PRESIDENT’S Letter

Looking Ahead

By Jenn Matheson, Ph.D., LMFT, AAMFT Approved Supervisor

I AM PLEASED TO BEGIN MY TERM AS PRESIDENT OF COAMFT, and I appreciate the support and encouragement of our Board members and membership. My hopes for the Colorado Division are many, but none more important than continuing to enhance our service to you, our members. We exist to serve your needs and to improve the profession of marriage and family therapy in Colorado. This improvement is not just for us as professionals, but also for our clients whose lives we strive to help make healthier and happier.

During my time as President, I hope to guide our Board’s activities toward improving your access to information through technology designed to make your involvement in Association activities more efficient and easily accessible. If you are unable to attend all of our events in person, perhaps you will log in to a live stream of an event. If you have always wondered what we discuss in our Board meetings, or you are thinking of running for a Board position, you’ll now have opportunities to join our monthly Board meetings online!

Finally, our brand new, improved, more aesthetically pleasing website will be launched in January and will be more user-friendly and full of timely, important information to serve your professional needs. We will stay in touch with you through frequent blog postings on the site, and we invite you to continue to connect with us and other members through your Facebook and Twitter accounts.

I feel prepared to begin my time as President because of all I learned from Darin Wallis in the past two years. Darin is serving his final year on the Board in 2015 as Past President. In the last two years as President, Darin was instrumental in developing COAMFT’s close and collegial relationships with members of the professional counselor and social work associations in the state. He also provided opportunities for continuing education such as motivational interviewing and suicide assessment trainings. He worked behind the scenes with our lobbyists to ensure members’ interests were well represented in all legislative issues, both here in Colorado and at the National level. Darin will continue to serve our profession in the next year as the new Chair of the Council of Division Presidents at AAMFT, a position he was elected to and started Jan. 1, 2015. Darin will continue to make his mark on our Association in countless ways, and I want to thank him for his time, expertise, and dedication to COAMFT.

I would also like to thank and acknowledge Vice President Kristal Steeves whose term ended on Dec. 31, 2014. Kristal had the daunting task of organizing our Annual Conference for the past three years. This is perhaps the most challenging and time consuming of all the positions on the Board, and Kristal has led three successful, highly-rated conferences. Our conferences are legendary among other Division Leaders, and Kristal has continued to set a high bar for others to admire.

Please help me welcome new Board members who began their terms on Jan. 1, 2015. Dr. Sondra Beres is our President-Elect and will serve in this capacity for the next two years in preparation for her two year term as President in 2017. She is a well-respected professor at Regis University’s MFT program. Sondra was instrumental in Regis achieving accreditation for their MFT Master’s program, and I know she will bring her organizational skills and commitment to MFT education to her Board position.

We are also delighted to welcome Dr. Jennifer Cates to her position as Vice President. Jennifer is the Chair of the MFT program at Regis University and I know her leadership skills will be well utilized by the Board. She will be in charge of organizing our next two Annual Conferences, and she has already jumped in with both feet to learn the ropes and move forward to ensure the very best Conference we can provide for you.

Continuing on the Board in 2015 are Secretary Aaron Anderson, Treasurer Ethan Bratt, Member-at-Large Roxanne Bamond, and Student/Associate Representative Rick Elgersma. Their dedication and time has been outstanding.

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LETTER FROM THE
Editor

By Rachel Gall, MA, LPC

GREETINGS, COAMFT MEMBERS!

Substance abuse and dependence are persistent problems in the US. In 2013, nearly 10% of the population of individuals age 12 and older had used an illicit drug within the past month, with the most common drug being marijuana (SAMHSA, 2014). 50% of the population of individuals age 12 and older had used alcohol within the past month, with 23% of this population having engaged in binge drinking, 8% of the US population aged 12 and older met DSM-IV criteria for substance dependence or abuse. These numbers have remained relatively consistent over time.

Research on the effectiveness of family therapy to treat substance abuse has grown in the past 15 years, with family therapy now being considered one of the most effective treatment approaches (Rowe, 2012). Its effectiveness increases with the added involvement of other systems such as school, the juvenile justice system, and other social services. In addition, family therapy for substance use is considered a more culturally appropriate treatment with a wide variety of ethnic groups (Rowe, 2012). Research is expanding with other diverse populations as well, including women, the LGBTQ population, and veterans (O’Farrell & Clements, 2012).

As MFTs are aware, there is a reciprocal relationship between substance abuse and family functioning (Rowe, 2012). Preliminary results related to mechanisms of change of alcohol abuse treatment indicate that enhanced relationship functioning leads to drinking reduction, as opposed to the other way around (O’Farrell & Clements, 2012). Family members can help or hinder progress, provide motivation, and help maintain abstinence or exacerbate use (Rowe, 2012). For families, other mechanisms of change include increased parental follow-through with discipline and monitoring as well as altering negative parenting practices. Even if the substance user is unwilling to seek help, MFTs can help the family cope, reduce emotional distress, help motivate their family member to seek treatment, and use supportive resources such as Al-Anon (O’Farrell & Clements, 2012).

Among individuals who identified that they needed substance abuse treatment, the most commonly reported reason for not receiving treatment was a lack of insurance coverage and an inability to afford the cost of treatment (SAMHSA, 2014). Despite the high costs of treatment, these costs only account for 1% of the juvenile justice system’s total cost of dealing with drug abuse (Rowe, 2012). Although family therapy is considered one of the most effective treatments for substance abuse, it is not necessarily the most cost effective. In addition, most of the current research neglects to include cost implications (Morgan & Crane, 2010).

Another barrier to effective outcomes in the treatment of substance abuse is dropout rates. Across all therapeutic modalities, individuals with substance abuse/dependence issues have the highest dropout rates, rivaled only by individuals with schizophrenia or psychotic disorders (Hamilton, Moore, Crane, & Payne, 2011). At the same time, across all diagnoses, MFTs have the lowest dropout rates (Hamilton et al., 2011). Therefore, MFTs are in a unique position to provide effective treatment.

A consistent theme running through the articles in this issue is that the addiction is effectively “the other member of the family.” Our authors are aware that while the substance abuser may be the identified patient in the family, each family member has a relationship with the substance. Family therapists must assess the function of the symptom of the substance abuse/dependence, and treat the underlying relational dynamics. MFTs recognize that if the substance user is treated in isolation, the family will return to its homeostatic state despite the family member having received treatment.

I hope that the articles in this edition of the newsletter provide you with practical tools to treat this commonly occurring issue in your practice!

Sincerely,

Rachel Gall

Rachel is a graduate of the Denver Family Institute and is currently a doctoral candidate in counseling psychology at the University of Northern Colorado. She owns a private practice in Denver.

References


Thomas Edison, when asked why he had a team of twenty-one assistants...

“If I could solve all the problems myself, I would.”

LEGISLATIVE ISSUE ONE: EXPANDING LEGAL TREATMENT OF MINORS

The Colorado Chapter of the National Association of Social Workers is putting forward a bill this upcoming session regarding mental health treatment for minors ages 15-18. Currently CRS 65-103(2) states that someone 15 years old or older may consent to mental health treatment rendered by a facility or professional person. However, “professional person” is defined in statute as a licensed MD or Psychologist. We hope to expand the definition of professional person, under this particular subset of statute only, to include Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Addiction Counselors, and Licensed Marriage and Family Therapists.

This comes out of the broader discussion about scope of practice, which arose but was not addressed by the Involuntary Commitment Task Force. Many mental health practitioners feel that this particular section of statute regarding treating minors without parental consent might be the easiest first step in the broader discussion about scope of practice issues. The problem with the current law is that it technically only permits MDs, psychologists, or mental health professionals who work at a facility to treat minors. Any other professionals in private practice are not currently authorized to provide service without a parent’s approval. This law, however, does not reflect current practice in the field. The changes in this bill bring the law into alignment with what is actually happening in the field.

Upon discussion with the Department of Regulatory Agencies, it seems that failing to permit this broader treatment of minors was an oversight by that department when the Mental Health Practice Act last went through the legislative review process. The department has no objection to the legislation, and may even support it. At this point, there is no known opposition, likely due to the fact that this is already happening in practice.

The bill is currently in drafting, with the first large stakeholder meeting scheduled. The sponsors have been identified, and the first draft is complete. After the upcoming stakeholder meeting, feedback will be returned to the drafter and, if necessary, a second draft will be circulated.

LEGISLATIVE ISSUE TWO: REPARATIVE THERAPY

This bill is still in the very early stages of formation. The conversations on this topic have been ongoing for several years, and in previous years did not yield legislation. However, we have reason to believe that this session a bill banning reparative therapy may be introduced, beginning in the Senate. No drafts have been made available to date, and it’s unclear which stakeholders, if any, have been engaged in drafting or even formulating bill ideas. It does appear that the sponsor is interested in garnering as much support as possible from the mental health community.

Anne Barkis, JD, MSW, is a Senior Associate at Mendez Consulting, LLC.

LAWYER’S CORNER

STANDARDS FOR ADDICTION COUNSELING

The definition of marriage and family therapy practice, contained in C.R.S. 12-43-503, includes treatment of emotional and mental problems, alcohol and substance abuse, and domestic violence. MFTs, therefore, have the legal ability to provide assessment, diagnosis, treatment planning and treatment of addictions. MFTs, however, should not undertake addiction counseling, unless they have the training and competence to treat such problems.

The basic standards for addiction counseling are contained in the NAADAC Code of Ethics, which can be obtained at naadac.org. Principle 1, contained in the Code of Ethics states, “I shall avoid bringing personal or professional issues into the counseling relationship.”

Would that it were true that all addiction counselors adhered to this principle. Too many addiction counselors like to inform clients about their own personal narrative: how they were seriously addicted to alcohol or other substances, which interfered with their personal relationships, their employment, and their ability to function. Such counselors believe that there is a therapeutic value to the client in being told repeatedly, “I’ve been there. I have overcome serious addictions, like the ones that you are facing. Look at me – I am living proof that you can recover from addictions.” Providing clients with such a narrative violates Principle 1 of the Code of Ethics for addiction counselors.

Too often I have heard Licensing Board Members discussing complaints and expressing disapproval when therapists have communicated personal information to clients regarding the therapist’s mental health or personal problems. Providing too much information of a personal nature to clients is often considered a boundary violation. It should certainly be avoided. As professionals, we can communicate with clients and demonstrate that we are able to relate with them and their problems, without providing personal narratives and stories about the unhealthy behaviors that we have engaged in. Let clients respect us for the wisdom we exhibit, the caring attitude that we display, and the respect that we demonstrate to clients.

COAMFT LOBBYISTS • Mendez Consulting, LLC
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Also, our Newsletter Editor Rachel Gall has generously agreed to continue her work for COAMFT even though she is on her clinical internship during her graduate studies. Robert Baerncopf is the Student Forum Coordinator again this year, and we are so grateful to both of them for their wonderful work that leads to an outstanding newsletter each quarter. Our Elections Committee is a standing committee, and we are pleased to welcome back Rita Lewis and Hannah Dudley as well as new member Bita Ashouri Rivas.

All of our Board members are volunteers. I hope you will look for ways to volunteer your own time to our Association sometime in the future. It is both rewarding and invigorating to be involved in such a vibrant, energized Association. Finally, I would like to thank Laura Vincent who has been our brave and unflappable Administrative Guru for many years. She ensures all important requests, reports, and requirements are met, as well as providing essential expertise in marketing, publications, communications, and mailings. Her most important contribution, perhaps, is her commitment to COAMFT and helping us transition smoothly from one Board to the next, year after year.

As you can tell, we have an amazing team of MFTs who run this Division of AAMFT and will provide the type of leadership you have come to rely on and expect from COAMFT. We are proud of the ways in which other Divisions look to us for advice and guidance, and we will continue to meet your professional needs in the future. I look forward to meeting or speaking with many of you in the upcoming months. Please feel free to email me at drjennmatheson@gmail.com with any questions, concerns, or feedback. Thank you for your dedication and commitment to our professional home, COAMFT.

Jenn Matheson, Ph.D., LMFT is President of COAMFT. She is Clinical Director of Aspen Trauma Therapy Institute where she specializes in the systemic treatment of grief, loss, and trauma. As a former award-winning tenured associate professor in MFT at CSU, Dr. Matheson has dozens of publications and presentations as well as prior funding through NIH for her research. Outside of work, Jenn enjoys cooking, driving sports cars, film and theater with friends and family, and mindfulness meditation.

President’s Message continued from page 1

Save the date!
Annual Conference
Friday, September 18, 2015
Arvada Center for the Arts & Humanities
Secrets, Cybersex, Infidelity, Addictions, Trauma – and Forgiveness?
presented by
Janis Abrahams Spring, Ph.D., ABPP

This course will offer concrete clinical interventions to help couples struggling with infidelity. Participants will be able to:
• Describe an open secrets policy that helps couples and therapists manage secrets in couples therapy.
• Specify what makes cybersex so appealing and addictive.
• Explain how an understanding of contributing factors reduces a couple’s vulnerability to future affairs.
• Describe a trust-building exercise that fosters connection between partners after an affair in cyberspace and in the flesh.

Details and registration information coming soon!

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THE “OTHER” MEMBER OF THE FAMILY

By Mita M. Johnson, Ed.D., LPC, LMFT, LAC, MAC, SAP, ACS, AAMFT-Approved Clinical Supervisor

HOW PREVALENT IS SUBSTANCE MISUSE IN THE UNITED STATES?

Approximately 17 million adults ages 18 and older had an alcohol use disorder (AUD) in 2012; an estimated 855,000 adolescents ages 12-17 had an AUD (NIAAA, 2014). It is estimated that more than 10% of U.S. children live with a parent with alcohol problems (NIAAA, 2014). In 2014, 23.7% of 12th graders, 18.5% of 10th graders, and 8.3% of 8th graders had used illicit drugs in the past 30 days (NIDA, 2014). After marijuana, prescription and over-the-counter medications account for most of the top drugs abused by 12th graders in the past year (NIDA, 2014). Almost two-thirds (64%) of high school seniors find no harm in regular marijuana use, compared to one-third (35%) 20 years ago (NIDA, 2014). The statistics confirm the fact that 1 in 10 people struggles with a substance misuse problem.

Substance misuse and addictive behavior disorders (SABDs) have a ripple effect that impacts not only the person (client) struggling with the disorder but everyone associated with the client. Children, adolescents, siblings, grandparents, other relatives, spouses, and family friends suffer from the consequences of SABDs; the addiction or addictive behavior is the “other” member of the family who seems to disrupt any sense of normalcy. Our current scientific understanding of addiction is that it is a disease that stresses not only the client—addiction often stresses the family to the point of destabilizing the family unit dynamics.

People associated with the client will try many things to “fix” the client. Often times the family members do not realize that they must go through recovery support services, including counseling, themselves in order to protect and rebuild the family unit. Constructive engagement of the family in the recovery process will help to stabilize the family unit and bring healing to the family. Active engagement in the recovery process interrupts the family’s inclination to rescue or enable the client.

There are several important components to recovery for a family impacted by a SABD (NCADD, 2014). Support groups provide psychoeducation about SABDs and support from other group members also struggling with similar issues. Family therapy can assist the family in many ways to break the desire to isolate. Communication skills within the family unit are often disrupted by SABDs; recovery requires that the family relearn appropriate communication skills.

Each person in the family has to learn to detach from the client and take responsibility for their own behavior. Blaming, enabling, denial, rescuing, and minimizing the problem are behaviors that have been found to be ineffective; learning new ways of interacting is key to recovery and healing. Children have to go through a recovery and healing process as well; children have to be engaged in the process of family and individual recovery.

Marriage and family therapy can help to recognize and engage personal and family strengths, with the goal to identify and build resiliency both individually and as a family. Psychoeducation can help family members to understand what current brain science has revealed about SABDs as well as understand the next steps for recovery of the client and the place of relapse in recovery. Marriage and family therapy can provide the tools the family needs in order to regain stability while empowering the family and the client to do the work of recovery.

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The husband called for an appointment. He wanted family counseling which would include three children aged 10, 14 and 16, his wife, and himself. His wife had been abusing alcohol and cocaine; she needed her five to six shots of the “hard stuff” every evening to wind down after a tough day. She needed a line or two of cocaine during the day to get all the things done that her family expected of her.

His 10-year-old son was presenting an unhealthy bonding style for his age; he was trying to take care of his mother. The 14-year-old daughter was displaying anxiety and difficultly communicating with family members. The 16-year-old daughter had bouts of depression punctuated by episodes of cutting and hypervigilance. The family was not communicating; the rescuing and enabling behaviors were keeping the mother grounded in her using behaviors. The family did not understand the nuances of addiction, but they knew their family was not functioning well.

Motivational interviewing skills were used to determine the wife/mom’s motivation to engage in detox, treatment, and relapse prevention, with the broader goal being sustained sobriety. Motivational interviewing was used to assess the level of motivation of the other family members regarding behaviors, thoughts, and communication styles that needed to change. Cognitive behavioral, strategic and structural family therapy tools were used to change behaviors and realign family members within their new chapter of sobriety. With time and hard work by all family members, the “other” family member was disengaged and the family was able to stabilize, heal, and grow.

References

Mita M. Johnson, Ed.D., LMFT, is an educator, trainer, speaker, supervisor, and clinician with over 25 years of field experience.
Undressing Sex with Dr. Neil Cannon

Sex Trivia

Question: Which category of people is not allowed to drive automobiles in Russia?
A. Fetishists  
B. Transsexuals  
C. Exhibitionists  
D. All of the above  
E. None of the above

Please see answer at bottom of page.

Local Workshops

Here is our local education program for the American Association of Sexuality Educators, Counselors & Therapists (AASECT). All events are from 11am to 1:30pm. I can accommodate a few guests each month if you would like to learn more about AASECT or sexuality in general.

February 9, 2015 – Sex & Body Image presented by Rachel Alpert, LCSW
April 6, 2015 – The Myth of Sex Addiction presented by David Ley, Ph.D.
August 3, 2015 – Women & Sexuality presented by Rachel Corbett, MD
October 5, 2015 – Adult Babies and Diaper Fetishes by Rhoda Lipscomb, Ph.D., LPC

Sex Therapy Supervision

The American Association of Sexuality Educators, Counselors & Therapists (AASECT) is the leading certification body in the world for sex therapists. As a Clinical Fellow of the AAMFT and a Certified Supervisor for AASECT, supervision hours count for both. Individual and group supervision is available by Skype each Friday.

Now Teaching at the University of Michigan

It is with great pleasure that I share with you, my Colorado MFT friends and colleagues, that I just accepted a teaching position at the University of Michigan where I will be teaching in the School of Social Work Sexual Health Certificate Program.

The University of Michigan is one of the leading programs in the world for clinicians on a path towards becoming sex therapists. I am so honored to be a part of such a fine institution.

And to avoid starting any rumors, this is a part-time position and I am not relocating to Ann Arbor. Everything related to my practice and supervision commitments in Colorado will remain unchanged. And yes, I am as committed as ever to my faculty position at Denver Family Institute.

I’m always happy to consult at no charge with COAMFT members on cases related to sexuality.

I work with any matter related to human sexuality:
- Libido and gaps in sexual desire
- Infidelity
- Sexual dysfunction for men and women
- Fetishes and cross-dressing
- Gender variance
- Open relationships
- LGBT issues
- “Sex Addiction”
- Dominance, Submission & Kink (BDSM)

50 shades of anything sexual!

Trivia Answer: As of January 2015, all of the above were banned from driving automobiles in Russia as it was decided that these are all mental disorders that would make driving unsafe. We have it so good living in Colorado!
ADDICTION AS A RELATIONAL DISORDER

By Jim Thomas, LMFT

WHY WOULD EVOLUTION FAVOR OR ALLOW ADDICTION? It serves no function and one only need look at the death of an addict, say, Phillip Seymour Hoffman, to see addiction’s dire consequences. What causes the addict or alcoholic to pull away from close relationships, from family and friends, as they go deeper into use and dependency? The answer may lie in our attachment system and drive to bond emotionally with others throughout the lifespan. Author Phil Flores and others hypothesize that addictive substances hijack the attachment system in the brain. Similar chemical processes occur, even with some process addictions, to those that happen with secure attachment. Evolution may have allowed the attachment system to be compromised by the use of substances. Thus, though against their own interest, a person may continue to shoot up heroin.

Attachment theory postulates that humans arrive in the world with an expectation of bonding with caretakers. Over the past three decades or so, a growing understanding that we do not outgrow this need has emerged. Our attachment system, largely embedded in the limbic system, pulls us towards others. Adult romantic love is an extension of what Bowlby described as a powerful innate need as strong or stronger as any other. Our ability to bond throughout life gets reframed as a strength rather than a dependence to be overcome.

At the core, attachment comes down to emotional co-regulation. When we gain a secure bond with another person (parent, friend, partner), that person can become a “wiser and stronger” presence when distress overtakes us. Avoidant or dismissive attachment strategies lead individuals to diminish their need for close, vulnerable relationships, for human contact and comfort. These strategies lead individuals to be more prone to alcohol and drug abuse. This fits the understanding of addiction as an attachment disorder.

It appears that many addictive substances such as alcohol and opiates work in the brain to give us much of the same relief we would find in a close, secure emotional bond. Many addicts, like emotional withdrawals or avoidantly attached individuals, seek to down-regulate their emotions by numbing or denying them. They squelch the very emotions that tell them that they need close relationships. As the drive of the attachment system for the oxytocin rush of close connection gets replaced by drugs or alcohol, addicts also begin pulling away from loved ones and family. How often do we see this in our clients or our families? As a person gets lost in an addiction, they emotionally withdraw from those around them.

What does this mean for family therapists?

Impact of Use on Relationships: The use of alcohol, drugs and other addictive processes work against the natural tendency to bond emotionally and vulnerably. Addiction often fuels negative cycles. Working with emotion and vulnerability takes a deft touch. Emotions overwhelm when a person has numbed pain, hurt, sadness, and longing over time.

Loving Interventions: We can advocate and support loving interventions in our work. As Stephen Wilkins, a local interventionist, told the author, “Addicts almost always want to get clean.” Rather than waiting for the mythological “hitting bottom” or the other canard of “the addict must want to quit,” we lean in to unmet needs for closeness to prompt change.

Use an Attachment Lens to Frame Addiction: To put use, abuse or addiction in an attachment lens humanizes and normalizes. It removes the stigma. We offer a frame for the problem that puts it in the couple’s distancing or confl ictual pattern they get stuck in. “It makes sense as you feel criticized for not being enough, you find yourself drinking more to numb out. And the more he/she drinks (to the partner), the more frustrated you get. So you reach out to say, “Stop drinking so much and be with me.” To the drinker: “You hear this as more criticism.” In this way, we explore together the unmet needs and emotions hidden by the use.

Attachment Reframe: The therapist can step out of linear debates with clients about whether they have a drinking problem, are alcoholic, or addicted. We focus on process. Take marijuana use, legal like alcohol. I might speculate aloud, “I don’t know if you are addicted to pot, or that you have a pot problem. I wonder though if your relationship might have a pot problem. It seems when you smoke, you go away from him.” Clients can then start to look at how the substance use impacts their closeness and bond.

In summary, viewing addiction as an attachment disorder offers a new perspective supported by growing research evidence. As systems interventionists, we can activate the nascent attachment needs substances often cover. The consideration of reduced use or abstinence takes on a new meaning for the couple or family. Growing closer becomes a motivator for change.

Jim is Past President of the COAMFT, Clinical Fellow and AAMFT-Approved Supervisor, and Director Emeritus of the Denver Family Institute. He currently works in private practice and directs the Colorado Center for Emotionally Focused Therapy.

We are always looking for students to volunteer in many capacities:

- Opportunities to contribute to the newsletter with book or conference reviews
- Volunteer with COAMFT

Contact editor Rachel Gall at racheltgall@gmail.com or 303-720-6154 for more information.

Seeking student participation!
COLORADO 2015 EXTERNSHIP
The Evidence-Based Approach for Couples

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The Externship Program Includes:
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Participants Will Learn:
• To see marital distress from an attachment perspective
• To help partners reprocess the emotional responses that maintain marital distress
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• Supplementary materials provided, including “Externship Manual”
• Follow-up courses and supervision will be available

Endorsed by EFT Originator Dr. Sue Johnson, who says, “Lisa and Jim are an engaging, effective training team.”

Your ICEEFT Certified Trainers:
Jim Thomas, MA, LMFT
and
Dr. Lisa Palmer-Olsen

Training occurs in a unique co-created learning community. Role-play work facilitated by trainers and experienced EFT clinicians including Certified EFT Therapists and Supervisors. Homeroom option is available for small group discussion and support on Thursday, Friday and Saturday from 8 to 8:50 a.m.

The 2012, 2013 and 2014 Colorado Externships received high marks and praise from attendees.

Early registration rates available through March 31, 2015!
Register Online TODAY at www.coloradoeft.com/eft-trainings

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HOW DO MARRIAGE AND FAMILY THERAPISTS BENEFIT FROM FURTHER TRAINING IN ADDICTIONS COUNSELING?

By Linda Osterlund, Ph.D., LMFT and Chaya Abrams, MA, LPC, LAC

LINDA: When I was training for my Master’s degree in Marriage and Family Therapy in the late 1980s substance abuse was only a small part of the core curriculum. When I started my internship working at an inpatient adolescent treatment center, I remember feeling unprepared, and wondering how I would be effective with addicted populations when I wasn’t “in recovery” myself. After this experience, and over 20 years doing counseling in a variety of settings, I learned that addictions impact me, and most every client in one way or another, and I needed to be prepared to address it with my clients. Overall, my ability to work with addiction issues has enabled me to work more effectively with clients.

CHAYA: In 2006, armed with a brand-new Master’s degree in Counseling and a great deal of anticipation, I began my search for full-time agency employment. Little did I know then how very humbling and impactful my first position specializing in substance use and co-occurring disorders would be. Through the daily rigor of group, individual, and crisis intervention, I became witness to the heartbreaks, challenges, and triumphs that come along with treating addictions. Since 2007 until the present, I have been fortunate and blessed to not only treat individuals and groups suffering from addictions, but also to author and co-author grants, assist in program development for training Addictions Counselors within the State of Colorado, and train students in the field about this unique area of study. Not only does working with addicted populations bind clinicians to other healthcare professionals in the act of promoting integrated health care, but it also brings to light the unique opportunity to offer compassionate and humane treatment for all.

According to NSDUH (National Survey of Substance Use and Health), there is a proven need for specialty treatment among people ages 12 and above for illicit drug and alcohol use, and they are not receiving it. In fact, associated statistics indicate that 94.6% feel they do not need treatment, 3.7% feel they need treatment, but are not making an effort to obtain it, and 1.7% feel they need treatment and are making an effort to obtain it. As a result, there are 20.6 million people needing treatment, but not receiving it (SAMHSA, 2013).

By definition, substance use and behavioral disorder counselors advise people who suffer from alcoholism, drug addiction, eating disorders, or other behavioral problems. They provide treatment and support to help the client recover from addiction or modify problem behaviors. They work in a wide variety of settings, such as mental health centers, community health centers, prisons, and private practice.

According to the Bureau of Labor Statistics, employment of substance use and behavioral disorder counselors is projected to grow 31 percent from 2012 to 2022, much faster than the average for all occupations (http://www.bls.gov/ooh/community-and-social-service/substance-use-and-behavioral-disorder-counselors.htm). Growth is expected as addiction and mental health counseling services are increasingly covered by insurance policies.

The Affordable Care Act (ACA) ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include mental health and substance use disorder services, including behavioral health treatment. Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014. Between October 1, 2013, and March 1, 2014, over 220,000 Coloradans signed up or were approved for health coverage, according to data from Connect for Health Colorado and the Colorado Department of Health Care Policy and Financing.

With the increase in numbers eligible for mental health and substance abuse disorder services, there is an increased demand for service providers.

The Colorado Association of Addiction Professionals (CAAP; also known as the Society of Addiction Professionals of Colorado: SACC) is an association of concerned professionals seeking to improve the quality of substance abuse and other addiction treatment services through education, training, and advocacy (see: http://www.caap.us/). According to CAAP, Addictions Counselors are needed across the state.

As of March 15, 2014, in the State of Colorado, the Department of Regulatory Agencies (DORA) lists the following active providers: 343 CAC (Certified Addictions Counselor) Is, 823 CAC IIs, 1,741 CACIIIs, and 393 LACs (Licensed Addictions Counselor). Counselors need specialized training in addictions counseling in order to provide specialized addiction treatment services. Many of those practicing in Colorado are retiring, and fewer are being trained to provide substance abuse services. As evident in Colorado, DORA lists many inactive or expired Addiction Counselors, specifically 678 CAC Is, 1,005 CAC IIs, 1,165 CAC IIIs, and 43 LACs.

In light of the identified need for addictions counseling in Colorado, it would greatly benefit our clients and our community for interested Marriage and Family Therapists to pursue further training in addictions counseling.

Linda Osterlund, Ph.D., LMFT is the Associate Dean and Associate Professor at Regis University in the Division of Counseling and Family Therapy. In spring 2015, Regis University is launching a graduate certificate in addictions counseling level I and II, preparing graduates for eligibility as CACII and LAC in Colorado.

Chaya Abrams, LPC, LAC is an Affiliate Faculty Member at Regis University within the Division of Counseling and Marriage and Family Therapy. She is also a Licensed Addictions Counselor, and has worked within the field of addictions for the past nine years, in both clinical and administrative positions, including grant writing on both state and federal levels for the offender, substance use, and co-occurring populations. Chaya has been instrumental in program development for the Regis University graduate certificate in Addictions Counseling levels I and II.
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A FAMILY SYSTEMS APPROACH TO TREATING ADOLESCENT SUBSTANCE ABUSE

By Jamie Blair Echevarria, LCSW, LMFT, CACIII and Janna Phillips, LCSW, LMFT, LAC

WE HAVE WORKED TOGETHER in the Adolescent Substance Abuse Program (ASAP) at Denver Family Therapy Center, Inc. ASAP is an intensive outpatient program for adolescents and their families where the adolescent is diagnosed with a substance abuse diagnosis. ASAP utilizes a family systems approach to treating the substance abuse goals.

The ASAP program consists of family therapy sessions, individual sessions with the adolescent, and treatment groups: a multifamily group and a peer support group as well as urine screens. The therapists involved with ASAP take a broad systems approach where collaboration is valued with many members of the family’s team such as doctors, school professionals, probation officers, courts and caseworkers. Our goals with the clients we see go beyond their drug use. We believe if their family functioning goals are met, the need for use will automatically decrease or be eliminated. This is the power of family therapy.

As family therapists, we look at substance abuse differently than most substance abuse counselors. We see substance abuse as a content area or a symptom, and our treatment process is the same as it is with other non-using families. Basically, there is no “magic” in treating substance abuse. Any therapist who understands systems and family therapy interventions can work effectively with substance abusing clients.

We pull from a variety of family therapy models in our work including Structural, Strategic, Solution-Focused, and Narrative therapy. We also use Motivational Interviewing not only with the adolescent using substances, but to address family ambivalence as well. In every first session, we do a Genogram with the family and we also pull from the Circumplex/FACES assessment tool. This tool views families on a spectrum of cohesion and adaptability. At times, when the families we see are disengaged, as therapists we help them establish connection. Other times, we help address conflict and boundaries within the family if they are assessed as more enmeshed. With most of our families, earning trust back with each other is a central goal.

It has been our experience that adolescents are not typically “customers” for substance abuse treatment. In other words, they are not the one in the family most motivated for therapy or change in the area of substance use/abuse. The customer is most often a parent, or perhaps another professional (probation officer, case worker, etc.).

In our initial stage of treatment, we make sure to take time to understand what the adolescent is motivated for, and help them establish goals in this area. Their goals often center around improved relationships with their parents, improved school or work performance, or reduction in legal involvement. When we are willing to spend time focusing our treatment on the goals that the adolescent is motivated for, we find that the adolescent then becomes willing to engage much more in the treatment process.

Inevitably, the adolescent’s goals are difficult to achieve without making changes in their substance use patterns. This approach is based on the Stages of Change model by Prochaska and DiClemente. This model matches the intervention to the level of motivation of the client. This approach is also consistent with Strategic Family Therapy, where the therapist works to circumvent resistance, and Solution Focused Family Therapy, where the therapist collaborates with the client to determine the goal and focus of therapy, and work where the client is motivated to work.

We find that adolescents are often in the “Pre-contemplative” stage of change, and are therefore not ready to make a plan of action for how they are going to discontinue the use of their substance.

Therefore, it is much more effective to get some therapeutic momentum started by focusing on something that the adolescent is ready to make changes around.

Additionally, we can work with the family (who tend to be much more motivated for a change in the substance use patterns), and help them make changes in the family that will impact the adolescent’s substance use.

A helpful tool for our therapists practicing a systemic approach to treating substance use is to map out the relationships between the family, the client, and the substance. This can be done using a Minuchin Map, or a map of the triangles in the family.

As we think about the substance use systemically, we can see that the substance begins to play a role, or act like a member of the family.

An intervention that can be quite revealing is to interview the client and different family members about their relationship to the client as well as to the substance. Additionally, the therapist can create a sculpt of the family that includes the substance. It is often discovered that the adolescent has a unique relationship with the substance, and that relationship may be serving a function in the family system. When these dynamics can be assessed, the therapist can intervene with the family and indirectly impact the adolescent’s substance use.

We find that new therapists are often afraid to work with clients who are substance abusing, when really they have all the skill necessary to work with these clients and their families! In our program we focus primarily with adolescents who are using substances, but working systemically to treat substance abuse can be used with any client, in any age range, as well as in the context of family and couples therapy.

Jamie Blair Echevarria is an LCSW, LMFT, and CACIII (Certified Addictions Counselor, level III). She has worked in the fields of family therapy and substance abuse for the last 12 years. She is the Director of the Adolescent Substance Abuse Program (ASAP) at Denver Family Therapy Center.

Janna Phillips is an LCSW, LMFT, and a LAC (Licensed Addictions Counselor). She has worked in the family therapy and substance abuse field for the last seven years.
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Robert Baerncofp, Student Forum Coordinator
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Rachel Gall, Newsletter Editor
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AN INTERVIEW WITH MICHAEL RUTTENBERG, MS, LMFT
By Shalonda Haggerty

A LOOK AT TREATING ADDICTIONS FROM A CORRECTIONAL RESIDENTIAL FACILITY PERSPECTIVE

Michael Ruttenberg is a Licensed Marriage and Family Therapist with a Master’s of Science degree, currently working as a clinical Director for Larimer County Community Corrections. He has worked with individuals with addictions for almost 17 years, ranging from adolescent residential facilities to adult residential facilities. In this interview, he offers the MFT family insight and advice on what it is like working with addictions from a residential facility director’s perspective.

Shalonda: What is your background with addiction clients in the correctional system?

Michael: I have worked in addictions since 1997. I worked in a residential adolescent facility for young people ages 14 to 21 involved in the child protection and juvenile delinquency systems from 1997 to 2005. This was a state-licensed chemical addictions residential program. We had an addictions track and a non-addictions track, a day treatment program, as well as an emancipation unit. I worked as a clinician and as a program manager across all programs, conducting individual therapy, family therapy, adventure-based therapeutic activities, and groups of all sorts.

Currently, I work in the adult corrections arena developing and clinically supervising collaborative dual diagnosis and addictions programs in residential and community-based settings. We provide state-sponsored and licensed services that are gender specific and responsive in addictions and severe and persistent mental illness. We have a men’s and women’s 90-day residential addictions program, a men’s and women’s 6-month residential dual diagnosis program, and a community-based outpatient program for addictions and dual diagnosis. Along with these services we also have community-based collaborative programs to serve a dually diagnosed population serving a probation sentence with fully integrated criminal justice supervision, mental health treatment and addictions services, life skills and wrap around case management, utilizing the Integrated Dual Disorder Treatment (IDDT) model out of Case Western University.

Shalonda: What is your general approach in working with addictions?

Michael: My approach to treating addictions as well as mental illness is to work in a holistic and systemic way addressing the entirety of the individual including their significant relationships. All of this within a collaborative approach with the systems they are connected to. We strive to address the emotional, the cognitive, and the behavioral aspects of the individual within themselves and the relationships they have.

Shalonda: What are some of the complications to working with addictions and families of those individuals who are incarcerated, as a Marriage and Family Therapist?

Michael: One major complication as an MFT working with couples, families, and individuals in the criminal justice system is that many of the people we serve have significantly damaged these significant relationships, at times past repair. We do a lot of outreach to the families and significant others to try and engage them in the individual’s treatment. This at times can present many interesting ethical dilemmas. The other component in working in corrections is that the individual is typically not asking for help nor do they see their behavior as a problem. Along with this, they are serving a criminal justice sentence and we end up with having to communicate a lot of information to individuals that are supervising the client from a criminal justice perspective (we have all the releases to ethically do this). This creates a dynamic in which we need to navigate and establish a trusting therapeutic relationship that has very different boundaries around confidentiality than anyone was ever taught in graduate school. We also have to navigate the fact that because the client has not asked for treatment nor do they see their behavior as a problem, we have to be careful of taking what the client is telling us as the truth. At times they will tell us what they think we want to hear. We need to be careful to not play into this dynamic and explore the client’s experience in many different ways to get to the underlying truth for the client.

Shalonda: Any practical advice/ideas for MFTs working with addictions?

Michael: The biggest advice I would give is to take the classes and get the training to not only achieve licensure in MFT but in Chemical Addictions Counseling (CAC) as well. Develop what I refer to as healthy cynicism in working with the population. What I mean by this is to not take everything that the client is telling you as the absolute truth: believe them, but don’t buy it all. Always look for discrepancies in their statements of fact and point those out with curiosity and no judgment to help the individual get honest with themselves and those around them regarding their addictions. Addiction is steeped in lies and deceit as a protection for themselves. Addiction clients have typically made un-kept promises and outright lied to those that they love; it takes ruthless honesty to recover from addictions.

I would also suggest to become versed in Motivational Interviewing (MI), not just educationally but obtain adequate supervision in this model of interaction. MI seems easy and intuitive at face value from an intellectual perspective and very difficult in practice to truly adhere to the concepts and skills as a package. There is a network of trainers and a mechanism to be evaluated for competency. This is called MINT, the information can be found on http://www.motivationalinterviewing.org/. I would encourage anyone interested in working in addictions to pursue certified training and coaching in this model.

Shalonda Haggerty is a current MFT grad student at Argosy University Denver campus and the founder of STAR Girlz Empowerment, Inc.
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BOOK REVIEW:
SOLUTION-FOCUSED SUBSTANCE ABUSE TREATMENT
BY TERI PICHOT WITH SARA A. SMOCK

By Laura Talkington, LPC-C

“Solution-Focused Substance Abuse Treatment,” written by Teri Pichot with Sara A. Smock, is a refreshing book outlining brief solution-focused therapy through an addiction lens. The book starts with a history of the various substance abuse models used by clinicians and the 12-step model widely known to the public. The first section highlights the relatively recent start of addictions-based therapy models and the potential advantages and disadvantages of the various models.

As a marriage and family therapist student, this book highlighted that my previous education and training has not adequately provided me the confidence or competency to treat clients struggling with addiction. This book provides an in-depth discussion on what solution-focused therapy is and the basics around the therapy model.

Chapter 4 provides the reader with assessment tools to meet practice standards that are in line with the solution-focused brief therapy model. This assessment process allows the clinician to measure effectiveness at both pre-treatment and post-treatment. The chapter continues with a list of “10 core assessment areas in the field of substance abuse” to further help clinicians in assessing the client’s substance abuse past, present, and future in many areas including: consequences, support systems, education, previous treatments, and the client’s strengths and advantages.

Many of my colleagues have worked or are currently working in the substance abuse field providing therapy through a group setting. Pichot and Smock address how to apply solution-focused substance abuse treatment in a group setting in chapters 6 and 7. Chapter 6 provides a pragmatic, step-by-step process that therapists can use in the group setting. This chapter also provides a transcript that therapists can utilize to picture how each element from the step-by-step process can be implemented. Chapter 7 continues the group therapy discussion by providing a more thorough discussion on how to implement themes in group therapy. The chapter provides ideas on how to form a cohesive, bonded group, and how to solidify the work clients are doing in group therapy and the work clients may have participated in prior to group therapy.

The most practically useful section of the book is “Forms and Handouts” located in Chapter 9. The text walks readers through a history, the basics, and complications of what can be perceived as an “easy” therapy model. The authors graciously provide the reader with tangible forms and handouts to help aid the therapeutic process. These handouts are not only for the clinician; the authors provide a “treatment contract/homework sheet” for the client as well. This outlines the client’s goal, the modified goal, and homework.

Homework in therapy has been a controversial topic in my training at times. The “treatment contract/homework sheet” holds the client accountable as they are collaborating with the clinician on what the homework should be. Pichot and Smock state, “Having all of the assignments on the same page allows clients to reflect upon previous assignments to determine if they are satisfied with their progress and to be reminded of how far they have come.” Chapter 9 provides ample resources for the clinician to enhance one’s practice with substance abusing clients.

Overall, the book is an easy read and a break from the systematic approach of most academic texts. The book provides a refreshing, organized, and applicable approach to solution-focused brief therapy in both individual and group settings.

References

Laura Talkington is an LPC Candidate and a second-year student at the Denver Family Institute.
**Question:** How has Emotionally Focused Therapy (EFT) impacted your work?

I find my couples and families speaking about getting “to the heart of the matter” quickly in therapy. Showing up more fully as a person in the therapist role fits elegantly within EFT. Also, the couple and therapist move in synchronized ways using something naturally wired in to us as social mammals to gain a secure emotional bond. And the changes that occur really do result in seemingly unsolvable problems being resolved. In short, I enjoy my work with couples and families more than ever!

**Question:** Does EFT conform to any “gold standard” in terms of research validation and the standards set out for psychotherapy?

In terms of the gold standard set out by bodies such as APA for psychotherapy research, EFT epitomizes the very highest level of both outcome AND process research. Over the last 25 years, the EFT research program has systematically covered all the factors set out in optimal models of psychotherapy research. Drop-out rates in EFT studies are low, and the results are robust (meaning long-lasting).

**Question:** Some models say they are research-based, but EFT is evidence-based, is that difference important?

This refers to the 27 outcome studies providing empirical-validation for EFT, such as the fMRI study. Recent research involves outcome studies of couples facing trauma and stressful events (the Dalton and MacIntosh studies, and a study on EFT effects on attachment security with an fMRI component). The fMRI component shows that EFT changes the way contact with a partner mediates the effect of threat on the brain. This is the first study to show changes in brain functioning based on a systemic, relational intervention. I think that is exciting for our field. EFT also has the largest effect size (1.3) of any couples therapy in the field. “Research-based” means based on research about couples, but there is yet to be outcome-based research on the effectiveness of the approach.

**Question:** What is one of the biggest challenges in using EFT?

Often therapists come to the EFT Externship understanding the importance of vulnerability to foster a secure bond between partners (or in families). The surprise comes from the need for the therapist to also be vulnerable. EFT as an experiential, humanistic, systemic therapy requires us to be more emotionally responsive and engaged in deeper, more intimate ways. We cannot coach people to vulnerable places without going there ourselves. Learning to do this often brings up our own attachment history and emotional inner life. The good news, and there is some process research to support this, is that process benefits many clinicians both personally and professionally.

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The Colorado Center for EFT News

The “Gaining Traction Get to Softenings” Workshop, March 27th and 28th has sold out.

A Core Skills Group, follow-up study in EFT post-Externship, is forming in Summer 2015. If you have or will be taking the EFT Externship and are interested in participating in core skills, email register@coloradoeft.com

The Colorado EFT Community is among the fastest growing EFT Clinical Communities in the world.

EFT Tidbit: *Hold Me Tight*, by Dr. Sue Johnson, was recently published in Turkish. It has been published in 19 languages indicating the cross-cultural validity of this approach based on attachment needs and primary emotions evident across cultures and diverse populations.

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The meta-analysis (Johnson et al., 1999) of the four most rigorous outcome studies conducted before the year 2000, showed a larger effect size (1.3) than any other couple intervention has achieved to date. Studies consistently show excellent follow-up results, and some studies show that significant progress continues after therapy. EFT has a body of process research showing that change does indeed occur in the way that the theory suggests. This level of linkage between in-session process and rigorous outcome measurement is unusual in the field of psychotherapy. EFT is the only model of couple intervention that uses a systematic empirically-validated theory of adult bonding as the basis for understanding and alleviating relationship problems. The generalizability of EFT across different kinds of clients and couples facing co-morbidities such as depression and PTSD has been examined and results are consistently positive. Outcome and process research addressing key relationship factors, such as the forgiveness of injuries, has also been conducted with positive results. EFT studies are generally rigorous and published in the best peer reviewed journals. In brief, EFT researchers can show that, as set out in the Johnson (2004) seminal text, *Creating Connection: The Practice of Emotionally Focused Couple Therapy*, EFT works very well, results last, we know HOW it works so we can train therapists to intervene efficiently and we know it works across different populations and problems. It also links congruently to other bodies of research such as those examining the nature of relationship distress and adult attachment processes. There is an outcome study in progress of the new educational program based on EFT (Hold Me Tight® Program: Conversations for Connection). A pilot study has also been completed at the VA in Baltimore on EFT with veteran couples dealing with PTSD. Completed and ongoing EFT research consistently supports the efficacy of the Emotionally Focused Therapy model.
attuned to the impact of cultural differences, especially with regards to power disparities between cultures inclusive within the family. Investigating how culture and racial differences play out in families, how power is addressed, and how therapists might help families address these complexities has shaped Dr. Miller professionally.

As a therapist, Dr. Miller comes from a strong feminist, postmodernist background, greatly influenced by bell hooks, Virginia Satir and more recently by Attachment Theory. She uses methods that help people focus on how they connect in relationships. She assists people on how to identify and understand barriers to those connections, such as ineffective interaction patterns, discrimination and oppression, and past experiences that play out in current relationships. Of utmost importance is remaining aware of her own values, beliefs, and internal experience which helps her attune to the needs of her clients. She attends to issues that arise in her that interfere with her ability to be effective with clients. Her therapeutic process mirrors her internal one, thus helping clients consider what obstructions exist between what is and what they want in their relationships.

Dr. Miller is passionate about how she can be a positive force within our field. She contributes via research, teaching and mentoring her students. She does not shy away from being a voice for change, especially regarding increasing underrepresented voices within the MFT field. She is excited to connect with and become an active member of our community. Dr. Miller’s warm, approachable style has already endeared her to many and she is a welcome addition to COAMFT.

Rachel Weddle is a graduate student in the MAMFT program at Regis University. She has taken two classes with Dr. Miller and is a member of COAMFT.

The Research Corner aims to assist readers to stay informed in the rapidly developing world of marital and family therapy research.

HIGHLIGHTING ARTICLES IN THE MOST RECENT JOURNAL OF MARITAL AND FAMILY THERAPY, VOLUME 40, ISSUE 4, A PUBLICATION OF AAMFT

Insecure Attachment Behavior and Partner Violence: Incorporating Couple Perceptions of Insecure Attachment and Relational Aggression is an empirical study by Oka, Sandberg, Bradford, and Brown that examines the connection between insecure attachment, relational aggression, and physical violence. Although intimate partner violence (IPV) has been well-documented in the literature, the role and potential influence of relational aggression on IPV has been relatively unexamined. Relational aggression is defined as the intentional exclusion of someone from a relationship or group. A few examples of relational aggression include targeting a partner’s sense of being, ignoring affection during conflict, triangulating a third party to take sides, and engaging in social sabotage by spreading rumors or embarrassment. Two important results from the study indicated that 1) an insecure attachment style precedes the use of aggression/violence (but not vice versa) and 2) men are more like to use physical aggression and females are more likely to use relational aggression in relationships. The authors encourage all therapists to be vigilant about relational aggression in therapy and to address any aggressive behaviors in the moment.

Conditional Inference Trees: A Method for Predicting Intimate Partner Violence is an empirical study by Salis, Klem, and O’Leary that provides initial support for an assessment to help identify the threshold of psychological aggression that makes physical aggression more likely to occur. Overall, the assessment measured each partner’s level of psychological aggression at baseline and could subsequently predict which partners would become physically aggressive 12 months later. The results also specified gender differences between men and women. Women on average need to demonstrate more psychological aggression than men before becoming a significant risk for physical aggression. Men on the other hand have a lower “burn-point” or a “shorter fuse,” causing physical aggression that is more likely to occur at a lower threshold. The authors hypothesize that gender role socializations from an early age can partly explain these differences. Although providing treatment to couples engaging in IPV is controversial within the field of MFT, further research is needed to clarify when and how therapists can be the most effective when physical violence has occurred in a relationship.

Individual Therapy for Couple Problems: Perspectives and Pitfalls is a theoretical article by Gurman and Burton which examines the limitations and subtle complexities of utilizing individual therapy for couple problems (ITCP). Although conjoint couple therapy has become the community standard for improving a couple’s relationship, there continues to be an alarming number of systemically trained therapists providing ITCP with individuals, which has nearly nonexistent empirical support. Regardless of whether it is client or therapist preference to use ITCP as a treatment format, there are five central areas of concern that therapists should be aware of. These include: 1) the therapist’s inability to directly (in vivo) observe the couple’s relationship patterns, 2) unintentionally taking sides within the working alliance, 3) inaccurately assessing a couple’s communication patterns based on individual reports, 4) increasing the opportunity for therapeutic drift from treatment goals, and 5) the ethical concerns regarding the “participating nonparticipants” who are influenced by proxy. Given the frequency with which ITCP is both requested and provided, the authors propose that greater empirical and clinical attention is needed to increase our awareness and understanding of potential benefits and limitations.

Relationship Education in Community Settings: Effectiveness with Distressed and Non-Distressed Low-Income Racial Minority Couples is an empirical study by Quirk, Strokeoff, Owen, France, and Bergen that examined the relational outcomes of couples who participated in a couple relationship education (CRE) program. Most research examining the effectiveness of CRE programs share the common limitation of utilizing primarily middle-class Caucasian participants. The current study expanded the generalization of previous research by demonstrating that low-income partners from a racial minority group benefit from relationship education similarly to their middle-class Caucasian counterparts. Results also indicated that distressed partners seem to obtain greater outcomes after completing a CRE program than partners who do not report being as distressed. In addition, both distressed and non-distressed couples benefitted slightly more from participating in a group CRE format when compared to couples who participated in the same CRE administered individually.

Jesse Sperry graduated from the Denver Family Institute and currently serves as the Research Coordinator to facilitate evaluation and research. He is currently an Educational Counselor with Denver Kids and works systemically with students and families in Denver Public Schools and has a private practice.
I BEGAN AS A SUPERVISOR IN THIS PROFESSION as some of you might also have begun: somebody gave me a chance. I had just obtained my independent level license as a Marriage and Family Therapist and had been working as a clinician for a number of years and decided that I was interested in becoming a supervisor. I began my journey as a supervisor with no framework from which to operate except for referencing my own experience in being a supervisee under supervision. I was encouraged along the way, by an AAMFT Approved Supervisor who later served as my mentor in this process, to begin working toward becoming an AAMFT Approved Supervisor. The journey felt a bit daunting at first, but I have found it to be a rewarding and fulfilling experience. Overall, it has given me a framework from which to operate as a supervisor and broadened and deepened my work as a supervisor.

Part of the reason that I decided to pursue this training was due to the value I place on supervision along with the value I place on a systems approach to our work. Becoming an AAMFT Approved Supervisor seemed like the perfect fit for my interests. You can start the process in a few different ways, however, finding and contracting with an Approved Supervisor Mentor should be one of the first steps for everybody. This person can help walk you through understanding the requirements and the process. After this relationship is established, some people take the 30 hour course first and then start the supervision component, commonly referred to as “sup of sup.” Others, like me, started with the supervision component and then took the course at a later point, which you can take all at once or split into two 15 hour sections. There are some requirements around having to have a certain number of active supervisees that you are supervising for a certain period of time during the process, which is why I decided to start with the supervision component first since, at the time, I had just begun supervising a handful of MFT clinicians and interns. There is no “right” way to start the active process, and it is nice to have options.

I recently attended the Annual AAMFT conference in Milwaukee, Wisconsin in order to complete 15 of the required 30 hours of the didactic /interactive track. The course was taught by Dr. Toni Zimmerman, a fellow Colorado professional and AAMFT Approved Supervisor. I enjoyed attending this part of the course at a national event as it brought together professionals from across the country with wide ranges of experience and knowledge. I found it helpful to learn from their collective wisdom.

The course covered a variety of topics related to the practice of supervision such as the roles of the supervisor and how to utilize a variety of supervision modalities, ethics and legalities of supervision, and “Person-of-the-Therapist”: maintaining awareness of contextual influences and power and privilege influences within the client/supervisee relationship as well as within the supervisee/supervisor relationship. Additionally, in this course, we started “The Paper.” The idea of writing a paper can seem a bit intimidating, so it was helpful that we started talking about the components of the paper in this course and were able to start an outline.

For more detailed information on the specific steps associated with becoming an AAMFT Approved Supervisor, I would encourage you to review the AAMFT website along with the “Approved Supervision Designation: Standards Handbook” put out by AAMFT and available on their website. Additionally, you can find upcoming trainings for the supervisor designation on this website. For those inspired to start this journey locally and in 2015, Dr. Zimmerman and Colorado State University will be offering the 30 hour track, the 15 hour didactic component, and a 5 hour refresher course in February.

Supervision needs to be clearly focused on the real nature of practical coaching and mentoring. Reflectiveness results in mindful work where we constantly consider what to do, why we do it and examine it to see how we can do it better. Supervision is a forum for reflecting on work in the presence of another or others who facilitate that process. -Dr. Mike Carroll
GUIDELINES FOR NEWSLETTER BOOK REVIEWS

1. Books should be published within the last five years.

2. Reviewers should not have a current or past relationship of a personal or professional nature with the author of the work to be reviewed.

3. Reviews should be between 300-500 words.

4. Times New Roman, 12-point font is preferred. Please avoid using all caps, special fonts, right justification, or double spaces after periods. Please submit single space copy electronically.

5. The review should convey a clear sense of the work’s intent and content. Please provide an evaluation of the book’s quality, including writing style, accuracy, originality, relevance, importance, etc.

6. Other aspects of style (capitalization, punctuation, quotations, bibliography) will follow the APA Style Guidelines. Note: it is not necessary to make page references following quotations from the reviewed book. Please do not use footnotes.

7. Reviewers are responsible for the accuracy of statements included. Reviews will be edited for grammar, style, and length.

COAMFT newsletter conference reviews should follow the above listed guidelines as well. Pictures are a welcome addition and will be included depending on space available.

COAMFT NOTES & More

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Please contact the Newsletter Editor at racheltgall@gmail.com, 303-720-6154, or the COAMFT office at 303-792-3966 with any questions.

FROM THE COAMFT OFFICE

Please make sure your mailing and email addresses are up to date by contacting AAMFT. The data lists used by the COAMFT office are generated by AAMFT. Email blasts and mailing addresses are used to contact members of important events. The Colorado office cannot make updates or address changes for members.

CALL FOR VOLUNTEERS

COAMFT is always eager for volunteers. We need people with interest in creating new networking relationships, contacting conference sponsors, and working on the Finance Committee. If there is another area you are interested in, please let us know—we will find a place for you! Contact camftco@hotmail.com, any Board member (contact information listed on page 2) or by calling 303-792-3966.

CALENDAR

COAMFT Board Meetings—All members, students, and volunteers invited!
Friday, February 20 • 4-6 p.m. • Contact the COAMFT office for information.
Saturday, March 28, 12:30-2:30 p.m. – following March Membership Meeting CSU Denver Center, 2nd Floor Event Atrium, 475 17th Street, Denver 80202
Friday, April 17 • 4-6 p.m. • Contact the COAMFT office for information.

Save the date – 2015 Annual Conference Friday, September 18
Arvada Center for the Arts, 6901 Wadsworth Blvd., Arvada 80003
Visit www.coamft.org for current COAMFT events and updates.

The COAMFT newsletter is a publication of the Colorado Association for Marriage and Family Therapy and is provided automatically with membership. Its purpose is to link the COAMFT leadership with the members, to promote communication within the Colorado Division, to provide information of current interest to the membership and to serve as the “voice” of COAMFT to the broader professional field.

The COAMFT newsletter, by its content, promotes and supports the Vision and Mission of the Association:
Vision: COAMFT is a leader in helping Colorado families be safe places for people to grow and develop because every family, couple and individual has the skills and tools needed to meet challenges and strengthen relationships.
Mission: To be a dynamic, vibrant division of AAMFT that supports, provides resources, links people and advocates effectively for its membership and its larger constituency: the individuals, couples and families whose mental health and relationships are a primary concern.
This is the opportunity to:

- Meet and hear from the leadership of COAMFT;
- Network! Plan to bring your brochures, business cards, and marketing material;
- Shake hands with the award winners for Therapist, Student, Supervisor, and Educator of the Year;
- Support the Minority Scholarship recipients;
- AND . . . receive valuable information regarding new Colorado law and legal issues.

Saturday, March 28 • 8:30am-12pm

Colorado State University Denver Center
2nd Floor Event Atrium
475 17th Street • Denver 80202

PDCs will be offered. You must attend the entire presentation to receive a certificate.

This is a FREE COAMFT event, but you MUST reply to save your place. Email camftco@hotmail.com or call 303-792-3966.