.). New York: Guilford.

St. George, S., & Wulff, D. (2008) *Community-minded family therapy*. Manuscript submitted for publication.

Strong, T. (1993). DSM-IV and describing problems in family therapy. *Family Process, 32*, 249-253.

Tomm, K. (1991). Beginning of a HIPs & PIPs approach to psychiatric assessment. *The Calgary Participator, 1*(2), 21-22, 24.

Waldegrave, C. (1990). Just Therapy. *Dulwich Centre Newsletter, 1*, 5-47.

Waldegrave, C. (2000). "Just Therapy" with families and communities. In G. Burford & J. Hudson (Eds.), *Family group conferencing: New directions in community-centered child and family practice* (pp. 153-163). New York: Aldine deGruyter.

Weinblatt, U., & Omer, H. (2008). Nonviolent resistance: A treatment for parents of children with acute behavior problems. *Journal of Marital & Family Therapy, 34*(1), 75-92.