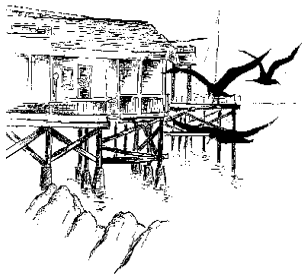
The Monterey County Chapter

California Association of Marriage and Family Therapists

July / August 2021 Newsletter



Benefits to MC-CAMFT Membership:

- Reduced fees at our events
- Invitation to our Members only annual gatherings
- Access to Members only Salons, which are intimate workshop offerings taught by fellow Members
- Periodic Newsletter with relevant CAMFT informa tion and Member created writing
- Opportunity to contribute your writing to our News letter, including things such as a column, book re view, workshop or conference review, poem, opinion piece or article
- Free advertising in our Newsletter and "Classifieds" section of our website
- Inclusion in our "Find a Therapist" website directory
- Access to Member and Announcements Forum on our website where you can seek feedback from other members and post things to the community
- Opportunity to submit a proposal to host a Salon for our Members
- Option to join us on the Board as a volunteer com mittee chair or ad hoc committee member
- Opportunity for MC-CAMFT to co-sponsor your workshop, so you can offer CEUs to your attendees
- Free Mentoring by experienced clinicians
- Invitation to suggest any member activity you find interesting, and we'll consider it!

Benefits to MC-CAMFT Website:

◊ Current Member Directory
◊ Classifieds Page for Members
◊ Chapter Board Contact
◊ Specialized Forums
◊ Online Newsletter
◊ Networking Opportunities
◊ Chapter Documents Access
◊ Sponsorship Opportunities
◊ Membership Information

MC-CAMFT CALENDAR

AUGUST 2021 - Neighboring Event

Interrupting Systemic Racism In the Mind and On the Ground

Date: Friday, August. 6, 2021
Time: 1:30 p.m. to 3:30 p.m. (Pacific Time)
Place: Online Webinar – Details at Registration
Fees: Members $35, Non-Members: $45, Students/Pre-license: Free

Register Here: https://www.mbpsych.org/event-4374034

In This Issue...

2021 MC-CAMFT Board Roster

2021
Board of Directors
- Officers -

President:
Jennifer Farley
jennifer@shamanhealingmonterey.com

Treasurer:
Susan West
831-206-7639

Secretary:
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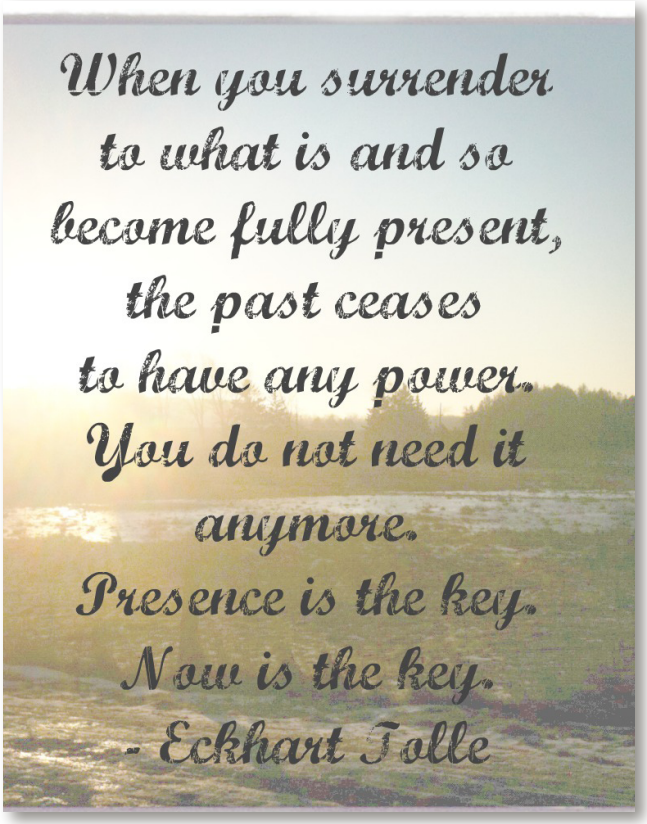
rochellehall.consult@gmail.com



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2021
- Committee Chairs -

Membership Chair: OPEN
Public Relations: OPEN
Programs Chair: OPEN
Pre-Licensed 3000 Hour Club Chair: OPEN

Legislative & Ethics Chair:
Michael Newman

Mentorship Chair:
Pat McDermott, LMFT
patmcdermft@comcast.net

Newsletter Editor:
Ross E. Farley III
ross@shinealight.info

Hospitality Chair:
Olivia Fae Stadler
olivia.stadler@yahoo.com

Continuing Education Chair:
Raceal McWhorter, LMFT
racealarttherapist@gmail.com

Member-At-Large:
Carmen Martin, LMFT
lovehealing@me.com

Member-At-Large:
Sarah Lauterbach, LMFT
sarahlauterbach.lmft@gmail.com

Jennifer Farley

2021 Board President

Our next planned CE event is not until September, but that doesn't mean that we are taking a break! Our volunteers are busy behind the scenes ensuring that the foundation of our chapter remains strong. We are reviewing our by-laws, strategizing ways to bolster community resource information for our membership and beginning to explore possibilities for meeting in person again. That being said, we don't want to make the shift from virtual to in person without hearing more about this from our membership. To gather information about how you all are feeling about the possibility of returning to in person events, we created a simple survey that we are asking our membership to complete. It is VERY short, and we are REALLY relying on your feedback to clarify how to proceed with event planning for the remainder of the year and into 2022.

Here is the link to the survey: https://www.surveymonkey.com/r/P62G2DZ

If you are in need of CEs this summer, I suggest that you check out the CAMFT virtual conference recordings that are available until August 7, 2021. Also, our "neighbors" over at the Monterey Bay Psychological Association are offering an important CE workshop entitled Interrupting Systemic Racism in the Mind and on the Ground, taught by Courtney M. Bonam, PhD. There are more details about this event in the newsletter.

In other news, I am seeking someone to take on the position of President-Elect. It is time to start ensuring that the next leader of the chapter is thoroughly trained to continue forward. The President-Elect role is a position where one is in training to step into the President role. Previous leadership experience is encouraged, along with an enjoyment for collaboration. Our board is made up of dynamic, warm and knowledgeable volunteers, so leading the team is more of a pleasure than anything else! If you are interested in this position, or if you know someone who would be great as the next MC-CAMFT leader, please reach out to me directly at Jennifer@ShamanHealingMonterey.com. Of course, ultimately our membership elects this position, but it is helpful to have preliminary conversations to ensure anyone interested is qualified and well informed of the responsibilities of the role.

Happy summer everyone! May You Be Well,

Jennifer Farley

August 6th 2021 - Neighboring Organization Event to check out!

"Interrupting Systemic Racism In the Mind and On the Ground"

Since George Floyd's murder in 2020, national conversations about race have centered on systemic racism—with some conversations calling into question the legitimacy of critical race theory as a framework for teaching and learning about racial dynamics in the United States. During this workshop, we will explore both critical race theory and systemic racism as essential for examining race from a psychological perspective, and review two useful evidence-based strategies for interrupting systemic racism. In doing so, we will place special emphasis on how physical space has been used as a tool to construct and reinforce racial boundaries and hierarchy.

By attending this workshop, practitioners within the helping professions will strengthen their racial analysis skills and become better equipped to engage in race-related conversations that arise among clients and colleagues who belong to a diverse range of racial groups—including White people and people of color.

Courtney M. Bonam is an Assistant Professor of Psychology and Critical Race and Ethnic Studies at the University of California at Santa Cruz. Previously she was a faculty member in Black Studies and Psychology at the University of Illinois at Chicago. She has been awarded grants and fellowships from the Ford Foundation, the University of California Chancellor's Postdoctoral Fellowship Program, the Society for the Psychological Study of Social Issues, and the American Psychological Association. Professor Bonam researches racial stereotyping as it shapes social perceptions and judgments relevant to racial inequalities in health, wealth, and wellbeing. Her work focuses on two understudied targets—physical spaces and multiracial people, to highlight the social construction of race and expand dominant psychological approaches to studying race. She also examines how social justice education can mitigate psychological processes that reinforce racial inequality. Professor Bonam completed a Postdoctoral Fellowship in the Goldman School of Public Policy at the University of California at Berkeley. She earned a BA in Psychology from the University of Michigan and a PhD in Psychology from Stanford University. Journals she has published in include Journal of Social Issues, Cultural Diversity and Ethnic Minority Psychology, and Journal of Experimental Psychology: General.

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Register Here: https://www.mbpsych.org/event-4374034

The California Psychological Association is co-sponsoring this event with the Monterey Bay Psychological Association. CPA is approved by the American Psychological Association to sponsor continuing education for psychologists and is recognized by the BBS to offer CE credit for its licensees. CPA maintains responsibility for this program and its content.

Important Notice: Those who attend the workshop and complete the CPA evaluation form will receive 2.0 continuing education credits. Please note that APA CE rules require that we only give credit to those who attend the entire workshop. Those arriving more than 15 minutes after the start time or leaving before the workshop is completed will not receive CE credits. Cancellations received with less than 48-hours' notice will not have registration fees refunded

Member Article

Couples Corner

offered by EFT trained therapist **Amy Somers**

So here we are, in our disconnection protest, i.e., fighting, with our partner. At least we recognize it. It's even sweet, in a weird and stressful kind of way. What to do now? For my husband and me, our Hold Me Tight workshop with Dr. Michelle Gannon and Dr. Sam Jinich said the next step was to recognize our dance. You know the one. We call ours "The Storm." We each have assigned steps that we move through countless times, based on our attachments of origin. We get stuck in the negative dance (cycle); locked in to Nowhere. In studying the steps, the hope is more compassion and understanding for each other, and for ourselves. Naming the moves can shift a couple to see the negative cycle as the enemy. Working together decreases conflict and tension. I know, right? Easier said than done.

Dr. Sue Johnson noticed general roles, based on attachment of origin, called The Pursuer and The Withdrawer. Most people are a bit of both, usually one is more emphasized. My husband is a Pursuer, I'm a Withdrawer. As a Withdrawer, I began with Avoidant attachment. His was Anxious. Simply put, the more anxious he feels, the more he pursues, the more I avoid and withdraw. The more I withdraw, the more anxious he becomes, the harder he pursues. You see the dilemma. I started with him (of course I did!) but I can just as easily start the cycle by withdrawing.

Withdrawers withdraw, also shut down, get quiet, avoid, get defensive, problem solve, give up, try to keep peace, refuse to talk, change the subject, focus elsewhere, become logical, minimize partner's concerns, find an exit and go behind a wall. Common attachments beliefs are "I'm never good enough," or, "I'm fine without you." Withdrawers fear rejection.

Pursuers pursue, complain, remind, point out partner's mistakes, prod, plea, blame, seek justice, criticize, tell partner how to change, demand attention, ask questions, yell, threaten, desperately try to reconnect and express disapproval. Common attachment beliefs are "I'm all alone," or "I'm unimportant." Pursuers fear abandonment.

I guess the key is (and here's the hard part) to be able to recognize your own role: actions, behaviors, energy and how you are responsible for pulling the partnership into the negative cycle. I should say for me this is the hardest, because when we fight, all I want to do is pull away and find peace somewhere else. Convinced everything is his fault; I am not to blame. Studying the steps of the dance and speaking in generalities de-personalizes each partner a bit, kind of a zoom-out to bigger picture perspective. Agreeing on the dance is a group project both partners can map out and talk about in a more neutral way, to work in tandem on a resolution.

Every couple I know has a negative cycle. Based in underlying attachment patterns, most couples give a great deal of airtime to this dance that controls them. I invite you to be curious, take the time, map it out to see how your attachment of origin choreographs this dance for you. Are you a Pursuer? Withdrawer? How does this define you and where is your growth edge? C.G. Jung said, "Until you make the unconscious conscious, it will direct your life and you will call it fate." The great news is that you have a choice, as does your partner. Awareness suggests change, change brings connection into view. Intent solidifies healthy connection. Healthy connection can lead to secure attachment. What's your role and what will you choose?

Guest Article

Social Media and Video Conferencing Platforms for Group Therapy and Community Mental Health Outreach for LGBTQIA+ Individuals— The SAAHAS Experience

Jagruti R. Wandrekar, Advaita S. Nigudkar

Abstract

E-health and telehealth are rapidly evolving areas of intervention that may show high potential for use with LGBTQIA+ individuals. Research on the therapeutic utility of these with respect to mental health is limited, particularly in India. SAAHAS (Sexuality, Acceptance, Awareness, Health, and Support) is a queer-affirmative, cognitive behavior therapy-based group therapy model of intervention for LGBTQIA+ individuals. We describe here our facilitator experience with expanding the offline group therapy model to online platforms using Google Meet, with an analysis of attendance and modalities of engagement and a description of our therapy notes and themes of discussion. We describe facilitator experience of continued therapeutic support through WhatsApp by analyzing the chats and thematic coding of the same. We also describe here our attempt at using social media for community mental health outreach through dissemination of mental health messages on Instagram and Facebook; data was analyzed using engagement metrics. Observations of the utility and limitations of these video conferencing and social media platforms and suggestions for effective use are provided.

Introduction

SAAHAS (Sexuality, Acceptance, Awareness, Health and Support) is a therapy group for LGBTQIA+ individuals in Mumbai, that is run by two queer mental health professionals. It works with a queer affirmative cognitive behavior therapy (CBT)-based framework, and has been demonstrated to show preliminary promise in bringing about positive mental health outcomes for participants.1 We have outlined here some ways in which we used video conferencing and social media platforms to provide therapeutic continuity. We used Google Meet for our regular sessions and found some challenges as well as some benefits in the adaptation, which are described here. We used WhatsApp for therapeutic discussions between sessions and describe here how peer and facilitator support were provided using this platform. Instagram and Facebook were used as platforms to disseminate some key mental health information to the LGBTQIA+ community. We describe our experiences and outline some recommendations for mental health professionals who wish to work with this group on how to use social media platforms for actual therapy, between session therapeutic contact, and community mental health messaging.

Research on Social Media Based in the Health Field

Past research has suggested that the Internet and social media have significant value for LGBTQIA+ individuals—they provide safe and accessible spaces to explore and express their gender and sexual identities, help them to access affirming psychosocial support and establish connections, and are platforms for them to find resources and acquire information about gender, sexuality, and mental health.2-4

Social media, e-health (web-based), and telehealth (phone-based) platforms as modalities for interventions are a relatively new area of study in the field of health care. Some of their benefits include their accessibility across geographical barriers, ease of use and convenience, reduction of patient wait-time and costs incurred; LGBTQIA+ individuals may also perceive these to be safer than offline public health platforms because of the discrimination and stigma that they often face while accessing health care in offline spaces.2,5-7 Online spaces may also be less transitory than online spaces.8

There is evidence for chat-based platforms like WhatsApp and WeChat being used effectively for different health care purposes, for example, online social support to promote smoking cessation9-10 and for survivors of domestic violence11; these platforms have been found to be useful as aids to clinical decision-making and patient care, as well as patient learning, and have generally been found to rate high on user satisfaction.12,13

Social media has many potential applications for enhancing community public health outreach, but there is much lesser research documenting the actual usage of the same.14 Some advantages of the social media include the ability to target new and diverse audiences, the ability to receive feedback immediately, increase engagement, and also build communities.13 Among specific social media platforms, Instagram and Facebook have been used effectively for dissemination of public health messages and social support.4,12,15

Despite the preference for online health support espoused by LGBTQIA+ individuals, there is relatively lesser research about the efficacy of online health care interventions with LGBTQIA+ individuals. Some guidelines have been laid out for the same.16 We found some programs utilizing e-modalities such as QueerViBE which uses online video tutorials to build stigma competence,17 and Rainbow SPARX which provides computerized CBT.18

In India, a study examined the use of Internet dating platforms such as Planet Romeo and Grindr and Facebook groups such as Pink Kolkata Party in community building, identity formation, and negotiating intimacies and friendships.8 Another study explored the online platforms used by SAATHI (online library, mobile counselling, e-conferencing, and forums, and a Facebook group), with respect to HIV prevention and destigmatization.19

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An ethnographic study examined the online and offline community created by GayBombay through their website.20 Some studies examined the use of blogging in queer community building,21,22 and social media advertising in promotion of awareness about LGBTQIA+ issues.23 We did not find research focusing on online video and chat platforms (particularly Google Meet and WhatsApp) as modes of therapeutic intervention for mental health, or any social media (Instagram, Facebook in particular) for community mental health promotion of LGBTQIA+ individuals in India.

Currently, given the background of the Covid-19 pandemic, online therapeutic interventions are particularly important. LGBTQIA+ youth may have found the pandemic stressful due to confinement to unfavourable work environments and isolation from their usual identity-affirming social connections, and may be likely to seek out resources and community online at this time.24 This article aims to bridge this gap in research, documenting experiences of providing online interventions as a part of expansion of the SAAHAS group as well as using social media platforms for promotion of community mental health.

Introduction to Year 2 at SAAHAS

We started SAAHAS in 2018 as an offline therapy group meant for LGBTQIA+ individuals. The first year's experiences, including details about group formation and group building processes, safety measures, and participant recruitment and socialization protocol, have been described elsewhere.1 For the purpose of safety, potential participants who filled in the recruitment form met the facilitators for a face-to-face interview, where mutual expectations, safety measures, group rules, confidentiality, and the limits to the same, were discussed, and only following this, were they allowed to attend group sessions. We took informed signed consent for offline and online participation in the group, and for the use of anonymous data for research purposes and publication.

We had a total of 52 participants over 2 years who attended at least 1 session, and we had 25 new participants in the second year. A total of 67.31% of our participants were cis men who were gay or bisexual, while 13.46% were cis women who were lesbians, 15% were transgender and nonbinary, and 5.77% were questioning. In the first year at SAAHAS, we had observed that 78% of the participants were cis gay or bisexual men, and sexual minority women and trans individuals showed lower participation, possibly due to the "politics of access."1

To remedy this, we had 1 session geared specifically toward marginalized communities within the LGBTQIA+ community, communicated specific content geared toward transgender, and bisexual individuals on our social media, and we specifically disseminated information about the group on LBT only platforms; participation of transgender and non-binary individuals, and of lesbian and questioning cis-women, was found to have increased by 33% following these attempts. Participant ages ranged from 19 to 48. We tried to make the group intersectional by explicitly discussing intersectionality in our social media posts and all material used for promotion of the group, and we also addressed intersectionality as a topic of discussion in session 6. Table 1 describes topics of the 13 monthly sessions conducted, summary of the discussion, meet modality, and number of participants. The number of participants ranged from 6 to 26 per session and average number of participants per session was 9.

Table 1. https://journals.sagepub.com/doi/full/10.1177/26318318211017278#

Regular check-ins with participants about their experiences of online and offline platforms, and meticulous group records and observation notes, formed a part of quality control.

Transitioning to Group Therapy Sessions via Videoconferencing

The last 4 sessions were conducted online on Google Meet during the Covid-19 pandemic. The links for the same were shared on a closed WhatsApp group. While participants reported that they were keen to attend the group meetings, some of them expressed privacy-related concerns as they were confined at home with their parents who they had not disclosed their gender identity and sexual orientation to. Hence, we decided to allow participants to join in either on video, audio, or chat depending on their preference. Out of the 26 participants who attended at least 1 of the sessions, 38.46% joined on video, 26.92% on audio, and 34.61% on chat. Despite initial reservations that this would make the conversation chaotic, we were able to have structured meetings, with disciplined participation, and each participant spoke at least once.

One of the major benefits of online meet was increased participation. We noticed that average participation for the 4 online sessions was higher than for offline sessions at 24 (2.7 times more than the offline sessions), with attendance ranging from 22 to 26. A total of 23% of the participants were not residents of Mumbai and were either new to SAAHAS or were old participants who had migrated to other cities.

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The convenience of online meet was reported by them as one of the major reasons why participants could attend. In addition, during the time of Covid-19, with higher isolation experienced by individuals and being in an invalidating home environment, these group meets provided an opportunity for discussion with likeminded individuals and affirmation of their identities and their experiences. The sense of solidarity with respect to getting through the pandemic together also came across in the sessions.

As facilitators, we did face some challenges—one of them being that the cohesion of the group may have been compromised by the absence of video for many of the participants. We believed this to be especially true with respect to new participants who hadn't already formed bonds with the other members. Also, privacy restrictions may have affected the freedom with which people could share concerns, and the quality and stability of the Internet connection across participants fluctuated, leading to some disturbances in the session. Personally, managing the session flow with different points of input—video, audio, and chat, and ensuring that there were no parallel derailing conversations and the session stayed on track—was a bit of a challenge. This was managed by setting clear agendas and having more structured sessions led by facilitators.

Using WhatsApp for Between Session Therapeutic Contact

When we started SAAHAS, we also created a WhatsApp group for all the participants, which was intended purely as a convenient way to coordinate group meetings and disseminate messages for the group. However, over the past year (even before the pandemic), we decided to utilize the group as a means of facilitating between session therapeutic contact.

Our experiences suggest that WhatsApp groups can be a good way of maintaining between session therapeutic contact. Some of the suggestions that emerged from our experience are as follows:

> WhatsApp communication was meant as an addition rather than a substitute to regular group sessions, and this was clarified with participants.
>
> We took consent of all participants before adding them to the group. Also, we ensured that we only added participants to a WhatsApp group after they attended the first actual group therapy session and became acquainted with other group members. Participants were not allowed to add other members to the group.
>
> It is crucial to have clearly defined and explicitly stated guidelines with respect to the kind of engagement expected and encouraged on the WhatsApp group. Some of our rules included—maintaining confidentiality and not outing individuals without their consent, stating and respecting pronouns, only affirmative statements and no name calling, restricting sharing on the group to content related to LGBTQIA+ mental health, with no irrelevant forwards or messages, and checking in with the facilitators prior to sharing content if they weren't sure of the relevance. We also had a discussion on etiquette to maintain if group participants wished to talk to specific participants one on one, and rules for the same included no solicitation or cruising.
>
> As facilitators, we performed 2 roles. We let the conversation and discussions flow spontaneously and intervened when we felt our inputs were necessary or would be fruitful, ensuring that the discussion stayed affirmative, or in the case of a dispute. At the same time, we also took a more active stance on occasions to lead discussions on issues.
>
> For the purpose of this article, we conducted thematic analysis of our WhatsApp chat conversations. Chats were divided into (a) facilitator-run and scheduled chat sessions and (b) spontaneous group discussions. We analyzed the chat messages and divided these into (a) facilitator inputs and (b) peer support inputs. We further analyzed the nature of these inputs and applied code labels for each separate theme that emerged, where each theme symbolized a specific kind of therapeutic input.

The facilitator-organized chat discussion was held with the participants at a pre-decided time. The chosen topic was based on request by a participant dealing with parental restrictions on expression after coming out to them. Table 2 describes the kinds of inputs provided by the facilitator as well as the participants in the discussion. Around 8 participants were active in the discussion, while the others attended passively.

Following this discussion, which was well received, there were also spontaneous other discussions prompted by group members. Table 3 describes the usage of the chat group by the participants, kinds of peer support offered, and kinds of facilitator inputs provided.

We found that WhatsApp as a platform lent itself to more peer support, and helped to decenter the therapists. It helped to strengthen the SAAHAS group therapy "community," with contact and support in-between monthly sessions, thereby strengthening social support networks. Besides convenience and the possibility of obtaining instant support rather than having to wait for the next session, further advantages of WhatsApp may be the catharsis from writing issues out on text, and the availability of the conversation for review later5; this may ensure that individuals can remember and refer to the discussion whenever they need to, and even those participants who are passive or unavailable when the conversation is happening can benefit from it later.

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While WhatsApp chats can be a platform for sustaining therapeutic discussion, we do believe that enforcing the rules mentioned above is crucial. It may be a challenge for the facilitator to regulate the discussion and ensure a healthy "signal-to-noise" ratio to ensure accurate learning and fewer messages that are barriers to learning or are irrelevant. While we found that participants typically provided helpful comments mentioned above, we were mindful of comments by participants that could potentially be unhelpful, as below:

Misgendering/using incorrect pronouns.

Stigmatizing and pejorative terms—terms suggesting transnegativity, homonegativity, stigma about mental health, classist, communal, casteist, sexist, or ableist language.

Judgmental and blaming comments.

Advice that was potentially harmful.

Information that was incorrect, unscientific, or unverified.

Attempts to take over the conversation (rather than giving others room to express their opinions).

Derailing/irrelevant comments that could disrupt rather than aid the discussion.

Spam—random comments or posts unrelated to LGBTQIA+ issues, mental health, or the topic of discussion.

One of the risks of using WhatsApp is that of privacy—one cannot guarantee that group members do not "out" people (share that they are queer with others without their consent), or share screenshots of conversations. This has to be outlined while taking informed consent, and forming the WhatsApp group after an initial face-to-face group session may build trust between members.

Use of Instagram and Facebook for Community Mental Health

We utilized Instagram and Facebook for community mental health work. Research on the effectiveness of varied social media platforms and the use of metrics designed specifically for the same is an emerging phenomenon in market research, but we attempted to use the same metrics to obtain insights into the impact of our social media outreach communications as a pilot. We focused on reach and engagement metrics. The reach of a post describes the potential unique viewers of a post. Organic reach refers to reach of a post as it is and paid reach is reach after posts are sponsored. Engagement on a post or account describes the measurable interaction with the post or posts on an account, that is, number of likes, comments, shares, and saves of posts. Engagement rates can be calculated in many ways; the formulae used by us here were:

Engagement rate by reach = total of all engagements/reach × 100

Average engagement rate = total engagement rate/total number of posts

Engagement rate by reach demonstrates how many people who saw a specific post or certain group of posts found it/these valuable, which may indicate the utility of the content.

With respect to content, we put up introductory posts, podcasts, and news articles about SAAHAS to recruit participants, posts summarizing what we discussed during each session, posts describing research findings of our related papers in simple terms, along with general articles and posts about LGBTQIA+ mental health, on topics such as mental health indicators, how to choose therapists, do's and don'ts for allies, mental health concerns of transgender individuals and bisexual individuals, and suicide prevention strategies.

As of the date when this article was written, we had 273 followers on the Instagram page and 553 followers on the Facebook page. Table 4 describes post content categories, reach, and engagement metrics on both social media platforms. The reach metrics suggest that through our accounts, we were able to reach out to more than 10,000 individuals via Instagram and more than 50,000 individuals via Facebook, with an average of around 250 and 1,000, respectively, per post on the two platforms. The overall engagement rates by reach suggest that 15.94% of individuals on Instagram and 8.22% of individuals on Facebook who shsaw at least one of the posts on the accounts, engaged with the content and therefore may have found it useful. An average post was engaged with by 0.38% of the individuals who saw it on Instagram and 0.16% of the individuals who saw it on Facebook. Posts about allyship, choosing a therapist, our research summaries, as well as posts summarizing our sessions on abuse within queer relationships and planning for a future without marriage, showed the most engagement across platforms. While we were able to reach out to more individuals via Facebook, the engagement rates for posts were higher on Instagram than on Facebook.

As a trial, we self-funded the sponsorship of 3 posts, and found that the paid reach was exponentially higher than the organic reach. Thus, to scale up the community mental health outreach, sponsoring posts may be a good strategy, but this may be time limited, and to keep the engagement high, this would need to be accompanied by regular active involvement via stories, polls, more regular posts, careful choosing of hashtags, using carefully curated content, and so on; more research on what helps to increase engagement is needed. Organizations would need to allocate manpower and finances for the same if they wish to use social media for community outreach.

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Conclusion

Our experience, although brief and limited, outlines the utility of using video conferencing and social media platforms for mental health of LGBTQIA+ individuals. With respect to intervention, a combination of audio, video, and/or chat may provide flexibility for participants when transitioning to online rather than offline group therapy meets. WhatsApp may be a useful mode of continuity of therapeutic intervention; it may also help to decenter the therapist and harness peer support. With respect to community mental health, we describe how Instagram and Facebook can be effectively used and how engagement metrics may be a relatively novel index to study their effectiveness. We thus aimed to continue offering some support to our usual participants as well as to LGBTQIA+ community members at large by expanding the reach of SAAHAS using online platforms, and shared our experiences of the challenges faced.

Given the increasing globalization, reducing digital divide and increasing use of the Internet, as well as the unique benefits of social media for LGBTQIA+ individuals and for mental health messaging in particular, more rigorous research on these modalities is the need of the hour.

Acknowledgements

The authors would like to thank the SAAHAS members for being a part of our very own queer community, and for allowing us to use their experiences in this article.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Can Therapy Be Harmful?

The fact that therapy can be hurtful is a painful truth we often try to ignore.

Katherine King Psy.D.

KEY POINTS

-Treatments that are powerful enough to heal inevitably have risks, including counseling and psychotherapy.

-Research about the harmful effects of therapy is insufficient.

-Sources of harm are varied and include the therapist, the intervention, and health care systems.

When you pick up a bottle of medicine at the pharmacy, or even grab something over the counter, you expect to see a little booklet come along with it. If you take the time to read it, you learn the proper dose and frequency, who should avoid the medicine, and all about its potential side effects, overdose risks, and potential interactions with other drugs. We implicitly understand that drugs that have the power to cure us can also do harm. Treatments that are powerful enough to heal inevitably have risks. The same is true for counseling and psychotherapy. For all that therapy offers, we do ourselves a disservice by ignoring the potential for harm.

Research about the harmful effects of therapy is insufficient, but it does exist (e.g., Parry, Crawford, & Duggan, 2016; Boisvert & Faust, 2002; Berk & Parker, 2009). Since some of the benefits of therapy come from the positive expectancy that it will help, therapists don't like to publicize potential downsides or risks. Further, the media seems to be biased in favor of psychotherapy these days. While this is good for destigmatizing the need for mental health care, it also means that research about its potentially adverse effects tends not to get picked up and distributed broadly.

One type of harm that has been researched is called iatrogenic harm. This is a fancy word from the field of medicine to describe the inadvertent harmful effects of diagnostic or treatment interventions. A good example in medicine might be the nausea, hair loss, and other effects of chemotherapy.

There are a number of factors that might lead to harmful therapy. One editorial by Parry, Crawford, and Duggan (2016) enumerated several. They suggested we consider the risks of the intervention itself. For example, a person may learn relaxation skills with their therapist but then misapply this tool in daily life as a way to avoid the routine and necessary stressors of life. A diagnostic assessment might lead a person to receive a diagnosis that is painful to learn, or even later discovered to be inaccurate.

The therapist themselves may also be a source of harm for their clients. The therapist might make an error in providing treatment, e.g., teaching coping skills in a way that is misleading or inaccurate. A therapist might hold certain biases or assumptions and impose those on the client. While there are times where therapists knowingly exploit or harm their patients, such cases are thankfully quite rare. What is more common is for well-intended therapists to inadvertently cause harm without even realizing it.

This article also highlighted the potentially painful interactions between therapist and client. For example, a therapist might attempt to use a motivational intervention with a client only to induce feelings of shame or make the client feel criticized for their difficulties. The therapist may lack the needed skill or expertise to notice and repair the damage caused in such moments, further worsening and complicating the harm.

There may not be a good stylistic fit between the therapist and client. For example, a therapist who tends to use humor might inadvertently hurt an earnest or sensitive client who feels the therapist's lighthearted approach is minimizing their suffering. A poor match could also occur when a skillful therapist ends up seeing a client outside their area of expertise. The interventions that are helpful with one set of clients may be counterproductive or even harmful with others, leading to unintentional harm by even well-intentioned and usually competent therapists.

Parry and colleagues (2016) also discussed risks that arise from what the client brings to the interaction. For example, a client can become dependent on their therapist and develop difficulties making autonomous decisions between sessions because they want to run everything by the therapist first. Some clients may have been taught to hide their emotions or to never criticize authority figures, which makes it more difficult for therapists to receive important feedback or to read what is happening emotionally in the moment.

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Another area highlighted in this article were the systemic factors that might lead to harm. For instance, a health care system might require therapists to have caseloads that a too large to give adequate time and attention to each client. Systems may also lack clinicians with the expertise needed to appropriately serve their clients. If trauma or substance abuse are common, but clinicians do not have the specialized expertise needed to address such challenges, then the situation is ripe for harm.

The good news is that negative effects from psychotherapy are thought to be relatively rare, with estimated rates typically around 5% (Parry, Crawford, & Duggan, 2016). Nonetheless, as therapists, clients, and caring loved ones of people in therapy, we cannot forget that such risks do exist. There may not be a little paper booklet that comes with every therapy session, but just like other medical treatments, we should be on the lookout for potential adverse effects. The sooner we are aware of them, the sooner we can take action to alleviate them. Even better, with more research in this area, the mental health field can come to understand harm better and reduce the likelihood of it happening in the first place.

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