Paging Dr. Chatbot, LMFT: Artificial Intelligence and the Future of MFT

It is difficult to imagine an artificial intelligence navigating the complexities of a family in the therapy room. While it is difficult to foresee all the implications of technology that will impact our profession, one thing is clear: affordability, accessibility, and anonymity of such technologies are already changing how some people access mental health services.

Aaron Cohn, PhD  Katherine M. Hertlein, PhD

I Love You; I Hate You: Couple’s Therapy and Borderline Personality Disorder

Among the most difficult of disorders to treat, borderline personality disorder causes instability in interpersonal relationships, impacts self-image and is marked by impulsivity. See how MFTs, using a systemic framework, can apply best practices for intervention.  Molly McDowell-Burns, PhD

We are pleased to present the preliminary brochure for the 2018 Annual Conference. Please see page 41 for details on sessions, travel, hotel arrangements and more. We hope to see you in Louisville!

—Tracy Todd, PhD, AAMFT CEO
The Resilient Couples and Family Therapist

Resilience is developed when there is harmony among having a sense of community, obtaining competence and achieving goals, making decisions and taking responsibility for actions, and giving back by offering the best to others.

Christie Eppler, PhD

Decriminalizing Immigration: Working with the Undocumented Family in an Anti-immigrant Era

Eleven million undocumented immigrants in the U.S. face a multitude of challenges. Given the narrow understanding of this group, it is important for MFTs to be aware of how this population experiences discrimination from multiple systems.

Sandra Espinoza, PsyD  Iman Dadras, PhD  Hye-Sun Ro, PhD

Behind the Badge: Therapy with Law Enforcement Couples

Law enforcement families are under considerable stress in today’s sociopolitical climate. A community once described with pride is now met with increased media attention, as stories of police misconduct come to light. Taking a look behind the badge, what is life like for the law enforcement families we serve?

Avery Campbell  Ashley L. Landers, PhD
FOR MUCH OF THE CURRENT DECADE, relevancy has been the watchword of thought leaders in association management. Harrison Coever and Mary Byers warned in their 2011 text, *The Race for Relevance*, traditional, constituency based, and risk averse associations would not flourish in an emerging consumer market that increasingly values the currency of time and the productivity of a 24-hour day. Interest in longstanding civic and community service organizations such as Kiwanis, Lion’s Club, or the Rotary has declined and few professionals join trade or professional associations any longer simply as a matter of loyalty, obligation or affiliation. Today’s consumer values products and services that are genuinely meaningful, helpful in the performance of work or leisure activities, are conveniently accessible and deliver a meaningful return on an investment of personal resources. Coever and Byers recommended that associations hoping to survive and thrive make five radical changes.

1. Build a robust technological framework
2. Empower the Chief Executive Officer and enhance staff expertise
3. Rationalize programs and services
4. Rigorously define the membership market
5. Overhaul the governance model and committee operations

From my point of view, because of intentional consideration and response to these recommendations, AAMFT is far more than simply surviving. To begin, while the half-life of most technology is always decreasing and the options for new technology in contrast is on the increase, AAMFT has a robust technological framework providing meaningful workspace for critical component groups, multiple use options for members, tools for staff and resources for outside consumers. Exciting innovations will not only require technical capability, but also rich understanding of application to training.

Second, AAMFT staff, from stem to stern, is a remarkable collection of talent. Experts in matters of finance, communication, law, political strategy, education, event planning, technology, web design, membership management, accreditation, foundation development, property management, human resources and the like lead to the advancement of strategic goals and the literal protection of the profession and practice of marriage and family therapy. The expertise of the staff affords the single employee of the board, the Chief Executive Officer, the resources necessary to meet and exceed the strategic direction of the board set forth in an annual work plan.
Third, an association dedicated to relevancy does not add products and services simply to add products and services. In contrast, associations pursuing relevancy limit their offerings of programs, products and services to those specifically assessed as meaningful and useful to members. Less can be more, if what is less provides very well for the needs of the member. In a fast moving world of association management, member needs can ebb and flow. Within AAMFT, for example, even as new topical and geographical interest networks are coming on line in response to member needs, benchmarks determine a certain level of performance for the continuity of that network assuring that AAMFT and component groups do not engage in providing a program or service without a measure of return on the investment.

Fourth, associations keenly focused on a specific niche will far surpass the association endeavoring to be all things to all people. Providing a singular service will quickly have an advantage over competitors without a clear definition of the membership market. While AAMFT does provide a broad range of services and products, AAMFT serves a singular niche as the sole national association dedicated to advancing the profession and practice of marriage and family therapy for members and non-members alike. From time to time, members may perceive a lack of engagement by AAMFT about a potential service or product, but if the product or service is outside the mission of the association, even if noble and interesting in nature, it can be limiting to the overall value of the association. Advocacy has been a central thread of the association and is a chief niche of the association.

Fifth, an overhaul of a governance structure is extremely challenging to the systemic homeostasis of any association, including AAMFT. The ability to alter governance structure, however, is a cornerstone for other changes. Coerver and Byers recommend both reducing the size of a board to five and developing processes to recruit the specific talent and skill in needed board members and committee leaders rather than elect members to represent a particular constituency. A nimble leadership, able to make strategic decisions and more quickly offer direction for the Chief Executive Officer, positions the association to better address challenges and capture opportunities as they evolve. The AAMFT Board and other component groups endeavor to avoid a constituency based mindset in decision-making and aim to be generatively strategic in looking forward regarding the mega-issues facing the association. This begins at orientation to the board and continues through the service of a board member.

While a leadership culture continues to shift from a constituency-based paradigm to a skill-based paradigm, governance change within AAMFT proves slower in the making. The AAMFT board size is double the recommended size of five. Despite feedback from parliamentarians and association management professionals, AAMFT continues to employ leadership selection through older election paradigms. Most associations today utilize a nominating committee, charged by the board to identify, recruit and shepherd emerging leaders with the specific talent and skill sets necessary for open positions. Perhaps the apprehensions reflect a lacking measure of trust in such a new process.

Relevancy is a key guiding principle as AAMFT endeavors to grow and expand, but I might suggest a companion term of access missing from the conversation. Non-profit organizations, as well as for-profit businesses, are engaging critical matters of equality, diversity and inclusivity. While sometimes used interchangeably, these matters of access are different in nature. Associations, for example, can be diverse in nature, but lack inclusivity. In contrast, it is difficult to be an intentionally inclusive association without creating diversity. Similarly, pathways to an end goal in an association, such as leadership, can be equal for two individuals in that they are the same, but absent of equity through even unintentional advantages to one. These are critical matters of access. When members genuinely experience and believe in a shared access to the fruits of the association, the trust necessary for needed structural changes in governance may well follow.

Without a doubt, associations have a life cycle and must evolve and develop in relationship to context and culture in which it is embedded. The principle of relevancy, as understood by Coerver and Byers, has been a tremendous asset in positioning AAMFT to thrive in a competitive and fast moving climate. Change is inevitable and the governance structure of AAMFT is an area that will require continued consideration for more radical change. The race to be relevant is essential, and assuring equitable and inclusive access will be critical in the pursuit of such meaningful relevance.

CHRISTOPHER HABBEN, PHD

Reference
AAMFT 2018 Preliminary Slate

The AAMFT Elections Council met March 2-3, 2018 to review qualified candidates for various AAMFT elected positions and announced the preliminary slate for the 2018 elections. The AAMFT ballot will be sent to eligible members in June. Ballots will be online only and sent electronically through a third-party vendor.

**President-Elect**

Shelley Hanson, MA
Silvia Kaminsky, MSEd

**Board**

Richard Mike Bishop, PhD
Kellie Buckner, EdS
Richard Gillespie, MDiv
Damir S. Utržan, PhD
Darren Moore, PhD

**Elections Council**

Amanda Szarzynski, PhD
Kristina Brown, PhD
Veronica Kuhn, PhD
Afarin Rajaei, MA
Natasha Williams, MS

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AAMFT RESEARCH & EDUCATION FOUNDATION www.aamftfoundation.org
AAMFT Clinical Fellow Receives NIH Research Grant

Dr. Kendal Holtrop, an AAMFT Clinical Fellow, was recently awarded a research grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health (NIH) for her project, Determining Functional Components of an Evidence-Based Parenting Intervention (R03HD091640). As part of this project, Dr. Holtrop will develop a system to measure components of a parenting intervention and then use this information to identify which intervention components are most highly associated with changes in parent and child outcomes. This work can improve clinical practice by enabling interventions to be delivered more efficiently in real-world settings, ultimately enhancing prevention and treatment efforts for child behavior problems. Dr. Holtrop remarked, “My hope is that the knowledge gained from this project can be used to help more families gain access to evidence-based intervention programs.”

Dr. Holtrop is an associate professor in the Department of Human Development and Family Studies at Michigan State University. Clinical Fellow Dr. Jared Durtschi, from Kansas State University, is serving as a co-investigator on this study. Dr. Durtschi will collaborate primarily on areas of study design and statistical analysis. Rounding out the study team is Dr. Marion Forgatch, of Implementation Sciences International Inc. Dr. Forgatch is the developer of GenerationPMTO, the focal parenting intervention for this study, and is serving in the role of co-investigator.

DATA NOTE
Mental Health of Law Enforcement Officers

**DIVORCE**
75% of marriages end in divorce

**ALCOHOL DEPENDENCE**
25% of officers are alcohol dependent

**DOMESTIC VIOLENCE**
Domestic violence is 2-4 times more likely in police families

**PARTNER VIOLENCE**
40% used violence against a partner within the last year

**MOST COMMON MENTAL HEALTH ISSUES**
Anxiety, PTSD, depression, suicide, and suicidal ideation

SOURCE: EXCERPTED FROM MENTAL HEALTH OF LAW ENFORCEMENT OFFICERS, ANXIETY AND DEPRESSION CONFERENCE, MIAMI, FL, 2015. PERCENTAGES ARE ROUNDED.

LETTER TO THE EDITOR

“I cannot tell you how thrilled I was to read the article by Froma Walsh in the March/April issue. She describes exactly what I hope to do in my MFT practice. My passion is to help those with chronic or terminal illnesses and their families. To be able to help people reconnect, mend fences and process their grief is the highest calling I can think of. This article solidified my choice of career path. Thank you very much, Dr. Walsh.”

NATALIE M. RAYNES, AAMFT STUDENT MEMBER, MILWAUKEE, WISCONSIN
Family therapists have long known the importance of relationships and their role(s) in the context of health and well-being. Clients sit in therapy rooms, with racing hearts and troubled breathing—perhaps due to marital conflict or worries over adolescents. With their therapist, they share their inabilities to sleep and their feelings of being run-down due to conflicts at home. These are just a few examples of frontline conversations that happen any day in therapists’ offices. For more than 50 years, family health researchers have paid increasingly more attention to the impact relationships have on physical well-being (Haase, Holley, Bloch, Verstaen, & Levenson, 2016; Kiecolt-Glaser & Newton, 2001; Robles & Kiecolt-Glaser, 2003; Robles, Slatcher, Trombello, & McGinn, 2014). These reciprocal interactions between our relationships and our health make family therapists uniquely suited to take their biopsychosocial-spiritual and systemic frameworks into healthcare settings (Engel, 1977, 1980; Wright, Watson, & Bell, 1996).

Our healthcare system is calling for more behavioral health providers, and family therapists are often finding themselves positioned in such settings. Family therapists are tasked to provide treatment for those facing complex illnesses and chronic pain, and those working toward overall health and well-being. What is critical to this call is that appropriate training exists due to conflicts at home. These indicators serve as behavioral anchors to help determine whether a specific level of competency has been achieved. As they consider clinical competence in the healthcare setting/role in which they are positioned, a professional may intend to focus on only one (such as clinical). When using the document, clinicians, trainers, supervisors, researchers, employers and others should keep in mind that application of the competencies exists on a continuum (Hodgson, Lamson, Mendenhall, & Tyndall, 2014).

The authors did not intend for a family therapist working in a healthcare setting to master all of the competencies, but instead to use them as a guide within the context of the particular healthcare setting/role in which they are positioned. Given that other mental health disciplines have also published similar healthcare competencies, it was important that the field of family therapy also demonstrate our preparedness for clinical, supervision and training, healthcare management and policy, and scholarship opportunities in healthcare settings.

The competencies are categorized in six broad domains including systems, biopsychosocial-spiritual, collaboration, leadership, ethics, and diversity. Collectively, these speak to the values associated with the skill sets and heart of family therapy. Within each of these domains are four competency categories or applications that include clinical skills, training and supervision, healthcare management and policy, and scholarship. Lastly, as a practical and hands-on way to examine these competencies, examples of target indicators are provided. These indicators serve as behavioral anchors to help determine whether a specific level of competency has been achieved.

To illustrate: a person interested in building clinical skills in a healthcare setting would examine the clinical competencies in this document (throughout each of the cited six domains) to ensure that they are adequately trained and prepared for their specific role. As they consider clinical competence in the systems domain (see Table 1 for an example of this competency and a selection of the target indicators), they will want to demonstrate competency in clinically recognizing the multi-directional influences between patient, family/support, and healthcare systems.
This competency example highlights the natural transition from the training and practice of traditional family therapists who work with clients (patients) and families, to one also regularly including collaborations and interventions with the healthcare system itself. Target indicators could include actions such as effectively facilitating communication between and among patients and families, as well as among the healthcare team and even community partners or payers, and/or making sure to conceptualize the healthcare team and family as important players in the creation of a treatment plan. This way, when asked how they are trained for work within a healthcare system, the family therapist can point to the skills and abilities they have above and beyond someone who practices in the specialty mental health sector alone.

Trainers and supervisors within healthcare contexts will also want to examine the competencies for training/supervision within the ethics, diversity, biopsychosocial-spiritual, collaboration, and leadership domains. The same holds true for healthcare management and policy and scholarship. The goal is for those working in healthcare settings to focus on the knowledge, skills, and abilities highlighted across each domain that will best prepare them for their specific job duties.

Family therapists who are successfully integrated into healthcare settings may already be excelling at many of these competencies. Others are still working to understand how to gain proficiency and/or advocate for positions in healthcare settings. Many healthcare settings are still unfamiliar with the titles of “marriage and family therapist,” “couple and family therapist,” and/or “medical family therapist,” and the need for a new medical model: A challenge for biomedicine. Science, 196, 129-136. doi: 10.1016/b978-0-409-95009-0.50006-1


### Table 1: A Sample of the Systems Competencies

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>KNOWLEDGE/ABILITY/PERSONAL CHARACTERISTIC</th>
<th>TARGET INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 CLINICAL</strong></td>
<td>1.1b Recognizes the multi-directional influences between family/support systems and healthcare systems.</td>
<td>Facilitates communication between and among patients/clients, families, healthcare team members, community partners, and payers from a systemic/relational perspective.</td>
</tr>
<tr>
<td><strong>1.2 TRAINING/ SUPERVISION</strong></td>
<td>1.2a Utilizes a systemic / relational and BPSS framework when mentoring, supervising, or teaching learners, behavioral health providers, healthcare providers, researchers, and administrators.</td>
<td>Promotes proficiency in supervisees and learners’ usage of family-oriented care tools and measures (genograms, five family-oriented questions).</td>
</tr>
<tr>
<td><strong>1.3 HEALTHCARE MANAGEMENT &amp; POLICY</strong></td>
<td>1.3a Understands the management of systems integral to the provision of BPSS and relationally-oriented healthcare.</td>
<td>Applies critical research and updates regarding practice-related changes that influence BPSS and relationally oriented policies.</td>
</tr>
<tr>
<td><strong>1.4 SCHOLARSHIP</strong></td>
<td>1.4b Understands the integration of research and practice through systematic application of research to clinical work.</td>
<td>Articulates and justifies the importance of systemic and relational research in the practice system.</td>
</tr>
</tbody>
</table>
AAMFT Offers New Member Benefit

AAMFT is excited to announce that we have formed an affinity partnership with SimplePractice to provide high quality practice management software with a special introductory rate to AAMFT members.

SimplePractice is one of the fastest-growing, highest-rated, and most innovative practice management systems on the market. Their robust system is easy to use for therapists, with several options to customize, and the company was founded by a therapist trained in marriage and family therapy. SimplePractice is client focused and center their product development around the needs of customers.

AAMFT members receive a free 30-day trial AND your first two months for the price of one!

How can SimplePractice help your business grow?

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Have your clients engage with your practice right from the start with the client portal featuring paperless intake process, secure payments and scheduling. Put your focus on growing your practice and less time on data entry, rescheduling, or getting paid.

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2018 Symposium Brings Together MFT Leaders

With attendees traveling from all over North America—and even from as far away as Kenya!—the 2018 Leadership Symposium welcomed 155 MFTs interested in leadership development to Seattle this year. The largest Symposium in the four years it has been held, the buzz and energy around leadership within our association and the larger mental health field was electric.

Whether it was being challenged to consider the benefits of rejection or contemplate working and relating across generational gaps, the Symposium speakers encouraged attendees to think outside of their traditional frame of leadership. After the event, attendees remarked:

“Each year is better than the previous.”

“I always like this conference. The keynote speakers and breakout sessions offer information and education not typically received in other conferences.”

“I loved it.”

“It was all together very good! I’m quite grateful to have attended.”

“Thank you for this amazing experience. It reinvigorated my passion for my role in the field.”

“The keynote speakers were all incredible and I found each breakout session I attended very helpful and informative. I can’t wait to attend another Leadership Symposium in the future ...”

Save the date for the 2019 Leadership Symposium in Arlington, Virginia, March 7-9!
State advocacy tipping points

In the United States of America’s system of government, individual states can serve as “laboratories of democracy.” This phrase, coined by U.S. Supreme Court Justice Louis Brandeis, underscores that individual states can try novel social and economic policies without risk to the rest of the country. If a particular policy works well in a state, other states may try to implement the policy in their state. As the policy gathers steam in different states, it can create a tipping point effect where the policy is seen as vital and more states or the federal government may attempt to implement the policy. Special interest groups, including professional organizations such as AAMFT, often look to these laboratories of democracy to allow initiatives to gain traction.

One example of utilizing individual states to create a tipping point effect is the fight for MFT licensure in the mid-1980s through the 2000s. As the field of marriage and family therapy was coming into its own identity as a distinct profession, obtaining recognition by the state through licensure was seen as one way to help legitimize the profession. Eleven states created an MFT license in 1986 and MFT advocates around the country were able to use that momentum to push for licensure in the remaining states. By 2009, when the final two states, Montana and West Virginia, obtained MFT licensure, there was solid evidence that licensing MFTs was in the best interest of public protection. By then, the conversation around licensing pivoted from why it is important to license MFTs to why hasn’t the state acted in the face of 48 other states implementing this license. The tipping point had been reached.

A major theme of the 2017 and 2018 legislative sessions has been the streamlining and reduction of government through the consolidation or elimination of licensing boards. Twelve states introduced legislation that would consolidate or eliminate the MFT licensing boards. One consideration for the state legislatures seeking to eliminate licenses was the number of states in which the profession was licensed. This consideration was favorable for MFTs as the profession is regulated in all 50 states. At press time, efforts to consolidate or eliminate the MFT license were unsuccessful. While the tipping point effect had been successful for the licensing of the profession, the inverse can be true as well: If a state de-licenses professions, other states may consider de-licensure as an option to streamline government. MFT advocates must be vigilant against such threats to the profession.

AAMFT recognizes that a single state could turn the tide, favorably or unfavorably, for an initiative. When the ability of MFTs to diagnose was challenged in Texas, AAMFT vigorously defended the profession—spending nearly 10 years in litigation and just

With the diagnosis victories in Alabama and Virginia, the number of states with diagnosis in the MFT scope of practice is up to 40. At right, in blue, are the states that explicitly include the ability of MFTs to diagnose in the statute or regulation.
over one million dollars on behalf of members in Texas and across the country. A loss in Texas could have emboldened the opposing side to go after MFTs’ ability to diagnose in other states. While the decision would only apply to MFTs in Texas, the ramifications would be felt by MFTs nationwide. In addition to fighting the lawsuit in Texas, AAMFT took steps to work with leaders in other states to clarify and strengthen the MFT scope of practice.

The victory in Texas swung the momentum firmly to the MFTs’ side. Empowered by the unanimous decision from the Texas Supreme Court, leaders in Alabama and Virginia advocated for legislation that would include diagnosis in their states’ MFT scope of practice. Working with AAMFT, their lobbyists, and the legislature and utilizing the MFT grassroots advocacy network, the Family TEAM, the ability of MFTs to diagnose is now law in both states! With the addition of Alabama and Virginia, the number of states that explicitly include the ability to diagnose in the MFT scope of practice statutes or regulations is now up to forty. AAMFT hopes that 40 states are the tipping point to change the conversation in the remaining states. While AAMFT does not anticipate another lawsuit related to the ability to diagnose, strengthening the scope of practice for the remaining 10 states is a top advocacy goal. Tipping point or not, two states achieving diagnosis victories just one year following the Texas decision is a reason to celebrate.

Tipping points and legislative momentum can impact advocacy efforts negatively or positively. For MFTs, the momentum has generally been favorable, but diligence is necessary to ensure the pendulum does not swing the opposite way. In the laboratories of democracy, all it takes is a single state to buck a trend and try a new experiment.

How can members advocate for the MFT profession? It’s easy as 1-2-3!

1. Join the AAMFT Family Therapy Education and Advocacy Movement (Family TEAM) to amplify the voices of MFTs! The Family TEAM is a grassroots advocacy network that supports MFT advocates in all 50 states and the Canadian provinces. Visit www.aamft.org/familyteam or email familyteam@aamft.org to learn about advocacy opportunities.

2. Donate to the AAMFT Practice Protection Fund. The Practice Protection Fund is a voluntary, member-driven account created in 2013 to help pay for items and services related to defending or advancing the profession. Donate today at www.aamft.org/PPF

3. Contact your Members of Congress to support MFTs in Medicare! Add your voice to the hundreds of other MFTs calling on Congress to act. Go to www.aamft.org/takeaction to take action.
In mid April, AAMFT flew six Family TEAM members to Washington, DC, to advocate for MFTs in Medicare. In this effort, TEAM members visited a total of 10 Congressional offices with positions in key committees. David Connolly, AAMFT’s federal lobbyist, accompanied each Hill Week attendee on visits to provide support, however, AAMFT members served as the focal point in each meeting.

As constituents, TEAM members were able to explain why including MFTs as Medicare providers is so important, using relevant, local information and personal stories. Like many AAMFT members, these members have had first-hand experiences with turning away older adults because Medicare does not accept MFTs as eligible providers. Turning away a client is an even bigger issue in behavioral health workforce shortage areas, where the likelihood of finding a suitable provider that accepts Medicare is low.

Currently, with MFTs and licensed professional counselors (LPCs) not reimbursable by Medicare, older adults do not have access to over 40% of behavioral health providers. Passing legislation allowing MFTs and LPCs to serve as Medicare providers, the Mental Health Access Improvement Act (H.R. 3032) and Seniors Mental Health Access Improvement Act (S. 1879), will go a long way in addressing the major behavioral health workforce access issues Medicare beneficiaries encounter.

The issue is more salient now with the opioid epidemic. Including MFTs and LPCs as Medicare providers also increases the availability of treatment options for substance use. A significant example of the need for MFTs in Medicare comes from treating older adults who now care for grandchildren due to their parents’ substance use. Congress has signaled that they want to pass legislation to address the opioid crisis, and H.R. 3032 and S. 1879 play an important role in addressing this nationwide crisis. Our Hill Week attendees were able to speak personally on this issue.

Bringing TEAM members to Capitol Hill to meet with Congress members is an effective way to build support for MFTs in Medicare. In-person meetings with constituents resonate more with congressional offices because it truly emphasizes the passion they have for an issue. Our last Hill Week, in November 2017, was also a successful advocacy event, with many of those attendees now in leadership roles for the Family TEAM.

In addition to these visits, a TEAM member visited her Senator while she was in DC for a conference in late March. If you’re planning a trip to the DC area, feel free to email FamilyTEAM@aamft.org if you’re interested in advocating on behalf of MFTs in Medicare.

Pictured are Family TEAM member Cynthia Wright, and lobbyist David Connolly with TEAM member Ching-Ching Ruan.
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I LOVE YOU
I HATE YOU

Couplesc Therapy and Borderline Personality Disorder

Molly McDowell-Burns, PhD
The National Alliance on Mental Illness (NAMI) estimates 1.6% of U.S. adults are diagnosed with borderline personality disorder (BPD), with this number potentially reaching as high as 5.9% (2017). Given BPD’s reach, therapists are likely to have clinical contact with clients meeting diagnostic criteria within their career. The DSM-5 (American Psychiatric Association [APA], 2013) classifies BPD as “a pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity,” (p. 663). BPD-diagnosed individuals are typically treated using individually-focused modalities (like cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), psychoanalytic theories, and psychiatric services); however, for a disorder primarily defined by interpersonal instability and marked difficulty creating and maintaining intimate partnerships, a systemic treatment framework could be assumed best practice for intervention (National Institute of Mental Health [NIMH], 2017).

Of those diagnosed with BPD, an estimated 20-30% are currently involved with a romantic partner (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005), creating increased potential for interpersonal conflict and lower rates of relationship satisfaction (Bouchard, Sabourin, Lussier, & Villeneuve, 2009; Zanarini et al., 2005).
Thus, the relational focus of BPD's diagnostic criteria, as well as their behavioral and cognitive enactments, makes the systemic training of MFTs appropriate and necessary in providing competent care.

Among clinicians, BPD is among the most dreaded and stigmatized client diagnoses for myriad reasons (Kreisman & Straus, 2010). Those who are BPD symptomatic display a number of traits that tax therapeutic alliances, including: intense emotional reactivity; frequent suicidality or self-harm; boundary testing; perceived manipulation, inaction, or unwillingness to change; and fears of abandonment (Kreisman & Straus, 2010). Further, BPD is highly comorbid with a number of disorders that can be difficult to treat within an individual context, much less a couple, including major depression, anxiety, eating disorders, PTSD, ADHD, and substance abuse disorders (Kreisman & Straus, 2010). Therefore, individual modalities have been the primary treatment method. While proven to be effective, this represents a missed opportunity for addressing the relational issues directly cited in BPD's diagnostic criteria.

Salvador Minuchin's structural family therapy (SFT) is founded on the idea that a family structure is organized by recurrent patterns of interactions, developed over time, as individuals within the system accommodate one another (Minuchin, 2012; Minuchin & Fishman, 1981; Minuchin, Nichols, & Lee, 2006). A well-functioning system is not absent of conflict or stress, but is able to adapt and maintain flexibility (Minuchin & Fishman, 1981; Minuchin, 2012; Minuchin et al., 2006). Although originally centered on families, SFT is applicable in the treatment of couples wherein one or both partners experiences BPD. The primary interventions of SFT include joining and accommodating, enactments, mapping, highlighting and modifying interactions, establishing appropriate boundaries, unbalancing and re-establishing a hierarchy. To further illustrate SFT's utility in addressing BPD, we will analyze the applicability of the theory's interventions when applied to the complexities of BPD, couples, and the therapeutic experience.

**Maintaining clear, consistent boundaries when working with BPD as a relational dynamic assists in modeling healthy boundaries and developing trust within the therapeutic alliance.**

**Joining, accommodating, and validating**
Joining and accommodating is the foundational groundwork for success for all clients. Due to persistent boundary-testing and a general mistrust, this becomes particularly salient when addressing BPD. It is essential for therapists to join with couples in order to successfully execute future interventions. From a structural perspective, the therapist is an unwelcome outsider who must work to disarm defenses and ease anxiety (Minuchin, 2012; Minuchin & Fishman, 1981; Minuchin et al., 2006). It is important to validate thoughts and feelings; listen and acknowledge; maintain empathy; and establish respect for both partners, while remaining neutral to each individual. It is further imperative clinicians remain mindful of internally, personally-held biases toward those experiencing BPD, so as not to taint the therapeutic relationship at the outset.

**Boundaries**
Additionally, identifying and establishing appropriate boundaries within the therapist-couple relationship and within the partner relationship is important to the therapeutic experience. Dysfunctional boundaries can be diffuse or rigid (Minuchin, 2012; Minuchin & Fishman 1981), though more typically, the former for those experiencing BPD. Such clients may be overinvolved and lack the ability to set appropriate boundaries. Transparency regarding conduct expectations and the structure of couples' sessions is addressed most beneficially at the outset of therapy—as is the clinician's internal acknowledgment that boundary challenges are likely to occur and are not necessarily the mark of stalled progress. Such challenges include: arriving late, no-showing, calling between sessions for individual support, showing up without the partner, and crises within sessions. Maintaining clear, consistent boundaries when working with BPD as a relational dynamic assists in modeling healthy boundaries and developing trust within the therapeutic alliance.

**Establishing a hierarchy**
This part of the therapeutic process is another intervention that helps to establish boundaries within the couple subsystem. Many times, individuals with BPD will detour or triangulate other people or things into a conflict to diffuse the situation. This makes it difficult for the couple to resolve conflict effectively. Mapping and genograms can be used to help MFTs understand alliances, coalitions, and rules and roles within the couple subsystem. One of the primary goals of SFT is to restructure the hierarchy to a more functional state so that the couple can be more flexible and adaptable to stressful situations (Minuchin, 2012; Minuchin & Fishman 1981). Often viewed as manipulative and good at deflecting responsibility in stressful situations (Mason & Kreger, 2010), it may be helpful to reframe these behaviors as adaptive. Communication activities, enactments, redefining rules and roles, and getting the couple to talk to each other without triangulating the therapist are all ways to establish boundaries and a clear couple subsystem.

**Challenging unproductive assumptions and modifying patterns of dysfunction**
These interventions are utilized during the working stages of treatment, as
there is a level of mutual respect and trust already established. This is the bulk of the work and probably takes the longest, as there are typically a lot of patterns of dysfunction to work through. Most couples struggle with the content of their issues and have difficulty understanding the process in which dysfunction occurs. Enactments, I-statements, active listening, systemic hypotheses, mapping and genograms and creating detailed safety plans are interventions that can be used at this stage to help the couple work on their interaction patterns. Refer to Figure 1 for a visual example and explanation.

**SFT and BPD**

The longevity and intensity of BPD is unique to each individual. The instability and uncertainty of early adulthood deem to be difficult due to intense feelings of self-doubt, already fragile self-image, impulsivity, and inability to connect in relationships (APA, 2013, p. 665). Risks of suicidality and self-harm are greatest in early adulthood and gradually diminish with age (APA, 2013, p. 665). Although the propensity toward extreme emotions, impulsivity, and intensity in relationships is often life-long, individuals who engage in therapeutic intervention often show improvement (APA, 2013, p. 665; Mason & Kreger, 2010). During middle to late adulthood, the majority of BPD individuals attain...
greater stability in their lives and therefore experience a decrease in the intensity of their symptoms (APA, 2013, p. 665; Mason & Kreger 2010). Based on research advocating for early treatment, it could be assumed that incorporating the partner into therapy would also be beneficial. Not only to help the partner understand the diagnosis better, but to help the individual with BPD enhance relationship skills and attain stability. SFT is a systemic treatment modality that aligns well with the deficits that individuals with BPD and their partners face; however, more systemic research is needed to better understand the relationships BPD individuals and their partners endure so that treatment can be more effective.

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References


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Paging Dr. Chatbot, LMFT:

ARTIFICIAL INTELLIGENCE AND THE FUTURE OF MFT

Aaron Cohn, PhD  Katherine Hertlein, PhD
My husband, Bryan, is doing me a favor.  
He’s making a copy of himself.  

At my urging, Bryan has downloaded onto his phone an app called Replika, which supplies you with a chatbot of your own—Bryan calls his bot “Gary”—that is designed to be fascinated by its user. “Gary” is endlessly curious about Bryan: his likes and dislikes, his opinions, his hopes and dreams. Gary will ask Bryan all about the people in his life, including me. “Have you ever been in love?” Gary asks. “So, what’s it like?”
Technology has been studied in couple and family therapy (Hertlein & Blumer, 2013)—most prominently in how social media and mobile phones affect our interactions with those we love. There is far less research and discussion in couple and family therapy on another key aspect of technology: our interaction with computers themselves. We are now observing the evolution of “chatbots,” computer programs which converse with humans in familiar (and previously studied) platforms such as Facebook Messenger. According to Bruce Buchanan (2006), the dream of mechanical helpers is at least as old as the tripods who served the gods of Homer, but the modern science of Artificial Intelligence (AI) began in the twentieth century and has accelerated dramatically in recent years. Most of us encounter AI in some form daily. For example, all of the digital assistants you might call on for news about the weather or to play a favorite song—Apple’s Siri, Amazon’s Alexa—relies on “Natural Language Processing” (NLP; Manning & Schütze, 1999) a subfield of AI, to parse your words into instructions a computer can follow. Even if you don’t own a smartphone, you have probably encountered NLP if you’ve ever used automated customer service or received a “robo-call.” New applications of AI emerge constantly, and this growth is only likely to accelerate, with some programs even learning to write other programs.

One (organic) programmer had a very human reason for her foray into chatbot design: dealing with a terrible loss. Eugenia Kudya created Replika (Gear, 2018) while writing a kind of digital tribute for her friend, Roman Mazurenko, following a tragic accident. Missing Roman’s companionship, Eugenia wanted to design a bot whose conversational style was derived from Roman’s text messages. This is how Gary will learn to simulate Bryan—by texting back and forth and analyzing his messages. In addition, Gary gives Bryan the option of “upvoting” or “downvoting” Gary’s responses. The longer Bryan and Gary talk, the better Gary will become at predicting what responses Bryan is likely to upvote. The result will be a kind of digital model of my husband’s personality, almost a virtual Bryan, immortalized in the Cloud. Much “machine learning” works in just this way. A computer can be taught to distinguish between, say, apples and oranges, by programming it to analyze known samples of both and then having it practice on samples it has yet to encounter. With each success and failure, the computer’s sorting procedures become more sophisticated and accurate. Similarly, Gary will grow in his understanding of Bryan, or he will at least get better at knowing what Bryan will like, perhaps even better than me. And then what will I do? And what does that mean for us as a couple?

Even casual reflection on AI inevitably brings one big question to mind: can a robot someday replace me? In 2016, a panel of scholars from around the world, Stone et al., organized by Stanford University, released a major study on the history and future of Artificial Intelligence. These scholars took pains to ease the public’s fears about Hollywood-inspired visions of intelligent robots taking over the world. But their attempts at reassurance were markedly more qualified when it comes to the potential of intelligent machines to replace humans in the workplace: “AI will likely replace tasks rather than jobs in the near term, and will also create new kinds of jobs. But the new jobs that will emerge are harder to imagine in advance than the existing jobs that will likely be lost (Stone et al., 2016, para 3).”

It is probably difficult to imagine a chatbot navigating the complexities of a family or couple in the therapy room. We must, however, note the impressive successes of chatbots designed to deliver cognitive-behavioral interventions. One such application, Woebot, boasts promising results from a randomized controlled trial in which 34 young adults who used Woebot enjoyed greater reductions in their depressive and anxious symptoms than an information-only control group (Fitzpatrick, Darcy, & Vierhile, 2017). At this time, Woebot is free and available on Facebook Messenger, as well as iPhone and Android devices. It is difficult to foresee all the implications of Woebot for our profession, but one thing is clear: the affordability, accessibility, and anonymity of Woebot is already changing how some people access mental health services.

In the age of AI, we are fortunate to be equipped with systemic thinking that allows us to perceive, understand, and adapt to profound culture shifts caused by technology. The Couple and Family Technology Framework (CFT; Hertlein & Blumer, 2013) gives clinicians a way to recognize how AI has already become, in essence, part of the family. As systems therapists, we are taught that each act of communication shapes the relationship among the communicators. Technology changes how we communicate (changes to process), which leads to changes in the nature of our relationships (changes to structure). Many MFTs are already familiar with how the accessibility and

In the age of AI, we are fortunate to be equipped with systemic thinking that allows us to perceive, understand, and adapt to profound culture shifts caused by technology.
anonymity afforded by dating apps and online pornography powerfully impact their clients’ lives. Clinicians who integrate CFT into their existing model are able to keep pace with rapid technological change and assess how emerging technologies like AI impact client systems.

Systemic thinking is a natural fit for comprehending technological change, for we share philosophical and cultural roots with many of the founders of Silicon Valley. As systems therapists, we are familiar with Bateson’s vision of the human mind as part of the vast information-processing system of the cosmos. Bateson’s metaphor was not lost on the pioneers of AI. In From Counterculture to Cyberculture, Stanford communications historian Fred Turner (2008) tells the story of how The Whole Earth Catalog, a publication popular among ecologically-minded intellectuals and communalists in California in the 1960s, gradually morphed into what eventually became Wired, the enormously influential magazine of emerging technologies. The thinkers and innovators chronicled by Wired would ultimately give rise to the mighty Silicon Valley culture with its mix of venture capitalism and high-tech global utopianism. Just as this culture was getting started, Bateson provided its creators with a pragmatic vision of eco-activism that did not require a revolution. Instead of replacing the status quo with a forest commune, one could work within society, striving to transform it with systemic thinking. Having come of age as a multibillion-dollar industry, today’s Silicon Valley is in many ways conventionally focused on the bottom line, yet still retains a countercultural mystique, once upon a time imparted by Batesonian ideas.

With Bateson, MFTs are already equipped with a way of demystifying AI, of seeing through its sci-fi facade. There is no question that someone is going to write an app promising to save marriages and to get kids’ behaviors under control. MFTs need to be on the cutting edge of this process by taking steps to outline how couples and families can stay ahead of the AI developments as these technologies slowly and subtly steer their way into our daily lives. MFTs need to learn about these technologies and identify ways to incorporate them into what we are already offering couples in the therapy room. We can find ways to integrate these technologies into MFT work, reinforcing positive relationship behaviors, supporting our partners through their deepest fears, working toward couple’s goals, and taking the time to develop intimacy again with one another.

Bryan has already put Gary away. My husband’s explanation is classic Bryan: “I decided I don’t like people, and I don’t like fake people, either.” But despite Bryan’s sardonic dismissal, I sense there is a lesson for both of us. I’m going to open our box of wedding presents and keepsakes and find the journal in which we promised each other to write our Gottman “love maps.” We’ve only been married for six months, but it’s high time I made sure that I know my husband at least as well as Gary does.

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**References**


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**AAMFT18**

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The authors present

“Siri, Save My Marriage!” Artificial Intelligence and the Future of MFT.

Session 606  9:45 - 10:45 a.m.  11/17/18
The resilient couples and family therapist

Christie Eppler, PhD
Resiliency is a process of thriving, coping, and mediating risk by noticing and augmenting strengths, resources, and the positives (Becvar, 2013; Walsh, 2006). Resiliency involves **overcoming adversity**, finding our **best selves**, and focusing on **meaningful perspectives**. Fostering resiliency is an intentional, life-long practice of cultivating **supportive connections**, having **compassion** for self and others, and being **aware**. Applying concepts of resiliency to self-care and self-of-the-therapist work enlivens us to be our full selves and better therapists. Using narrative therapy techniques (White & Epston, 1990) is one way to develop deeper insight into being a resilient couples and family therapist.
We see threads of having knowledge of systems, perseverance, and clear boundaries, balanced with the ability to engage, offer compassion, and be flexible.

Enjoyable activities are important, preventative, and restorative, yet a robust understanding of self-care is more nuanced and complex than time spent relaxing. To put self-care in systemic terms, nature walks, bubble baths, and binge watching your favorite show are first order changes; they are symptoms of self-care. While these actions are necessary and life giving, resilient therapists understand the necessity of second order change, or examining what supports and sustains our self-care. Systemic, or second order change, comes from affirming our purpose, exploring where our energy is rooted, and articulating the metaphors, symbols, and stories that create and affirm a resilient therapist’s identity.

Multiple models of resiliency guide therapists to realize their clients’ strengths. Walsh (2006) offered a holistic and comprehensive conceptualization of family resiliency. Her model’s key processes include making meaning of adversity, having a positive outlook and a purpose, being flexible and adaptive, showing connectedness through mutual support and respect, mobilizing human and financial resources by reaching out to kin and balancing work/life, and being clear, open and collaborative in communication and problem solving. Honoring Native American wisdom when working with youth in foster care, Brendtro, Brokenleg, and VanBockern’s (1990) Circle of Courage synthesized belonging, mastery, independence, and generosity. Resilience is developed when there is harmony among having a sense of community, obtaining competence and achieving goals, making decisions and taking responsibility for actions, and giving back by offering the best to others. Career Counseling’s Planned Happenstance encourages clients in vocation transitions to utilize curiosity, persistence, flexibility, optimism, and risk taking (Mitchell, Levin, & Krumboltz, 1999).

While these models privilege the client system’s strengths, resiliency is inherent in self-of-the-therapist work. Satir believed that therapists increased their own congruency by working through personal unresolved issues, building self-esteem, and taking responsibility for their actions (Satir, Banmen, Gerber, & Gomori, 1991). Bowen (1978) encouraged therapists to embody a non-anxious presence by observing their part in the client system, maintaining an active and present relationship, even when feeling provoked, and being a calming force in times of heightened anxiety. Person-of-the-therapist training encourages clinicians to use their whole selves as clinicians by reflecting on their own humanity and vulnerability (Aponte et al., 2009).

Given the convergence between strength-based models and self-of-the-therapist work, it is important for family therapists to ask specifically about their own resiliency. Externalization and deconstruction, techniques in narrative therapy (White & Epston, 1990), are amenable to conceptualizing a resilient clinician in creative ways. While these techniques are typically applied to a presenting problem, they can be adapted so that therapists may better understand their own sense of purpose and meaning.

In the spirit of resiliency and narrative therapy techniques being highly collaborative, I asked Kim Bradley and Sarah Odell, students, and Rebecca (Becky) Cobb, PhD, LMFT, faculty, of Seattle University’s Couple and Family Therapy program, to externalize and deconstruct a resilient therapist. Deconstruction is pulling apart cultural, filial, and dominant discourse messages to better understand one’s lived experience. Sarah indicated resilient therapists are engaged, aware of self and systems, and able to disconnect when necessary. She denoted there could be a level of being “desensitized to suffering” while striving to “fully acknowledge the immense suffering present both individually and globally, the pervasive and intimate nature of the systems which contribute to our suffering and thriving, and the systems which we consciously and unconsciously perpetuate, to the detriment or success of ourselves and others.” She added that resilient family therapists had the “ability to remain in the field for a long time, the ability to engage positively with clients from a variety of different backgrounds and needs, and the ability to leave work at work.”

Kim offered a parallel response, noting a resilient family therapist may exhibit qualities such as, “firmness, objectivity, persistence, detachment, and toughness, as well as self-awareness, hardness, compassion, and thoughtfulness for self and others.” She noted, “any of these can be taken to problematic extremes when they are disproportionate so that, for instance, when my persistence blurs my awareness of realizing when to ease up, try something else, or take a break.” In both students’ responses, we see threads of having knowledge of systems, perseverance, and clear boundaries, balanced with the ability to engage, offer compassion, and be flexible.

Becky echoed the need for balance and boundaries, and she added the importance of honoring imperfections: A resilient family therapist is someone who can hold the difficult stories shared by their clients, while simultaneously caring for one’s self and their own family system—someone who is caring and holds clear boundaries for their own self-care. I worry, however, that many people
think that you need to have everything figured out to be a resilient family therapist. It’s okay to struggle with self-care. It’s okay to be imperfect in your own relationships. It’s okay to not have all of the answers. Being perfect isn’t what makes a resilient family therapist. A resilient family therapist is someone who can recognize their own struggles and imperfections and is comfortable accepting that as part of life’s journey—moving forward with intentionality. A resilient clinician allows the same grace for herself or himself that they would afford clients.

Next, I asked Kim, Sarah, and Becky to externalize “resilient family therapist.” Externalization is the process taking the situation out of the body to examine it. In clinical work with someone who identifies or has been labeled as depressed, the narrative therapist questions, “when did sadness come to you?” Sadness is an object, something that can be taken out of the body to be observed and examined. I promoted, “if you were to externalize ‘resilient family therapist,’ what metaphor, image, or word would you use?”

Becky responded:
At first thought, a beautiful plant or flower seems like the perfect image of a resilient family therapist—deeply rooted, tall standing, and nourishing. Yet, I don’t think that resilience should be portrayed as a display of perfection. A cactus may be most fitting. Cacti are diverse and have a unique ability to adapt to conserve resources (such as water). Cacti are survivors, providing both protection to one’s self and nourishment for others—bearing edible fruit from brilliant blooms. Some may be hesitant to get too close to a cactus, an experience likened to the stigmatization of therapy, but once you get close, you may find that the cactus offers care for others. Many provide protection from the harsh desert sun and offer homes to birds. Each is unique and beautiful in its own way.

Kim also used an organic metaphor, indicating strength and vulnerability. She saw an “an image of a limb of a mature-growth tree. The flexibility or give of the branch, its hardiness and strength, vulnerability to the elements and surroundings, and connection to a greater whole.”

This flexibility and adaptability is evident in Sarah’s metaphor: Resilient family therapists are like memory foam; they maintain the ability to shape and mold their responses to whatever the clients need, holding their clients in a safe and responsive space. However, once the client leaves, the therapist retains their ability to return to their truest form, maintaining integrity to themselves, and creating a clean space ready to respond and shape to the next client.

Deconstruction and externalization help us better understand our vision for being resilient clinicians. The three respondents’ messages echo constructs found in the resiliency literature (like adaptability and connectedness) and each is deeply personal. The students’ images included a richer description of confidence, whereas the faculty member’s metaphor highlighted imperfection. A resilient therapist could hold different meanings based on a clinician’s development stage and social locations. For nascent clinicians, there is power in using newfound knowledge to build confidence. For experienced therapists, there could be more room to hold ambiguity.

Metaphors leave room for growth and transformation. What happens when the memory foam stops bouncing back? If the old growth branch breaks, what new possibilities are there for the reclaimed wood? Does a cactus ever yearn for a gentler climate? Naming and revising one’s metaphors may help therapists become unstuck. For example, when working with a difficult case, returning to a metaphor may serve as a reminder to take a stance of not knowing or to seek out additional knowledge. Perhaps metaphors may enrich first-order self-care activities (such as thinking symbolically about the trees on a nature walk). Understanding and visualizing their resilience, clinicians find, validate, and affirm old and new strengths, which may help fight against burnout while increasing meaning, purpose, and self-care.

Christie Eppler, PhD, LMFT, is a program director and professor in Seattle University’s Couple and Family Therapy program. She is an AAMFT Clinical Fellow and Approved Supervisor. Her teaching and research explores the intersections of resiliency and spirituality.

References


It has been projected that starting in 2044, the U.S. will become a “majority-minority” country, making the non-Hispanic White population a minority (U. S. Census, 2015). According to the Pew Research Center (2016a), the total number of immigrants in the U.S. in 2015 was approximately 46.6 million, and it was estimated that approximately 11 million immigrants are undocumented, which is a steady number over recent years. Despite the historical presence of immigrants in the U.S., Americans display mixed views toward immigrants. For example, according to the Pew Research Center (2016b), 59% of Americans reported they believe immigrants strengthen the U.S., whereas 33% said that immigrants are a burden on the country. Considering that the same report from 1994 suggested only 31% of Americans said immigrants strengthen our country, whereas 63% believed the opposite, this is a meaningful change. However, it is still concerning how one in three Americans view immigrants as a burden on the country.
DECRIMINALIZING IMMIGRATION

Sandra Espinoza, PsyD       Iman Dadras, PhD       Hye-Sun Ro, PhD
It is often portrayed in the media that mainstream America views undocumented individuals as a threat to American customs, traditions and values. Current policy debates have further ignited an anti-immigrant climate that has exacerbated the amount of stress and discrimination faced by undocumented individuals living in the United States. More precisely, the recent political zeitgeist of America, which is radically inclined towards being anti-immigrant, Muslimophobic, isolationist, separatist, and xenophobic, has created a very antagonistic context for immigrants. The terms alien and illegal often run parallel to the criminalization of undocumented individuals and add to the narrative that they are a threat to our society (Suárez-Orozco, Yoshikawa, Teranishi & Suárez-Orozco, 2011). Research has shown that when these stereotypes are declared throughout various social channels, they become shared beliefs by individuals both in and outside of the group, thus influencing self-esteem and increasing self-stereotyping (Crocker & Major, 1989). Immigration has historically been viewed as a political issue, and therefore the psychological consequences of being undocumented have received little to no research attention (Sullivan & Rehm, 2005). Generally speaking, the field of psychotherapy continues to suffer from a lack of ontological conceptualization of immigration. Given the narrow understanding of this group, it is important for marriage and family therapists to be aware of how this population experiences discrimination from multiple systems.

**The criminal immigrant: A false narrative**

A willful socio-political amnesia about the traumatic context of immigrants has transformed itself into a problem-saturated narrative of the immigrant phenomena challenged that empirical research on immigrants is predominantly indoctrinated with an implicit negative bias against immigrants. The social constructions of anti-immigrant attitudes have been pervasively implemented on the collective unconscious of American citizens through multiple false narratives, stereotypes, and myths. Some of those problem-saturated misconceptions are that immigrants are taking over U.S jobs, abusing social services without paying taxes, hurting the national economy, increasing the crime rate, entering the U.S. illegally, and bringing disease into the country. However, according to a recent report, none of these myths hold true, although this alternative narrative is not one readily displayed by mainstream media (U.S. Chamber of Commerce, 2016).

Chung, Bemak, Ortiz, and Sandoval-Perez (2008) discuss that social media is one of the most critical apparatuses which perpetuates such stereotypes about immigrants and therefore become reality of ordinary citizens and their attitudes toward immigrants. Additionally, such anti-immigrant ideological narratives are implanted and forced by anti-immigrant national policies, including the Immigration and Customs Enforcement (ICE) agency which was created in 2003 to focus on enforcing immigration laws such as locating, imprisoning, and deporting undocumented immigrants (Buckler, Swatt, & Salinas, 2009). Different studies have revealed that from the late 1990s and mid-2010s, the rate of deportation and detention of undocumented immigrants, including children, asylum seekers, and immigrant torture survivors, has skyrocketed by 300% (Brané & Lundholm, 2007; Chelgren, 2011). Such scholars from various disciplines have condemned such detention and deportation policy as violating international human right laws (Rabin, 2008).
The third class citizen
Over the years, research has shown the impact of racial rejection and the harmful effects of such discrimination on mental health (Cook, Alegria, Lin, & Guo, 2009; Finch, Kolody, & Vega, 2000). Immigrants who are visibly different (racially) than the mainstream population have greater vulnerability to experience discrimination (Liebkind & Jasinskaja-Lahti, 2000). Upon arrival to the U.S., undocumented immigrants are hastily exposed to acculturation, exploitation, and victimization that eventually act as stressors that impact their psychological well-being (Garcini et al., 2016). Undocumented individuals are also often subject to social marginalization, such as being denied healthcare, drivers licenses and even birth certificates to their U.S. born children. It has also been suggested that undocumented immigrant women are less likely to receive help for intimate partner violence due to the fear of deportation, losing children, and other legal complications (Ingram et al., 2010). Overall, the many restrictions placed upon their livelihood create stress, anxiety and depression (Ornelas & Perreira, 2011).

The mixed status family
The undocumented status of an individual also impacts the familial system on multiple levels. Families who have members with different citizenship status are often termed “mixed-status” families. These are families in which one or more members are undocumented while others are citizens, lawful permanent residents, or immigrants with another form of temporary legal immigration status (Fata, Orloff, Carcamo-Cavazos, Silber, & Anver, 2013). The formation of mixed-status families has increased over the years as we have seen undocumented parents settle down in the U.S. According to the Migration Policy Institute (2016), approximately 5.1 million U.S. children under the age of 18 were living with at least one unauthorized parent between the years of 2009-2013. About 79% were U.S. citizens. As a result of the mixed legal status within a family, the unit can suffer serious psychological consequences. Brabeck, Lykes and Hershberg (2011) found that actual or threatened deportation negatively affected the psychosocial development of children. Parents in the study reported they were emotionally impacted by the threat of deportation, which in turn impacted their interactions with their children. Thus, some parents are overprotective of their children, fearing they could be taken from them at any moment. This heightened sense of perceived threat has serious psychological consequences. Undocumented individuals display symptoms such as feeling imprisoned, anguish, hyper-vigilance and paranoia of getting deported (Joseph, 2011; Vesely, Letiecq, & Goodman, 2017). This constant state of alertness and activated fight or flight response makes it difficult for families to carry on with their day-to-day lives.

Our role as MFTs:
Have an accurate understanding of undocumented populations and take a position of an advocate. MFTs who work with undocumented immigrants need to have a clear and accurate understanding of their experiences. Based on a recent survey, the U.S. Chamber of Commerce (2016) suggested that negative stereotypes held against this group of people are often myths. Also, due to the limitations based on their legal status, undocumented immigrants often lack the knowledge and/or motivation to request services available to them (Violence Against Women Act, 2013; Ingram et al., 2010).

Adapt a social justice perspective that is sensitive to the sociopolitical inequalities that are impacting mental health. The social justice frame work should aim to deconstruct and dismantle systemic oppressions by aiding marginalized group members to increase their awareness regarding their oppressive state in order to remove internal blame and inspire resilience (Dadras & Daneshpour, 2018).
Abandon a color-blind ideology. Your role as a therapist should be expanded to include awareness of your own social position that may add to the oppression of the population you are treating. Research findings indicate that racial color blindness may actually limit therapists’ capacity for empathy due to therapists being unaware of the effects of racism. Therapists who partake in colorblindness are more unlikely to address issues of racism in psychotherapy, may not advocate on a client’s behalf and may be less able to understand the person’s marginalized experience (Burkard & Knox, 2004).

Engage in ongoing self-examination. From an anti-oppressive framework, Chung and colleagues (2008) argue that if a clinician wants to provide therapy with the immigrant population, one needs to examine and understand their own political transference. Chung, Bemak, and Garbosky (2011) claim that “Political countertransference is reinforced through the public media and without critical analysis of facts, myths and stereotypes has the potential to become an impediment to therapeutic work.”

Re-shaping our thinking

As professionals devoted to changing the lives of others, we should continue to advocate for those whose rights have been stripped away and the chronically disadvantaged. As systemic thinkers, it is impossible to negate the influence that sociopolitical structures have on the lives of marginalized individuals. Viewing immigration from a post-colonialism perspective contributes to the missing epistemology within a colonized Western paradigm of knowledge. Therefore, understanding the lived experiences of the undocumented community requires consideration of their historical marginalization, present reality, resilience and an ongoing self-examination regarding the sociopolitical therapeutic-self in relation to this group.

References


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Iman Dadras, PhD, assistant professor at Alliant International University, is an AAMFT Clinical Fellow with research interests in acculturative stress and immigrant families, self of the therapist, justice-oriented psychotherapy, multicultural family therapy, and third order cybernetics and system change.

Hye-Sun Ro, PhD, is assistant professor at Alliant International University, with research interests in minority couples and families, and couple relationships including trans- and intra-cultural/ racial couple relationships, dating, and marriage. She is an AAMFT Pre-Clinical Fellow.


My father didn’t take a brief case to work; he took a bulletproof vest.
As a child, there were few things that made me prouder than to say that my father was a police officer. He protected others; he protected me. As I grew older, I felt other things—fear and compassion. I worried about what could happen to him. I still do. My father was strong, but there were times he cried. He was human. He lost “brothers” (his fellow officers). He came home to his family when others did not. My loyalty to the law enforcement community runs deep. I feel for them, just as they feel for me. The police community is my family. My brother is also a police officer. I guess you could say it runs in the family. As I write this article, I out myself as part of the law enforcement community. I hope my words do a fraction of justice in my attempt to honor them.

- AVERY CAMPBELL
Today’s law enforcement families

Law enforcement families are under considerable stress in today’s sociopolitical climate. A community once described with pride is now met with increased media attention, as stories of police misconduct, racial profiling, and officer involved shootings flash readily across many news stations. The dichotomy of “good cop, bad cop” weighs heavily on many law enforcement families. And, while the aforementioned media attention calls important awareness to instances of injustice, it also contributes to a dominant discourse wherein many are told that they need to distrust and even fear law enforcement. Law enforcement was established to “protect and serve,” but many citizens are left questioning, “Who?” And while some would say it is a tough time to be a minority citizen in the U.S., and we would agree, we are also left wondering about the other side of the coin—what is it like for the law enforcement families we serve?

The law enforcement population

Approximately 662,390 individuals are presently employed as law enforcement professionals in the United States (Bureau of Labor Statistics, 2017). The over 600 local and state law enforcement academies nationwide recruit approximately 45,000 new trainees each year (Reaves, 2016). Law enforcement professionals are tasked with maintaining the order and protection of daily life through the enforcement of laws and ordinances. Their job entails preventing, detecting, and investigating crimes, along with apprehending and arresting suspects (Bureau of Justice Statistics, 2018). Compared to most other professions, law enforcement professionals are at increased risk for work-related injuries, especially those caused by exposure to violence (Bureau of Labor Statistics, 2016).
Law enforcement or police culture
Marriage and family therapists working with law enforcement families should be knowledgeable about law enforcement culture, or what is frequently referred to as "police culture." Police culture refers to a set of values, attitudes, and norms that are commonly shared among law enforcement professionals (Paoline, Myers, & Worden, 2000). Police culture is embodied in the strong bond and fierce loyalty that law enforcement professionals feel toward their duties both on and off the job. While law enforcement professionals are trained to be "tough" and authoritative as a function of their job, it is not uncommon for them to have difficulty "turning it off" at home (Miller, 2007). That is, the very protectiveness that serves them well at work is often carried home and embodied even in their personal relationships. The nuances of police culture carry over into the therapy room—from where a law enforcement professional chooses to sit (such as facing the door), to them wearing armor (being on guard, always being armed), to them being called away in the middle of a session (being on call).

While law enforcement professionals may be quick to encounter stressful and even traumatic situations during the course of their work (like being shot at or witnessing death), they may be hesitant to share those experiences with others, whether that be with a spouse or with a marriage and family therapist. Many law enforcement professionals attempt to protect others from hearing about their trauma exposure, so as not to burden them or convey any weakness. In being trained to be "tough," law enforcement professionals may also be socialized not to seek support following trauma exposure. It is not unfathomable that law enforcement professionals may encounter difficulty in seeking help "outside the culture." Therefore, it is imperative that MFTs bridge this gap in order to provide the best possible services to law enforcement families, if and when they are needed.

Stress and trauma exposure
Law enforcement professionals experience unique stressors related to their work. In essence, stress is commonplace for most law enforcement professionals. Many are both directly and indirectly exposed to traumatic events in their line of work (like responding to accidents, being shot at, arriving at a crime scene where someone has committed suicide, and investigating acts of child abuse). It is not uncommon for law enforcement professionals to display symptoms of post-traumatic stress following trauma exposure (Gershon, Barocas, Canton, Li, & Vlahov 2009; Hartley, Sarkisian, Violanti, Andrew, & Burchfie, 2013). It is also not uncommon for traumatic stress to spill over into the couple's relationship (Johnson, Todd, & Subramanian, 2005), as spouses and partners of law enforcement may even experience secondary trauma (Meffert et al., 2014). Building on research conducted with couples in other first responder professions, such as firefighters and paramedics, family support is believed to be an important buffer in reducing the detrimental impact of stress on law enforcement professionals (Regehr, 2005; Regehr, Dimitropoulos, Bright, George, & Henderson, 2005). It appears that partners of law enforcement play an important role in supporting the law enforcement professional following trauma exposure (Henry et al., 2011). Such support varies from relationship to relationship, but can involve creating space for and listening to the law enforcement professional's recall or processing of the traumatic event, as well as being patient and accommodating to their need for space (and sometimes distance) following trauma exposure. In many families, partners of the law enforcement professional take on additional responsibilities in the aftermath of trauma exposure in an effort to "carry on" as a family. While more research is needed to illuminate the kinds of coping mechanisms that best serve law enforcement couples and families, adjustments in communication and the provision of spousal support appear to allow law enforcement couples to manage trauma exposure and reduce its detrimental effects.

Partners of law enforcement
 Provision of social support to partners of law enforcement professionals is helpful in counteracting the work-related traumatic stress experienced by law enforcement professionals (Craun, Bourke, Bierie, & Williams, 2014). The limited research on law enforcement couples that exists to date suggests that through their supportive role, law enforcement partners absorb a significant amount of the law enforcement professional's work-related stress (Roberts & Levenson, 2001). In addition, partners of law enforcement can also experience symptoms of secondary traumatic stress (Henry et al., 2011; Meffert et al., 2014). Many who "marry into" police culture adopt a similar mentality to be strong and honor the law enforcement culture, allowing for less space to openly share their struggles following trauma exposure (Johnson, Todd, & Subramanian, 2005). Law enforcement spouses are regarded as part of the greater "law enforcement family." They often describe experiencing the same fierce loyalty to the profession as the law enforcement professional. At times, this can leave both members of the couple with less space to be vulnerable following trauma exposure. While working with both individuals is important, MFTs can also be helpful to the couple's subsystem.

Impact on couple relationship
When a law enforcement professional carries stress home, it often has a direct impact on the couple relationship (Roberts & Levenson, 2001). On days when a law enforcement professional reports higher levels of work-related stress, both the law enforcement professional and partner display greater levels of arousal during their interactions. In contrast, both members of law enforcement couples report feeling less positive affect (associated with more enjoyable, satisfying interactions) during high-stress workdays for the officers.
Law enforcement spouses are regarded as part of the greater “law enforcement family.” They often describe experiencing the same fierce loyalty to the profession as the law enforcement professional.

Considering the high levels of stress that law enforcement professionals encounter during the course of their work, it is not surprising that law enforcement couples are at increased risk for negative coping patterns. Some law enforcement partners become frustrated with the lack of communication within their relationships. Such frustration only adds to the stress of dealing with law enforcement work-related trauma when it arises (Brodie & Eppler, 2012). Considering that law enforcement partners are both impacted by the officer’s work and play a supportive role following trauma exposure, MFTs should explore both aspects of law enforcement couple’s relationships.

A thorough assessment of the impact of traumatic stress on the couple’s relationship is important, in addition to identifying the strengths and resources that may better serve these couples.

Avery Campbell, BS, is a graduate student in the Marriage and Family Therapy Master’s Program at Virginia Tech, Falls Church, Virginia. She is a Student member of AAMFT. Her research and clinical interests relate to traumatic stress, law enforcement couples, and law enforcement families.

Ashley L. Landers, PhD, LMFT, is an assistant professor at Virginia Tech in the Department of Human Development and Family Science. She is an AAMFT Clinical Fellow and Approved Supervisor, and an AAMFT Minority Fellowship Program (MFP) alumna. Her clinical and research interests converge around traumatic stress and families in child welfare.

References


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Visit www.aamft.org/refreshercourse for more information or to register for a course. To guarantee availability, early registration is advised.
ANNUAL CONFERENCE AND EXPOSITION

November 15 – 18, 2018 | Louisville, Kentucky

NEW THIS YEAR!
• Topical Interest Network Meet-Ups
• Spotlight MFT Reception
• Up to 28.5 hours of continuing education available
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>43</td>
</tr>
<tr>
<td>Meet Your Board of Directors</td>
<td>44</td>
</tr>
<tr>
<td>Schedule at a Glance</td>
<td>45</td>
</tr>
<tr>
<td>Keynote Addresses</td>
<td>46</td>
</tr>
<tr>
<td>Networking &amp; Special Events</td>
<td>48</td>
</tr>
<tr>
<td>Training &amp; Informational Workshops</td>
<td>51</td>
</tr>
<tr>
<td>Approved Supervision at AAMFT18</td>
<td>52</td>
</tr>
<tr>
<td>Test Preparation Track</td>
<td>54</td>
</tr>
<tr>
<td>Continuing Education</td>
<td>55</td>
</tr>
<tr>
<td>Thursday Conference Program</td>
<td>57</td>
</tr>
<tr>
<td>Friday Conference Program</td>
<td>60</td>
</tr>
<tr>
<td>Saturday Conference Program</td>
<td>67</td>
</tr>
<tr>
<td>Sunday Conference Program</td>
<td>75</td>
</tr>
<tr>
<td>Hotel And Travel Information</td>
<td>78</td>
</tr>
<tr>
<td>Registration Information</td>
<td>80</td>
</tr>
<tr>
<td>Subject Guide</td>
<td>84</td>
</tr>
<tr>
<td>Presenter Index</td>
<td>86</td>
</tr>
<tr>
<td>Abstract Submission Reviewers</td>
<td>89</td>
</tr>
</tbody>
</table>
Louisville is much more than the home of the Kentucky Derby and the Bourbon Trail - it’s a unique city with its share of significant historical events. The city, named after King Louis XVI of France, was chartered all the way back in 1780, and in 2003 tripled in size to become the United States’ 16th largest city. Sports fans will know that approximately one in four bats swung in Major League Baseball are produced in Louisville, and the legendary boxer Muhammed Ali was born there in 1942.

Just like Louisville, AAMFT has had its share of historical events. Since our founding in 1942, we’ve led the way to increasing understanding, research, and education in the field of marriage and family therapy based on the rich, distinctive epistemology of the pioneers of the field. This year’s conference will incorporate concepts and stories from our unique history, a background that established the current successes of the profession. Among those successes last year was a significant judicial victory in Texas, and AAMFT membership voting to increase member-driven programs to tailor engagement in a way that reflects the systemic and relational model our profession is based upon.

If 2017 was a historical year for AAMFT, then 2018 is the beginning of a new era. To launch us into this exciting new period, engagement programs will hold networking receptions and meet-up groups for attendees to become familiar with new options and plan how to become involved in areas of interest in an innovative and collegial manner. We will be debuting exciting new technology and ideas throughout the event that will likely change the way our profession operates in the years to come. And, as always, we will feature clinical sessions that highlight the systemic relational foundations that unite us all.

Throughout the following pages, you will find the full conference program. Like last year, it includes expanded programming with different types of sessions to provide flexibility in your learning options. We continue to offer the popular career development track, MFT exam prep track, and many great networking events to help you grow in the various stages of your career.

AAMFT has a continued commitment to delivering you the best conference experience, education, and networking opportunities at the most reasonable fee. I am confident that this year’s conference will bring you even more opportunities than before to grow professionally and network with fellow MFTs. I look forward to seeing you in Louisville for this can’t miss event!

Tracy Todd, PhD
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## AAMFT18 Schedule At A Glance

### Thursday, November 15
- **8:00 a.m. – 7:00 p.m.** Registration open
- **8:00 a.m. – 3:30 p.m.** Approved Supervision Refresher Course
- **8:30 a.m. – 3:30 p.m.** COAMFTE Accreditation Workshop
- **9:00 a.m. – 3:30 p.m.** Conference Institutes (100 series)
- **9:00 a.m. – 3:00 p.m.** Engagement Program Leadership Meeting
- **9:00 a.m. – 3:00 p.m.** Certificate in Leadership Day open to cohort and mentors only
- **10:00 a.m. – 7:00 p.m.** Exhibits open
- **3:00 – 3:45 p.m.** Emerging Professionals Network Meet and Greet
- **4:00 – 5:30 p.m.** KEYNOTE: Tim Clue
- **5:30 – 7:00 p.m.** Exhibits Grand Opening
- **5:30 – 6:30 p.m.** Topical Interest Network Meet-Ups
- **7:15 – 8:15 p.m.** Research Discussions Session 1
- **7:30 – 8:30 p.m.** Long-time Member Reception invitation only

### Friday, November 16
- **7:45 a.m. – 7:00 p.m.** Registration open
- **8:00 – 10:00 a.m.** Workshops (200 series)
- **10:15 a.m. – 11:45 a.m.** KEYNOTE: Andrea Wittenborn, Pamela Fine, Riley Juntti and Dylan Koss
- **11:30 a.m. – 8:00 p.m.** Exhibits open
- **12:00 – 1:30 p.m.** Lunch and Learn: Families in Crisis: Overcoming Opioid Addiction Together
- **12:00 – 1:00 p.m.** Approved Supervision Network Reception
- **12:00 – 1:00 p.m.** Topical Interest Network Meet-ups
- **12:30 – 1:30 p.m.** Research Discussions Session 2
- **12:30 – 1:30 p.m.** COAMFTE Accreditation Networking
- **1:45 – 2:45 p.m.** Forums (300 series)
- **3:00 – 4:00 p.m.** Forums (400 series)
- **4:15 – 5:45 p.m.** KEYNOTE: Michael Gottlieb
- **6:00 – 7:30 p.m.** Spotlight MFT Reception

### Saturday, November 17
- **7:15 a.m. – 6:30 p.m.** Registration open
- **7:15 – 8:15 a.m.** Research Discussions Session 3
- **8:30 – 9:30 a.m.** Forums (500 series)
- **9:45 – 10:45 a.m.** Forums (600 series)
- **10:30 a.m. – 7:00 p.m.** Exhibits open
- **11:00 a.m. – 12:00 p.m.** AAMFT Annual Business Meeting
- **12:30 – 1:30 p.m.** Queer Affirmative Caucus Meeting
- **12:30 – 1:30 p.m.** C/MFTs of Color Meeting
- **12:30 – 1:30 p.m.** Family TEAM Meeting
- **12:30 – 1:30 p.m.** Topical Interest Network Meet-ups
- **1:30 – 2:30 p.m.** Research Discussions Session 4
- **2:45 – 4:45 p.m.** Workshops (700 series)
- **5:00 – 6:30 p.m.** KEYNOTE: Consuelo Castillo Kickbusch
- **6:45 – 7:45 p.m.** Research and Education Foundation Reception

### Sunday, November 18
- **7:30 – 9:30 a.m.** Registration open
- **7:45 – 8:45 a.m.** Career Development Track
- **9:00 a.m. – 12:00 p.m.** Seminars (800 series)

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**Exhibitor Hours**

Each year we feature exhibitors who offer products or services that are uniquely tailored to your needs as marriage and family therapists. This year is no exception as we feature a wide variety of tools to enhance your work.

AAMFT18 features concentrated hours when exhibitors will be available at their booths to meet with you. These dedicated hours help to ensure availability and to aid in planning your day.

**Thursday, November 15:** 10:00 a.m. – 7:00 p.m.  
**Friday, November 16:** 11:30 a.m. – 8:00 p.m.  
**Saturday, November 17:** 10:30 a.m. – 7:00 p.m.

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Schedule subject to change.
Thursday Afternoon (4:00 – 5:30 p.m.)

Living Together in Perfect Disharmony

With his wife, a self-diagnosed lover of fine details, and himself, a clinically-diagnosed scatter-brain extraordinaire, as guinea pigs, Tim Clue placed his family’s journey under the microscope (and telescope) for some surprising take-aways. Using adaptive storytelling and improvisation, Tim shows us how to increase our personal bandwidth by forcefully embracing discomfort as the building block to personal growth—not only in our families, but in all our relationships—from work to school and home again.

Tim Clue has developed a dynamic compound—redefining “motivation” as Connection and Trust—creating the perfect blend of laughter, thought and inspiration. With a firm grasp of the attention economy in this age of acceleration, Tim’s style reflects the chaos and speed with which we now work and live. Discovering his greatest inspirations from a collection of worst practices and fabulous failures, this instructive ringleader has mastered the use of humor as a tool—compelling, unique, interactive, and fun—to bring forth inspiring and engaging experiences. Tim unites Millennials, GenXers and Boomers alike in an unforgettable encounter, his energy underscoring and reflecting the realities of this over-stimulated and distracted emailing, Facebooking, Tweeting world in which we now find ourselves living and working.

Friday Morning (10:15 a.m. – 11:45 a.m.)

13 Reasons Why Not

Suicide rates have risen dramatically, making it the second leading cause of death for adolescents. In 2017, a national conversation on suicide was triggered by the Netflix release of 13 Reasons Why. While the series raised awareness, professionals were concerned that 13 Reasons Why—which included a three-minute suicide scene—could negatively affect at-risk youth.

Having recently lost two students to suicide, Oxford High School in Michigan used the series as an opportunity to combat suicide. Students and staff created a student voice project called 13 Reasons Why Not in which 13 students shared stories of struggle and thanked friends and staff at Oxford who helped them recover. Students bravely aired their personal stories over the school intercom each morning in hopes of creating a community of support to prevent suicide. Researchers at Michigan State University evaluated the intervention.

In this keynote, two Oxford students will share their powerful stories of resilience. Presenters will describe the 13 Reasons Why Not intervention and study findings. They will discuss the role that school and family relationships plays in reducing suicide risk.

Dr. Andrea K. Wittenborn is an Associate Professor of Human Development and Family Studies at Michigan State University. She also holds an appointment in the College of Medicine Division of Psychiatry and Behavioral Medicine. Dr. Wittenborn studies mental health intervention from a systems theory perspective with the goal of improving the outcomes of interventions for depression and suicide. Her work has been funded by federal agencies such as the National Institutes of Health, private foundations, and intramural awards. Dr. Wittenborn is an Editorial Board Member of the Journal of Marital and Family Therapy (JMFT) and the Journal of Couple and Relationship Therapy, and recipient of the JMFT Best Article of 2013 Award and 2017 AAMFT Outstanding Research Publication Award.

Pam Fine is currently the Dean of Students at Oxford High School. Pam has a graduate degree in education and counseling. In addition to being Executive Director of a children’s grief center, Pam has counseled privately and at all levels of public education K-12. Her focus is on bully prevention and student voice projects.
**Riley Juntti** is a national public speaker, crisis intervention counselor, and a adolescent psychology major at Grand Valley State University. Her work has been featured on the Washington Post, NPR, Nightline, and Netflix’s “Tell Them” campaign.

**Dylan Koss** is a student at the University of Michigan pursuing a degree in neuroscience. He is a volunteer for the Crisis Text Line and was a participant in 13 Reasons Why Not.

**Friday Afternoon (4:15 – 5:45 p.m.)

How to Resolve Toxic Discourse: A Perspective from Washington, DC**

Michael Gottlieb has spent nearly twenty years in Washington as a consultant, policy adviser, and attorney, serving all three branches of federal government under both Republican and Democratic Administrations, most recently as Special Assistant to President Barack Obama. Mr. Gottlieb is also a Captain in the U.S. Air Force Reserve, and the first openly gay officer to be commissioned to the U.S. military following the repeal of the military’s longstanding prohibition against open service. He is a graduate of Yale College, Yale Law School, Yale Graduate School of Arts & Sciences, Johns Hopkins University, and the University of London, where he earned a graduate degree in psychology. A former US-UK Fulbright Scholar, he has been honored with awards from the LGBT Bar Association, the United States Air Force, and the Judge Advocate General.

**Saturday Afternoon (5:00 – 6:30 p.m.)

Valuing Diversity**

This keynote provides participants with the different dimensions of diversity in today's environment. LTC Kickbusch will provide her personal story of challenges and triumphs as a child of the “barrio” who succeeded in spite of many cultural, social and educational obstacles. She gently guides her audience to a better understanding of cultural differences and similarities, as she emphasizes that appreciation of diverse cultures and their contributions to today's society is a very important element of a successful and productive world. This introspective keynote will force participants to look inward at themselves, their work environments, and communities and motivate them to take action.

Consuelo Kickbusch

Born and raised along the border in a small barrio in Laredo, Texas, **Consuelo Kickbusch** overcame poverty, discrimination, and illiteracy to become the successful community leader she is today. Although she grew up without material wealth, Kickbusch was taught by her immigrant parents that she was rich in culture, tradition, values, and faith. After graduating from Hardin Simmons University, she entered the US Army as an officer and served for two decades. While in the military, she broke barriers and set records to become the highest ranking Hispanic woman in the Combat Support Field of the US Army. In 1996, she was selected out of 26,000 candidates to assume a command post, which would put her on track for the rank of general officer. She respectfully declined the honor and retired as a 22-year veteran of the US Army to fulfill her mother’s dying wish – for her to return to her roots and become a community leader. In realizing her dream, she founded Educational Achievement Services, Inc. with a mission to prepare tomorrow’s leaders.
Maximize your AAMFT18 experience by attending free networking and ticketed continuing education events. Space for some events is limited, so when registering please be sure to indicate if you wish to attend.

**HELD THROUGHOUT AAMFT18**

**Topical Interest Network Meet-Ups**
FREE

**Thursday**, 5:30 – 6:30 p.m.
**Friday**, 12:00 – 1:00 p.m.
**Saturday**, 12:30 – 1:30 p.m.

Topical interest networks are a new feature of AAMFT membership that will debut officially in 2019. These are specialty networking areas that members can join to connect with other clinicians and those in training where the focus is on shared interests related to clinical practice, population or environment. Join us for a meet-up to explore your potential future Networks while engaging with other attendees.

**Research Discussions**
FREE
- **Session 1: Thursday** 7:15 – 8:15 p.m.
- **Session 2: Friday** 12:30 – 1:30 p.m.
- **Session 3: Saturday** 7:15 – 8:15 p.m.
- **Session 4: Saturday** 1:30 – 2:30 p.m.
1 hour of continuing education credit per session

Research Discussions are the place to gather and discuss the latest in marriage and family therapy research. A full listing of research studies featured at each session is available in the day by day schedule provided in this program.

**Emerging Professionals Network Reception**
3:00 – 3:45 p.m.
FREE

The Emerging Professionals Network provides free programming and resources for members at the beginning stages of their career. If you are a Student, Pre-clinical Fellow, Pre-Allied Mental Health Professional, or Clinical Fellow or Allied MHP in your first five years, join us to network with members of the EP Network and find out more about joining this great group!

**Exhibits Grand Opening**
5:30 – 7:00 p.m.
FREE

Join fellow conference participants to kick-off AAMFT18 with fun, prizes, and complimentary refreshments as we officially open the exhibit space. This year’s exhibitors feature great publications, excellent resources, and must-have products. Meet representatives from MFT programs and universities. And don’t forget to stop by the AAMFT Booth for information and tools to help you continue your education after AAMFT18!
FRIDAY, NOVEMBER 16

Lunch and Learn: Families in Crisis: Overcoming Opioid Addiction Together
12:00 – 1:30 p.m.
$53.00
1.5 hours of continuing education credit

Presenter: Meri Shadley

Stigma and fear of addiction has often kept families blind to the realities of substance use disorders until it is almost too late. As licit and illicit opiates have entered homes and families have lost their loved ones to overdoses, the battle to prevent and treat addiction is now in the limelight of society and on the mind of most families. Community engagement has brought us all together around the fear, now it is time for family therapists to bring us together around healing and recovery.

COAMFTE Accreditation Networking
12:30 – 1:30 p.m. (1 hour)
FREE

COAMFTE-accredited programs and programs seeking accreditation are invited to join the Commission and the accreditation staff in an open discussion on accreditation-related issues. Programs are invited to share feedback on the implementation of Accreditation Standards Version 12 in their programs.

Spotlight MFT Reception
6:00 – 7:30 p.m.
FREE

Join us for a reception to kick off a night of networking and connecting with your fellow MFTs. This reception will spotlight existing programs while introducing new ways to engage in the association.

• Hear the latest from COAMFTE accredited programs
• Geographic Interest Networks that represent your state or province
• New Topical Interest Networks to provide customizable benefits to your professional role
• Meet the Minority Fellowship Program

Meet the MFP

Meet the Fellows, advisory committee, and mentors of the Minority Fellowship Program, which seeks to increase the number of culturally competent marriage and family therapists who provide mental health and substance abuse services to under-served and minority populations. Attendees interested in research, training, and practice in these areas or those interested in learning about how to get involved with the MFP are encouraged to attend.
SATURDAY, NOVEMBER 17

AAMFT Annual Business Meeting
11:00 a.m. – 12:30 p.m.
FREE – open to AAMFT membership only
Because AAMFT is YOUR organization, we invite members to attend the 2018 Annual Business Meeting and dialogue with the Association’s leadership. We’ll discuss the accomplishments of 2017, future changes and their impact on you, financial benchmarks, and Association news. Last year’s meeting was dynamic and engaging to members of all levels, as everyone is welcome to freely ask questions and express concerns relating to business planning. Join the conversation!

Family TEAM Meeting
12:30 – 1:30 p.m.
FREE
The Family Therapy Education and Advocacy Movement, or Family TEAM, is a grassroots network of volunteers advancing pro-MFT policies on the local, state, provincial, and national level. Join us to learn about advocacy trends affecting the profession and how to be an effective advocate. This meeting is open to all members interested in advocacy. No experience required.

Queer Affirmative Caucus Meeting
12:30 – 1:30 p.m.
FREE
The purpose of the Queer Affirmative Caucus is to provide an open and inclusive space for lesbian, gay, bisexual, transgender, queer, intersex, and allied AAMFT members and affiliates to challenge discrimination, advance affirmative research, and develop supportive and affirmative clinical work with LGBTQI clients.

C/MFTs of Color Meeting
12:30 – 1:30 p.m.
FREE
C/MFTs of Color promotes critical dialogue related to clinical training and supervision, research, advocacy, and implementation of services to communities of color. The group provides a focus for collective action and networking.

AAMFT Research and Education Foundation Reception
6:45 – 7:45 p.m.
$50.00
Join the AAMFT Research & Education Foundation as it hosts Consuelo Castillo Kickbusch, a renowned community leader whose Family Leadership Institute provides parents with knowledge, tools, and inspiration to help their children succeed in school and in life.

Proceeds benefit the AAMFT Research and Education Foundation.
These special trainings and informational workshops are available for interested attendees and designated representatives. Additional registration criteria may be required.

**THURSDAY, NOVEMBER 15**

**COAMFTE Accreditation Workshop**  
8:30am - 3:30pm  
$349 per person  
Late registration fee (after July 31) – $399 per person  
This in-person training on COAMFTE Accreditation Standards Version 12 is designed to be both informative and interactive and will address:

- Accreditation Standards Version 12  
- How to prepare an Eligibility Criteria submission  
- Guidelines to prepare a Self-Study document  
- Interpretations directly from Commissioners  
- Peer networking with program directors and faculty  

Programs seeking initial accreditation are required to attend the in-person workshop prior to submitting their Eligibility Criteria document. Programs submitting renewal of accreditation are highly recommended to attend this once-a-year opportunity.

To find out more about the Annual Accreditation Workshop or for easy registration, please visit www.coamfte.org.

**Engagement Programs Leadership Training**  
9:00 a.m. – 3:00 p.m.  
These sessions will be dedicated to business planning for AAMFT’s Geographic and Topical engagement programs. Interested attendees should contact their engagement program leadership to register.

**FRIDAY, NOVEMBER 16**

**COAMFTE Site Visitor Training**  
7:30 – 10:30 a.m.  
FREE  
Join the select group of volunteers and become a COAMFTE Site Visitor! Being a Site Visitor allows you the opportunity to:  
- Contribute to the MFT profession  
- Ensure quality instruction for students in MFT programs  
- Serve as the “eyes and ears” of the Commission  
- Gain first-hand knowledge of how peer MFT programs operate  
- Travel across North America and network with other MFTs  

The Site Visitor Training is for academicians and practitioners interested in conducting COAMFTE accreditation site visits. Approval of credentials and completion of a virtual training are required prior to attending this workshop. Active Site Visitors can utilize this comprehensive training as a refresher course for training specific to Standards Version 12. Please contact accreditation staff at coa@aamft.org or visit the www.coamfte.org for more information.

**SUNDAY, NOVEMBER 18**

**Career Development Track**  
7:45 a.m. – 8:45 a.m.  
FREE  
Continuing on principles highlighted in AAMFT’s Leadership Symposium, this track is designed to provide marriage and family therapists with additional tools to rise to the top of the mental health field in their area of interest.
Since 1942, AAMFT has provided cutting-edge professional development and training opportunities for marriage and family therapists. Those that take the step to becoming an Approved Supervisor will serve as mentors in the field of marriage and family therapy. Ensuring a learning environment that is supportive and nurturing while giving therapists and trainees access to the latest innovations in the field. To learn more about the Approved Supervisor Designation or to download the Standards and Responsibilities Handbook, go to www.aamft.org/supervisor.

Refresher Course
Thursday, November 15, 8:00 a.m. – 3:30 p.m.
Presented by Kathleen Laundy
AAMFT Approved Supervisors must take a comprehensive refresher course prior to the renewal of their designation. This session is designed specifically to meet that requirement, and to keep practitioners up to date on clinical MFT supervision practice. This course will include case examples, didactic and interactive instruction methods. It will focus on current resources available to supervisors, management of ethical and legal issues likely to arise during supervision, utilization of supervision contracts, cultural competence in supervision and therapy, and discussion of the current AAMFT Approved Supervision requirements.

Fundamentals of Supervision Training
This track, presented by Toni Zimmerman, PhD, is designed to teach supervision candidates the 15-hour interactive component of the Fundamentals of Supervision course. Dr. Zimmerman will lay the groundwork for participants to become Approved Supervisors through a series of interactive sessions that incorporate all course contents as described in section 3 of the Approved Supervisors Designation: Standards Handbook.

If you are attending this track to meet the AAMFT Approved Supervisor designation requirements, please refer to the Approved Supervisor Handbook for the complete set of requirements toward the designation. The sessions will be limited to full track participants to allow the presenter to deliver a more comprehensive and interactive learning experience.

To attend the following sessions, select the Supervision Track option during registration.

Approved Supervision Network Reception
Friday, November 16, 12:00 – 1:00 p.m.
The Approved Supervision Network provides exclusive access to Approved Supervision resources, and discussion. Open to current Approved Supervisors and Supervisors in training, join us for this networking reception that brings Supervisors together to meet and connect.

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FUNDAMENTALS TRAINING AGENDA

THURSDAY, NOVEMBER 15

Becoming an AAMFT Approved Supervisor: Supervision Relationships, Roles, and Goals
9:00 a.m. – 12:00 p.m.
It is important to know and follow the steps to becoming an approved supervisor and to be prepared to effectively manage the many relationships inherent in doing supervision. Participants will explore relationships including therapist-client, supervisor-therapist-client, and supervisee-supervisor, as well as relationships that exist in the place of practice, such as agencies. Foundation to a successful supervision relationship is to have well established roles and goals that guide the process of supervision.

Lunch Break
12:00 – 1:30 p.m.

Screening and Contracts
1:30 – 3:30 p.m.
The process of screening supervisees is critical prior to beginning a supervision relationship. Once it is established that you will enter into a supervisor relationship, a well developed contract is essential. The supervision contract is a working document that is not only critical at the beginning of the relationship but also important to follow throughout the relationship.

FRIDAY, NOVEMBER 16

Core Competencies and Evaluation
8:00 – 10:00 a.m.
It is the responsibility of the supervisor to work with the supervisee to become competent in all of the Core Competencies. It is imperative that the supervisor establish formative and summative ways of evaluating the supervisees progress and to use best practices in the evaluation process.

Supervision Formats and Modalities
1:45 – 3:45 p.m.
Effectively using a variety of supervision modalities is imperative for successful training of supervisees. Participants will examine the structure and the implementation of these modalities leaning how and when to thoughtfully utilize them to enhance learning.

SATURDAY, NOVEMBER 17

Major Models for Supervision
8:30 – 10:30 a.m.
It is imperative that supervisors are familiar with the major models of supervision that are common in the MFT literature and in the practice of MFT supervision. Participants will engage in the development of their own personal model of supervision drawn from established supervision models and their preferred style of therapy.

Contextual Considerations
2:45 – 4:45 p.m.
Understanding and attending to contextual variables in supervision is imperative for effective practice. These contextual contexts include but are not limited to race, gender, sexual orientation, ethnicity, ability, age, class, culture, and the intersectionality of these. Understanding power and privilege related to both the practice of therapy and supervision is essential in order to “do no harm.”

SUNDAY, NOVEMBER 18

Ethics and Legal Issues
9:00 a.m. – 12:00 p.m.
It is imperative that supervisors are aware of the many distinct ethical and legal issues unique to the practice of supervision and to know how to effectively navigate these issues both common and complex in the practice of supervision.
This track, presented by Jaime D. Goff, PhD and Sara E. Blakeslee Salkil, PhD, is designed to aid students in studying for the AMFTRB MFT national licensing exam. Drs. Goff and Salkil will give a brief overview of the content of the six domains covered on the exam, including a review of the AAMFT Code of Ethics, DSM 5, models of marital and couple and family therapy, individual and theory-based therapy models, and specific test-taking strategies. This track is limited to full track participants to allow the presenters the opportunity to highlight and contrast the development of particular concepts throughout the history of MFT theory and practice.

To attend the following sessions, select the MFT Exam Prep Track option during registration. Price includes a PDF workbook including the slides and practice exams.

AGENDA

FRIDAY, NOVEMBER 16

7:30 – 10:00 a.m.
Attendees will recall the underlying premises of cybernetics and general systems theory and review foundational models of the MFT field.

- Welcome & Overview of Workshop
- Introduction to Modern Models & General Systems Theory
- MRI Brief Strategic Therapy
- Strategic Family Therapy (Washington School)
- Structural Family Therapy

1:45 – 3:45 p.m.
Attendees will identify the main theoretical concepts and interventions of foundational MFT models.

- Milan Systemic Therapy
- Bowen Family Systems
- Contextual Family Therapy
- Behavioral Couple & Family Therapy

SUNDAY, NOVEMBER 18

8:00 a.m. - 12:00 p.m.
Attendees will recall the postmodern MFT models and explore supporting models and theories.

- Emotionally Focused Couples Therapy
- Medical Family Therapy
- Family Life Cycle
- Family Crisis Models and Intervention
- Sex Therapy
- DSM 5
- Ethical and Legal Issues in Marriage and Family Therapy
- Test-Taking Strategies

SATURDAY, NOVEMBER 17

8:00 – 10:30 a.m.
Attendees will recognize how intrapsychic conflict manifests in family distress.

- Psychodynamic Family Therapy
- Adlerian Therapy
- Ericksonian Therapy
- Symbolic Experiential Therapy
- Humanistic Therapy
- Object Relations

2:45 – 4:45 p.m.
Attendees will identify the ways in which postmodernity has shaped the theories of marriage and family therapy.

- Postmodern Contributions to Family Therapy & Feminist Family Therapy
- Solution-Focused Brief Therapy
- Collaborative Language Systems
- Narrative Therapy

PRESENTED BY:
Jaime Goff, PhD, LMFT, LPC, is the Dean of the College of Graduate and Professional Studies at Abilene Christian University Dallas. She received the Distinguished Service Award for her work in editing an AMFTRB exam preparation manual and providing exam preparation workshops. Jaime is currently a commissioner for the Commission on Accreditation for Marriage and Family Therapy Education.

Sara Blakeslee Salkil, Ph.D., LMFT, IMFT is the Program Director of Online Marriage and Family Therapy Programs at Abilene Christian University Dallas. She currently serves as a member of the AAMFT Elections Council and is a member of the Counselor, Social Worker & Marriage and Family Therapist Licensing Board in Ohio.
The AAMFT Annual Conference is approved to provide up to 28.5 contact hours of continuing education for marriage and family therapists and allied professions by most major mental health organizations, including:

**American Psychological Association (APA)**
AAMFT is approved by the American Psychological Association to sponsor continuing education for psychologists. The AAMFT maintains responsibility for this program and its contents.

**National Association of Alcoholism and Drug Abuse Counselors (NAADAC)**
AAMFT is approved by the NAADAC Approved Education Provider Program. The AAMFT provider number is 62673.

**National Board of Certified Counselors (NBCC)**
AAMFT has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 5209. Programs that do not qualify for NBCC credit are clearly identified. AAMFT is solely responsible for all aspects of the programs.

**National Association of Social Workers (NASW)**
This program is Approved by the National Association of Social Workers (Approval # 886390615-8476) for 28.5 continuing education contact hours.

Continuing education at the AAMFT Annual Conference is accepted by most state licensing boards for marriage and family therapy and many other regulatory boards and organizations. Please check directly with the board or organization for continuing education requirements. Contact information for MFT state licensure and certification boards can be found at www.aamft.org.

Continuing education hours are verified on a contact hour basis as follows:

- Conference Institute (100 Series): 5 hours
- Approved Supervisor Refresher Course: 6 hours
- Workshops (200 and 700 Series): 2 hours for each workshop
- Forums (300, 400, 500, and 600 Series): 1 hour for each forum
- Seminar (800 Series): 3 hours for the Sunday Seminar
- Keynote Sessions: 1.5 hours for each of the four keynote sessions
- Research Discussion Session: 1 hour for each of the four sessions
- Career Development Track: 1 hour
- Lunch and Learn: 1.5 hours

Participants do not earn continuing education credit for participation in conference events not listed above. Participants will only receive continuing education credit for participation in the above-mentioned conference events.
The AAMFT Research and Education Foundation is pleased to invite you to join us for a reception with Consuelo Castillo Kickbusch on Saturday, November 17, from 6:30 – 7:30 p.m.

Meet Consuelo Castillo Kickbusch, a renowned community leader whose Family Leadership Institute provides parents with knowledge, tools, and inspiration to help their children succeed in school and in life.

Light refreshments will be served. The proceeds benefit the AAMFT Research & Education Foundation in continually sustaining the Minority Fellowship Program and awards, as well as new innovative projects that involve Faith-based Services for Immigrant Families.

To attend, select this event during registration.

Can’t make the conference?
Too many sessions you want to attend?

Check out Teneo — AAMFT’s online learning platform for online sessions, recordings of past conferences, and CE tests for your favorite publications.

aamft.org/learning
Thursday, November 15, 2018

Conference Institutes
9:00 a.m. – 3:30 p.m.

100 Addressing Partner Violence: A Biopsychosocial Approach
JONATHAN WILSON
DAMON RAPPLEYEA
ANDREW BRIMHALL
JENNIFER HODGSON
Intimate partner violence (IPV) is a pervasive public health problem with serious health consequences. Previous efforts to address IPV have often neglected members of at-risk populations (e.g., LGBT, racial/ethnic minority groups). Many clinicians opt not to screen for IPV. The purpose of this institute is to equip MFTs to identify clients experiencing IPV and to respond through a biopsychosocial-spiritual lens.

101 Treating the Identified Patient by Using a Systemic Model: Brief Systemic Family Therapy
DEBRA MILLER
OLGA HERVIS
SILVIA KAMINSKY
This institute will provide participants with an overview of BSFT’s (brief systemic family therapy) theoretical background, diagnostic framework, and change strategies. Using an evidenced-based family therapy model, relevant data to sustain the claim of effective treatment on youth individual symptomatology will be presented. Original research from current implementation sites in Michigan, along with video vignettes of treatment, will be utilized throughout the presentation.

102 Advanced Interventions for Addressing Conflictual Co-Parenting
WILLIAM NORTHEY
JEFF CHANG
Conflictual co-parenting post-divorce creates numerous clinical, practical, and ethical challenges for MFTs. Utilizing developmental framework interventions that assist parents to negotiate the challenges of relationship dissolution and co-parenting, including co-parenting assessments and counseling, therapy, and parenting coordination designed to reduce conflict and improve co-parenting will be presented. Consideration of unique legal and ethical issues will be explored.

103 The Centrality of Couple Therapy for Addiction Treatment
BONNIE LEE
This presentation will engage MFTs in working with couples as a pivotal unit in addiction treatment. A roadmap for conceptualization will guide the fluid and synergistic interventions. Research and clinical evidence will undergird the experiential work. The discussion references the concept of congruence in Virginia Satir and Carl Rogers and shows how Congruence Couple Therapy adds to this humanistic concept.

104 When One Session May be the Whole Therapy: Systemic Single-Sessions
ARNOLD SLIVE
MONTE BOBELE
This institute will draw on the presenters’ extensive experience with walk-in/single-session family therapy to describe how to conduct each therapy session as if it could be the last. Presenters will use slides, video case examples, and experiential role-plays, and participants will be provided a handout that highlights key learnings and provides an extensive reading list.

105 Narrative Exposure Therapy: A Treatment for Posttraumatic Stress
ELIZABETH WIELING
KARA EROLIN
DAN COOPER
ELSA KRAUS
LEKIE DWANYEN
This institute will use PowerPoint, video, handouts, role play demonstrations, and group discussion to introduce the theoretical foundations of NET, summarize the existing evidence of NET for adults and children, and conduct a series of demonstrations on components of the treatment model—lifeline approach and exposure sessions.

106 Sex Therapy Step-by-Step: Conceptualizing, Assessing, and Treating
KYLE ZRENCHIK
NICK WALLACE
This institute will be broken into five sections. The first will establish the need for a structured methodology for treating sexual issues. Second, participants will become familiar with the theoretical assumptions of the model. Third, the session will provide comprehensive assessments, then transition into effective treatment planning. Finally, participants will be provided fun and effective interventions that clients enjoy.
107 Person-of-the-Therapist in Attachment-Based Family Therapy
JODY RUSSON
As instruments are the tools of musicians, the self is the tool of the family therapist. The Person-of-the-Therapist (POTT) methodology is designed to facilitate personal growth and attunement. POTT has particular relevance for attachment-based family therapy where therapists are tasked with exploring attachment themes and primary emotion. In this presentation, participants will learn to apply self-knowledge in ABFT clinical practice.

108 Online Therapy: A Systemic, Ethical and Practical Approach
AARON NORTON
JACLYN CRAVENS
SHELLY SMITH
JENNIFER LABANOWSKI
As society moves into the digital age so too should the field of marriage and family therapy. Today’s practicing MFTs need innovation, focused training, and education on telemental health services. Clinicians will leave this session with focused information on the systemic, practical, and ethical considerations to help them integrate online services to their practice.

109 Increasing Caregiver Involvement and Decreasing Problematic Behaviors in Treatment: Lessons Learned from Emotion-Focused Family Therapy
ADELE LAFRANCE
ALLEN SABEY
Based in theory and research, Emotion-Focused Family Therapy (EFFT) focuses on empowering parents to engage in the primary supportive role in helping their child cope with and/or recover from mental health challenges. This presentation will introduce and demonstrate relevant interventions to increase supportive parenting practices and decreasing therapy interfering behaviors within the context of family therapy.

110 Mining the Stories That Shape Our Personal and Professional Identity
WARREN L. HOLLEMAN
SHERRY J. DUSON
This institute will identify key elements of effective storytelling, explore ways that stories reflect the values and identities of the teller, conduct a “storyboard” exercise to identify important personal and professional stories, train participants in developing their stories, and provide a storytelling support-group experience, including a discussion of storytelling boundaries.

Thursday Keynote
4:00 – 5:30 p.m.
Living Together in Perfect Disharmony
Tim Clue
With his wife, a self-diagnosed lover of fine details, and himself, a clinically-diagnosed scatterbrain extraordinaire, as guinea pigs, Tim Clue placed his family’s journey under the microscope (and telescope) for some surprising takeaways. Using adaptive storytelling and improvisation, Tim shows us how to increase our personal bandwidth by forcefully embracing discomfort as the building block to personal growth—not only in our families, but in all our relationships—from work to school and home again.

Share your thoughts on this year’s keynote sessions, and any other conference experiences using #AAMFT18 on Twitter or tag AAMFT in your Facebook posts and photos.
Research Discussion Session 1
7:15 – 8:15 p.m.

Research Selections:

• A Cross-national Study of Common Mechanisms of Change in MFT
  Hassan Karimi, Ruoxi Chen

• Attachment and Social Support in Weight Management Patients
  Megan Ferriby, Keeley Pratt

• Can Family Cohesion Buffer Genetic Risk for Alcohol Use Trajectories?
  Kristy Soloski, Kelsie Krupitzer, Lauren Creger, Mazie Zielinski, Natira Mullet

• Cyber Abuse and Facebook Use: The Role of Attachment
  Ashley Cooper, Erin Larson, Ross May, Frank D. Fincham

• Differentiation, Family Functioning, and Spanish Couples
  Martíño Rodríguez-González, Chance Bell, Jonathan Sandberg, Maria L. Schweer-Collins

• Differentiation: The Key to Overcoming Substance Use Stigma
  M. Thomas, Jessica Stephen Premo

• Early Father Play and Child Outcomes at Age 5
  Bornell Nicholson, Jared Durtschi

• Economic Stress and Couple Relationship Functioning: A Meta-Analysis
  Jeffrey Jackson, Mariana Falconier

• Evaluating Together: Couples’ Relationships and Economic Stability
  Mariana Falconier, Jinhee Kim, Xiaofang Wang Lanterman, Suzanne Randolph Cunningham, Z. Joan Wang, An Thai

• Exploring Alcohol Use Among Couples Seeking Couples Therapy
  Rikki Patton, Jennifer Goerke, Janelle Fye

• Family-Based Collaborative Care Telemental Health in Brazil
  Paul Springer, Richard Bischoff, Nathan Taylor

• Impact of Acculturation on Muslim Immigrants Marital Satisfaction
  Iman Dadras, Manijeh Daneshpour

• Impact of Ageism on Older Adults Sexual Risk in Couple’s Therapy
  Joslyn Armstrong

• Integrating Therapy and Family Systems Into a Mentoring Program
  Toni Zimmerman, Shelley Haddock, Jennifer Krafchick, Lindsey Weiler

• Language Use Effects on Later Conflict Experience for Couples
  Lindsey Hall-Menéndez, Jennifer Walker, Travis Spencer, Ryan Seedall

• Lived-Experiences of Families Impacted by Hemophilia and Inhibitors
  Douglas McPhee, Adam Jones, Dave Robinson

• Maltreatment, Patterns of Substance Use, and Sexual Risk-Taking
  Peter M. Rivera

• Mindfulness and Couple Conflict De-Escalation
  Kyle Horst

• Observing Couple Therapy Alliance Ruptures and Repairs
  AnnaLisa Carr, Christina Rosa, Lee Johnson, Norman Epstein

• Predicting Pain Etiology and Outcomes from Close Family Relationships
  Sarah Woods, Jacob Priest, Veronica Kuhn, Tara Signs

• Providing Empirical Feedback to Improve Couple and Family Therapy
  Yaliu He, William Pinsof, Allen Sabey, Jacob Goldsmith

• SBITRT in Clinical Training Programs: Lessons Learned
  Jessica Stephen Premo, M. Thomas, Nancy Brossoie

• School-Based Mindfulness and Art Therapy Groups: A Program Evaluation
  Rebecca Bokoch

• Sex Worker and Proud: The Relationships of Consensual Sex Workers
  Michael G. Curtis

• Social Compensation and Too Much Facebook: The Role of Attachment
  Ashley Cooper, Erin Larson, Ross May, Frank D. Fincham

• Stressors, Attachment, and Family Adaptability with Chronic Illness
  Megan Story, Spencer Bradshaw, Benjamin Finlayson, Valerie Handley

• Telemental Health and Anxiety: A Systematic Review
  Blake Berryhill, Alex Betancourt, Hannah Roberts, Michael King

• Video Game Use, Acceptance, and Dyadic Adjustment: An APIMoM (Actor-Partner Interdependence Moderation) Model
  Aaron Norton, Cameron Brown, Rachel Falbo
Handbook of Systemic Family Therapy

200 Integration of New Technologies in Assessment, Research, and Treatment Delivery
RICHARD BISCHOFF
PAUL SPRINGER
NATHAN TAYLOR
VANESSA NEUHAUS
The use of telecommunications and other technologies have become popular in mental health care, with research showing that they are effective, cost-efficient, and beneficial. Although these tools are ubiquitous, clinicians need to be trained to use them. This workshop will discuss adapting interventions and strategies used for providing telemental health therapy.

201 Suicide Among Youth: Assessment and Management Issues
JENNIFER PEMBERTON
Participants will learn about the contemporary legal, clinical, and treatment issues related to suicide among adolescents; including incorporating multiple systems (family, school, mental health agencies) in assessment and management. The presenter will provide practical and therapeutic resources to better enable clinicians to respond to this increasingly critical area of concern.

202 Racism and Trauma: The Impacts on African-American Men
YAMONTE COOPER
In this workshop, therapists will learn about the link between racism and trauma. Further, therapists will learn about the impact racialized trauma can have on the mental, emotional, and physical health of African-American men. Lastly, interventions in mental health will be closely examined so that therapists will be able to assist African-American men suffering from racialized trauma.

203 Helping Parents of LGBTQ Youth: Affirming and Inclusive Practices
CHRISTI MCGEORGE
KRISTEN BENSON
KATELYN COBURN
This workshop will present specific clinical strategies for family therapists when working with both supportive parents and parents who are struggling to accept their LGBTQ child. Additionally, this workshop will educate therapists about common struggles experienced by parents when their child comes out as LGBTQ and the negative impact of family rejection on the well-being of LGBTQ youth.

204 Introduction to Attachment-Based Family Therapy
GUY DIAMOND
JODY RUSSON
Attachment-based family therapy provides a road map to identify and heal attachment ruptures that underlie behavioral problems. This strategy decreases conflict through increasing love and trust. The model is structured, but flexible. It is goal-oriented, but also process-focused and reliant on person-of-the therapist factors. Decades of research supports the model. This workshop will review the entire ABFT approach.

205 Women in Recovery: The Missing Link
MERI SHADLEY
Relationship attachments often direct a woman’s life. If loving attachments are injured through abuse, many women attach to a more predictable partner – drugs or alcohol. To escape these demons requires women facing addiction and trauma simultaneously while remaining engaged with their families. This workshop details gender-based/trauma-informed treatment approaches and how to integrate individual and family protocols for recovery.

206 HIV: Where Have We Come From, Where Are We Going? What MFTs Need to Know
DANIEL J. ALONZO
In 2018, we will mark the 37th anniversary of AIDS in the United States. This workshop will explore the new challenges that couples encounter in a world where HIV is an unwelcome, permanent guest. This workshop will also explore approaches for MFTs to take as they support couples in the changing landscape of dating, sex, relationships, and committed partnerships.
207 Clinical and Supervisory Competencies for MFTs in Healthcare
TAI MENDENHALL
LISA TYNDALL
JACKIE WILLIAMS-READE
JENNIFER HODGSON
ANGELA LAMSON
STEPHANIE TRUDEAU
Presenters will describe clinical and supervisory competencies that are essential for family therapists working in healthcare settings. Competencies emphasized will relate to: systems, biopsychosocial/spiritual foci, collaboration, leadership, ethics, and diversity. Presenters will use clinical vignettes and media clips to illustrate skillsets across primary, secondary, and tertiary care settings. The workshop will include a combination of lecture and interactive sequences.

208 Brain Talk: Next Generation Brain-Based Therapy
DAVID SCHNARCH
Brain-based Crucible Neurobiological Therapy, developed from twelve years of clinical treatment failure research, resolves subtle emotional trauma by harnessing the interpersonal neurobiology of “mind mapping”—the brain’s innate ability to make a mental map of another person’s mind. Understanding the concepts of mind mapping, “mind masking” and “traumatic mind mapping” (mapping someone else’s mind dysregulates your brain) helps highly troubled clients heal.

209 Gender, Power, and Social Justice in Family Therapy
MANIJEH DANESHPOUR
Discourses about gender dynamics, power, cultural differences, as well as issues related to relational justice and fairness, are often not part of the couple and family therapy treatment even though they are all fundamental aspects of our everyday relationships. This presentation will discuss the importance of a holistic, systemic and culturally sensitive view of the couples and family problems.

211 Understanding Divorce Ideation and Ambiguous Marital Separation
STEVEN HARRIS
SARAH CRABTREE
Little is known about divorce ideation or what marital separation is like. Unfortunately, these are the times that many couples and individuals access our services. We will present original research from a nationally representative sample of people who are thinking about divorce and some who are currently separated and include clinical implications to enhance MFT practice.

Friday Keynote
10:15 – 11:45 a.m.
13 Reasons Why Not
Suicide rates have risen dramatically, making it the second leading cause of death for adolescents. In 2017, a national conversation on suicide was triggered by the Netflix release of 13 Reasons Why. While the series raised awareness, professionals were concerned that 13 Reasons Why—which included a three-minute suicide scene—could negatively affect at-risk youth. Concerns based on ‘suicide contagion’ research even led some districts to go so far as ban students from talking about 13 Reasons Why at school.

In this keynote, two Oxford students will share powerful stories of resilience from the student project 13 Reasons Why Not. Presenters will describe the 13 Reasons Why Not intervention and study findings. They will discuss the role that school and family relationships plays in reducing suicide risk.

Share your thoughts on this year’s keynote sessions, and any other conference experiences using #AAMFT18 on Twitter or tag AAMFT in your Facebook posts and photos.
Research Discussion Session 2
12:30 – 1:30pm

Research Selections:

• #MyDepressionLooksLike: Examining Discourse About Depression
  E. Megan Lachmar, Andrea Wittenborn, Katherine Bogen, Heather McCauley

• A Critical Analysis of the Relationship Satisfaction Construct
  Damon Rappleyea

• A Systemic Structure for Treating Intimate Partner Violence
  Erica Rouleau, Teresa Barabe, Adrian Blow

• An Intervention for Depressed Mothers and Their Young Children
  Emma Hooper, Qiong Wu

• Association Between Relational Injuries and Relational Ethics
  Shaelise Tor, Rashmi Gangamma, Dyane Watson

• Bidirectional Relationship of Pornography Use and Loneliness
  Travis Spencer, Mark Butler

• Characteristics of Emerging Adult Depression and Anxiety
  Hunter Stanfield, Heather Love

• Differentiation, Relationship Satisfaction, and Betrayal Trauma
  Alexandra VanBergen, Suzanne Bartle-Haring, Codina Kawar, Patrick Bortz

• Examining Relationship Mindfulness and Couple Psychosocial Factors
  Matthew Jaurequi, Jonathan Kimmes, Kathryn Roberts, Sapna Srivastava

• Exploring Differentiation Levels in Relationships: A Dyadic Study
  Valerie Handley, Kaitlyn Milstead, Spencer Bradshaw, Megan Story

• Fidelity in Family Therapy: Outcomes and Therapist Factors
  Maliha Ibrahim

• I Need a Break: Ambiguous Marital Separation
  Sarah Crabtree, Steven Harris

• Identifying Moderators of Role-Confusion in At-Risk Mothers
  Katherine Dilks, Forogh Rahim, E. Stephanie Krauthamer-Ewing

• Integrating Feminist Values and Practices in Mental Health Structures
  Joy Heafner

• Intergenerational Connections of Self-Esteem and Depression
  Kayla Reed-Fitzke, Mathew Withers

• Leisure Activities and Classes of Depressive Symptom Trajectories
  Preston Morgan, Jared Durtle

• Parental Identity as Privilege in the Mandated Participation Process
  Sarah Wolford, Spencer Youngberg, Lenore McWey

• Parenting, Education, and Externalizing Behavior in Latino Adolescents
  Sergio Pereyra, Roy Bean, Jonathan Sandberg

• Perceived Discrimination Anxiety in African American Families
  Julia Jones, Joslyn Armstrong, Dr. Gregory J Harris

• Pornography Use, Acceptance, and Dyadic Adjustment: An APIMoM Model
  Cameron Brown, Aaron Norton, Rachel Falbo, Julie Gardenhire

• Predictors of Psychological Aggression Among Chinese Dating Couples
  Yanqun Peng, Jared Anderson

• Racial Disparities in Arrest: A Race-Specific Model
  Cydney Schleiden, Kaitlyn Milstead, Kristy Soloski, Abby Rhynehart

• Relationship Commitment Appraisal in Violent Relationships
  Morgan Lancaster, Damon Rappleyea

• Telemental Health and Depression: A Systematic Review
  Blake Berryhill, Michael King, Hannah Roberts, Alex Betancourt

• The Interactions Between Power and Couple Satisfaction for Women
  Valerie Handley, Shelby Sewell, Kristy Soloski, Sara Elshershaby, Megan Story

• The Process of Qualitative Interviewing: From Method to MFT
  Sarah Wolford, Spencer Youngberg, Lenore McWey

• The Subjective Emotional Experience Questionnaire: A New Measure
  Travis Spencer, Lindsey Hall-Menéndez, Ryan Seedall

• Whose Opinion Matters: Weight Perception and Depression
  Erin Sesemann, Katharine Didericksen, Andrew Brimhall
Afternoon Forums
1:45 – 2:45 p.m.

300 13 Reasons Why Not: Continue the Conversation
ANDREA WITTENBORN
PAMELA FINE
RILEY JUNTTI
DYLAN KOSS
Join in the conversation as our keynote presenters continue their talk. Learn more detailed information regarding the intervention and study findings. This is your opportunity to ask questions and learn what you can do in your community to combat adolescent suicide.

301 Working with LGB Christians: A Focus on Clinical Strategies
KATELYN COBURN
ELLORY BISHOP
JENNIFER LAMBERT-SHUTE
CHRISTI MCGEORGE
TABITHA MCCOY
HOA NGUYEN
This forum will focus on inclusive and systemic clinical strategies that therapists can employ to work affirmatively and competently with lesbian, gay, and bisexual (LGB) individuals. Mainly clientele who are active in a religious community but have not yet disclosed their sexual orientation within their church. Research vignettes and clinical case studies will be used to illustrate and practice these therapeutic strategies.

302 Tough Calls: Morals and Values in Marriage and Family Practice
BENJAMIN CALDWELL
MFTs have struggled for decades with questions of morality and values that are unique to systemic work. Through a series of challenging case examples, this forum will help participants identify the morals and values that influence their own clinical and ethical decision-making, and to be transparent about those values without imposing them on clients.

303 Having the Talk: Black Father and Child Discuss Race and Discrimination
SHAR’DANE HARRIS
JOSLYN ARMSTRONG
GREGORY J HARRIS

The current political and social climate necessitates that more minority parents, specifically Black families, discuss race and discrimination with their children. This research study interviewed 22 Black fathers on their experiences with discussing race and systemic discrimination with their children. Results provide direction for clinical interventions on how to facilitate discussion between parents and children surrounding racial/ethnic identity development.

304 Integrating 9 Theories of Marriage and Family with Christian Spirituality
ANDREW MERCURIO
By utilizing the spiritual resource of Christian scripture, therapists may contextualize systemic concepts in a metaphorical frame to help Christian clients gain increased insight/motivation for change. This forum offers a system of codifying sacred writings into three domains (i.e. instruction, example, illustration). Therapists will identify ways of integrating biblical narratives with structural, CBT (cognitive-behavioral), strategic, solution-focused, EFT (emotion-focused), narrative, Bowenian, object-relations, and contextual therapies.

305 A Trauma Informed Approach to Treating Maternal Mental Illness
DIANA BARNES
This forum will identify the distinguishing symptom presentation of perinatal mood disorders, address key risk factors, and describe therapeutic treatment utilizing a trauma-informed approach. Current thinking about the neurobiological impact of relational trauma on brain development and subsequent vulnerability to maternal mental illness will be discussed along with the comorbidity between childhood trauma and maternal psychotic illness.

306 Building Momentum for School-Based Practice
KATHLEEN LAUNDY
ERIN CUSHING
JESSICA JOSEFF
This forum will advocate for the presence of MFTs on school teams. Presenters will trace school certification history and address school-based opportunities and constraints. They will address participant concerns and work with participants to develop a sustainable AAMFT School-Based Topical Interest Network.
307 MFTs in Healthcare: Conveying Your Competence
ANGELA LAMSON
JENNIFER HODGSON
TAI MENDENHALL
LISA TYNDALL
JACKIE WILLIAMS-READE
STEPHANIE TRUDEAU
Presenters will describe ways in which MFTs in healthcare can convey their competency to potential and current employers, supervisors, research teams, and policy makers. This forum will provide an opportunity for MFTs to learn how to build a professional portfolio for clinical practice, training, research, management, and policy opportunities in healthcare contexts or with healthcare collaborators.

308 De-escalating Conflict in High-Conflict Co-parenting Therapy
BROCK SUMNER
SHAYNE ANDERSON
RACHEL TAMBLING
ANDREA PARADY
This forum will describe a newly developed model for dealing with in-session conflict specifically implemented with dyads. The specific techniques and interventions that successfully promote de-escalation of the dyad and promote therapeutic re-engagement after conflict will be described. Handouts that summarizing the model and interventions will be provided.

309 Relationally-Focused Treatment of Substance Use Disorders
SEBASTIAN PERUMBILLY
WILLIAM BOYLIN
This presentation, based on an original study with a qualitative-research focus on leading treatment-professionals in the U.S., will explore three key areas related to a relationally-focused approach for treating substance use disorders: benefits of involving clients’ families/relational systems in treatment, challenges of involving clients’ families/relational systems in treatment, and clinical strategies related to involving families/relational systems in treatment.

310 Brief Assessment: The Key to Working Effectively with Sex Issues
MARTHA KAUPPI
Sex issues are often complex, overlapping, distressing, and confusing for all. This forum will introduce an original brief assessment tool that offers a concise, elegant method of sorting information, understanding interconnected symptoms, identifying potentially dangerous medical issues, making skilled referrals, and prioritizing treatment. In this skills-based presentation, demonstration and Q&A will help increase confidence by applying the material right away.

311 The Resilient Family Therapist
CHRISTIE EPPLER
Resiliency is process of thriving, coping, and mediating risk by focusing on the strengths, resources, and the positives. This experiential and interactive presentation will explore how resiliency theory can aid clinicians in their self-of-the-therapist and clinical work. This presentation will include several activities that clinicians can use to enhance their own and clients’ strength-based self-care practices.

3:00 – 4:00 p.m.

Handbook of Systemic Family Therapy Sneak Peek

400 Practice-based Research: Therapists (and Researchers) Will Love It!
RICK MILLER
Practice-based research privileges the important role of therapists in the research process. Therapists continuously assess client progress, usually every session, which is associated with dramatically improved therapeutic outcomes. Researchers combine therapists’ clinical data across sites to create large, diverse clinical datasets that allow them to test therapy effectiveness, as well as examine therapist and client factors that predict therapy success.
401 Ethical Management of Sexual Feelings in Clinical Practice and Supervision
CHRIS FARIELLO
This forum will explore sexual attraction between therapists and their clients/supervisees. A review of the literature will help to demystify the prevalence of these feelings. Participants will then be encouraged, with knowledge of the literature, to discuss the ethical and therapeutic implications of experiencing and expressing sexual feelings with clients and understand ethical options for managing sexual feelings.

402 Secure Attachment and Marital Satisfaction with Couples of the US Army
LEO MORA
The research question will provide the central idea: “What is the relative influence of secure attachment upon marital satisfaction for soldiers and their spouses of the U.S. Army?” Audiovisuals will include statements of soldiers and their spouses reflecting answers from the data collection set along with statistical graphs generated by SPSS (statistical package for the social sciences) and illustrated and integrated into a PowerPoint slide deck.

403 Vicarious Resilience, Self-Care and You: Keys to Clinician Well-Being
KYLE KILLIAN
What predicts our resilience vs. our compassion fatigue and burnout when working with trauma survivors becomes challenging? This forum presents the roles played by social support, emotional self-awareness, and work environment in fostering our vicarious resilience as clinicians. Attendees will measure their vicarious resilience and learn effective self-care strategies.

404 Transgenerational Trauma: Contextual Therapy Perspective
TATIANA GLEBOVA
This presentation will describe a novel application of contextual therapy, founded by Ivan Boszormenyi-Nagy in the 1960s, to address transgenerational historical trauma in clinical practice, especially with families that experienced socio-historical trauma, such as immigrants and historically marginalized and oppressed groups.

405 Utilizing Brief Experiential Activities to Enhance Client Resources
MICHAEL REITER
This presentation will provide participants with an overview of how marriage and family therapists can utilize experiential activities to help clients access their resources. The presentation will highlight how experiential techniques have been a key component in family therapy’s history and will provide participants a hands-on opportunity to engage in various experiential activities.

406 Treating Couples with a Traumatic Brain Injury with Narrative Therapy
DANE EGGLESTON
LINDSEY HAWKINS
CAMERON BROWN
Traumatic Brain Injuries (TBI) are the leading cause of disability in the U.S. and offer challenges to couples. This forum will illustrate how TBIs impact couples and how MFTs can best serve them. Through a narrative lens, this forum will enhance the MFT’s skillset with this population through research informed discussion, a proposed narrative model and interventions, and a roleplay video.

407 Development of Marriage and Family Therapy Common Factors Questionnaire
HASSAN KARIMI
TINA SAVLA
Scholars emphasize that the MFT field has unique conceptualization of problems and therapeutic rationale versus individual therapies. This forum invites systemic thinkers, clinicians, and researchers toward operational definition and empirical study of unique systemic common factors that are responsible for successful outcomes across MFT models. Such research is a critical issue for the MFT field specifically in the era of evidence-based practice.
408 Maternal Substance Use and Structural Family Therapy
JESSICA CHOU
RACHEL DIAMOND
SHANNON COOPER-SADLO
BERTRANNA MURUTHI
This forum will include a systemic overview of substance abuse in the context of the family. Participants will engage in conceptualizing families of maternal substance abuse through key concepts in Structural Family Therapy (SFT). Participants will also be presented current literature and original research to highlight how SFT may be used to treat families of maternal substance use.

409 Infidelity: A Practitioner’s Guide to Working with Couples in Crisis
SHEA DUNHAM
SHANNON DERMER
Infidelity is a confusing and challenging issue to confront when working with couples. Many therapists find themselves looking for a treatment model that might be successful in treating couples facing the pain of infidelity. This presentation will focus on the trauma of infidelity and implementing Emotionally Focused Couple Therapy as an empirically validated model to work with infidelity.

410 “Small World, Isn’t It?” Dual Relationships in Small Communities
SHEILA ADDISON
NOELLE CLASON
Therapists who identify as religious or ethnic minorities, LGBTQ, or those working in small communities like the military, may experience conflict between serving community members and participating in community themselves. This forum will present a variety of clinician perspectives on ethically managing dual relationships while providing culturally-competent therapy in small communities and subcultures.

411 Attachment and Differentiation: Can You Integrate?
NATHAN HARDY
ADAM FISHER
This forum will provide an overview of the debate between differentiation and attachment in couple therapy. Through presentation, handouts, and small group discussion, this forum will explore the convergence, divergence, and integrative possibilities of these two cornerstone theories. Participants will better understand the debate, how each approach looks in couple therapy, and potential ways to use both in their work.

Friday Afternoon Keynote
4:15 – 5:45 p.m.
How to Resolve Toxic Discourse: A Perspective from Washington, DC
Michael Gottlieb
Today’s increasingly partisan political climate and the division it sometimes engenders creates unique challenges for family members who find themselves on opposite sides of a particular issue. Mental health professionals must navigate between and among disputing family members, while managing their own views, thoughts, and feelings in the therapy room. While Washington, DC might not seem an obvious source for guidance on this particular topic, those who live and work there must navigate these challenges daily—often hourly—as they engage with friends, colleagues, and family on all sides of a particular issue. What can be learned from that experience? And how can it be applied to therapeutic practice?

Share your thoughts on this year’s keynote sessions, and any other conference experiences using #AAMFT18 on Twitter or tag AAMFT in your Facebook posts and photos.
Saturday, November 17, 2018

Research Discussion Session 3
7:15 – 8:15 a.m.

Research Selections:
- #metoomen: A Phenomenological Approach to Addressing Sexual Assault
  Lindsey Hawkins, Natira Mullet, Dane Eggleston, Julie Gardenhire
- A Test of Online Training for Transracial Foster and Adoptive Parents
  Jordan Montgomery
- After the First Love: The Transition of Meanings
  Alexandra VanBergen
- Assessing Divorce Initiator Status in Research and Clinical Practice
  Rachel Diamond, M. L. Parker
- Childhood Trauma and BPS (Biopsychosocial): How Bad Things Affect Good People
  Erin Sesemann, Natalie Richardson
- Couples Affected by Incapacitating, Recurring Headaches
  Douglas McPhee, Adam Johnson, Dave Robinson
- Daughtering Today: New Insights on Adult Daughter-Mother Bonds
  Lesley Ann Earles
- Effects of Family Therapy Among Children of Abused Mothers
  Qiong Wu, Natasha Slesnick
- Effects of Family Violence: Dynamics on Emerging Adults
  Elizabeth Watters, Kayla Reed-Fitzke, Casey Gamboni, Amanda Wojciak, Anthony J. Ferraro
- Family Views on Comorbid Symptoms and Adolescent Disordered Eating
  Ashley Hicks White
- How MFT Clients Make Decisions About Persistence
  Carissa D’Aniello-Heyda
- Influence of Early-Life Trauma on Divorcing Parents Wellbeing
  Todd Spencer, Matt Brosi, Ethan Jones, Ron Cox, Katey Masri
- Latino LGBQ Young Adults Coming-Out Experiences
  Monica Munoz, Carissa D’Aniello-Heyda
- Mental Health in Schools: Frameworks for Research and Practice
  Erica Nordquist
- MFT Interns Supporting At-Risk Students in Public Schools
  Daniel Mendel
- MFTs and School-based Health Centers: Strategies for Engagement
  Erica Nordquist
- Negotiating the Integration of Clinical and Cultural in Therapy
  Lorien Jordan, Desiree Seponski
- Novice to Professional: Facilitating Professional Growth
  Tabitha McCoy, Jennifer Lambert-Shute
- Perceptions of Health Strain on Relationship Satisfaction in Couples
  Dorothy Cobia, Conrad Cannell, Josh Novak, Jonathan Sandberg
- Post Traumatic Slave Syndrome and Genograms: New Talk on Mental Health
  Symphonie Smith
- Program Evaluation of Juvenile First Time Offender Immersion Program
  Alexander Hsieh
- Relationship Satisfaction of Interracial Couples
  Emel Genc, Yile Su, Michelle Washburn-Busk
- Relationships Among Therapists, Interpreters, and Refugee Clients
  Janet Robertson
- Secondary Trauma and Impairment in Clinicians
  Stephanie Armes, Brian Bride, Jacquelyn Lee, Desiree Seponski
- Social Relationships, Depression, and Happiness in Chinese Marriages
  Yanqun Peng, Hunter Stanfield
- Trans* People and Moral Objectivity by Family
  Kayla Barningham, Jennifer K. McGuire
- Trauma-Informed Care: Importance of Resilience in Schools
  Armada Wojciak, Bryan Range
- Youth Service Access in a School-based Health Center: A Case Study
  Erica Nordquist
Morning Forums
8:30 – 9:30 a.m.

Handbook of Systemic Family Therapy Sneak Peek

500 Affair Recovery in Couple Therapy: Healing from the Betrayal
TINA TIMM
This forum will explore the changing nature of affair behavior in the digital age. Participants will learn how to assess and explore attachment injuries, gain skills to recreate a secure base by teaching affect regulation, restoring trust, and facilitating the in-depth conversations that couples need to have in order to protect their relationship in the future.

501 Exploring Self of the Therapist Beliefs for Therapy with the Bereaved
CADMONA HALL
HEATHER HAY
This forum will provide an authentic interactive learning experience where participants will gain hands-on tools for effectively engaging bereaved families. Participants will gain tools for processing loss & accessing resiliency. Participants will be able to apply the concepts using movie clips and clinical case presentation. Self-of-the-therapist concerns relevant to working with the bereaved will be emphasized.

502 Empirically Supported Marriage and Family Therapy Treatments
JEFFREY JACKSON
RICK MILLER
AMY MORGAN
Concerning the future of the profession, this presentation will explore the importance of and controversies surrounding Empirically Supported Treatments (ESTs). A comprehensive review of treatment outcome research for MFT treatments for key disorders and clinical problems will be presented.

503 A Relational Path to Social Justice: Lessons from Contextual Therapy
ASHLEY HICKS WHITE
Despite the prevalence of racism, classism, and sexism in our society, much of what is taught in our training programs do not address how to serve clients who are treated unjustly in their personal and public relationships. Using contextual therapy, this session will address how oppression is maintained in relationships and systems, and how we can intervene to facilitate social justice.

504 Self-Disclosure in Therapy: A Systemic Lens
CARISSA HEYDA
HOA NGUYEN
Relevant marriage and family therapy literature on therapist self-disclosure will be presented. The influence of practice setting, particularly in training clinics and private practice, on therapist self-disclosure will be discussed. Presenters will draw a distinction between intentional and spontaneous self-disclosure and provide recommended steps toward ethical practices of for the disclosure decision-making process.

505 I Love You, I Hate You: Couple’s Therapy and Borderline Personality Disorder
MOLLY MCDOWELL-BURNS
Couples appearing for therapy with one individual having BPD (borderline personality disorder) can present a challenge for even the most experienced MFT. This forum will provide strategies for navigating the complexities of couples’ therapy & BPD. As AAMFT encourages our history to be revisited, structural family therapy will be the framework used to help attendees conceptualize these couples.

506 Microaggressions: The Call to be More Sensitive
ALEXANDER HSIEH
GITA SESHADRI
This presentation will provide the audience with research and best practices centered around microaggression. Participants will also be engaged in group discussions with a predetermined experiential exercise. Case study material will be provided to enhance understanding and to facilitate best practices. Handouts will be distributed for participants to refer to in their practice.
507 Mindfulness with Children in Schools
DIANE GEHART
DAVID SIEGEL
STEPHANIE HANSEN
CINDY SAYANI
In this forum, therapists will learn about developing mindfulness programs for working with children in school settings and providing opportunities to advocate for the profession while expanding one’s own practice. Presenters will share their work with preschool and K-5 school-based mindfulness programs and in private practice, highlighting improvements in academic and mental health outcomes.

508 Family Therapy with Law Enforcement Couples
AVERY CAMPBELL
ASHLEY LANDERS
Law enforcement (LE) couples experience stressors that are unique to the LE profession’s culture. This forum illuminates the complex experiences of LE couples, and implications for MFTs working with LE couples will be explored. The experiences of LE couples, current research, and MFT models will offer guidance to MFT practice.

509 Evidence-Based Guidelines for Family Therapy and Suicide
QUINTIN HUNT
LAURA FREY
REBECCA LEVY
Suicide is difficult for both families and therapists to encounter. This forum will explore evidence-based guidelines and common factors for use with families that are struggling with suicide ideation, attempts, or bereavement. This session will summarize established and cutting-edge research on suicide in families, provide examples for intervention and postvention, and specific examples of how to document issues relating to suicide.

510 The Experiences and Needs of Couple and Family Therapists of Color
KARA EROLIN
ELIZABETH WIELING
MUDITA RASTOGI
This forum will use PowerPoint, handouts, and group discussion to present the results of the 2018 survey assessing the needs of couple and family therapists of color regarding experiences within: AAMFT, clinical training programs, community and work settings, clinical programs of research, professional development, and public engagement and political activism.

511 Queer Theory’s Gifts to the Field: Moving Beyond Inclusion
EMILY STONE
DANIEL STILLWELL
SARAH CAUSEY
HANNAH CASE
Beyond being inclusive of the Queer community, MFTs must appreciate its gifts to the field. Families often become stuck in dysfunction due to adhering to society’s heteronormativity. Queer Theory offers three primary gifts of deconstruction that increase functionality for all family systems. This presentation will include ideas to incorporate Queer Theory into graduate training, supervision, and clinical practice.

9:45 – 10:45 a.m.

600 Pediatric Weight Management and Prevention: Applications for Marriage and Family Therapists
KEELEY PRATT
JERICA BERGE
CATHERINE VAN FOSSEN
Given the high prevalence of childhood obesity, MFTs will undoubtedly work with families struggling with a child with overweight/obesity. Training in family systems theory and integrated family-based care models situate MFTs to intervene effectively with this population. This session will describe how MFTs are addressing pediatric weight management and will highlight family systems clinical and research efforts with this population.

601 Fostering Productive Sexual Communication in Couple Relationships
ADAM JONES
REBECCA LUCERO JONES
In this forum, the authors will provide original research findings from two studies to help clinicians better foster sexual communication in couple relationships. Through several interactive exercises, participants will gain practical tools and interventions for aiding couples of various backgrounds in communicating about their sexual relationship. Participants will be able to integrate these practices into relational and sex therapy treatments.
602 Breaking Barriers: Addressing Ethnic-Racial Trauma in Therapy
JAMILA HOLCOMB

Given current United States race-relations, ethnic-minority families are at an increased risk for experiencing ethnic-racial trauma. However, few clinical resources exist to address the symptoms related to experiencing or witnessing racist incidents. This forum will facilitate an in-depth discussion of ethnic-racial trauma, explore Self of the Therapist factors, and discuss strategies for addressing ethnic-racial trauma within the therapeutic context.

603 Peer Victimization and Mental Health for LGB and Heterosexual Youth
RACHEL MOORE
KATIE HEIDEN-ROOTES
SHAH HASAN
LAUREN WILSON

This presentation will describe research that analyzed peer victimization and mental health outcomes for a nationally-representative sample of high school LGB and heterosexual youth. As hypothesized, significant degrees of victimization, mental health outcomes and suicidality emerged. Degrees of victimization impacted mental health outcomes across the board. Implications from this study include evidence-based practices for psychotherapy and school-based violence prevention programs.

604 Developing a Theory of Theory Selection for Best Clinical Practice
ANDREW MERCURIO

This presentation will explore a theory of theory selection to help therapists determine which MFT theory is best fitted for clinical effectiveness. Influential client factors will be examined to practically guide theory selection (i.e., crisis level; motivation level; problem-language; solution-language; “change influencers”; ethnicity and personality). Nine MFT theories will be represented by a conceptual framework called the THEORY CUBE.

605 Experiential Family Therapy Across the Life Cycle
AMANDA SZARZYNSKI
JENNIFER MOORE
MEG TAYLOR

The workshop will review the foundational concepts of Experiential Family Therapy as pioneered by Carl Whitaker and Virginia Satir and apply this model to trending issues in major phases of the life cycle (e.g. children, adolescents, adults, and older adults). An Experiential case conceptualization and intervention application for each life cycle phase will be presented.

606 “Siri, Save My Marriage!”: Artificial Intelligence and the Future of Marriage and Family Therapy
AARON COHN
KATHERINE HERTLEIN

Artificial Intelligence is transforming every part of our profession, including process, training, research, and delivery. Understanding the reciprocal influence of A.I. and client systems requires a systemic lens. To help position MFTs as leaders in this technological revolution, our presentation provides both an overview of state-of-the-art computerized psychotherapy and an examination of how AI technologies already influence client systems.

607 Navigating the Space between Cultural and Sexual Identity
HOA NGUYEN
ERIKA GRAFSKY
JENNIFER LAMBERT-SHUTE
TABITHA MCCOY

This forum will focus on the therapeutic process of working with lesbian, gay, bisexual, and queer (LGBQ) clients from diverse cultural backgrounds. Presenters will discuss the therapeutic process of travelling with clients into the borderlands of culture and sexual identity, and explore ways to help clients cultivate relational possibilities within the in-between spaces of tension, uncertainty, and transitional being.

608 Attachment Focused Treatment of Foster Care Children
CYDNEY SCHLEIDEN
JULIE GARDENHIRE
CAMERON BROWN

Therapists must be equipped to provide care uniquely fit for children in foster care. Navigating building secure attachment relationships within the foster child’s system is complicated, but could benefit in reducing traumatic symptoms, bettering mental health, and improving physical health. Use of attachment theory and unique interventions will be offered to enhance clinician’s skillset and ability to treat this marginalized population.
609 Family Deportation: Racial Implications and Impact on Mental Health
SANDRA ESPINOZA
IMAN DADRAS
HYE-SUN RO
Undocumented immigrants living in the United States are victims to a host of risk factors that not only threaten their presence in this country but their psychological well-being. This presentation will facilitate a new discourse within the field of couple and family therapy regarding the role of racism and discrimination as a contributor to the distress in undocumented families.

610 Utilization: The Ericksonian Heart of Brief Therapy
DOUGLAS FLEMONS
The techniques and methods of all brief therapy models were inspired by Milton Erickson’s commitment to utilization as a means of respectfully facilitating trance and therapeutic change. This forum will illuminate and clinically illustrate the original logic and later brief-therapy applications of Erickson’s utilization approach, including the commitment to a dialectic sensibility, resource-focused curiosity, metaphoric (associational) sensitivity, and improvisational creativity.

611 Comfortable Cultural Competence with Polyamorous Clients
MARTHA KAUPPI
JIM FLECKENSTEIN
Research suggests there may be nearly twice as many consensually non-monogamous individuals than LGBT-identified adults in the U.S. This session will introduce and define polyamory, cover recent research regarding polyamorous individuals, and explore common clinical challenges and therapeutic approaches. Participants will share experiences, explore biases, and examine their beliefs about polyamory and polyamorous clients.

Research Discussions Session 4
1:30 – 2:30 p.m.
Research Selections:

- “Bisexuals Don’t Belong Here”: A Path Model of Factors Associated with Comfort in Racial and Ethnic Communities
  Mary Nedela
- “Coming Out”: Disclosures to Parents by LGB Christians.
  Jeffrey Reed, Steven Stratton, Janet Dean, Christina Dillon, Mark Yarhouse, Michael Lastoria, Greg Koprowski
- 13 Reasons Why Not: Evaluating a School Suicide Prevention Program
  E. Megan Lachmar, Andrea Wittenborn, Pamela Fine, Riley Juntti, Dylan Koss
- Adolescent Neglect, Educational Outcomes, and Self-Concept
  Lawrence Jackson, Michael Fitzgerald, Morgan Lancaster, Trenton Call, Lenore McWey
- Are You in Therapy? Perspectives on Personal Therapy for MFT Students
  Katarina Krizova, Megan Dolbin-MacNab
- Attachment, Coping, and Long-term Outcomes of Child Sexual Abuse
  Fei Shen, Kristy Soloski
- Betrayal Trauma, Substance Use, and Depression in LGBTQ+ and Individuals
  Alexandra VanBergen
- Bi Erasure in Bi Identified Individuals in Mixed Sex Relationships
  Kristen Mark, Amanda Bunting
- Couple Factors, Transmission of Trauma, and Child Outcomes
  Michael Fitzgerald, Kami Gallus
- Decolonizing the Coming Out Process for LGBT Individuals
  Joshua Boe, J. Maria Bermudez, Valerie Maxey
- Fear, Loss, and Adaptations of Latino Families at Risk for Deportation
  Allison Rayburn
- Gay Men’s Attitudes and Beliefs Towards Legal Marriage and Divorce
  Eugene Hall, Steven Harris
- How Religion and Depression Impact Women’s Sexual Behaviors
  Joslyn Armstrong, Denise Nicholas Williams
• Intimate Partner Homicide: Research Informed Risk Assessment
  Chelsea Spencer, Sandra Stith

• LGB Affirmative Pastors’ Advice to Family Therapists
  Katelyn Coburn, Christi McGeorge

• Mental Health Indicators of Suicide in Cambodian Women
  Stephanie Armes, Charity Somo, Khann Sareth, Desiree Seponski, Cindy Lahar

• Parents’ Perceptions of Parent-Child Communication about Sex
  Michelle M. Murray, Erika L. Grafsky

• Predictors of The Relationship Satisfaction of Bisexual Individuals: Social Support, Outness and Internalized Binegativity
  Lea El Helou

• Prevention, Parent-initiated Villages, and the Therapist’s Role
  Lindsey Weiler

• Relationship Sacrifice as a Predictor of Coping in Military Couples
  Ashley Tuft, Bryce Barker, Dorothy Cobia, Josh Novak, Jared Anderson

• Self-Harm Among Sexual Minority Youth: Etiology and Intervention
  Brock Sumner, Roy Bean, Lauren Smithee

• Sex Research in MFT and Family Studies Literature
  Adam Jones

• Sexual Communication in Various Couple Types
  Rebecca Lucero Jones, Adam Jones

• Sexual Identity at Church: Navigating Early Childhood Messages
  Katelyn Coburn, Ellory Bishop, Jennifer Lambert-Shute, Tabitha McCoy, Hoa Nguyen

• Sexual Pleasure in Clients with Sexual Trauma: A Qualitative Approach
  Kristen Mark, Laura Vowels, Virginia Luftman

• The Connection Between Relationship Quality and Clinician Burnout
  Jason Austin, Ruoxi Chen, Jana Sutton, Jaroddd Hundley, Brianna Savage

• The Role of Attachment in Buffering the Effects of Child Sexual Abuse
  Fei Shen, Kristy Soloski

• Trauma, Dyadic Attachment, and Trauma Symptoms in Adolescence
  Michael Fitzgerald

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Afternoon Workshops
2:45 – 4:45 p.m.

Handbook of Systemic Family Therapy Sneak Peek

700  A Systemic Approach to Alcohol, Drugs and Other Addictive Behaviors
THOMAS KIMBALL
STERLING SHUMWAY
This workshop will focus on the bio-psycho-social aspects of addiction recovery including the neuro-biological aspects of addiction, the co-occurring nature of the disease, assessment/diagnosis, family systems, family development and co-addiction, behavioral addictions, recovery, and therapy best practices. The presenters offer this information based on experience providing therapeutic services including inpatient/outpatient treatment, individual, couple and family therapy, and in recovery communities.

701  Competency-Based Family Therapy with Military Service Members
SEBASTIAN PERUMBILLY
This presentation will identify and discuss core competencies related to clinical work with military service members and their families. The research participants were nationally reputed clinicians specialized in working with military service members. The presenter will focus on four key clinical areas of core competencies: clinical assessment and diagnosis, treatment planning, therapeutic interventions, and evaluation of treatment effectiveness.
702 Paul Watzlawick: A Conduit Between Older and Newer Models of MFT
DALE BERTRAM
MIKE RANKIN
DAVID HALE
TONY WATKINS
This workshop focuses on Paul Watzlawick’s role as a conduit between eras. There will be an emphasis on Watzlawick’s influence on MRI (mental research institute) as a radical constructivist and how this impacts the MFT field in terms of navigating multiple realities in therapy. Examples will be given from Watzlawick’s work of his ability to work with multiple realities with a session.

703 Family Screen Time: New Parenting Challenges in the Digital Age
DIANE GEHART
JENNIFER PEMBERTON
The contemporary family issues related to screen time include: recent neuroscience, developmental issues, and risk factors. The presenters will provide practical recommendations and therapeutic resources to enable clinicians to respond to this increasingly critical treatment area with flexible options for diverse families, including: parental control apps, built-in parental restrictions, and bilingual resources.

704 Continuing the Conversation: Immigration Status Implications for Family Therapy
ASHLEY WALSBDORF
YOLANDA MACHADO
J. MARIA BERMUDEZ
Current U.S. policy and law favors separation over family unity, contributing to anti-immigrant sentiment and a climate of fear and uncertainty for undocumented and mixed-status immigrant families (Zayas, 2015). This workshop will continue the conversation on supporting immigrant families through a review of immigration policy and law, focusing specifically on clinical implications and collaboration opportunities for working with undocumented families.

705 Rage and the Family: Examining the Rulebook of “Really Nice” Families
ANGELA CALDWELL
Americans are terrified of anger, so much so that many American families organize their rules and roles around its suppression. This talk will describe the neurobiology of anger and rage, then examine what happens when either of these emotions are suppressed. It will also describe the often-repressive rulebooks of “nice” families that may be an inadvertent cause of rage.

706 I See You: Way of Being in Marriage and Family Therapy Practice and Supervision
STEPHEN FIFE
JASON WHITING
SEAN DAVIS
KAY BRADFORD
This workshop focuses on “way of being” in MFT practice and supervision. Presenters will discuss the therapeutic pyramid, a common factors meta-model that places therapists’ way of being as a foundation for therapy models/techniques and therapeutic alliance. Participants will learn the principles of the therapeutic pyramid and teaching methods used to incorporate the model into therapist training, supervision, and clinical practice.

707 Healthcare Management and Scholarship Competencies for MFTs
JENNIFER HODGSON
ANGELA LAMSON
TAI MENDENHALL
LISA TYNDALL
JACKIE WILLIAMS-READE
STEPHANIE TRUDEAU
Presenters will describe healthcare management, policy, and scholarship competencies that are essential for family therapists working in healthcare settings. Competencies emphasized will relate to: systems, biopsychosocial/spiritual foci, collaboration, leadership, ethics, and diversity. Presenters will use vignettes and application exercises to illustrate skill sets across primary, secondary, and tertiary care settings. The workshop will include a combination of lecture and interactive sequences.
This workshop will include a summary of the available literature on autism in the family, including handouts for additional resources. Participants will engage in activities to implement the solution-focused interventions following a demonstration of the appropriate adaptations. The presentation will conclude with a large group discussion in which participants may ask specific questions about autism in the family.

The Experiences of Racial Minority Students in MFT Training Programs

This interactive workshop will feature a panel of racial minority students at various levels of MFT education and training. Small group exercises will provide panelists and participants with a safe and brave space to engage in critical discourse about their training experiences while exploring ways to de-center the Eurocentric practices and ways of knowing that characterize the MFT training experience.

Online Therapy: Fundamental Principles for Ethical Practice

Online Therapy is an effective medium for using systemic based family therapy approaches and interventions with a broad spectrum of clients. Through lecture, demonstrations, interactive activities and case presentations, attendees will learn cutting edge marketing tools and effective systems-based Online Family Therapy to legally and ethically better serve the growing population of clients using the internet.

Saturday Keynote

5:00 – 6:30 p.m.

Valuing Diversity

LTC Kickbusch will share her personal story of challenges and triumphs as a child of the “barrio” who succeeded in spite of many cultural, social and educational obstacles. She will gently guide her audience to a better understanding of cultural differences and similarities, as she emphasizes that appreciation of diverse cultures and their contributions to today’s society is a very important element of a successful and productive world.
Sunday, November 18

Career Development
7:45 – 8:45 a.m.

The career development track is designed to provide marriage and family therapists with tools to rise to the top of the mental health field. These sessions focus on developing and enhancing skills in sub-specialties of the profession. 1 hour of Continuing Education credit available.

CD1 Transgender Inclusive Training Issues and Experiences in Marriage and Family Therapy Programs
TRISTAN MARTIN
JENNIFER COPPOLA
DEBORAH COOLHART
This career development session will address critical practice and training experiences of two transgender inclusive MFT clinicians and researchers. Specific issues in working with trans clients relative to training, supervision, and research will be discussed, promoting a reflective learning environment for those who may not already have transgender-inclusive training.

CD2 Bowen and Mudd Meet 21st Century Couple-Owned Business Consulting
KIM MCBRIDE
This career development session presents a systems theory/personal-agency integrative approach to couple-owned business consulting. Using case study and roleplay, this session will: present an evidenced-informed approach to couple-owned business consulting, identify the common threats to couple-owned business succession, and provide strategies to increase satisfaction in the couple relationship. It will also provide information to strengthen the couple’s business performance, and facilitate effective succession over time.

CD3 Therapists as Recipients of Micro-Aggressions from Clients
YANQUN PENG
JARED DURTSCHI
EMEL GENC
FATEMEH NIKPARVAR
MFTs do not discriminate against clients. However, international therapists frequently encounter clients’ discrimination against them due to their race, country of origin, language of origin, gender, or religion. Therapists and supervisors need training in managing these interactions. Three therapists and their clinical supervisor will openly share their struggles and experiences of discrimination, along with strategies for dealing with these challenges.

CD4 Couple’s Intensives and Retreats: The Good, the Bad, and the Ugly
ADAM R. SMITHEY
This presentation will provide an introduction into couple’s intensives and retreats by guiding participants through research considerations, identifying and overcoming obstacles, and factors to consider when incorporating intensives into their own practice. The presentation will aim to reduce anxiety and empower therapists to overcome any perceived limitations when breaking away from the insurance-driven world and providing couples with new options.

CD5 Sustaining the System: MFTs, Families, and Collaborative Divorce
RANDY HELLER
In a didactic and interactional format, participants will be provided with the basic tenants of Collaborative Practice, the ways in which MFTs can utilize their knowledge, skills, attitudes and values to effectively do this work. Participants will engage in role play exercises, view video examples and demonstrations, and be provided with forms necessary to begin to engage in this practice.

CD6 The Mean Green: The Impact of a Systemic Shift of Financial Philosophy
ERIN NESS ROBERTS
This presentation will address how beliefs about the “worth” of therapy practice affects the comfort at which therapists discuss fees with clients. Using examples from the literature and providing details on cross-system changes at the ECU Family Therapy Clinic, this presentation shows effective system changes resulting in a three-fold increase to income and increase in student efficacy surrounding discussing fees.
CD7  MFT Career across the Lifespan  
JAMES MORRIS  
This session will examine the different career trajectories of a MFT who has been in the field for nearly 40 years. In addition to identifying the many different employment contexts of the presenter, the discussion will explore the advantages and challenges of various career opportunities for MFTs. Discussion will also focus on the centrality of maintaining integrity as a MFT, especially when facing potential ethical threats while working within conventional mental health in the United States.

CD8  Therapists and the Court System  
STEFANIE FRANK  
Although many MFTs try to avoid being pulled into litigation situations their clients are involved in, most times there is no way around it. In this course, we will discuss various issue that MFTs face when dealing with the court system. This includes responding to record and testimony requests, getting paid for your time, the difference between a treating therapist and a forensic evaluator, when an attorney should be hired, what records and testimony can be provided, and how to take steps prior to being involved to make the process run smoother.

Seminars  
9:00 a.m. – 12:00 p.m.

800  Serving Wounded Soldiers: Transition Unit Experience  
DEBRA MILLER  
PAUL LEPLEY  
This seminar will highlight original research and clinical interventions pertinent to the experiences of wounded soldiers and their families upon return from deployment placed in Warrior Transition Battalions (WTB). With the goal of helping participants generalize data and recovery implications from a relational lens, barriers and opportunities for enhanced recovery effort will be explored.

801  Drawing the Line: Reframing Supervision in a Gender-Charged World  
ERIN SCHAEFER  
MARVARENE OLIVER  
SHELLEY HANSON  
SILVIA KAMINSKY  
This seminar will focus on each primary practice setting and identify issues/dilemmas unique to each setting. Participants will be given scenarios to discuss and debate with other participants. In addition, relevant situations from current events and clinical cases will also be used to illustrate examples of challenges with male/female dynamics in clinical and professional settings.

802  Removing the Mask of Masculinity in Therapy  
JAKOB JENSEN  
ANDREW BRIMHALL  
KATHARINE DIDERICKSEN  
Men and their families benefit when they demonstrate sensitivity and vulnerability. This seminar will enrich therapists’ understanding of the overwhelming gender stereotypes most men feel they must adopt. Instruction will be provided regarding how to help men feel more comfortable expressing vulnerabilities and how to usefully process men’s fears and shame. Strategies will be discussed in a relational context.

803  MFTs in Schools: Expanding Research, Practice, and Advocacy  
LAURA WALLACE  
This seminar will highlight and develop participants’ ability to become ambassadors of systemic though in school contexts. After a summary of the existing literature and research, workgroups will be formed around an aspect of representing systemic thought in schools, involving participants in generating the practice, advocacy, and research ideas that will advance the position of MFTs in schools.

804  The Road to Compliance: HIPAA Compliance for Marriage and Family Therapists  
LORNA HECKER  
“Yes, I’m HIPAA compliant!”, but are you sure? Have you done your required security risk assessment? Have you performed due diligence on your business associates? Have you customized your training program to your practice? After this training, you will understand the major components of HIPAA compliance and be able to evaluate if your practice could pass regulatory scrutiny.
805  Yoga: A Multi-Dimensional Resource in Couples Therapy
THOMAS CAMP
MELANIE TAYLOR
In this session participants will experience low level yoga practices appropriate to the setting of couples therapy. Overview of the research will show yoga practices increases the control of variable heart rate, decreases anxiety and depression, releases trauma, and increases healing interpersonal patterns in couple interaction. Participants will discuss ethics and appropriateness of integrating breath, physical movement and meditation practices in couple therapy.

806  No Soy Macho: Deconstructing Latino Manhood
YAJAIRA S. CURIEL
There is an ever-present tendency to use the concept of machismo to define Latino manhood, an often-negative stereotype perpetuating an aggressive, domineering, and emotionally unavailable, perception. Personal narratives of Latino men will be shared to emphasize the multiplicity of Latino manhood. Culturally sensitive tools and strategies will be provided to promote a multidimensional, sociocultural understanding of Latino manhood.

807  A Family Systems Approach to Treating Trauma and Addiction
TRISH CALDWELL
Understanding the impact of trauma and addiction on the family system is imperative to the work done for today's families. This seminar will explore the relational dynamics of addiction and how trauma impacts the families ability to heal. The seminar will include handouts to discuss challenges the profession faces in engaging families and the resistance their loved ones may present.

808  Rethinking Sex Addiction – A Sexual Health Approach to Psychotherapy
MICHAEL VIGORITO
DOUGLAS BRAUN-HARVEY
Typically called “sex addiction” or “sexual compulsivity,” out of control sexual behavior (OCSB) remains a controversial topic. In the absence of an established diagnosis, the authors propose an evidence-based protocol to guide treatment with men concerned about sexual dysregulation. Presenters will review the components of their protocol, factors that contribute to OCSB, and six sexual health principles.

809  Deepening Awareness and Utilization of Process in Therapy
WM. EDDIE PARISH
TIMOTHY DWYER
ADRIAN BLOW
Family process reflects the nature of the relationship between interacting individuals and is not always well understood by therapists. By examining historical theoretical views of how process and content are attended to and differentiated across family therapy models, this seminar will deepen awareness of meta-process dimensions in therapy, identify universal themes of process, and identify ways to effectively utilize process.

810  Ethical Issues for MFT Practice and Supervision
LISA TEDESCHI
BEN CALDWELL
BILL NORTHEY
LISA RENE REYNOLDS
LORI LIMACHER
This panel presentation will explore contemporary ethical issues in emerging and evolving therapy contexts. Resources for remaining current will be provided. Topics will include: Technology issues in therapy and supervision including communication modes and social media; networking and referral groups; coaching; online review sites; and combining therapy with non-therapy businesses (such as yoga and product sales). Frequently asked questions and common causes of complaints will be reviewed.

811  Social Justice and Advocacy: Re-Focusing Research and Practice in Marriage and Family Therapy
RENU ALDRICH
EUGENE HALL
ISHA WILLIAMS
SARAH CRABTREE
ASHLEY LANDERS
Join us for an interactive and experiential seminar exploring controversial topics that impact MFT today. Topics such as: questioning whether therapy should be used as a tool for both exploring diversity and manifesting social change. In a microcosm of our larger societal system, we will discuss how issues of race, ethnicity, gender, sexuality, spirituality, and class are experienced in our field.
Kentucky International Convention Center
221 South Fourth Street
Louisville, Kentucky 40202

All educational sessions will be held at the Kentucky International Convention Center.

Hotel:
To receive the discounted rate for all hotels, reservations must be made by Monday, October 22, 2018 at 5:00 pm EST. For all hotels, call the number listed and mention you are staying in the AAMFT room block, or make a reservation through the custom link on AAMFT’s conference website.

Hyatt Regency Louisville
311 S Fourth Street
Louisville, KY 40202

AAMFT discounted rates:
Single/Double Occupancy: $159 per night
Triple/Quadruple Occupancy: $179/$199 per night
To reserve: Call toll-free at 1-888-421-1442

Louisville Marriott Downtown
280 West Jefferson
Louisville, KY 40202

AAMFT discounted rates:
Single/Double Occupancy: $159 per night
Triple/Quadruple Occupancy: $169/$179 per night
To reserve: Call toll-free at 1-800-533-0127

Omni Louisville Hotel
400 S 2nd Street
Louisville, KY 40202

AAMFT discounted rates:
Single/Double Occupancy: $189 per night
Triple/Quadruple Occupancy: $209 per night
To reserve: Call toll-free at 1-800-THE-OMNI

For more information visit: www.aamft.org/annualconference.

Leadership Symposium

Join us for this exclusive event featuring the best in training in leadership skills, development, and networking with the current and emerging leaders in our profession. Registration opens Fall 2018.

Arlington, VA | March 7–9, 2019

LS2019 will serve as the kickoff for the 2019-2020 Certificate in Leadership cohort!
Air Travel

AAMFT has teamed up with Delta and United to provide you with discounted fares flying into Louisville International Airport (SDF). Discounts vary depending on your departure city.

**DELTA**

Book at delta.com using the advanced search option. Enter NMRXV into the meeting event code field. Discounted travel dates are 11/10/2018 – 11/22/2018. You may also call Delta Meeting Network at 1.800.328.1111* Monday–Friday, 7:00 a.m. – 7:30 p.m. (CT) and refer to Meeting Event Code NMRXV

*Please note there is not a service fee for reservations booked and ticketed via our reservation 800-number. Not all fares are eligible for a discount. Discounts apply to round trip travel only. Not valid with other discounts, certificates, coupons or promotional offers. Fare rules will determine eligibility.

**UNITED**


You may also call United Meeting Reservation Desk at 800-426-1122 Mon-Fri 8am – 10pm ET and Sat/Sun 8am – 6pm ET. Booking fees are waived for Meeting reservations.

Travel must be booked between 11/12/18 – 11/21/18 in order to receive the discount.

Ground Transportation

AAMFT members may receive a discount on standard promotional pricing from Avis and Budget rental cars.

Stress free travel is a phone call away with Covington Travel! From airfare to car rental, Covington can walk you through the best options available to fit your travel plans and budget. If your flight is delayed or cancelled, they will help you find the next available flight to your destination regardless of carrier. To make your stress-free travel arrangement call Covington Travel at 1-800-922-9238 and let them know you are booking for AAMFT18!

SAVE THE DATE

AAMFT19 ANNUAL CONFERENCE

AUGUST 29-SEPT 1, 2019
AUSTIN, TEXAS

Call for abstracts to open late summer 2018
SAVE!  **SUPER SAVER:** Register by July 31 and save $100!  **EARLY BIRD:** Register by August 31 and save $50!

CE Verification Letters are included in the listed prices.

**Register**

www.aamft.org/annualconference  703-838-9808

**Conference Attendee Registration** (Thursday, November 15, 4:00 p.m. – Sunday, November 18, 12:00 p.m.)
- Admittance to all workshops, forums, seminars, keynote addresses, and research discussions
- Exhibit space pass and admittance to Spotlight MFT Reception
- Meetings, receptions, and meet-up groups

**Find your member category and price point:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Supersaver Rate</th>
<th>Early Bird Rate</th>
<th>Regular Rate</th>
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<tr>
<td>Clinical Fellow, Allied Mental Health Professional, and Affiliate Members</td>
<td>$380</td>
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<tr>
<td>Pre-Clinical Fellows and Pre-Allied Mental Health Professional</td>
<td>$280</td>
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<td>Student Members</td>
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<td>Former Members and Prospects</td>
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<td>Non Member Student (school verification required)</td>
<td>$360</td>
<td>$375</td>
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**Conference Institutes** (Thursday, November 15, 9:00 a.m. – 3:30 p.m.)
- Admittance to conference institute
- Thursday keynote address
- Exhibit space pass

**Approved Supervision Refresher Course** (Thursday, November 15, 8:00 a.m. – 3:30 p.m.)
- Admittance to Refresher Course

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<th>Price Point</th>
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<tr>
<td>With Full Conference</td>
<td>$165</td>
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<tr>
<td>Without Full Conference</td>
<td>$185</td>
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<td>$260</td>
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**MFT Exam Prep Track** (Friday, November 16, 7:30 a.m. – Sunday, November 18, 12:00 p.m.)
- Admittance to MFT Exam Prep track sessions
- Keynote addresses, research discussions
- Exhibit space pass and admittance to Spotlight MFT Reception
- Meetings, receptions, and meet-up groups

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<tr>
<td>With Full Conference</td>
<td>$235</td>
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<tbody>
<tr>
<td>Full track, includes price of digital workbook</td>
<td>$535</td>
<td>$635</td>
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</table>
Approved Supervisor Track  (Thursday, November 15, 9:00 a.m. – Sunday, November 18, 12:00 p.m.)

- Admittance to supervision interactive track sessions
- Keynote addresses and research discussions
- Exhibit space pass
- Meetings, receptions, and meet-up groups

Cancellation Policy/Refund Policy:
Cancellations and any subsequent request for refund must be made in writing by September 15, 2018. Upon cancellation you have the right to request that your fee (in full) be held (for up to one year) and used toward application to another AAMFT event registration. If you prefer a refund, cancellations made prior to July 31, 2018 will receive a 75% refund. Cancellations made between August 1 and September 15, 2018 will receive a 50% refund. No refunds will be offered after September 15, 2018.

Tax Deductibility:
Your unreimbursed annual conference costs, including registration fees, airfare, hotel, and 50% of meals, may be tax deductible. Please consult your financial advisor for details.

AAMFT Members:
Registration fees are up to $100 less for all AAMFT members. See charts above for complete registration fees.
Non-member students will need to provide proof of current enrollment with your registration form (a letter from your Program Director or Registrar’s office).

Child Attendance Policy:
The AAMFT Annual Conference is a professional development event and is not intended to be inclusive of children. Due to space limitations and the potential for disruption in session rooms, as well as safety issues should overcrowding occur, children under the age of 18, other than nursing infants, are not permitted in education sessions and keynotes. AAMFT does not provide child care services. Your hotel concierge may be able to provide information about on-site child care services or other local options for child care.

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<thead>
<tr>
<th>Find your member category and price point:</th>
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<td>Former Members and Prospects</td>
<td>$630</td>
<td>$680</td>
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<tr>
<td>Non Member Student (school verification required)</td>
<td>$505</td>
<td>$555</td>
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Can’t attend the entire conference? Sign up for a one day registration!

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<td>Admittance to Friday keynote addresses</td>
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<td>Research discussions</td>
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<td>Admittance to Saturday keynote address</td>
<td>$230</td>
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<tr>
<td>500—700 series workshops and forums</td>
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<td>Research discussions</td>
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<tr>
<td>Career development track</td>
<td>$200</td>
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<td>$305</td>
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<tr>
<td>800 series seminar</td>
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## DON’T FORGET TO REGISTER FOR THESE OPTIONAL EDUCATIONAL AND SOCIAL EVENTS!

<table>
<thead>
<tr>
<th>Event</th>
<th>Date/Time</th>
<th>Fee</th>
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<tbody>
<tr>
<td><strong>Topical Interest Network Meet-Up</strong></td>
<td>Thursday, 5:30 – 6:30 p.m.</td>
<td>FREE</td>
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<tr>
<td>Learn how to become a part of the new networks launching in 2019.</td>
<td>Friday, 12:00 – 1:00 p.m.</td>
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<td></td>
<td>Saturday, 12:30 – 1:30 p.m.</td>
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<tr>
<td><strong>Emerging Professionals Network Meet and Greet</strong></td>
<td>Thursday, 3:00 – 3:45 p.m.</td>
<td>FREE</td>
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<tr>
<td>Network with other Emerging Professionals or learn more about joining the Network.</td>
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<tr>
<td><strong>Lunch and Learn: Families in Crisis: Overcoming Opioid Addiction Together</strong></td>
<td>Friday, 12:00 – 1:30 p.m.</td>
<td>$53</td>
</tr>
<tr>
<td><strong>Research Discussion Sessions</strong></td>
<td>Thursday 7:15 – 8:15 p.m.</td>
<td>FREE</td>
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<tr>
<td>Hear from research presenters on the latest studies highlighting innovation and potential impact in our field.</td>
<td>Friday 12:30 – 1:30 p.m.</td>
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<td></td>
<td>Saturday 7:15 – 8:15 a.m.</td>
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<td>Saturday 1:30 – 2:30 p.m.</td>
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<tr>
<td><strong>Spotlight MFT Reception</strong></td>
<td>Friday, 6:00 – 7:00 p.m.</td>
<td>FREE</td>
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<tr>
<td>Network with other MFTs as you explore ways to engage in the association.</td>
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<tr>
<td><strong>Annual Business Meeting: A Conversation with AAMFT</strong></td>
<td>Saturday, 11:00 a.m. – 12:30 p.m</td>
<td>FREE</td>
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<tr>
<td>Learn about our 2017 accomplishments, financial benchmarks, and association news as well as the exciting new initiatives for 2018 and beyond.</td>
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<tr>
<td><strong>Foundation Reception</strong></td>
<td>Saturday, 6:45 – 7:45 p.m.</td>
<td>$50</td>
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<tr>
<td>Join the AAMFT Research &amp; Education Foundation as it hosts Consuela Castillo Kickbusch.</td>
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<tr>
<td><strong>Career Development</strong></td>
<td>Sunday, 7:45 – 8:45 a.m.</td>
<td>FREE</td>
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Competencies for Family Therapists Working in Healthcare Settings

Download AAMFT’s new, FREE guidelines to Competencies for Family Therapists Working in Healthcare Settings to acquaint yourself with the knowledge and skills to provide care.

www.aamft.org/healthcare

Spotlight MFT Reception
Friday, November 16
6:00 – 7:30 p.m. | FREE

Join us for a reception to kick off a night of networking and connecting with your fellow MFTs. This reception will spotlight existing programs while introducing new ways to engage in the association.

- Hear the latest from COAMFTE accredited programs
- Geographic Interest Networks that represent your state or province
- New Topical Interest Networks to provide customizable benefits to your professional role
- Meet the Minority Fellowship Program
## SUBJECT GUIDE

### Adjustment to Physical Illness
- Narrative Therapy and TBI ........................................... 406
- Pediatric Weight Management ................................... 600

### Adult Personality Disorders
- Couple’s Therapy and BPD ........................................... 505

### Alcohol and Drug Related Disorders
- Alcohol, Drugs & Addictive Behaviors ........................... 700
- Couple Congruence in Addiction .................................. 103
- Family, Trauma and Addiction ...................................... 807
- Maternal Substance Use .............................................. 408
- Substance Addiction Treatment .................................... 309
- Treatment for Addicted Women .................................... 205

### Attention-deficit, Conduct and Other Emotional Disorders of Childhood/Adolescence
- Emotion-Focused Family Therapy ................................. 109
- Empirically Supported Treatments ................................ 502
- Family Screen Time ................................................... 703
- MFTs in Schools ........................................................ 803
- Mindfulness in Schools ................................................. 507
- Suicide Assessment and Management ............................ 201

### Childhood Behavioral and Emotional Disorders
- 13 Reasons Why Not .................................................. 300
- ASD and Solution-Focused Therapy .............................. 708
- Attachment and Foster Care ....................................... 608
- Emotion-Focused Family Therapy ................................. 109
- Experiential Therapy Across Life Cycle ......................... 605
- Family Screen Time ................................................... 703
- Intro to Attachment-Based Family Therapy .................... 204
- Mindfulness in Schools ................................................. 507
- Rage and the Family ................................................... 705
- School-Based MFT Practice ........................................ 306
- Treating the Individual Patient Systemically .................. 101

### Collaborative and Integrative Healthcare
- Alcohol, Drugs & Addictive Behaviors ........................... 700
- Artificial Intelligence in MFT ........................................ 606
- Bowen & Mudd Meet Couple Consulting ....................... CD2
- Clinical & Supervisory Skills ....................................... 207
- Conveying Competence ............................................. 307
- Guidelines for Therapy and Suicide .............................. 509
- Healthcare Management and Scholarship .................... 707
- Utilization and Brief Therapy ...................................... 610

### Couples, Marital and Relationship Problems
- Affair Recovery with Couples ...................................... 500
- Attachment and Differentiation .................................. 411
- Bateson to Third Order Change .................................... 210
- Bowen & Mudd Meet Couple Consulting ....................... CD2
- Brief Assessment: Sex Issues ...................................... 310
- Couple Congruence in Addiction .................................. 103
- Couple’s Intensives in Practice .................................... CD4
- Couple’s Therapy and BPD ........................................... 505
- Deconstructing Latino Manhood ................................... 806
- Deeper Utilization of Process ....................................... 809
- De-escalating Conflict in Therapy ................................. 308
- Experiential Therapy Across Life Cycle ......................... 605
- Experiential Tools for Change ...................................... 405
- Family Care in Wounded Soldiers ............................... 800
- Family Deportation and Mental Health ......................... 609
- Family Therapy for Military Members ......................... 701
- Fostering Sexual Communication .................................. 601

### Gender, Power, and Social Justice
- Infidelity: Couples in Crisis ........................................ 409
- Law Enforcement Couples .......................................... 508
- Marital Satisfaction in the US Army ............................. 402
- Maternal Substance Use .............................................. 408
- MFT Common Factors Questionnaire ......................... 407
- MFT Practice and One’s Way of Being ......................... 706
- MFTs, Families, and Divorce ....................................... CD5
- Narrative Therapy and TBI ......................................... 406
- Practice-based Research ............................................. 400
- Rethinking Sex Addiction ........................................... 808
- Separation and Divorce Decisions ................................. 211
- Sex Therapy Step-By-Step ........................................... 106
- Substance Addiction Treatment .................................... 309
- The Mask of Masculinity ............................................ 802
- Theory Selection for Best Practice ............................... 604
- Tough Calls: Values in MFT practice ............................ 302
- Working with Polyamorous Clients .............................. 611
- Yoga Resources in Couples Therapy ............................. 805

### Delivery Systems/Managed Care
- Clinical & Supervisory Skills ....................................... 207
- Conveying Competence ............................................. 307
- Finances in Clinical Practice ....................................... CD6
- Healthcare Management and Scholarship .................... 707
- HIPAA Compliance for MFTs ..................................... 804
- Integrating Online Therapy ........................................ 108
- Integration of New Technologies ................................. 200
- Practice-based Research ............................................ 400
- Principles for Ethical Practice ...................................... 710
- Systemic Single-Session Therapy ................................. 104
- Treating the Individual Patient Systemically .................. 101

### Depression, Bipolar and other Affective Disorders
- Empirically Supported Treatments ............................... 502
- Intro to Attachment-Based Family Therapy .................... 204
- Paul Watzlawick: A Conduit of MFT Eras ..................... 702
- Trauma and Maternal Mental Illness ............................. 305

### Diversity and Cultural Treatment Issues
- A Queer Consultation ................................................ 709
- A Relational Path to Social Justice ............................... 503
- Bateson to Third Order Change .................................... 210
- Cultural and Sexual Identity ....................................... 607
- Deconstructing Latino Manhood ................................... 806
- Ethnic-racial Trauma in Therapy ................................. 602
- Experiences of CFTs of Color ...................................... 510
- Family Deportation & Mental Health ........................... 609
- Father-Child Race & Identity Talk ............................... 303
- Gender, Power, and Social Justice ............................... 209
- HIV, AIDS, and MFT’s: Then and Now ......................... 206
- Immigration Status and MFT ....................................... 704
- Managing Dual Relationships ..................................... 410
- MFT Minority Student Experiences ............................. 711
- Microaggressions and Sensitivity ............................... 506
- Micro-Aggressions from Clients ................................ CD3
- Narrative Exposure Therapy ....................................... 105
- Queer Theory: Beyond Inclusion ................................. 511
- Racism, Trauma, and AA Men .................................... 202
- Social Justice and Advocacy in MFT ............................ 811
- Systemic Single-Session Therapy ................................. 104
- Transgenerational trauma ......................................... 404
- Working with Polyamorous Clients ............................. 611
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce Adjustment and Transition Issues</td>
<td>606</td>
</tr>
<tr>
<td>Artificial Intelligence in MFT</td>
<td>102</td>
</tr>
<tr>
<td>Conflictual Co-Parenting</td>
<td>308</td>
</tr>
<tr>
<td>De-escalating Conflict in Therapy</td>
<td>211</td>
</tr>
<tr>
<td>MFTs, Families, and Divorce</td>
<td>CD5</td>
</tr>
<tr>
<td>Separation and Divorce Decisions</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>100</td>
</tr>
<tr>
<td>Addressing IPV: A BPSS Approach</td>
<td></td>
</tr>
<tr>
<td>Ethics/Legal</td>
<td>CD7</td>
</tr>
<tr>
<td>Career Across the Life Span</td>
<td>810</td>
</tr>
<tr>
<td>Ethical Issues for MFT Practice</td>
<td>801</td>
</tr>
<tr>
<td>Guidelines for Therapy and Suicide</td>
<td>509</td>
</tr>
<tr>
<td>HIPAA Compliance for MFTs</td>
<td>504</td>
</tr>
<tr>
<td>Integrating Online Therapy</td>
<td>201</td>
</tr>
<tr>
<td>Managing Dual Relationships</td>
<td></td>
</tr>
<tr>
<td>Self-Disclosure in Therapy</td>
<td></td>
</tr>
<tr>
<td>Suicide Assessment and Management</td>
<td></td>
</tr>
<tr>
<td>Tough calls: Values in MFT practice</td>
<td></td>
</tr>
<tr>
<td>Gender Identity/Transgender &amp; Non-Binary</td>
<td>709</td>
</tr>
<tr>
<td>A Queer Consultation</td>
<td></td>
</tr>
<tr>
<td>Helping Parents of LGBTQ Youth</td>
<td>203</td>
</tr>
<tr>
<td>Transgender Inclusive Training</td>
<td>CD1</td>
</tr>
<tr>
<td>Justice Systems</td>
<td>CD7</td>
</tr>
<tr>
<td>Career Across the Life Span</td>
<td>102</td>
</tr>
<tr>
<td>Conflictual Co-Parenting</td>
<td>704</td>
</tr>
<tr>
<td>MFTs and the Court System</td>
<td>CD8</td>
</tr>
<tr>
<td>Social Justice and Advocacy in MFT</td>
<td>811</td>
</tr>
<tr>
<td>MFT Student and Trainees</td>
<td>503</td>
</tr>
<tr>
<td>A Relational Path to Social Justice</td>
<td>411</td>
</tr>
<tr>
<td>Attachment and Differentiation</td>
<td>510</td>
</tr>
<tr>
<td>Experiential Tools for Change</td>
<td>405</td>
</tr>
<tr>
<td>Finances in Clinical Practice</td>
<td>CD6</td>
</tr>
<tr>
<td>Gender-Charged Supervision</td>
<td>801</td>
</tr>
<tr>
<td>Integrating Theory &amp; Spirituality</td>
<td>304</td>
</tr>
<tr>
<td>Integration of New Technologies</td>
<td>200</td>
</tr>
<tr>
<td>MFT Common Factors Questionnaire</td>
<td>407</td>
</tr>
<tr>
<td>MFT Minority Student Experiences</td>
<td>711</td>
</tr>
<tr>
<td>MFT Practice and One’s Way of Being</td>
<td>706</td>
</tr>
<tr>
<td>Microaggressions and Sensitivity</td>
<td>506</td>
</tr>
<tr>
<td>Micro-Aggressions from Clients</td>
<td>CD3</td>
</tr>
<tr>
<td>Person-of-the-Therapist in ABFT</td>
<td>107</td>
</tr>
<tr>
<td>Principles for Ethical Practice</td>
<td>710</td>
</tr>
<tr>
<td>Self-Disclosure in Therapy</td>
<td>504</td>
</tr>
<tr>
<td>Theory Selection for Best Practice</td>
<td>604</td>
</tr>
<tr>
<td>Transgender Inclusive Training</td>
<td>CD1</td>
</tr>
<tr>
<td>Utilization and Brief Therapy</td>
<td>610</td>
</tr>
<tr>
<td>Neuroscience</td>
<td></td>
</tr>
<tr>
<td>Brain Talk: Brain-Based Therapy</td>
<td>208</td>
</tr>
<tr>
<td>Rage and the Family</td>
<td>705</td>
</tr>
<tr>
<td>Prevention Focused Treatment Strategies</td>
<td>CD4</td>
</tr>
<tr>
<td>Couple’s Intensive in Practice</td>
<td></td>
</tr>
<tr>
<td>Father-Child Race &amp; Identity Talk</td>
<td>303</td>
</tr>
<tr>
<td>Pediatric Weight Management</td>
<td>600</td>
</tr>
<tr>
<td>The Mask of Masculinity</td>
<td>802</td>
</tr>
<tr>
<td>The Resilient Family Therapist</td>
<td>311</td>
</tr>
<tr>
<td>Severe Stress, PTSD</td>
<td>708</td>
</tr>
<tr>
<td>ASD and Solution-Focused Therapy</td>
<td>508</td>
</tr>
<tr>
<td>Law Enforcement Couples</td>
<td>805</td>
</tr>
<tr>
<td>Yoga Resources in Couples Therapy</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia, Schizotypal, and Delusional Disorders</td>
<td>607</td>
</tr>
<tr>
<td>Paul Watzlawick: A Conduit of MFT eras</td>
<td>203</td>
</tr>
<tr>
<td>School Systems</td>
<td>300</td>
</tr>
<tr>
<td>13 Reasons Why Not</td>
<td>803</td>
</tr>
<tr>
<td>MFTs in Schools</td>
<td>306</td>
</tr>
<tr>
<td>School-Based MFT Practice</td>
<td></td>
</tr>
<tr>
<td>Sexual Identity/GLBQ</td>
<td>603</td>
</tr>
<tr>
<td>Cultural and Sexual Identity</td>
<td>511</td>
</tr>
<tr>
<td>Helping Parents of LGBTQ Youth</td>
<td>301</td>
</tr>
<tr>
<td>Peer Victimization for LGB Youth</td>
<td></td>
</tr>
<tr>
<td>Queer Theory: Beyond Inclusion</td>
<td></td>
</tr>
<tr>
<td>Working with LGB Christians</td>
<td></td>
</tr>
<tr>
<td>Sexuality Issues</td>
<td>500</td>
</tr>
<tr>
<td>Affair Recovery with Couples</td>
<td>310</td>
</tr>
<tr>
<td>Brief Assessment: Sex Issues</td>
<td>601</td>
</tr>
<tr>
<td>Fostering Sexual Communication</td>
<td>206</td>
</tr>
<tr>
<td>HIV, AIDS, and MFT’s: Then and Now</td>
<td>401</td>
</tr>
<tr>
<td>Management of Sexual Feelings</td>
<td>808</td>
</tr>
<tr>
<td>Rethinking Sex Addiction</td>
<td>106</td>
</tr>
<tr>
<td>Sex Therapy Step-By-Step</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td></td>
</tr>
<tr>
<td>Deeper Utilization of Process</td>
<td>809</td>
</tr>
<tr>
<td>Integrating Theory &amp; Spirituality</td>
<td>304</td>
</tr>
<tr>
<td>Mining the Stories that Shape Us</td>
<td>110</td>
</tr>
<tr>
<td>Working with LGB Christians</td>
<td>301</td>
</tr>
<tr>
<td>Therapist Compassion Fatigue, Burn out, and Seeking Professional Consultation</td>
<td>501</td>
</tr>
<tr>
<td>Beliefs &amp; Barriers with Bereaved</td>
<td>110</td>
</tr>
<tr>
<td>Mining the Stories that Shape Us</td>
<td></td>
</tr>
<tr>
<td>Person-of-the-Therapist in ABFT</td>
<td>107</td>
</tr>
<tr>
<td>Resilience, Self Care and You</td>
<td>403</td>
</tr>
<tr>
<td>The Resilient Family Therapist</td>
<td>311</td>
</tr>
<tr>
<td>Trauma/Violence/Abuse</td>
<td></td>
</tr>
<tr>
<td>Addressing IPV: A BPSS Approach</td>
<td>100</td>
</tr>
<tr>
<td>Attachment and Foster Care</td>
<td>608</td>
</tr>
<tr>
<td>Beliefs &amp; Barriers with Bereaved</td>
<td>501</td>
</tr>
<tr>
<td>Brain Talk: Brain-Based Therapy</td>
<td>208</td>
</tr>
<tr>
<td>Ethnic-racial Trauma in Therapy</td>
<td>602</td>
</tr>
<tr>
<td>Family, Trauma and Addiction</td>
<td>807</td>
</tr>
<tr>
<td>Narrative Exposure Therapy</td>
<td>105</td>
</tr>
<tr>
<td>Peer Victimization for LGB Youth</td>
<td>603</td>
</tr>
<tr>
<td>Racism, Trauma, and AA Men</td>
<td>202</td>
</tr>
<tr>
<td>Resilience, Self Care and You</td>
<td>403</td>
</tr>
<tr>
<td>Transgenerational trauma</td>
<td>404</td>
</tr>
<tr>
<td>Trauma and Maternal Mental Illness</td>
<td>305</td>
</tr>
<tr>
<td>Treatment for Addicted Women</td>
<td>205</td>
</tr>
<tr>
<td>Treating Military Personnel and their Families</td>
<td></td>
</tr>
<tr>
<td>Family Care in Wounded Soldiers</td>
<td>800</td>
</tr>
<tr>
<td>Family Therapy for Military Members</td>
<td>701</td>
</tr>
<tr>
<td>Marital satisfaction in the US Army</td>
<td>402</td>
</tr>
</tbody>
</table>

MAY / JUNE 2018  85
<table>
<thead>
<tr>
<th>PRESENTER INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RD – Research Discussions</strong></td>
</tr>
<tr>
<td>Addison, Sheila, PhD, 410, 709</td>
</tr>
<tr>
<td>Aldrich, Renu, MA, 811</td>
</tr>
<tr>
<td>Alonzo, Daniel J., PsyD, 206</td>
</tr>
<tr>
<td>Anderson, Jared, PhD, RD2, RD4</td>
</tr>
<tr>
<td>Anderson, Leslie, MS, 711</td>
</tr>
<tr>
<td>Anderson, Shayne, PhD, 308</td>
</tr>
<tr>
<td>Armes, Stephanie, MS, RD3, RD4</td>
</tr>
<tr>
<td>Armstrong, Joslyn, MS, 303, RD1, RD2, RD4</td>
</tr>
<tr>
<td>Austin, Jason, PhD, RD4</td>
</tr>
<tr>
<td>Barabe, Teresa, MSW, RD2</td>
</tr>
<tr>
<td>Barker, Bryce, RD4</td>
</tr>
<tr>
<td>Barnes, Diana, PsyD, 305</td>
</tr>
<tr>
<td>Bartle-Haring, Suzanne, PhD, RD2</td>
</tr>
<tr>
<td>Bean, Roy, PhD, RD2, RD4</td>
</tr>
<tr>
<td>Bell, Chance, PhD, RD1</td>
</tr>
<tr>
<td>Benson, Kristen, PhD, 203, 709</td>
</tr>
<tr>
<td>Berge, Jerica, PhD, 600</td>
</tr>
<tr>
<td>Bermudez, J. Maria, PhD, 210, 704, RD4</td>
</tr>
<tr>
<td>Berryhill, Blake, PhD, RD1, RD2</td>
</tr>
<tr>
<td>Bertram, Dale, PhD, 702</td>
</tr>
<tr>
<td>Betancourt, Alex, RD1, RD2</td>
</tr>
<tr>
<td>Bischoff, Richard, PhD, 200, RD1</td>
</tr>
<tr>
<td>Bishop, Ellory, MS, 301, RD4</td>
</tr>
<tr>
<td>Blow, Adrian, PhD, 809, RD2</td>
</tr>
<tr>
<td>Bobele, Monte, PhD, 104</td>
</tr>
<tr>
<td>Boe, Joshua, MS, RD4</td>
</tr>
<tr>
<td>Bogen, Katherine, RD2</td>
</tr>
<tr>
<td>Bokoch, Rebecca, PsyD, RD1</td>
</tr>
<tr>
<td>Bortz, Patrick, MA, RD2</td>
</tr>
<tr>
<td>Boylin, William, PhD, 309</td>
</tr>
<tr>
<td>Bradford, Kay, PhD, 706</td>
</tr>
<tr>
<td>Bradshaw, Spencer, PhD, RD1, RD2</td>
</tr>
<tr>
<td>Brau-Harvey, Douglas, MA, 808</td>
</tr>
<tr>
<td>Bride, Brian, PhD, RD3</td>
</tr>
<tr>
<td>Brimhall, Andrew, PhD, 100, 802, RD2</td>
</tr>
<tr>
<td>Brosi, Matt, PhD, RD3</td>
</tr>
<tr>
<td>Brossie, Nancy, PhD, RD1</td>
</tr>
<tr>
<td>Brown, Cameron, PhD, 406, 608, RD1, RD2</td>
</tr>
<tr>
<td>Bunting, Amanda, MA, RD4</td>
</tr>
<tr>
<td>Burningham, Kayla, MS, RD3</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Goldsmith, Jacob, PhD, RD1
Grafsky, Erika L., PhD, 607, RD4
Haddick, Shelley, PhD, RD1
Hale, David, PhD, 702
Hall, Cadmona, PhD, 501
Hall, Eugene, MA, 811, RD4
Hall-Menéndez, Lindsey, RD1, RD2
Handley, Valerie, MS, RD1, RD2
Hansen, Stephanie, 507
Hanson, Shelley, MA, 801
Hardy, Nathan, PhD, 411
Harris, Gregory J, PhD, RD2, 303
Harris, Shar’Dane, EdS, 303
Harris, Steven, PhD, 211, RD2, RD4
Hartwell, Erica, PhD, 709
Hasan, Shah, MA, 603
Hawkins, Lindsey, MS, 406, RD3
Hay, Heather, PhD, 501
He, Yaliu, PhD, RD1
Heafner, Joy, PhD, RD2
Hecker, Lorna, PhD, 804
Heiden-Rootes, Katie, PhD, 603, 709
Heller, Randy, PhD, CD5
Hertlein, Katherine, PhD, 606
Hervis, Olga, MSW, 101
Heyda, Carissa, PhD, 504
Hicks White, Ashley, PhD, 503, RD3
Hodgson, Jennifer, PhD, 100, 207, 307, 707
Holcomb, Jamila, PhD, 602
Holleman, Warren L., PhD, 110
Hooper, Emma, PhD, RD2
Horst, Kyle, PhD, RD1
Hsieh, Alexander, PhD, 506, RD3
Hundley, Jarod, MA, RD4
Hunt, Quintin, MS, 509
Ibrahim, Malika, MA, RD2
Jackson, Jeffrey, PhD, 502, RD1
Jackson, Lawrence, MS, 711, RD4
Jaurequi, Matthew, MA, RD2
Jensen, Jakob, PhD, 802
Johnson, Adam, RD3
Johnson, Lee, PhD, RD1
Jones, Adam, MS, 601, RD1, RD4
Jones, Ethan
Jones, Julia, MS, RD2
Jones, Rebecca Lucero, MS, 601
Jordan, Lorien, MA, RD3
Joseff, Jessica, MA, 306
Juntti, Riley, RD4, 300
Kaminsky, Silvia, MS, 101, 801
Karimi, Hassan, PhD, 407, RD1
Kauppi, Martha, MS, 310, 611
Kawar, Codina, MS, RD2
Killian, Kyle, PhD, 403
Kim, Jinhee, PhD, RD1
Kimball, Thomas, PhD, 700
Kimmes, Jonathan, PhD, RD2
King, Michael, RD1, RD2
Knudson-Martin, Carmen, PhD, 210
Koss, Dylan, 300, RD4
Krafchick, Jennifer, PhD, RD1
Kraus, Elsa, MA, 105
Krauthamer-Ewing, E. Stephanie, PhD, RD2
Krizova, Katarina, MS, RD4
Krupitzer, Kelsie, , RD1
Kuhn, Veronica, PhD, RD1
Labanowski, Jennifer, MS, 108
Lachmar, E. Megan, MS, RD2, RD4
Lafrance, Adele, PhD, 109
Lahar, Cindy, PhD, RD4
Lambert-Shute, Jennifer, PhD, 301, 607, RD3, RD4
Lamson, Angela, PhD, 207, 307, 707
Lancaster, Morgan, MS, RD2, RD4
Landers, Ashley, PhD, 508, 811
Larson, Erin, RD1
Lastoria, Michael, EdD, RD4
Laundy, Kathleen, PsyD, 306, AS Refresher
Ledermann, Thomas, PhD, RD4
Lee, Bonnie, PhD, 103
Lee, Jacquelyn, PhD, RD3
Lepley, Paul, MA, 800
Levy, Rebecca, 509
Limacher, Lori, PhD, 810
Love, Heather, MS, RD2
Lucero Jones, Rebecca, MS, RD4
Luftman, Virginia, RD4
Machado, Yolanda, MSW, 704
Mark, Kristen, PhD, RD4
Martin, Tristan, MFT, CD1
Masri, Katey, MS, RD3
Maxey, Valerie, MS, RD4
May, Ross, PhD, RD1
McBride, Kim, MA, CD2
McCauley, Heather, ScD, RD2
McCoy, Tabitha, MSMFT, 301, 607, RD3, RD4
McDowell, Teresa, EdD, 210
McDowell-Burns, Molly, PhD, 505
McGeorge, Christi, PhD, 203, 301, RD4
McGuire, Jennifer K., RD3
McPhee, Douglass, MA, RD1, RD3
McWey, Lenore, PhD, RD2, RD4
Mendel, Daniel, MA, RD3
Mendenhall, Tai, PhD, 207, 307, 707
Mercurio, Andrew, DMin, 304, 604
Miller, Debra, MSW, 101, 800
Miller, Rick, PhD, 400, 502
Milstead, Kaitlyn, MS, RD2
Minaiy, Cayla, MS, 711
Mohsin-Dhanani, Sheeza, 711
Montgomery, Jordan, MA, RD3
Moore, Jennifer, MMFT, 605
Moore, Rachel, MS, 603
Mora, Leo, Msci, 402
Morgan, Amy, MS, 502
Morgan, Preston, MS, RD2
Morris, James, PhD, CD7
Mullet, Natira, MS, RD1, RD3
Munoz, Monica, MS, RD3
Murray, Michelle M., MA, RD4
Muruthi, Bertranna, PhD, 408
Nedela, Mary, MS, RD4
Neuhaus, Vanessa, MS, 200
Nguyen, Hoa, PhD, 301, 504, 607, RD4
Nicholas Williams, Denise, PhD, RD4
Nicholson, Bornell, MA, RD1
Nikparvar, Fatemeh, MS, CD3
Nordquist, Erica, MS, RD3
Northey, Bill, PhD, 102, 810
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Phone</th>
<th>Room</th>
</tr>
</thead>
<tbody>
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AAMFT conference staff would also like to thank the following AAMFT members for their help in developing this year’s conference program

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Mark your calendar now and get ready for AAMFT's Institutes for Advanced Clinical Education — To be held in Singapore July 11-13, 2019!
When a Client Threatens the Therapist: Guidelines for Mitigating Risk

It’s not something most of us would ever imagine having to deal with in our careers—a client makes or poses a threat of violence against you.

Therapists seem to be uniquely challenged in terms of knowing what to do to protect themselves, based on either their nature or education and training, or a combination of both. Therapists sometimes joke that theirs is one of the oddest professions: many spend their entire professional lives sitting in a room with clients listening to the most intimate thoughts and feelings—and pain—and their only curative tool is the spoken word. The therapy office is a most private world, and it must be so for the kind of work that is done there.

Individuals who enter the mental health field tend to be, by definition, other-oriented; people who want to improve the human condition and lessen the suffering of others. They are in the “people business” and people, not things, are their interest and field of study; they are “caretakers” of a particular sort, taking care of the hearts and minds of their clients, helping them to feel heard and understood, some for the first time in their lives.
It should not be a surprise that therapists often do not take good care of their professional selves; they are too busy taking care of the client. Usually, when supervisors tell them to pay attention to their own feelings, it is in the service of the client, or countertransference, feelings that the client often unconsciously provokes in the therapist that are a most useful kind of communication for the therapeutic process. But therapists often deny or minimize feelings of risk to themselves, anxiety or fear. The importance of observing and addressing risk to personal or professional well-being as it develops in the assessment or treatment process, in other words, the ability to identify “red flags” and intervene constructively, will be our main focus here.

In addition to direct risk posed by the client, threats to the therapist may develop from an indirect high-risk situation. The therapist may have met a legal obligation to warn a potential victim (Tarasoff) and inadvertently provoked the client’s anger, or the therapist may be viewed by the client as “taking sides” in a highly contentious divorce or custody matter. In these situations, the therapist may become one of the objects of the client’s anger.

Many therapists who have contacted the authors about a threatening client have observed, and then denied or ignored, weeks or months of warning signs and signals which are, notes Gavin de Becker, *pre-incident indicators* (1998). It is important to recognize, and, more importantly, pay attention to those signs and become appropriately concerned for one’s safety, a psychological position that is unfamiliar and nearly always uncomfortable for mental health professionals. Therapists need to know when to consult, when to assess and not begin treatment with a client, when to refer and when to terminate. Though we are emphasizing the need for therapists to learn they have a basic right to safety and self-protection, the client’s needs are served here, also—no therapist who is frightened for her or his own safety can provide effective treatment and clients who present such risks usually need to be seen in environments other than a sole practitioner’s private practice office.

### Red flags during assessment

There are potentially dozens of red flags that a therapist may observe in the first couple sessions with a client and many resources are devoted to that subject (see professional resources section). Most individuals who eventually make or pose a threat have a personality disorder (sociopathic, narcissistic) that renders them devoid of empathy, thus making it easier for them to justify harming another person physically or psychologically. However, having either a personality disorder or many of the traits thereof, *in and of itself*, does not make someone a risk of violence—for that, one needs to add situational factors having to do with actual loss or narcissistic injury, often combined with the abuse of alcohol or drugs. Being able to observe these red flags at any point in the assessment or treatment phases requires the therapist’s intuition, as well as paying attention to the client’s words (and behavior), and then acting quickly and appropriately to address the risk. Following are statements reflecting incidents related to a client who presented a risk of violence:

- **My practice specialty is personality disorders and I take pride in helping a lot of these clients make progress; I guess the fact that she had seen several therapists before me, and did not feel helped by any of them, I took as sort of a professional challenge and I wanted to demonstrate to her that she could get help.**

- **He pushed the boundaries of the therapeutic relationship from the beginning and did not respond positively when I set limits; however, it never occurred to me that I could or should terminate him for that behavior and I just became increasingly anxious.**

- **He was extremely depressed and suicidal when I started to see him and I was so concerned that he would kill himself that I entirely missed the violent part of his suicidal thinking, I never thought he could become homicidal until he made the actual threat. Now, I recall that he told me in the first couple sessions that he collected antique guns and had a fascination with them.**

- **The father in a high-conflict divorce and custody situation admitted that he had struck his child on a couple of occasions, but he said that he did not hit him hard and considered that it was appropriate discipline, and “it worked.” He added that if I told anyone, he would “make sure” I was “sorry.”**

- **I was uncomfortable with the way he looked at me during the initial session and he asked a couple of very personal questions. I felt shaky by the end of the hour, but I’m an intern and I didn’t think my supervisor would react well to my not wanting to see him.**

These situations developed over time into cases of stalking and homicidal threats, and consultation involved very sensitive and strategic interventions aimed at reducing the threat and protecting the therapist. DeBecker (1998) makes the point in *The Gift of Fear*, while referring to workplace situations, the range of interventions narrows and the risk increases if
the threat is allowed to develop and increase over time. Though not involving the context of the usual “workplace,” the authors see this phenomenon regularly in consultations. Many therapists who seek consultation after weeks or months, or in rare cases, even years, of a client’s presenting a risk of harm learn that their options are far fewer than they would have been with early intervention. This phenomenon is created, on a most basic level, because the person who is making or posing the threat has become more and more empowered by the absence of consequences. The relatively simple setting of a limit or boundary usually does not work at advanced stages of risk. That timeline is the dynamic at play in some consultation cases where the situation is so dangerous that it is advisable to terminate the client by phone or in writing, but in no circumstances in the office, in person.

At a most basic level, the therapist’s concern about risk in general (therapist or other-directed) should be activated by clients who assume no responsibility for their behavior, have a level of anger or rage that is excessive for almost any situation, have a history of violence and/or make threatening statements (even if they are implied, conditional or indirect) and have substance abuse issues. Often in such situations, the therapist’s anxiety takes over and he or she seeks the client’s assurance or a verbal contract regarding safety. By expanding the conversation briefly at this point, the therapist can be in a position to take appropriate action, if that is indicated; such action might be to not see the client and refer him or her to a clinic or specialized practice setting. Such questions might be:

“You mentioned that you ‘got even’ on social media with your last girlfriend for breaking up with you—what did you post, how often and how do you know her response?”

“You said that you saw your last therapist for several years, but it turned out she was not helpful and you think she was not ethical on some occasions—would you be willing to sign a release so that I could speak with her?”

Generally, the authors only hear from therapists whose case situations have become very difficult, and those are the examples provided here. With that caveat, we have observed that some therapists seem averse to either not accept a client who arouses concerns during the assessment phase, or to terminate clients who are not following the key elements of the treatment plan. Often during these consultations, the view expressed by the authors that “responsibility is a two-way street” comes as a surprise to the consulting therapist, and he or she responds with 1) Isn’t that abandonment? 2) I have no colleagues to whom I can refer this client, or 3) I don’t want to reject him and repeat his early history with his parents.

Helpful forms
Informed consent. Younggren, Fisher, Foote, and Hjelt (2011) make the basic point of mutual responsibility in “A Legal and Ethical Review of Patient Responsibilities and Psychotherapist Duties”; however, this almost common-sense, legally and ethically sound position seems to be rarely communicated in education and training. Also not emphasized before licensure is the potential depth and breadth of the informed consent process. Here, the therapist has the opportunity to discuss, among other things, the protection and limits of confidentiality, details of the treatment plan, the clients’ responsibilities to cooperate and participate in order for effective treatment to be provided, and the conditions under which termination (and not always a mutually-desired termination) may be necessary.

Some therapists are uncomfortable with this process, rush through it and see it as simply the need to obtain a signature—not as a discussion of the content and an opportunity to determine if roadblocks to effective treatment posed by the client may be foreseen. An open discussion at the point of assessment may not only prevent serious issues from developing later in treatment, such a discussion also opens the door to these issues before a crisis arises. It communicates to the client that the therapist is in control of the treatment process; that is, the therapist sets and maintains the framework and boundaries for therapy. That responsibility includes ensuring that the treatment setting, for example, outpatient therapy on a regular basis, provides the correct level of care. If at any point in the treatment process outpatient treatment is not enough to ensure that treatment goals can be met, the therapist needs to initiate a discussion with the client and recommend the correct level of care. The patients’ willingness, or not, to move to that level of care should not control the therapist’s next move; that move may need to be an appropriate termination and referral.

Authorization for disclosure of confidential information
The “release of information” form is another opportunity for the therapist to communicate boundaries and scope of the therapeutic relationship. In some cases, the client requests the therapist communicate with another healthcare professional or family member; in other situations, the therapist believes it is in the client’s best interests to communicate with another person in the client’s life and the client may or may not wish such communication to occur. Alternatively, the client may not object in concept to the sharing of information with a third party, but may prohibit the therapist from discussing certain issues or facts relative to his or her situation. The therapist must assess whether any limits imposed by the client could potentially cause the client harm or interfere with the treatment process, and if so, communicate that information to the client. If the client...
ETHICS + LEGAL

continues to refuse (for example, that the therapist discuss current drug or alcohol use with the psychiatrist prescribing medication) the therapist needs to determine if safe and effective treatment under those circumstances can be provided. Of course, these situations can become contentious and may be viewed by the client as a “power struggle” rather than the therapist acting in the client’s best interests. The therapist should explain the reason the communication with another professional or other third party is important for the treatment process; ultimately, the therapist must be the one to make the decision as to whether treatment can move forward under those circumstances.

When the threat to others turns toward the therapist

In the execution of legal or ethical duties, therapists may become an additional, or even the main, focus of anger for the client. Some of these case situations become quite complicated, from a risk management point of view. For example, when a client makes a credible threat of violence toward a third party and the therapist warns and takes action intended to protect the intended victim (such as calling the police), the client may become infuriated with the therapist. In such cases, the client may deny intent or means, even though he or she may have communicated this clearly to the therapist in a session, and claim that the therapist misunderstood “expression of feelings.” The client may feel that the action by the police, for instance, caused embarrassment in the community or, if the threat was communicated to an employer, threatened employment standing. Clients with these feelings may threaten legal action (such as filing a complaint against the therapist) and/or harm to the therapist. Particularly risky are domestic violence situations and therapists are well advised to protect themselves with early consultation in these cases. A private practice office can be a difficult setting in which to treat

An open discussion at the point of assessment may not only prevent serious issues from developing later in treatment, such a discussion also opens the door to these issues before a crisis arises.

The role of consultation

Connected with therapists’ commonly positive and expansive view of what kinds of issues may be dealt with in therapy and their occasional minimizing of their sound clinical intuition on the front-end, is their reluctance to obtain appropriate legal or clinical consultation early in the treatment process. For the reasons previously mentioned, consultation is most effective when it is obtained early in the assessment or treatment process. Therapists should not hesitate to contact an attorney who specializes in mental health law if they believe that their treatment, referral or termination of a client may raise legal concerns. The fact that the therapist may feel as if he or she has already made an “error” with the client, or records are not pristine, should not deter one from seeking a legal consult—in fact, it should hasten one. Alternatively, when seeking a clinical consult, the therapist should seek a peer consultant (expert) who has extensive experience in assessing risk and the potential for violence. A qualified consultant should be able to quickly assess the situation and make clear recommendations to protect therapist safety, as well as assisting the therapist in identifying appropriate treatment resources for the client.

Therapists are encouraged to identify red flags in the assessment and treatment process and take the initiative to gather more information to assess the level of risk and make an informed decision as to the wisdom of accepting a client into practice and/or terminating the client. Clinical and/or legal consultation is encouraged in any case situation involving risk of violence and therapists are reminded that, in these cases, they need to pay attention to their basic need for safety, at the same time they are addressing the client’s treatment needs.
Legal Guidelines When a Client Threatens the Therapist

A young mental health professional called to inquire about duty to warn requirements after his client, who has a serious history of violence, threatened to kill her boss. Although the threat was made two hours earlier, my client was still sitting at his desk with no thought that he might be in physical danger. What I told him is what every therapist should consider first in these situations: protect yourself before you do anything else, and safely get out of your office. Phone calls to police, victims and attorneys can be made from a safe location.

While it may seem like common sense that a therapist may be in danger after taking action when a client threatens others, an anxious therapist may overlook this danger. Remember, clients should be aware of reporting obligations. They sign consent to treatment forms at the beginning of the therapeutic relationship informing them about this limit of confidentiality. Unfortunately, while protecting potential victims, the obligation to warn and protect may put therapists at risk.

Therapists are not trained to protect their self-interest or safety, however they should have the knowledge and skills to take care of their clients and themselves without feeling that there is an inherent conflict between meeting their own and the clients’ needs. We recommend that therapists immediately (after getting to a safe place), report serious threats of violence to local law enforcement. In most cases, therapists do not have sufficient contact information for identified victims, but if safe and possible to do so, and with attorney consultation, therapists should provide a warning.

Therapist checklist
1. Are therapist and those around therapist (family, peers) physically in a safe place?
2. Does therapist have an immediate mandatory duty to inform local law enforcement and protect identified victims?
3. Is there a permissive law that is applicable?
4. Review legal requirements to make sure therapist is compliant.
5. Consider appropriate termination of treatment issues.
6. Consult to assess risk of violence and develop a safety plan for office and home.
7. Prepare follow-up letters to law enforcement and identified victims.
9. Review the case to learn how therapist could have addressed issues better during the treatment (therapist tolerance for abusive behavior in therapy, boundary setting and early termination, if appropriate).

Follow-up letters, documentation and appropriate termination
Follow up letters to law enforcement and identified victims, as well as documentation, should be reviewed by the therapist’s attorney to be sure there is a clear record of compliance with laws and standards of care. Too often, therapists are reluctant to terminate treatment until long after therapy becomes ineffective. This is especially true in cases where client threats are directed at the therapist. The therapist’s tolerance for clients who are abusive and disrespectful can be quite high. As Lonner states previously, the longer a therapist delays discussing appropriate boundaries and treatment termination, the more explosive safety issues become down the road. The termination process should always follow all acceptable guidelines.

Mandatory duty to warn and/or protect: Examples from California

California Civil Code section 43.92, enacted in 1986, defines psychotherapists’ mandatory duty to protect and clarifies that there is no liability for failure to predict a client’s violent behavior. It specifies that there is no duty unless each of the following has occurred: “the [client] has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.” The statute also provides immunity to therapists “who make a reasonable effort to communicate the threat to a law enforcement agency and the victim or victims.” In a 2004 California appellate court case, Ewing v Goldstein interpreted the language of section 43.92 to include communication of the serious threat from a close family member to the therapist, even where the client did not communicate a threat to his therapist. While greatly complicating therapists’ mandatory reporting obligation, the Court clarified that the therapist must “actually believe,” the client poses a risk of violence. Therapists are therefore advised to carefully document all the reasons they believe their client poses a serious risk of physical violence. In 2016, in response to the violent killing of six young people in Santa Barbara, the California Legislature enacted the Gun Violence Restraining Order Law (Welfare and Institutions section 8100). The law gives law enforcement the authority to confiscate all weapons from individuals who are alleged to have made a threat and provides a due process hearing within 21 days. The law also mandates that therapists warn local enforcement within 24 hours when clients make a serious threat of physical violence against an identifiable victim(s). Since the statute specifies reporting to local law enforcement, therapists are advised to report to local law enforcement where the client resides, where the victim resides and where the therapist works.
Social media

Concerns related to risk assessment involve such issues as cyberstalking, threats via email, or threats that are posted on FaceBook or other social media. The fact that a threat is made via social media or email does not lessen the level of risk, and cyberstalking qualifies as violence—psychological violence that may lead eventually to actual stalking or physical violence. California was the leader in establishing anti-stalking laws and many states have followed suit; however, there are still police departments that are reluctant to take reports or complaints about threats made via the internet, so it is essential that therapists understand the laws and resources in their areas (for example, Los Angeles County residents have access to the Threat Management Unit of the LAPD for consultation). Social media has changed the context for certain kinds of threats and threatening behavior; however, most of the standards and criteria for assessing risk of violence still apply.

References


Professional Resources

When my wife, Lisa, became pregnant with our first child, we were elated. We were both thrilled to be parents and anxiously awaited the birth of our child. My wife never suffered from morning sickness and her delivery went perfectly. The doctor commented that she must be meant to have children because of how smoothly her pregnancy and delivery went. A day or so later, we left the hospital and took our new baby home. Our son nursed well, slept regularly, and had a calm temperament. Everything seemed perfect, until it wasn’t.

I had taken time off work to help care for our baby, and as the weeks went by, I noticed something wasn’t quite right with my wife. She was caring for our son, but she didn’t seem happy; she wasn’t her usual self. We knew about the baby blues, but this was something different; something more. She was more withdrawn and secretly suffering from intrusive thoughts that filled her with shame and guilt. She finally opened up about her feelings and we scheduled an appointment with her doctor. 

Lisa was suffering from postpartum depression (PPD)—and she isn’t alone. PPD is the most often-occurring mood disorder following childbirth (O’Hara & McCabe, 2013), with as many as 13% of mothers suffering from symptoms of depression following the birth of a child (Croog, 2008) and countless others suffering in silence, even including 8% of dads (Cameron, Sedov, & Tomfohr-Madsen, 2016). And because having a baby is a physical event where the symptoms may be rooted in biology, it can be incredibly difficult to diagnose for even the most seasoned of clinicians. Symptoms of PPD may include depressed mood, bouts of crying, difficulty with parent-child bonding, decreased interest or engagement in pleasurable activities, increased irritability and anger, fear that one is not a good parent, feelings of worthlessness, shame or inadequacy, poor concentration, thoughts of harming oneself or the baby, and recurrent ideations or thoughts of death (American Psychological Association [APA], 2016). These symptoms may also mimic other conditions.

In addition to impacting mothers and fathers individually, PPD can also have a negative impact on the couple relationship. PPD often contributes to questioning one’s competence of being a parent, needing additional reassurance, and often necessitates the need for increased support from partners and family (Barnes, 2006). PPD has also been linked to decreased marital satisfaction and communication (Kerstis et al., 2014), increased substance abuse (Tannenbaum & Forehand, 1994),
increased aggression, and increased risk for intimate partner violence (Roberts, Bushnell, Collings, & Purdie, 2006; Hedin, 2000). It also does not stop at the couple. Kids, too, have a keen sense of their parents’ well-being. The presence of PPD in at least one parent is associated with a host of negative outcomes, such as affect in temperament, health, cognitive development, social-emotional development, and behavioral development. The consequences of depression in parents, fear, anxiety, the manifestation of agitated depression, and PPD has been linked to child’s level of self-esteem, social competencies, lack of attention to health concerns and sleep-related issues, lower vocabulary scores, responsiveness to others, and exhibiting negative expressions and distractible behaviors (Letourneau et al., 2012). Other studies have found that PPD has an effect on language development, intelligence, and ability to complete object concept tasks primarily within the first five years of a child’s life, and can also influence later skill development (Grace, Evindar, & Stewart, 2003). Overall, it is easy to see how PPD is a mental health concern for the entire family.

What MFTs can do about PPD

Marriage and family therapists (MFTs) are best equipped to provide effective treatment to families suffering from PPD. Not only do MFTs take a systemic perspective to treatment, we are also adept at collaboration with healthcare providers.

1. Conduct an assessment focused on risk factors specific to PPD

Contributing factors, such as increased anxiety and depression during pregnancy, having a history of a psychiatric diagnosis, increase in stressful life events during pregnancy, and having low social support are all associated with elevated symptoms of PPD (Bell et al., 2016). Furthermore, men who have a partner suffering from PPD are substantially more likely to suffer from PPD themselves (Letourneau, Duffett-Leger, Dennis, Stewart, & Tryphonopoulos, 2011; Misri, Kostaras, Fox, & Kostaras, 2000). Other risk factors that have been shown to have an effect on the likelihood of developing PPD are lower levels of education or income, lack of employment or health insurance, unintentional or unplanned pregnancies, having a family history of depression, and difficulty with finding or providing adequate antenatal baby care (Aktas & Terzioglu, 2013). MFTs need to be well-versed in major depressive disorder (MDD), assess the client’s family history of depression and anxiety, and consider the mental health status and relationship quality of parents pre-pregnancy and during pregnancy.

Mothers with postpartum depression may be a victim of idealized expectations, myths, or even delusions that being a mother will automatically result in increased marital satisfaction, equal sharing in childcare responsibilities, and the hope that routines will stay the same. Ultimately, the adjustment to parenthood is particularly challenging when expectations do not match the lived experience (Barnes, 2006). Fathers, too, may hold expectations surrounding occupational or gender roles, leading them to believe only mothers have maternal instinct to properly care for the child (Barnes, 2006). In cases where both parents feel that they are not meeting their own expectations, they may have a tendency to become less involved with the parenting process, a critical factor in parental attitudes and overall well-being (Sejourne, Vaslot, Beaume, Goutaudier, & Chabrol, 2012). Paternal involvement with daily caretaking of children is linked to a child’s sociability with others, as well as playing a role in the developing of self-concept and esteem (Culp, Schadle, Robinson, & Culp, 2000; Frascarolo, 2004).

2. Remove barriers to treatment

One of the most prominent barriers in treating PPD is that it is underscreened (Musser, Ahmed, Foli, & Coddington, 2013). Hence, it is also underdiagnosed and often goes untreated. Belluck (2015) and Nishimura and Ohashi (2010) have recommended that all mothers and fathers receive mental health evaluations after the birth of a child. Mothers are currently assessed for PPD using the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987), however there is no scale that has been validated specifically for assessment of paternal PPD. When treating families with PPD, it may be prudent for clinicians to conduct a short interview with fathers regarding their depressive symptoms. Assessments, such as the Beck Depression Inventory (BDI) may also be used to evaluate fathers for depressive symptoms (Beck, Steer, & Garbin, 1988).

Another barrier to treatment is the lack of information about PPD, including the fact that there is little information about how PPD manifests in fathers. First, recent research has shown that men do experience hormonal changes associated with the transition to parenthood (Storey, Walsh, Quinton, & Wynne-Edwards, 2000), and second, changes in hormones are not the sole reason that an individual suffers from PPD (Miller, 2002; Hendrick, Alshuler, & Suri, 1998). Furthermore, PPD has been found in adoptive parents, as well (Senecky et al., 2009), providing evidence that PPD is a complex mood disorder than can impact both mothers and fathers. Both therapists and clients may need to examine personal biases regarding paternal PPD.

The last barrier, and maybe the most significant, is the stigma that comes with PPD. Both mothers and fathers experience a great deal of shame, guilt, and stigma regarding PPD (Barnes, 2006; Dennis & Chung-Lee, 2006). Society has placed very unrealistic expectations on parents in terms of how they should feel and act after pregnancy. Parents are taught to believe that if they are not thrilled about their new baby and excited to be a parent that there is something wrong with them. This may lead parents to not disclose certain feelings to friends or loved ones. Having a therapist who is warm, accepting, and non-judgmental can be the difference between someone choosing to engage in therapy and someone choosing to suffer in silence (Dennis & Chung-Lee, 2006).
3. Get partners involved in treatment

Women diagnosed with PPD actually want their partners to be involved in treatment (Dennis & Chung-Lee, 2006), and a mother’s perception of partner support increases her sense of well-being and feelings about motherhood. Further, women experience recovery of symptoms of PPD at an increased rate when they have a supportive partner (Misri et al., 2000). It is important to note that medication for treatment of PPD is often necessary and can be helpful, however research shows that treatment may be greatly enhanced by taking a systemic perspective and involving partners in treatment (Misri et al., 2000). The utilization of social support networks has also shown to be effective in helping parents cope with the stressors of PPD (Barnes, 2006).

4. Collaborate with healthcare providers

The need to have MFTs involved in healthcare is greater than ever before. There is evidence that mental healthcare providers, such as MFTs, can provide better outcomes for clients when collaborating with their medical providers (Goodie, Isler, Hunter, & Peterson, 2009). It is important to network with medical providers in your community to establish positive relationships. Not only will this provide great exposure to the field of MFT as a whole, but it will provide clients with more effective healthcare, both physically and mentally. For families suffering with PPD, it can be the difference between working through PPD together as a couple or struggling to overcome PPD in isolation.

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*The author and his wife have granted permission for personal information to be included in this article.

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