MAMFT News

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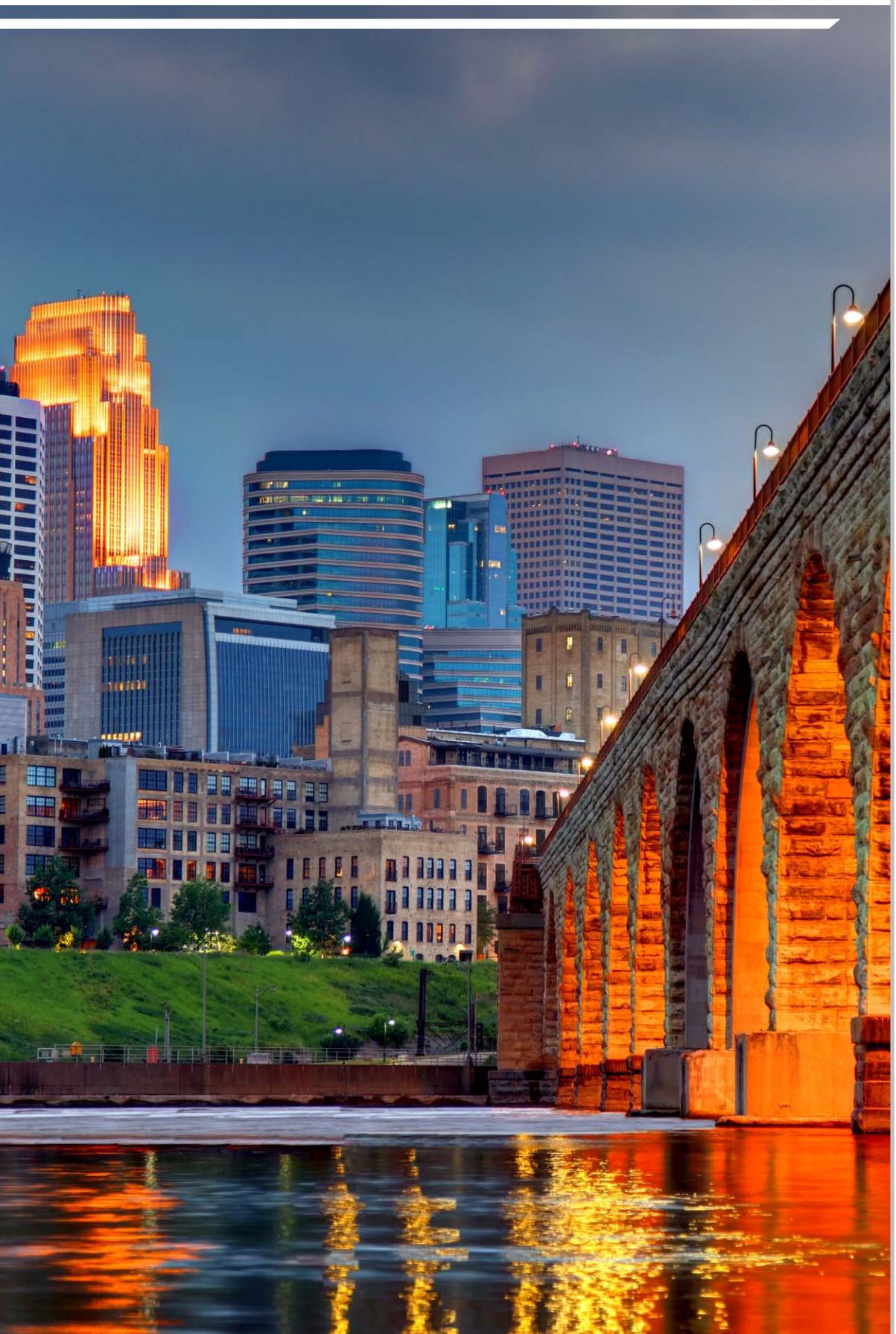

LETTER FROM THE EDITOR

"I want you to get excited about who you are, what you are, what you have and what can still be for you. I want to inspire you to see that you can go far beyond where you are right now"

–Virgina Satir

Welcome to Summer!

Throughout my past two years as Editor, I have worked alongside our MAMFT board and committee members to bring news and updates of change coming to our association and community. It is now time for exciting change to come to the newsletter!

In upcoming editions MAMFT will be seeking your contributions on topic specific themes, highlighting the wide range of expertise we have in our healing community in the Midwest. We look forward to our Annual Conference this fall where Manijeh Daneshpour, PhD, LMFT will be our keynote speaker, sharing her view on cultural competency and ethics. As we prepare for Manijah Daneshpour's keynote, for the Fall edition, we will be collecting submissions on the intersection of Social Justice and the Therapeutic Relationship. Please consider submitting an article, or encourage a colleague that is passionate about this topic to do so.

The MAMFT Newsletter will continue to accept articles relevant to our work, research, and current events. Our hope is to inspire and reach more of the talented clinicians in our community.

I hope that these summer months will reward you all with much deserved relaxation, reflection and time with loved ones. Here at the newsletter, I will be doing the same, along with some exciting rebuilding!

Christine Dudero, MA LMFT
MAMFT Newsletter Editor

PRESIDENT'S COLUMN
A NEW CHAPTER

In listening to people describe what the experience has been for our association to separate from our "parent" company, a variety of terms have been thrown out: conscious uncoupling, terminating, new insurgence, and re-inventing ourselves. It is probably a little bit of each of these terms and more. There is one thing that we can be sure of, it is *change*.

Change is exciting, new, and hard. There is something about tradition. It can feel like a warm cozy blanket that helps us feel secure. It connects us to the rich history of not only the association, but our profession as well. *AND*, change is sometimes necessary. So, the question often becomes, how can we honor the tradition and ways of the past and still stay nimble and be open to change.

I must admit that I am not a good example of that myself. I typically order the same thing from menus. I have routines that I follow. I resist change (I once bought a new laptop and it sat unused in my office for a year because I didn't want to switch everything over and learn a new system.) However, stepping into this role in the association this year, I have learned now more than ever that change is inevitable and there will always be people that are unhappy with change.

I know that I am speaking for the board right now, and we are a collective of many voices and opinions, but I like to think that none of us go into the decisions we must make with ill intent. When we are faced with a crossroads and need to decide if we need to create a new path forward, it is often the result of a lot of discussion and careful review. For a people pleaser like myself, it is very difficult to accept the fact that not everyone will be happy with the decisions the board makes.

We are now in the process of reviewing our bylaws. I know that term has taken on a whole new meaning with our recent departure from AAMFT, but it seems beneficial for us to do this. We are aware that some of the language and rules in our bylaws needs a little adjusting. I am saying this because we are hoping to send something out to our members this summer regarding the proposed bylaw changes. We would like to put these changes to a vote so that we can feel comfortable moving forward as a "new/old" association with bylaws that reflect our vision and purpose more accurately. I encourage anyone with concerns or questions about the proposed changes to come to a board meeting. We love to hear from our members because it is our members that we represent.

In closing, while sitting with many past presidents at the Council of Past Presidents, Herb Laube shared a term that resonated with me. He said that it feels like we are starting a new chapter. I liked that because it is the same story with the rich history. Characters change, the plot ebbs and flows, but the story remains. Our story is relationships. It is an important story to tell and one that our association does so with passion and pride. Please join me in our new chapter and help us carryout the story of MAMFT.

Megan Oudekerk, PsyD, LMFT, RPT-S
MAMFT President

June 15, 2018

Dear Members of MAMFT,

Prior to 2018, we were required to model our bylaws after AAMFT's bylaws. Now as an independent organization, the MAMFT board recommends making the following changes to our bylaws to best position MAMFT for future success in supporting the profession of MFT and meeting the needs of our membership.

Members have from June 15 -July 14 to review the proposed bylaw changes. Then a vote will take place from July 15-August 14. If passed, the new bylaws will go into effect on August 15, 2018. Please learn about the proposed changes using the below links:

Current Bylaws

Marked-Up Bylaws

Proposed Bylaws

Bylaw Changes Rationale

Per our current bylaws, members in the following categories vote on bylaw changes: Clinical Fellows, Pre-Clinical Fellow and Allied Mental Health Professionals. Voting will take place via an online ballot. Members will make a single "yes" or "no" vote in regard to approving the changes.

Thank you for taking the time to be informed. Please email Sara Bidler at executivedirector@mamft.net or Megan Oudekerk at president@mamft.net with any questions or feedback.

Sincerely,

The MAMFT Board of Directors

FINDING OUR VOICE
IN A DIVIDED NATION

Our country's social system is strained. In the American Psychological Association's (2017) most recent Stress in AmericaTM Survey, data finds the United States to be at its lowest point of stress-related health in recent history. 63% (n=3,440) of respondents reported the future of our nation as being a "very significant" or "somewhat significant" source of stress, slightly outweighing the expected stresses of finances (62%), work (61%), and all other measured variables. Across age groups, 59% of respondents further reported belief that this is the lowest point in our nation's history and endorsed feeling stressed when thinking about the current social divisiveness. As systemic scholars and practitioners, our unique skillset as Marriage and Family Therapists provide us with the tools necessary to expand our service beyond the clinical space and into the larger social system. As a professional association representing Marriage and Family Therapists and allied mental health professionals, there is a call to responsibility in taking action. In doing so, however, we must remain aware of the many challenges inherent to a professional association speaking out on the highly sensitive political issues at the core of our many divisions.

As a board, we've remained engaged in dialogue around this very topic. Although we unanimously agree that it's time for our voice to be heard, we want to ensure our language reflects the essence of our practice. We are aware that the diversity of our professional network does not share a political identity any more than the diversity of clients we are here to serve. With that in mind, the voice we aim to find will not be driven by partisanship or party-politics, but instead, embody our systemic approach to assessing dysfunction within human systems. Instead of aligning with one perspective on any given issue over another, we will aim to offer an equanimous voice that brings meaning to the dynamics that fuel the divide, the meaning systems and values that inform each stance, and the barriers that remain in the way of collective progress toward greater, collective health. We will aim to identify the rules that govern the interactional dynamics that have pushed us further away from one another, and offer solutions to disrupt problematic patterns in ways that open our system toward second and third-order cybernetic change. In such aspiration, it is important to acknowledge that the internal health of our professional association has some healing to do of its own…

As a board, we remain committed to our direct membership, the profession of MFT both within the state and at large, and in turn, the consumers of our service. In living up to our commitment, we have been listening. In our listening, we have learned that some MN-MFTs believe that MAMFT leadership has historically (and presently) reflected the majority white-Christian culture of Minnesota, leaving little room for the voices of those who may hold social positions outside that mainstream. In parallel, we have learned that some MN-MFTs believe that MAMFT leadership reflects a progressively-liberal agenda with little room for the voices of those holding traditionally conservative viewpoints. These opinions have not been expressed by just one individual, but several from either side of the aisle. From a statistical perspective, both of these viewpoints can't simultaneously be true as they are presented in ways that seemingly stand in contradiction to another. Nonetheless, in the groundlessness of socially-constructed realities they both seem to exist.

As we consider these stated concerns, we remain curious…

- Do these statements suggest that individuals can't identify with various identifications that may land on either side of these divided statements? For instance, can an individual not be Caucasian, Christian, and progressively liberal in their political leanings? Can an individual holding social positions outside of historically normative populations not also maintain some traditional, conservative viewpoints?
- Do these statements suggest that the assumed demographic makeup of the board determine the values and mission of the board?
- Do these statements suggest that the board itself remains unaware of its current makeup and representation, neglecting to maintain dialogue on how elected leadership continues to emphasize the need of our board to represent the diverse interests of our membership?

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- Perhaps most importantly, what is it that's seen as standing in the way of our membership and MN-MFTs bringing these concerns directly to the board, whether that's at our monthly meetings that always have an open door, or in writing through our quarterly newsletter?

As systems tend to function, it seems that many of the dynamics contributing to dysfunctional communication and divides in the larger macrosystem have manifested our professional association. In my greatest capacity to remain a careful observer, I can report that MAMFT *walks the walk* in its dedication to keeping an open-door policy. I've witnessed MAMFT's sincerity in its eagerness to hear from our membership, and in keeping its ongoing invitation for critical feedback that challenges our board toward growth. As a board, it is clear that we have our own learning and growth ahead–but we cannot learn from what remains unspoken. So as we keep the door open, we hope that more individuals can actualize the will to engage difficult, uncomfortable conversations that bring us into the realm of meaningful change and evolve our association into a system of **nonrelative** inclusivity.

This statement to our membership is not only an effort to remain transparent in the major conversations that entail much of our board meetings, but also an extended invitation to join a needed dialogue. As we enter these unchartered territories of community outreach, aware of the challenges ahead and determined to heal divides as we progress toward greater relational health, let's do so with courage and grace. Let's do so in ways that remain grounded in cybernetics and the importance of remaining detriangulated from systemic conflict as being an essential feature of healing divides. Let's do so in ways that balance the many feelings of intense passion at the core of these social issues with a critical consciousness of thoughtfully crafted interventions that target 2nd and 3rd order cybernetic change throughout the macrosystem. Let's not abandon what serves us well in the clinical space. And let's absolutely remain true to our code of ethics that protects our profession as much as it protects the citizenship.

If you find yourself taking issue with the use of language in how these topics are addressed moving forward, bring that dialogue to the table. If you find yourself challenged by a particular stance taken, bring that dialogue to the table. If you remain troubled by your observations of how you experience our professional association's execution of its mission, bring that dialogue to the table. And if you're already bothered by the premise of this very initial statement, my email is lvolini@stcloudstate.edu. Let's talk about it, directly. Myself, along with the board, are coming into this with the same good intention we provide our clients, and the same openness to learn from each other along the way–something to keep in mind as we engage one another.

So let's begin to detriangulate our professional association. Let's begin to manifest constructive communication and relational health within our association in ways that reflect our work with client systems. Let's do something different, something new, something significant. These initial statements will not be written in stone or delivered with an iron hammer, but instead, launch conversations that evolve in relation to the diversity of voices expressed along the way. In the essence of marriage and family therapy, let's remember that we learn in community—a most sacred learning that remains dependent upon diverse perspectives being expressed and heard. Just as we've observed throughout history, the sacred learning that moves toward collective change while breaking the patterns that perpetuate dysfunction, disconnection, and division.

I'll end this in reflection of Dr. Bill Forisha's visionary words, that "*family therapy is for more than just families.*" Let's turn that vision into reality and play our part in the healing of our strained Democratic-Republic.

In the meantime, here's to keeping the door open…

Lucas Volini, DMFT, LMFT
On behalf of MAMFT's Board of Directors.

Reference:

American Psychological Association (2017). *Stress in America: The State of our Nation*. Stress in America™ Survey. www.stressinamerica.org

To read the complete review of APA's findings, visit: http://www.apa.org/news/press/releases/stress/2017/state-nation.pdf

MAMFT OPPOSES THE PRACTICE OF SEPARATING CHILDREN FROM FAMILIES AT THE SOUTHERN BORDER

White House Administrations have long granted exceptions to immigrant families detained while crossing the border to ensure that children would not be separated from their parents/primary caregivers. This past April, Attorney General Jeff Sessions put into effect a "Zero Tolerance" policy created by President Trump that would no longer allow such exceptions. Over a 6 week period that followed (April 19 to May 31), a spokesperson for the Department of Homeland Security confirmed that 1,995 children have been unwillingly separated from their families and caregivers as they remain detained in government detention centers (Davis, 2018). 1,995 children in only 6 weeks. As this remarkable influx of child detainees is driving current facilities beyond capacity, the Department of Health and Human Services has recently located a desert in Tornillo, Texas where they plan to erect a "tent city" to house an additional 450 children (Soboroff, Kube, & Ainsley, 2018).

As systemically-trained mental health professionals, the concern for these children's wellbeing is both indisputable and alarming. An elementary understanding of the many consequences that follow traumatic disruptions to attachment figures should have been enough to deter any implementation of this policy–tragically, it was not. Our advanced understanding of the empiricism across disciplines demonstrating the lifelong impact of attachment-related trauma on neurobiological development of the individual along with the lasting impact on surrounding systems elevates our social responsibility to take a stand against these practices. That is why MAMFT, along with more than 100 other professional associations (including AAMFT) and 5,000+ mental health professionals, signed Child's World America's petition to stop separating children from their families along the southern border.

Along with the efforts of Child's World America, MAMFT further supports legislation recently introduced in the Senate that would protect immigrant children from being separated from their parents/caregivers. Driven by Senator Dianne Feinstein with full support from Senate Democrats, so long as Republican Senators support the efforts it can pass both chambers this coming week (Carney, 2018).

Notable Republican leaders have also stated dismay toward these harmful and traumatic practices, along with notable criticisms from the United States Conference of Catholic Bishops as they remind the current White House Administration of their power to stop these practices immediately without the need and delay of legislation moving through congress.

Promoting the health and wellbeing of children and families is a nonpartisan debate and social responsibility of our profession. When harm is being done, we are ethically obligated to use our professional presence to promote the safety of vulnerable populations. We appreciate the ongoing support of our membership in addressing these issues during such trying times of our collective and strained social system. If you have any feedback on ways MAMFT can further advance these efforts or wish to offer a comment on the matter, please send an email to socialjustice@mamft.net.

Carney, J. (June 8, 2018). Senate dems introduce bill to prevent separation of families at border. *News* (Senate). The Hill.

Davis, J. H. (June 15, 2018). Separated at the border from their parents: In six weeks, 1,995 children. *Politics*. The New York Times.

Soboroff, J., Kube, C., & Ainsley, J. (June 14, 2018). Administration will house migrant kids in tents in Tornillo, Texas. *Immigration*. NBC News.

Daly, M., Freking, K., & Colvin, J. (June 15, 2018). Republicans take a stand against separating children from parents at the border. *Politics*. The Associated Press.

MAMFT GREATER MN SPOTLIGHT
INTERVIEW QUESTIONS

Name:

Celleste Schnellbach

Credentials:

MS, Marriage and Family Therapy Clinical Trainee

Education:

Master of Science in Marriage and Family Therapy from Capella University

Place of employment/What do you do?

I work at the Human Development Center in Duluth, MN. I'm a therapist at HDC working primarily with children, families, and couples. I also have a few single adults; my caseload is a healthy mix of all of the above.

Why do you do what you do? What motivates you?

I've always had such a drive to help others. The ways in which I have wanted, and actually do, help others has changed over the years and right now I'm focusing on exploring this new chapter of my life where I'm no longer a student and instead am a full-time therapist.

A lot of my motivation comes from being so excited and passionate about marriage and family therapy as a field, and also from the couples and families in which I come into contact with through personal and professional means. Everyone has a family and exists in relationship(s) with others, and helping a wide variety of people through an even greater variety of challenges and celebrating triumphs over those challenges is really fulfilling. I just completed the DC0-5 training to be able to diagnose and conceptualize early childhood mental health issues, and I'm going to start working more with children ages 0-5. I'm trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) which is an evidence-based approach for treating trauma in children ages 3-18. I'm also trained in Sex Therapy for couples which is really fun, and it incorporates elements of Emotionally-Focused Therapy which couples seem to really enjoy. I have a huge interest in perinatal mood and anxiety disorders, so working with parents who experience postpartum depression and anxiety is an area that I plan to continue being an active part of and I hope to help continue bringing light to these issues in the Northland part of Minnesota.

How did you get into this field?

When I started at HDC I primarily worked as an ARMHS provider and Targeted Case Manager with parents who have children under the age of five. I worked closely with therapists on our team who all contributed to my growing interest in becoming a therapist myself. The program director at the time was a LMFT, and she initially sparked my interest in choosing the MFT field over other disciplines.

What do you know now that you wish you had known as a beginning therapist?

I just graduated in March 2018, so I'm still a beginning therapist. Check back in 5 or so years… One thing I have been working on is being gentle with myself, and (repeatedly) reminding myself that I'm competent; I know a lot already; and I still have a lot more to learn. Thankfully my supervisors are good at reminding me of these things, too!

How has a client impacted you?

Helping me to remember that everyone is doing the best they can with what they've got, including myself, and that people can do better when they know more.

How do you practice self-care and keep balance in life?

Naps are key in my world. I go the gym a few times a week, play with my dogs (Calvin, Pembroke Welsh Corgi & Wrenley, Australian Shepherd), watch movies/TV shows, cleaning/organizing my home, hang out with friends and family, and try to read a book for fun every once in awhile. Having great, supportive people in my life is really important and I have date night with my guy two nights a week!

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If you weren't a therapist what would you do instead?

I'd probably be an interior designer. I wanted to be a veterinarian growing up but I'm pretty terrible at math, and chemistry is really cool but also really tough for me, so that pretty quickly rules that out as an option.

What are people surprised to learn about you?

I graduated high school in a class of 17 students in the middle of nowhere, North Dakota. Our school was in the middle of a dirt field, in between five small towns. I also have six tattoos, my nose is pierced, and my earrings are actually ½ inch plugs.

What are some of your hobbies?

Napping (ha!); shopping clearance/sales; playing board/card games; playing volleyball, softball, and basketball; listening to music and going to concerts; and searching for agates and beach glass along the shores of Lake Superior.

Favorite quote?

"No mud, no lotus." - *Thich Naht Hanh*

Ultimate bucket list item?

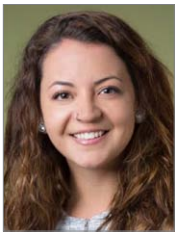
Visiting all 7 continents- yes, even Antarctica.

Best book recommendation?

Supernormal: The Untold Story of Resilience and Adversity by Meg Jay. The Harry Potter series is a close second.

What is your involvement with MAMFT and why do you choose to be involved?

I've been a member for a couple of years now. I choose to be involved to be connected with Minnesota's MFT family, stay current on Minnesota-related news and events, and also to get access to local trainings that are offered by MAMFT. I'm also interested in being a part of the Greater MN Committee!



Celleste Schnellbach, MS
Marriage and Family Therapy Clinical Trainee.

Greater Minnesota MAMFT Trainings

The Greater Minnesota Committee is responding to the request for more training opportunities outside of the metro area and has orchestrated the offering of **eight workshops to be held in Greater MN in 2018!** The trainings are either half-day or full-day trainings. Social events are being set up for after the trainings. You can register for one or both the training and social event. Find complete details at www.mamft.net under Events & Trainings.

Encourage your colleagues, whether they are a social worker, clinical counselor, or psychologist to register too, as these events are for any practitioners in the behavioral and mental health fields. **Members of MAMFT are able to register for free!** More good news: non-MFT's can join MAMFT as well and attend for free!

Sign up asap to be able to attend, as some have already reached capacity! Below are the remaining trainings for 2018:

July 17, 2018 - *"Acting Out": Understanding Behavior as a Trauma Response* to be presented by Mark Wilde, LMFT in **Moorhead**.

August 24, 2018 - *Trauma Healing: Neurophysiological Frameworks for Working with Trauma* to be presented by Barbara Nordstrom-Loeb, LMFT, BCDMT, CMA, SEP, WOS in **Brainard**.

September 7, 2018 – *The Principles of Pleasure: Four Important Skills to Help Therapists Work with the Good Stuff* to be presented by Laura Rademacher, MA, LMFT, CST in **Rochester**.

October 12, 2018 - *Unpacking Sexuality for Therapists* to be presented by Jennie Hilleren, MS, LMFT, CST, CSST and Anne Bauers, LAMFT in **Duluth**.

November 11, 2018 - *Taking Care of YOU: Burnout, STS and How to Be the Best You* AND *The Empty Office: Navigating the Ins and Outs of Providing High-Quality Supervision When Your Staff are Mobile* to be presented by Erin Rowlson, LMFT in **St. Cloud**.

SEXUAL SADISM DISORDER:
AN INTRODUCTION FOR MENTAL HEALTH PROFESSIONALS

Abstact

Sexual Sadism Disorder is characterized by the experience of sexual pleasure through causing, witnessing, or fantasizing about a non-consenting individual's physical or emotional pain. A commonly misunderstood disorder, its prevalence varies widely depending on the study and there is a lack of inter-clinician reliability concerning its diagnosis. Recent efforts have been made to reconceptualize sadism as a dimensional rather than as a dichotomous construct, resulting in the development of several validated instruments to assist professionals in more validly and reliably diagnosing Sexual Sadism Disorder. The aim of this article is to provide mental health professionals with foundational knowledge on sadism and to provide recommendations for how they can improve their understanding of this unique population so as to provide more effective and efficient care.

Sexual Sadism Disorder: An Introduction For Behavioral Health Professionals

The diagnosis of sexual sadism remains one of the most controversial and least commonly understood in mental health. Originally conceptualized in the 19th century as the experience of pleasurable sensations of sexual arousal resulting from acts of cruelty (Krafft-Ebing, 1912), sadism has since been incorporated into leading Western diagnostic systems. Sadistic Personality Disorder was introduced to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in 1987 as part of the organization's third text revision (DSM-III-R). It was incorporated to promote research into the phenomenon, and it was this research that resulted in the replacement of the syndrome by Sexual Sadism Disorder in the fourth (DSM-IV) and now fifth (DSM-5) editions. Sexual Sadism Disorder is currently listed as a paraphilia, where it is defined as "recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors" (APA, 2013, pg. 695). The World Health Organization's *International Classification of Diseases* first included mention of sadism in its ninth edition. Now in its tenth revision (ICD-10), the manual includes a code for Sexual Sadism Disorder, described as "A disorder characterized by recurrent sexual urges, fantasies, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering of a victim is sexually exciting to the individual" (WHO, 1992). To be diagnosed with sadism, a patient must have experienced these symptoms for at least six months and they must have resulted in significant impairment in their personal, social, or occupational functioning. Common comorbidities include Antisocial Personality Disorder, Substance Dependence Disorders, and other paraphilic disorders (American Psychiatric Association (APA), 2013; Berner & Briken, 2010; Eher et al., 2016; Mokros, Schilling, Weiss, Nitschke, & Eher, 2014; Robertson & Knight, 2013).

Patients diagnosed with Sexual Sadism Disorder are most often males who begin experiencing erotic fantasies involving the infliction of pain on others earlier in life (APA, 2013; McNamara & Morton, 2004). This fantasizing may be supplemented by the viewing of extreme forms of pornography (Kirsch & Becker, 2007). This fantasizing often increases in frequency and intensity into adolescence and adulthood, when fantasies may begin to be acted out, via the infliction of psychological suffering (e.g., manipulation or verbal abuse) and/or physical suffering (e.g., assault or bondage) on a non-consenting individual (APA, 2013; Chan & Heide, 2009; Mokros, Schilling, Eher, & Nitschke, 2012). During adulthood, the degree of violence needed to become sexually excited gradually increases – similarly to tolerance effects in substance abuse – as patients begin to experiment with carrying out their fantasies on non-consenting individuals to achieve the same erotic gratification. As age increases and sex drive diminishes, the urge to engage in sadistic acts often decreases (APA, 2013).

Given the strong negativity associated with the diagnostic label and its influence on decision makers in behavioral health systems (Marshall & Kennedy, 2003), the reliable and accurate diagnosis of sexual sadism is of considerable importance (Nitschke et al., 2013). Lack of agreement as to the etiology of sadistic fantasies, however, has resulted in some of the research literature reporting inconsistent findings. The following is a description of seven important areas concerning Sexual Sadism Disorder:

- The Prevalence of Sadism is Largely Unknown. The DSM-5 estimates the prevalence of sadism to be between 2%-30% (APA, 2013), with higher rates among committed

sexual offenders (approximately 10%) and those who have committed sexually-motivated homicide (37%-75%). This wide range of prevalence speaks to the need for new epidemiological studies both domestically and internationally.

- Sadism is Different than Dominance. The key to diagnosing sadism is the motivation behind the act(s). When it is the suffering brought about by the extreme behavior (e.g., infliction of pain, torture, domination, degradation, and pure cruelty) that results in sexual excitement, then a diagnosis of sadism may be appropriate (APA, 2013; Nitschke et al., 2013). When it is the expression of power/control over the victim(s) as manifested by the extreme behavior that results in sexual excitement, then this is a form of dominance rather than a clinical symptom of sadism. However, some authors have stated that domination, control, and power over the victim are key features of the disorder (Marshall & Hucker, 2006). Similarly, sadism is unique to minor forms of aggression (e.g., biting, scratching, spanking, hair-pulling) seen during normal "rough sex" which are usually consensual.
- Instruments Are Available to Help Diagnosis Sexual Sadism Disorder. Despite diagnostic criteria for Sexual Sadism Disorder having been published in both the DSM-5 as well as the ICD-10, academic reviews have established a lack of inter-clinician reliability for this diagnosis (Longpré, Proulx, & Brouillette-Alarie, 2016; Nitschke et al., 2013). Thankfully, several evidence-based instruments have been published which assist professionals increasing the reliability and, hence, the accuracy of their diagnoses. These instruments include the Severe Sexual Sadism Scale (SSSS; Nitschke, Osterheider, & Mokros, 2009) and the Short Sadistic Impulse Scale (SSIS; O'Meara, Davies, & Hammond, 2011), and their psychometric validity has been established.
- Collect Corroborating Diagnostic Evidence for Sexual Sadism Disorder. Although interviewing the patient suspected of sadism may be a useful source of information for diagnostic purposes, self-report is notoriously unreliable, and corroborating evidence from collateral sources such as friends and family as well as file records is recommended. Of particular diagnostic importance are statements made by the victim(s) of the offense(s) as well as detailed law enforcement reports which may point to a corresponding disposition in the patient which he or she may not readily disclose. In the absence of such information, a diagnosis of sadism is more difficult to establish, as the motive behind the potentially sadistic behavior may be unclear (Eher et al., 2016; Marshall & Kennedy, 2003).
- Sadism is a Risk Factor for Recidivism. Sadism is considered a risk factor for recidivism (Berner, Berger, & Hill, 2003; DeLisi et al., 2017; Eher et al., 2016). Certain comorbidities have also been found to increase the likelihood of certain individuals acting out their sexually sadistic thoughts and urges (Alghffar & Said, 2017).
- Sadism Can Be Thought of as a Spectrum: Although both the DSM-5 and ICD-10 conceptualize Sexual Sadism Disorder as a dichotomous construct (i.e., you have it or you do not), some scholars have advocated the adoption of a dimensional perspective (Marshall & Kennedy, 2003). The principal benefit of adopting a dimensional perspective is reduced reliance on clinical inference or patient self-report about sexually sadistic fantasies (Marshall & Hucker, 2006). The SSSS and SSIS instruments described above are derived from this perspective.
- Sadism Can Be Treated. Most patients with Sexual Sadism Disorder do not willingly seek help, either due to shame or fear of being reported to law enforcement, instead being forced to enter treatment after court mandate. That said, evidence-based interventions to address sadism exist using both psychotherapeutic and pharmacological approaches. Psychotherapeutic approaches to treatment include both cognitive-behavioral (e.g., cognitive restructuring and empathy training) and behavioral techniques (e.g., aversion therapy and systematic desensitization), whereas pharmacological approaches to treatment include the use of antidepressants to reduce impulsivity and anti-androgens to reduce sex drive (APA, 2013). It should be noted that patients diagnosed with sadism may be more resistant to both psychotherapeutic and pharmacological treatment compared to those without the disorder (Hamilton & Rosen, 2016).

Conclusion

Persons diagnosed with Sexual Sadism Disorder experience sexual excitement when causing, witnessing, or fantasizing about a non-consenting individual undergoing physical and/or emotional pain, suffering, and humiliation (Jozifkova, 2013). The accurate and reliable diagnosis

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of the disorder is of paramount importance due to both its implications for both community safety as well as individual liberty. Misdiagnosing a patient as having the disorder when they do not (a false positive) may result in unwarranted stigmatization and unnecessarily long-term detention or intervention, whereas misdiagnosing a patient as not having the disorder when they do have it (a false negative) may result in acts of serious violent recidivism. Due to the high cost of misdiagnosis, the following recommendations are presented:

(1) Using an evidence-based screening instrument during the diagnostic process for sadism

(2) Reviewing key journals in the field of sexuality and criminal justice on a quarterly basis to stay abreast of the latest peer-reviewed research on sadism

(3) Obtaining additional training for the assessment of and treatment techniques for patients diagnosed with sadism as part of ongoing Continuing Education

By following this guidance and by encouraging researchers to continue to disentangle the biological and environmental precursors to sadism, it is hoped that mental health professionals will be able to more effectively and efficiently work with this unique population.

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AN INTERVIEW WITH MAMFT'S EXECUTIVE DIRECTOR

SARA BIDLER

Sara Bidler, LMFT has served as MAMFT's Administrative Assistant the last six years and is now transitioning to the role of Executive Director. Olivia Newstrom, LAMFT is MAMFT's new Administrative Assistant. If you ever want to reach Sara, please email her at executivedirector@mamft.net. Olivia can be reached at info@mamft.net.

We asked Sara to answer the below questions so our readers can get to know Sara a little better. Starting with the fall edition of the MAMFT NEWS we plan to add a Member Spotlight section and include interviews of two members (one from Greater MN and one from the metro area).

Where did you attend graduate school?

I attended the University of Wisconsin-Stout.

How many years have you been in the field?

If you include the 2 years in graduate school, I have been in the field for 13 years.

How long have you been involved with MAMFT?

I started as a volunteer during the second year of my master's program, 12 years ago. I always tell people that my involvement with MAMFT began with bringing breakfast items from Sam's Club to the Fall Conference, which was held at Mayflower Church at that time. Within a few years I was co-chairing the Fall Conference and did that for three years before moving into the Administrative Assistant role.

Why did you choose to be a member of MAMFT so many years ago?

I had a lot of respect for my professors at Stout and they emphasized the importance of membership – that it is our ethical responsibility in terms of protecting our profession and a great way to be in connection with other systemic thinkers beyond graduate school.

What is something you hope to accomplish as the Executive Director?

I hope to strengthen/put in place systems that lead to greater member engagement. First, because I know how rewarding it is to get involved beyond membership and want that for all our members. And second, it concerns me when I see a small percentage of our members doing the bulk of the volunteer effort required to make MAMFT what it is. So, I would like to help more of our members get involved in a meaningful way.

What is something that people might not know about you?

That I was President of the Hip-Hop Farm Girls back in the day. ☺

What are your thoughts on MAMFT becoming independent from AAMFT?

I wish different options had been available to state divisions that empowered work at the local level while staying connected to AAMFT. But after 5+ years of not knowing what our future structure was going to look like, I'm grateful we are no longer operating within such ambiguity. I'm also excited about the world of opportunities that have been opened to us being fully independent. I'm proud of the tough work our leadership has done these past 5+ years to navigate this transition and to do it as smoothly as we did. We were the first state to go independent and I have talked with numerous board presidents and executive directors from other states over the past 6 months who want to know how we did it and who are all very impressed with what we have going on in Minnesota.

What is your favorite binge worthy show?

Honestly, I have never binge watched a show. It sounds like a fun thing to do, so maybe in a few years when my kids are a little older I will set aside a weekend day and try binge watching. But for right now the Late Show with Stephen Colbert is about all I watch (always a day late because I'm an early riser).

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If you are not working, what is something we might find you doing?

In addition to working part-time for MAMFT the last 6 years, I have also been a "stay-at-home mom", so most of my non-work time is spent being a mom (I have two boys ages 8 and 5). That will shift soon, as they will both be in school full-time this fall. I'm one of those people who finds housework and organizing stuff therapeutic (while at the same time being a never-ending battle) so I could easily be caught doing these tasks. I also enjoy getting together with friends, bonfires in our backyard, playing cards/board games with family, exercising, and time alone. ☺

Sara Bidler, LMFT
MAMFT Executive Director

HE SAID/SHE SAID

HE SAID:

In the Book of Common Prayer is this well-known phrase – "We have left undone those things which we ought to have done; And we have done those things which we ought not to have done." That about sums it up. When we don't have our act together our lives unspool like this. We don't follow through on good intentions and right living, and instead we do harmful or idiotic things, not getting it right coming or going.

The central issue, is, I believe, the lack of follow through. Having follow through means we can be counted on to get things done when we say we will, or we can be counted on to follow through with our good intentions and not procrastinate, avoid, or deny our responsibilities. It's sort of the stance of the avoidant teenager, no matter the age – 15, 25, 35, or 45, etc. Hopefully as we mature we can grow out of it, but that isn't a given. Some of us can carry avoidance and lack of follow through well into middle age or beyond. Since I am well beyond middle age – in fact, into my dotage, I know from experience what this is.

If marriages are built on secure attachment – knowing your partner will be there for you no matter what – that you can always count on your partner for reliable presence, for fidelity, for following through on availability, initiative, affection, generosity, and compassion. That is a lot, and we should do so gladly without complaint or excuses. It's a big part of being a grown up. And for a lot of people, being a mature and reliable grown up is a difficult and agonizing thing to embody.

Sure, anxiety, depression, environmental, and social factors are all significant restraints to being able to follow through - and that comprises much of our work. But, sometimes it's about courage, values, and sacrifice.

SHE SAID:

Okay, I admit I am still reacting to your first sentence… while I do not identify as a Christian, I was raised going to an Episcopal church, and I well remember the prayer of General Confession. Right after the part you have quoted is this memorable phrase: "and there is no health in us…" Being a strength-based therapist, that's one place the prayer loses me. Of course the purpose of prayer is different than my purpose as a therapist. Prayer is directed to a higher power, a source, perhaps The Source, of empowerment, love, healing. Therapy is directed toward the clients as the source, empowering the potential in people, enabling the power of relationship (yes, and love) to heal.

Maybe not so different…

So how do we tap into our clients' potential to be good for their promises, to be reliable and to follow through? This is at the core of trust-building, that which leads to secure attachment as you say. I think it starts with us, as part of the therapeutic relationship. How are we following through with our commitments to our clients? What are those commitments, beyond a promise to sit in a chair opposite them at a specified time every week or two?

What makes us reliable allies? What are our obligations as relational healers? What are the values we are living and how do they show up in our work? How do we show up? How can we draw forth courage and sacrifice from our clients if we are not demonstrating those same qualities ourselves? And how do we do that?

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HE SAID:

We grow up. By that, I mean that we take seriously our obligations and reliably meet them with dedication and care. Grown-ups are those who follow through. Grown-ups engage in work and shoulder the tasks. How pleasant it is to work with someone who follows through. It's the experience of teamwork. We are in a team with our clients, each of us doing our part.

In our marriages and families, we all do our part. We try to instill in our kids the importance of follow through. Maybe instead of yelling at them to pick up their rooms, we start by inviting them to work alongside us then we turn the task over to them to finish. We offer encouraging words before, during and after. With our wives and husbands, we gladly follow through. June will call Apple support this morning and straighten out some software glitches, pick up a quiche from Surdyk's for a meeting at our home tomorrow morning, and I'll pick up fancy Italian take out to bring home for supper, this being her birthday. We've been a team for over 50 years. By now, we've kind of gotten it down.

Follow-through – Doing those things we ought to do – and not doing those things we ought not to do. A relief.

SHE SAID:

Yes, we're part of a team, therapist and client/s. The reason we're on this team is because the client wants or needs to make changes, and maybe those changes relate to being good to their word, responsible, trustworthy. Here's where the therapeutic relationship is different than any other – different conditions, different expectations, different obligations.

To be concrete, I'm thinking of out-of-session assignments, "homework" that we often give clients. I'd be surprised if anyone who has regularly given therapeutic homework assignments would say clients follow through 100% of the time. Instead, clients forget, they avoid, they resist. Or they remember on the way to the next session and try to come up with something. They don't necessarily act grown up. They aren't always reliable.

We don't feel hurt or offended. We try not to judge and to just be curious. We help them explore their experience. What happened? Was the assignment too challenging? Too irrelevant? We bring the perspective that a client's "failure" to follow through is actually just information. It might mean they need to grow up. It might mean they need to speak up and say the assignment doesn't fit. It might mean they need the corrective experience of being accepted, not being shamed when they screw up. We wonder with them if this is something they learned or didn't learn, if it is a pattern, if it's something that they want to change.

Here's where our ability to meet and hold people with "unconditional positive regard" is essential. It's that paradox we face daily as therapists: the ability to accept and love people exactly as they are, while having great hopes and even expectations for them to grow and change.

Brier Miller & Ken Stewart

We are in a team with our clients, each of us doing our part.

PUBLICATION INFORMATION

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PLEASE NOTE Submission deadlines for 2018

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