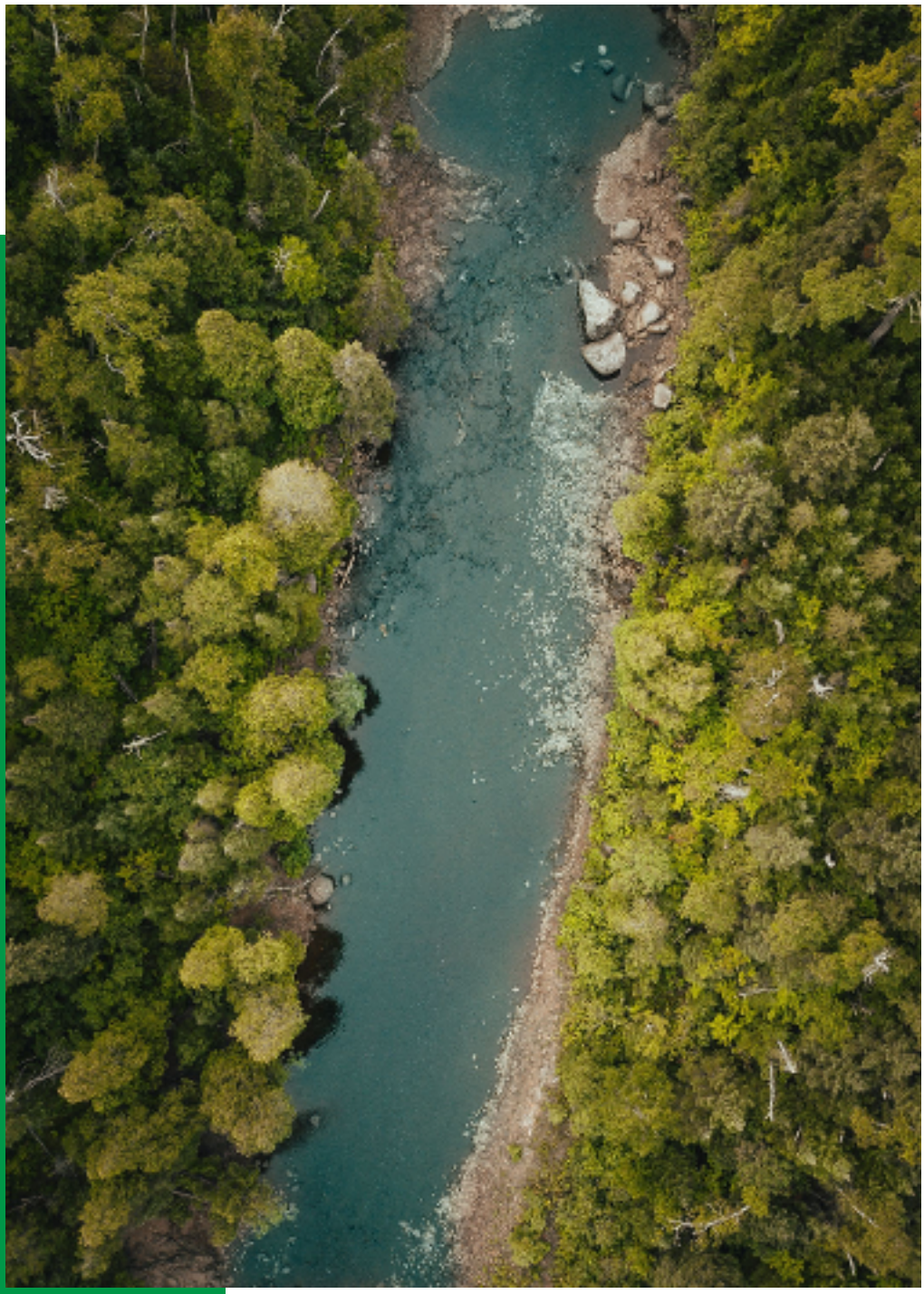
Volume 37, No. 1, Spring 2019

MAMFT NEWS

NEWSLETTER OF THE MINNESOTA ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY



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MAMFT News

NEWSLETTER OF THE MINNESOTA ASSOCIATION OF MARRIAGE AND FAMILY THERAPY

VOLUME 37, NO. 1
SPRING 2019

LETTERS TO THE EDITOR IN THIS EDITION FOCUS ON THE THERAPEUTIC RELATIONSHIP

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LETTER FROM THE EDITOR

"WE WILL NOT SURVIVE UNLESS WE DEPEND ON EACH OTHER"
-DR. JULIE SCHWARTZ GOTTMAN

This edition is packed with Letters to the Editor on the therapeutic relationship. Contributors share their expertise working with special populations and the authenticity of self as part of the therapeutic relationship.

As always, the newsletter is going through some changes. Perhaps you have noticed already that the newsletter has a new look! We will be shifting into a bi-annual format for the next couple editions as we work out our new look. Don't worry, we don't expect the bi-annual format to stay forever. We plan to return to publishing quarterly in the near future.

The MAMFT family would also like to welcome Ashley Baird Urbanski, MA LMFT as the new MAMFT Administrative Coordinator. Ashley has been a great help to me with these shifts with the newsletter,

WELCOME ASHLEY URBANSKI, MA LMFT TO THE MAMFT FAMILY

Welcome aboard Ashley!

With hello's also come bittersweet goodbyes. In this edition we say goodbye to the He Said, She Said column. Ken Stewart and Brier Miller have written the He Said, She Said column for over 15 years. To check out many of the past He Said, She Said columns, look at the archieve section of the newsletter on mamft.net. **Thank you Ken and Brier for your dedication and contribution to the newsletter over the years**. Your wisdom will be missed.

CHRISTINE DUDERO, MA LMFT
MAMFT newsletter Editor

The theme of our next edition will be: **All Things Attachment!**

Please consider submitting an article or encouraging a colleague with expertise in this area to do so.

As always, we enthusiastically encourage members and non-members alike to make submissions.All submissions will be edited for length, clarity, readability, grammar, spelling, biased language, and appropriateness to the mission of MAMFT Newsletter.

Opinions expressed in the MAMFT NEWS do not necessarily reflect the opinions of the Editors or of MAMFT.

All articles and materials for publication should be submitted via the MAMFT website

NEXT EDITION'S THEME: ALL THINGS ATTACHMENT!

PRESIDENT'S COLUMN

RELATIONSHIPS MATTER: ESPECIALLY ON THE BOARD

So far 2019 has proven to be a wintery blast of many unexpected snowstorms. In fact, for the first time in many years, we had to conduct a virtual board meeting due to a snowstorm. My hope is that by the time you are reading this article, you will find that spring is just around the corner and piles of snow are just a distant memory. (*Editor note:* It's April 10th and the photo below is from my backyard).

Even though I find myself longing for warmer days, I have realized that the silver lining with these snow days has been that I am able to spend more time with my family. Now that I am entering my second year as President of MAMFT, I am also grateful for the "family" that I have with the board. MAMFT believes that *relationships matter*, and I certainly have found that to be true throughout my life, but I have noticed that even more during my time on the board.

Before joining the board, I often thought that I would not have what it takes to be on the board. What skills did I have that would help the board? Surely there were many others that would be more qualified, right? My first job on the board was as Membership Chair. It was through this position that I was able to host a new member event. I was worried about how many people were going to come and if the food was good enough. At the end of the night, what I realized was that most people didn't care about where we were meeting or how many people came. What they seemed to care about the most were the connections that they formed with other people. One person even said that she had relocated from California and was grateful for a chance to connect with other family therapists because she was feeling alone in her private practice after moving across country.

The key ingredient in being successful was right there all along- *relationships matter*. This event was a "success" because people had an opportunity to connect and form relationships. I applied this knowledge to the board as well. Being a successful board member does not mean that you are aware of all the legislative issues or that you are a great event planner. It also does not mean that you like to speak in front of others or have the best PR skills. Successful board members connect with others. They connect with members, potential members, legislators, colleagues, other board members, and even members from other states. These relationships help the board make decisions. These relationships help the board gain awareness about the families we serve. These relationships help develop trust and a sense of community.

As the snow eventually melts away and spring once again returns, please consider volunteering for the board or running for a position in the next election. There are no magic skills. We are not looking for a polished resume. We are looking for people that care about MAMFT. We are always hoping to form new relationships and perhaps the next one might be with you!

THE KEY INGREDIENT IN BEING SUCCESSFUL WAS THERE ALL ALONG -- RELATIONSHIPS MATTER!

COMMITTEE UPDATES

ELECTIONS COMMITTEE

We are excited to start the new year off with our new board members: Jill Ellingson, Margaret Moore, Michael Kinzer, LynAnne Evenson, and Jenni Franke! Vanessa Slivken is our new Elections Committee Chair. We look forward to another strong year of MAMFT board recruitment. Please contact elections@mamft.net if you are interested in joining the board via an open position or committee. Stay tuned for more information on 2020 open positions!

GREATER MN

Please see the Greater Minnesota Conference flyer on page 24!

WELCOME NEW BOARD & COMMITTEE MEMBERS!

LEGISLATIVE

The legislative committee has grown! We welcome Tamara Statz as the new co-chair, and Casey McGraw is now our administrative committee member. Tamara is passionate about working with the aging population and ready to go talk to legislators about helping MFTs get access to Medicare to continue to support our aging population! We have a bill that has been introduced on the senate floor and we are rallying to get a hearing. Erin has several meetings over the next 3-4 weeks to talk to state legislators and get a hearing! Stay tuned for more information and feel free to send us an email if there are more legislative issues you want to see discussed and worked on! #mnleg #MAMFT2019

MEMBERSHIP

The membership committee is excited to welcome any and all members interested in serving on the committee. As a membership committee member you will have the opportunity to plan membership events, speak to potential new members, and be a part of the growth an organization that is working to support MFTs statewide.

PRE-CLINICAL

The Pre-Clinical committee ended 2018 with a bang at our CV event! We look forward to 2019 and the change in leadership as Tamara has been appointed co-chair of the Legislative committee. More to come!

PROFESSIONAL PRACTICES

The Professional Practices Committee is continuing collaborations with the Social Justice Committee to align efforts of larger system intervention with professional standards of practice in MFT. Preliminary collaborations with the Legislative Committee have also developed to integrate the framework of politically-differentiated family policy into MAMFT's efforts to influence legislators in framing policy that reflects the empiricism of our profession.

PUBLIC RELATIONS

The public relations committee continues to explore fresh ideas for reaching out to the community to promote the profession. Anyone with any ideas please feel free to contact publicrelations@mamft.net

STUDENT COLLABORATIVE

The Student Mentorship Program applications closed on December 3rd, with 15 admitted mentees and 5 mentors. Participants met during the Program Orientation on January 7th where they created career development goals for the semester. Fall 2019 Applications open May 1st.

SOCIAL JUSTICE

The Social Justice committee has been working to become a cohesive committee with a clear vision, mission and goals. We are growing and excited by all the energy and passion! We are collaborating with the board to create a statement that is a more accurate reflection of our history and responsibility regarding social justice. We are also organizing two events that will happen in the next couple of months. We look forward to the opportunity to come together and share our collective wisdom.We are also partnering with other committees to focus on areas of supervision for pre licensed practitioners and to work with our regulatory board for the purposes of increasing cultural competencies for ongoing licensure. We have big goals and can't wait to work together to achieve them!

TRAINING COMMITTEE

The 2019 Annual Conference will take place on September 12 & 13 with Diane Poole Heller, PhD as the keynote speaker! Registration will open in May!

THE IMPORTANCE OF THE THERAPEUTIC RELATIONSHIP IN THE TREATMENT OF OBSESSIVE COMPULSIVE DISORDER (OCD)

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

I started treating OCD somewhere between 1-2 years ago. After discovering that it runs in my family, I became interested in how the treatment works and why exposure and response prevention (ERP) is almost always pointed to as the gold-standard treatment. I'd never been very interested in Cognitive Behavioral Therapy (CBT) modalities prior to this time because they struck me as automated and less personal than more relational or insight-focused types of therapy. I'd like to share more of what I've learned since I've begun treating clients with OCD about how important the therapeutic relationship actually is.

To have some background, our training doesn't do much to help us identify OCD in clients. Recently, as I was "Konmariing" my office with the rest of America, I came across my old (OK, really old) "abnormal psychology" paperwork. Sure enough, I found the criteria for OCD, indicating that I did actually cover OCD in school. But what this class did not do for me, was to make OCD real in a way that I could understand how it shows up for people, and how I might identify it in clients.

Here is how the IOCDF.ORG website (an incredible resource) defines OCD: "Obsessive Compulsive Disorder (OCD) is a mental health disorder that affects people of all ages and walks of life, and occurs when a person gets caught in a cycle of obsessions and compulsions. Obsessions are unwanted, intrusive thoughts, images or urges that trigger intensely distressing feelings. Compulsions are behaviors an individual engages in to attempt to get rid of the obsessions and/or decrease his or her distress."

What this description and the description I found from my old notes don't indicate is how incredibly terrifying the obsessions can be for people who suffer from them and the intense responses that result. People with OCD can be in the middle of fight, flight, or freeze responses over and over and over, without relief. Many fears can't be avoided as they often can with phobias, because it is thoughts that are driving the pattern.

Another very important point these brief descriptions omit is that many types of OCD include "non-observable" compulsions. The IOCDF.org does eventually go more into the type of mental compulsions I'm addressing here, which can include a sort of "heavy analysis" or excessive attempts to "figure out" an obsessive problem or situation. Here is an example. A common theme in OCD includes the obsessive thought: "What if I am a pedophile?" Importantly, this is in the absence of any actual inclination to behave as a pedophile. However, the obsessive thought feels real and terrifying to the sufferer. The compulsion arises as attempts are made to talk oneself out of the obsession. "But I've never wanted to hurt a child… But I love my baby…But I've always enjoyed children…" All these rationalizations can be countered by very creative "What ifs…", such as "What if I am a pedophile and I'm just realizing it now?" Or the very clever: "What if I'm in denial?". In addition to the mental compulsions/rationalizations, a sufferer might start to avoid children. This is especially sad when we think of a new mother or father avoiding their baby. To increase the isolating nature of OCD, it is not hard to imagine someone feeling hesitant to tell their therapist: "What if they report me to CPS and I lose my child?" This is a *very common* theme, and so common in the OCD world it is called "pedophilia OCD", or pOCD.

Sometimes obsessions can center around more typical life problems, such as in romantic relationships (rOCD). Some sufferers worry about whether or not they are attracted to their partner. They might find themselves unwillingly focused on a perceived imperfection, then begin to try to talk themselves out of this concern. Hours can be spent in worry about if they love their partner. This issue can also bring up feelings of guilt, which the client might think will be relieved if they confess to their partner about their struggle, thereby causing the partner confusion.

Anxiety tends to be about avoidance. If I have an unpleasant feeling, I avoid that thing that I think caused it. With OCD, the difficult thought/obsession creates an unpleasant (often terrifying) feeling. The compulsion is one's attempt to neutralize the difficult feeling and thought… and it might work initially. However, as the distressing thoughts continue to arise, more compulsive attempts are made to try to neutralize the thoughts and feelings. Over time the OCD takes on a life of its own. (continued on next page).

LUCY GRANTZ, LMFT

THE IMPORTANCE OF THE THERAPEUTIC RELATIONSHIP IN THE TREATMENT OF OBSESSIVE COMPULSIVE DISORDER (OCD) CONTINUED

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

This is where exposure and response prevention (ERP) comes in. With ERP, and the gentle help of a therapist, the client gradually "exposes" him/her/themself to the distressing thought and feeling. This experience can be both terrifying and exhilarating for clients after they have been trying to suppress the thoughts and feelings, often for years (on average it takes 14-17 years for OCD sufferers to find the support they need). The therapy process can be incredibly liberating for clients and very rewarding for therapists as clients reclaim their lives.

ON AVERAGE IT TAKES 14-17 YARS FOR OCD SUFFERERS TO FIND THE SUPPORT THEY NEED

So what I've learned through treating OCD using ERP is because I am asking people to do things that cause them to feel like their lives are going to fall apart, the therapeutic relationship is crucial. A metaphor is often used for OCD that says that being in the middle of an OC cycle is like standing on a train track with a train coming toward you, but you are the only one who can see it. This is a terribly isolating picture. Consider how comforting it would be to have a therapist to step into that world with you.

LUCY GRANTZ, LMFT

THE DANCE OF JOINING: JOINING THE DANCE

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

The importance of establishing a therapeutic relationship is well known to clinicians. What is often ignored is the fundamental and essential role of body and movement patterns in forming and developing those relationships. In fact, non-verbal patterns - how we move and inhabit our bodies and world, communicate important truths about ourselves and others. They provide an essential lens for clinical work, establishing a non-verbal "dance" that takes place between therapists and their clients.
Why notice movement and body patterns in therapy?

On a fundamental level, everyone has a body and everyone is always moving in ways that uniquely reflect and communicate all of aspect their experiences, stories and histories. In addition, non-verbal interactions are the foundation of how we understand ourselves, process our world and form relationships. Neurologically, our bodies receive and respond to non-verbal information through mirror neurons, the Vagus nerve, the Limbic system and other neurophysiological structures. From our birth, patterns of relationship we are hardwired to connect through reflexes and other early neurological patterning which promote a sense of safety, nurturance and support. We know this from Attachment Theory and Object Relations, as well as Polyvagal Theory, and Neurological research. These early experience are the foundation for future relationship patterns. Infants who are not able to feel sufficiently safe, supported and nurtured develop relationships more cautiously later in life. Throughout the lifespan, the client's movement patterns will communicate the timing and process needed to establish a therapeutic relationship.

Many therapists already intuitively incorporate this on a rudimentary level. However a more nuanced ability to work with and understand non-verbal expressions requires additional training and skill. Attuning to details such as the size or dynamic quality of the movement, the shape, and quality of how the body is held, and the phrasing of movement sequences help to establish non-verbal synchrony and promotes feelings of connection. This facilitates interpersonal rapport and trust. Alternatively, therapist non-verbal mis-attunement can impede or even block the development of therapeutic relationships.

How does this look in a typical session? When clients enters my office, I immediately observe their movement patterns including the way they inhabit the space around them, and how they live in their body. I also notice their movement dynamics and the phrasing and rhythms of their movement patterns. I also notice aspects of their movement that are potential expressions of other aspects of their history and identity. Next, I compare my observations of the client's current to their past movement patterns, as well as my own movement patterns. Finally I modify and attune my own movements to join with the client on a non-verbal level. I am learning how to dance with them, and I join by following their lead and trying on their rhythms. With more withdrawn or cautious clients, I also use empathetic attunement to adjust to their non-verbal responses, as a way to signal my willingness to meet them where they are and follow their timing. Together we are co-creating a dance. The process is iterative and takes less time to do, than to describe. It promotes therapeutic relationships more quickly and effectively than a more verbally focused process.

"TOGETHER WE ARE CO-CREATING A DANCE"

JOINING THE DANCE (CONTINUED).

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

As therapists, our mirror neurons also activate our kinesthetic, proprioceptive and neuroceptive responses. Using Dance/ Movement Therapy (DMT) (DMT is a creative arts psychotherapy that works directly with embodied experiences as well as words to achieve clinical goals) techniques, paying our own attention to our own inner responses can provide insight about countertransference, transference as well as the client's experience of the world. (These techniques work best when the therapist is curious and honest rather than judgmental, about their own embodied experiences.) 'Somatic countertransference,' the therapist's awareness of their own somatic responses to the client, is an important tool for becoming aware of and distinguishing between

therapists' 'body biases/prejudices' and what they are sensing from their client's experiences. 'Kinesthetic empathy,' the intentional embodiment or taking on of their client's movement patterns, can provide clues to the clients experiences and their sense of the world. Both techniques provide insights into the non-verbal inter- and intrapersonal dynamics present in the session.

the therapists' 'body biases/prejudices' and what they are sensing from their client's experiences. 'Kinesthetic empathy,' the intentional embodiment or taking on of their client's movement patterns, can provide clues to the clients experiences and their sense of the world. Both techniques provide insights into the non-verbal inter- and intrapersonal dynamics present in the session.

Finally, from a systemically lens, consciously or unconsciously, the therapist's body, gestures and movement patterns are always part of and influencing the therapy session. Just as therapists use words intentionally and mindfully, their embodied presence - the 'Embodied Self-of-the-Therapist'- is also an important element that can promote therapeutic relationships. The process is a dance and following our client's non-verbal lead and synchronize our rhythms with theirs we promote trust and safety: Won't you join the dance?

Barbara Nordstrom-Loeb MA, MFA, LMFT, BC-DMT, CMA, PWAssoc, SEP, WoS, has a private practice and supervises in Minneapolis. She also teaches at UMN, received a Fulbright Scholarship to teach in Estonia, and has also taught in Lithuania, China, and South Korea. She has extensive diversity/multicultural curiosity and experience. As a therapist she focuses on the use of embodiment and creative expression for psychological, somatic, and spiritual transformation.

TRANSITIONS

TAMARA STATZ, MA LMFT

Hello MAMFT Family!

It is bittersweet that I get to say goodbye to my role as Pre-Clinical Representative! It has been a wonderful four years serving the folks who are experiencing this very important part of the journey as MFTs. I have seen so many committee members, peers, and dear friends transition through the journey from graduate school to full licensure. what a journey that is!

Thank you to everyone who has come to a gathering, event, or even just emailed to express interest in the Pre-Clinical happenings! I, too have found these gatherings and events helpful as I progressed through my licensure journey that culminated this past September when I achieved my LMFT licensure. I did not quite know what I signed up for when I put my hat in the ring for the Pre-Clinical Rep role back in 2014, but I am sure glad that I did!

Melissa Mrozek, MA, LAMFT, LADC has been appointed to complete the rest of my term as Pre-Clinical Representative for the next 2 years. She will make the role and committee her own and continue to further the interests of Pre-Clinical MFT folks in Minnesota. She can be reached at preclinical@mamft.net if you are interested in getting involved or have ideas!

What is this *transition,* then? I have resigned from the Pre-Clinical role in order to step into my new appointment as the Legislative Co-Chair alongside Erin Pash. Anyone who knows me is aware that I am passionate about the impact of legislation on our everyday lives and the lives of our clients, especially those most vulnerable to the impacts. I have been interested in this role for many years and this is the perfect time to step into it. I look forward to continuing to serve MAMFT, our clients, and ultimately the residents of the state of Minnesota in this new role.

Your (previous) Pre-Clinical Representative,
Tamara L. Statz, MA, LMFT
MAMFT Legislative Co-Chair
legislative@mamft.net

Tamara L. Statz, MA, LMFT specializes in working with older adults and their families experience grief, loss, transitions, chronic and terminal illness, dementia, and more. She is a passionate advocate and activist for older adult's rights, independence, privacy, and quality of life. She has a private practice called Vibrant Living where she goes into the homes of older adults to provide therapy. In addition, she is a clinical researcher at the University of Minnesota - School of Public Health where she is working on a counseling intervention to help families who are caring for a person with dementia who lives in long-term care. She has been on the MAMFT board since 2015.

Two words: GET INVOLVED.

FROM EATING DISORDER CLIENT TO EATING DISORDER THERAPIST: THE USE OF SELF-DISCLOSURE

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

Being able to trust your therapist is vital to any sort of successful therapeutic work, but it is especially true for those in eating disorder treatment. Throughout my years as a therapist treating eating disorders in various settings, including residential treatment, day programs, and outpatient therapy, I have learned the significance of trust and vulnerability within the therapeutic relationship.

As someone who went through eating disorder treatment myself, I know the thoughts that went through my head and the thoughts that my clients now share with me. There was the common thought, driven by the dark voices of the eating disorder: I should not trust or listen to my providers. I mean, how did they know what was best for my body? How could I trust that restoring weight would actually be helpful in a world that was telling me the opposite? My therapist and dietitian kept telling me that life would be better without the eating disorder, but how did they know? Had they been through an eating disorder? Throughout my treatment I never heard from someone who had actually recovered from an eating disorder. This made it hard to believe that recovery was worth it, let alone possible at all.

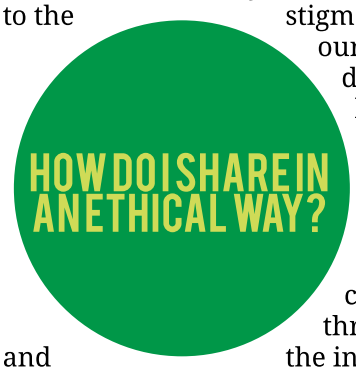
Eventually, after years of struggling and for a variety of reasons, I decided to give full recovery a shot. And, my providers were indeed correct, as I learned living without fear of food and weight gain was utterly freeing. However, I think it would have been easier to believe this in the first place if I had heard from someone with first-hand experience. I was always wanting to meet someone who was on the other side of an eating disorder.

This desire of my own eventually led me to speak publically about my recovery. I began to give speeches to educate the public about eating disorders and share my story. I was on radio shows and spoke at community events and recovery groups. After several years of sharing my personal narrative, my passion to help others and eradicate eating disorders continued to grow.

I decided to carry out this passion further by becoming a therapist and working to help combat eating disorders professionally.

This brings me to my work as a therapist and how my own journey has influenced my current work. At the forefront of this work is my goal to thoughtfully use my own experiences to benefit clients.

In the world of substance use treatment, discussing one's own recovery status as a professional is fairly common. Within eating disorder treatment, it is less so. However, it is my belief that hiding it just gives way to the stigma and shame that exists in our culture regarding eating disorders. Pretending and lying are not part of my repertoire. This is not what I want to model to clients. Thus, I model vulnerability by sometimes sharing with clients that I too have been through an eating disorder and the intense treatment that accompanies it.



However, at the forefront of my mind is always the question: How do I share in an ethical way in order to use self-disclosure in a helpful way?

First, I do not announce my story to every client. I do not share it in the first or even the second session. I use intuition and discernment to know when it might be helpful or unhelpful to share. I am also sure to keep in mind and tell clients that everyone's journey to recovery is different, including mine. Something that is helpful for one person, might not be helpful for another.

So far, when I have decided to be vulnerable and use self-disclosure as a therapeutic technique, it has made a world of difference within the therapeutic relationship and for my client's recovery journey.

First of all, I notice right away that clients become more at ease in my office. There is less shame and more acceptance immediately felt, which allows

FROM EATING DISORDER CLIENT TO EATING DISORDER THERAPIST: THE USE OF SELF-DISCLOSURE CONTINUED

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

... (continued) clients to be more open to sharing.

Furthermore, the client's ability to trust me as their therapist increases with self-disclosure. The eating disorder has less credibility and I gain more credibility, which makes recovery that much more possible. Trust and credibility need to be high because I am trying to convince my clients to do the things they have come to hate most – eating food and taking care of their body.

Clients report my self-disclosure has also increased their hope because they can start to believe full recovery is possible. This is one of the hardest things to believe when in the midst of an eating disorder. Some doctors, therapists, family members, and friends have even told my clients that they will probably struggle with eating their entire lives. I also heard this message while in treatment.

These comments lead to discouragement and often cause clients to ask, "What is the point of even trying?" I can be the person to tell them that trying is the best thing they can do because they do not have struggle for the rest of their lives. I tell them not to fall prey to this lie, and I use parts of my own story as proof. Yes, the journey is difficult, but the resulting freedom from an eating disorder is more worth it than I can ever express with words.

Ashley Baird Urbanski, LMFT is the current MAMFT Administrative Coordinator and also has a private practice, Holding Hope Therapy, LLC in Osseo. Ashley specializes in treating eating disorders, body image issues, and disordered eating. She is passionate about challenging cultural narratives about food and body in order to help others restore or create positive relationships with food and body.

CONFABULATION: A BRIEF REVIEW FOR MARRIAGE AND FAMILY THERAPISTS

JERROD BROWN

Please note: This blog is originally posted on the AAMFT website to support their upcoming webinar on Confabulation.

Confabulation is an unintentional memory disturbance. Such an inaccurate memory can simply be a distortion of an existing memory or the fabrication of a new memory. For example, a client may mistakenly believe that a real event from decades ago instead took place recently. In contrast, a client could create a fantastic memory of an event that never occurred. The likelihood of this phenomenon is often increased by the presence of a range of disorders and conditions. This includes psychosis (e.g., schizophrenia), trauma (e.g., brain injuries), fetal alcohol spectrum disorder, memory disorders (e.g., dementia, Alzheimer's disease, and Korsakoff's syndrome), and other neurological conditions. In light of the co-occurrence of confabulation with these disorders, marriage and family therapists should have a strong working knowledge of this memory disturbance.

Failure to identify instances of confabulation can have deleterious consequences in treatment settings. This is largely due to the fact that many clinical activities are informed by information self-reported by the client. For example, inaccurate information can contribute to misdiagnosis and the allocation of inappropriate treatment options. Further, confabulation can result in credibility and countertransference issues where therapists may struggle in their decisions of what to believe or not believe. Beyond assessment and treatment, confabulation could result in false reports of victimization or even perpetration of physical and sexual abuse. In such instances, the marriage and family therapist may be obligated to report this information to the appropriate legal authorities. As such, inaccurate information can result in criminal charges and wrongful convictions.

Despite these difficulties, marriage and family therapists are well positioned to identify confabulation and provide support to clients suffering from this affliction. A necessary first-step in this process is corroborating self-reported information with reliable sources (e.g., family and friends). This is particularly true of clients suffering from clinical and neurological disorders and situations when sensitive memories with severe consequences have been recalled. As this process can be very challenging for the marriage and family therapist, the professional must keep in mind that confabulation is unintentional in nature and without malicious intents.

When confabulation has been discovered, the marriage and family therapist should work with the client to address any underlying clinical or neurological disorder and improve their memory recall. Interactions with the client should be slowly paced, use simple and clear language, and employ open-ended questions. Opportunities include teaching the client self- and memory-monitoring strategies and introducing the client to memory diaries. Similarly, the development of a strong support system of family members and friends is imperative. This group can not only serve as collateral sources of information, but also help ensure the client feels unconditional love and support throughout the therapeutic process. Through such a systematic approach, marriage and family therapists can help clients suffering from confabulation improve both their short- and long-term outcomes.

Author Biography:

Jerrod Brown, Ph.D., is an Assistant Professor and Program Director for the Master of Arts degree in Human Services with an emphasis in Forensic Behavioral Health for Concordia University, St. Paul, Minnesota. Jerrod has also been employed with Pathways Counseling Center in St. Paul, Minnesota for the past fifteen years. Pathways provides programs and services benefiting individuals impacted by mental illness and addictions. Jerrod is also the founder and CEO of the American Institute for the Advancement of Forensic Studies (AIAFS) and the Editor-in-Chief of Forensic Scholars Today (FST). Jerrod has completed four separate master's degree programs and holds graduate certificates in Autism Spectrum Disorder (ASD), Other Health Disabilities (OHD), and Traumatic-Brain Injuries (TBI).

WHY (Y)OUR LICENSE MATTERS

ERIN PASH, TAMARA STATZ, LYNANNE EVENSON

Recently, there has been an uptick in conversation regarding licensure, coaching, the future of this field, etc. The reality is, this is a really important conversation and requires some further input. Being licensed as a Marriage and Family Therapist is a pretty awesome thing however if you aren't equipped with the right information and support system, being an unlicensed practitioner or a coach might appear to be a really appealing option. Addressing some of the reasons why people choose to ditch their license and justification for how to make having a license easier might convince people otherwise.

BEING A LMFT IS A PRETTY AWESOME THING!

What's the purpose of my license, anyway?

E: Well, the basic answer is, to protect the public. The MN Board of Marriage and Family Therapy originated in 1991 to provide the public with the opportunity to challenge if the care they were receiving from their LMFT was unethical. "The mission of the Board of Marriage and Family Therapy is to protect the public through effective licensure, and enforcement of the statutes and rules governing the practice of Marriage and Family Therapists to ensure a standard of competent and ethical practice." Seems pretty basic. The reality is, as a marriage and family therapist, you are also a consumer. As a consumer of lets say medical goods, aren't you glad some sort of rogue physician can't treat your illness? Or operate surgery on your child? Or how about the nurses who support the physicians; they are all obligated to licensed by a board, too.

Erin Pash, MA, LMFT
MAMFT Legislative Chair

Tamara Statz, MA, LMFT
MAMFT Legislative Co-Chair

LynAnne Evenson, MS, LMFT
MAMFT Elections Committee

So while the Board of Marriage and Family Therapy might give off vibes that they are around to get therapists in "trouble," they aren't. Their only job is to ensure that the care offered by marriage and family therapist in the glorious state of Minnesota is ethical, to protect the public, and the greater field as a whole.

T: Having a license regulated means that there is a baseline standard of ethics and laws that someone who earns the license must abide by. It gives the public and other referring professionals an understanding that someone who has earned this credential should be experienced and competent to practice MFT.

Most importantly, the public needs to have recourse when a clinician is practicing unethically. Believe it or not, *people do bad work*. We hear about it from clients' previous experiences and we may have even experienced it ourselves (therapists have therapists!). Without effective regulation, clients have nowhere to turn when a clinician is practicing unethically.

Ultimately, the Board isn't there to protect you and me directly. Where in the mission statement does it say it protects clinicians? It protects the public, our clients. It helps to ensure that the work being done in the name of "Marriage and Family Therapy" is of a standard quality and basic framework. It protects our field.

L: The work that is done in the name of marriage and family therapy applies to both practitioners and professionals. A practitioner is someone who obtained their graduate course work and practicum hours and is not licensed yet. This means that if someone decided after graduating that they were going to open a private practice, they can not be advertising themselves as a marriage and family therapist, or mental health professional. (continued on next page)

WHY (Y)OUR LICENSE MATTERS CONTINUED

(continued) That person is still a mental health practitioner and should be operating under the supervision of a board approved supervisor. When they talk about their cases with other professionals, it is not consulting, it is supervision. Again, this is to ensure that all practitioners are working and interacting in way that is ethical and protects the public.

T: The license process is not there to be convenient for us. It is a daunting process. And I believe it should be. When I go to see a professional, I want to know that there is a minimum requirement for their knowledge and skill. I want to know that they are required to continue to learn and hone their skill through continuing education requirements. None of this would be possible without a regulating body overseeing their practice. The Board of MFT is no different. I want to know that others in my field are meeting basic requirements ethically and if they are not, that their clients have a place to bring a complaint and find resolution

Fearing the License

E: There has been talk about how some people don't like living with the "fear of the board." This is the notion that the board will get you in trouble for something you did or didn't do. While reporting to a licensing board can be a little nerve-wracking, most of the time it's not. Most therapists only interact with the board annually when they renew their license or turn in information for CEU's. If we want to debunk the biggest myth of the board; The reality is, you can't get in trouble unless you violate one of the ethical rules (noted in the 5300's). Even if you make a mistake and lose track of fees from a client, or slip confidentiality, and they find you "guilty" you still likely will get on a plan to correct the mistakes and you will get a chance to keep on practicing. Unless you are found in a violation that directly causes harm to a client, it is unlikely you will lose your license. And to be fair, if you lose your license, you probably shouldn't have been practicing in the first place.

Additional fun-fact, MFT's have one of the shorter codes of ethics. Have you ever taken time to sit and read the social work code of ethics? You should, it's got some good info in there. But ultimately, one of the reasons it's so challenging to become a marriage and family therapist, is because once you get licensed, you're operating at the highest level in our field, and you are trained to be great. The nitty gritty of our ethical code is to eliminate people from our field who don't operate at such a high standard, or help people have advanced training (corrective action) in some areas to continue to support the high level of professional and ethical work we are trained to do.

L: "Suspicion always haunts the guilty mind" King Henry VI-William Shakespeare. I pause when I hear people say they fear the board, and I always ask, "Why?" Are you operating in an ethical manner? If so, what do you have to fear? Those of us who have gone through our programs and then the arduous task of supervision usually come out the other side of licensure with a clear understanding of the ethics and standards of our profession. I know that I can consult with other professionals to talk out whatever I am facing. If I have a question about something, like rules or ethical considerations, I know that I can email the board and get an answer from the people who interpret our rules and statutes. An answer that protects the public and also ensures that I am meeting the standards of our field; as a bonus the people answering aren't scary! As practitioners earning our license we should be embracing the oversight in knowing that supervisors are responsible for training us! When we become professionals we should be fiercely defending our profession against those who may bring us down by unethical behavior.

LYNANNE EVENSON, MA, LMFT

LynAnne Evenson, MS LMFT is passionate about social justice, health equity, and access to mental health care. She specializes in working with refugee and immigrant populations and presents on issues such as cultural competence and culturally informed care. Currently she works at M Health Fairview in the intensive outpatient program.

WHY (Y)OUR LICENSE MATTERS CONT.

Why Does It Matter?

E: If the previous few paragraphs didn't convince you that having a license is important, this next one surely will. Aside from protecting the public, being licensed gives the work you do standing in the greater medical community. Again, would you see a doctor who wasn't licensed? Or even a hair stylist (They are regulated by the Dept. of Health too!)? When you see that someone has a license, you know they are respected in their work and you have instant confidence that they would be at minimum an ethical choice for picking as a therapist. In addition, therapists were not So highly regarded in the recent past. We still fight stigma every single day from people who think they should just "deal with it," it" being their mental health. Until recently (last 20 years or so), therapy was pretty taboo and people in the medical community didn't refer to them much. Now they do. And to keep being a part of the mainstream medical culture, we need to show that we care about not only our profession but about our clients (their patients) as well. To note: the insurance companies only decided to put us "in network" and pay for our work, because we are licensed and regulated....

We are also here to remind you, YOU WORKED DAMN HARD FOR THOSE LETTERS AFTER YOUR NAME!! The reason why you worked so hard is because you believed that you could make change and impact people's lives. Not to sound cliché, but are you really going to give up that easy because it's not always pretty? I think it's fair to acknowledge that a lot of people have doubts about the mental health field as a whole. We are definitely in dynamic times and there is major reform coming to the health industry, but that's an opportunity to power through and create change. The likelihoods of anyone taking you seriously without that license? No clue. But I know first-hand, it helps get the change makers to listen.

T: I'm proud of the letters after my name. I know the effort that went into accomplishing it. It's hard for me to put a word on it exactly, but I *feel* different after accomplishing this. there was a change in myself personally and professionally when I transitioned from LAMFT to LMFT. I know that it means something in my field, to other mental health professionals, other health care professionals, and my clients. They know that I have jumped through hoops and have proven a level of competence. Not one part of me regrets taking the 5 years that I did to get licensed. I did it at my own pace, in my own way, and with excellent mentorship and supervision along the way.

Changing the System From Within

So, we know what you might be thinking, the 3 authors of this article, are involved in the system. We all volunteer our time to be part of the MAMFT board. Which is the professional association for Marriage and Family Therapists in MN and the distributors of this article. We are not members of the regulatory board. IF anything we know first-hand that there are lots of ways to get involved that can take a lot of time (if you've got it!) or next to nothing when it comes to making an impact and create change. It just takes dedication to your future, and faith in what we offer the community. Getting involved in the MAMFT, the legislation, showing up, sharing an article, or just being proud of your license are all small ways you can get involved. As a licensed professional in our community, it comes with some rules, some power, and a lot of respect. Respect that can create new laws, that can save lives, and create a future for mental health.

TAMARA STATZ, MA, LMFT

Tamara L. Statz, MA, LMFT specializes in working with older adults and their families experience grief, loss, transitions, chronic and terminal illness, dementia, and more. She is a passionate advocate and activist for older adult's rights, independence, privacy, and quality of life. She has a private practice called Vibrant Living where she goes into the homes of older adults to provide therapy. In addition, she is a clinical researcher at the University of Minnesota - School of Public Health where she is working on a counseling intervention to help families who are caring for a person with dementia who lives in long-term care. She has been on the MAMFT board since 2015.

SUGGESTIBILITY IN CHILDREN: A NEED FOR INCREASED AWARENESS, TRAINING AND UNDERSTANDING AMONG CRIMINAL JUSTICE AND MENTAL HEALTH PROFESSIONALS

A grave concern for children in clinical and forensic settings is suggestibility. This can be defined as the propensity to unintentionally incorporate inaccurate yet plausible information from external sources into memories. This is different than compliance because the information becomes internalized as a part of memories rather than simply assenting to someone's assertions. Although suggestibility can impact individuals of any age, children and others with comparable developmental levels may present the greatest risk of suggestibility. This risk of suggestibility subsequently decreases with developmental progression from childhood into adolescence and adulthood.

"ALTHOUGH SUGGESTIBILITY CAN IMPACT INDIVIDUALS OF ANY AGE, CHILDREN AND OTHERS WITH COMPARABLE DEVELOPMENTAL LEVELS MAY PRESENT THE GREATEST RISK OF SUGGESTIBILITY"

Research findings indicate that suggestibility in children is contributed to by cognitive and social factors. Cognitive factors associated with suggestibility include deficits in executive function, short- and long-term memory, working memory, attentional capacity, intelligence, and theory of mind (ToM). Social factors linked to suggestibility include verbal and non-verbal communication skill deficits, introversion (e.g., shyness), anxiety, psychosocial immaturity (e.g., irresponsibility and temperament), and avoidance coping styles. Any combination of these cognitive and social factors increases a child's proneness to trust authority figures and concede to inaccurate statements to obtain the approval of others.

Proneness to suggestibility is exacerbated by the presence of certain situational factors. Examples of these include the use of leading and repetitive questions, presentation of false and/or misleading evidence, and assuring the child that everything will be alright despite the severity of the situation. Unfortunately, many of these situational characteristics are present in clinical and forensic settings during tense and intimidating situations. For example, police interrogations can consist of all these dangerous approaches where any elicited information can be very influential in future proceedings of the criminal justice system. As a result, these situational factors can contribute to reporting errors that have devastating consequences like false allegations related to the recovery of repressed memories, false confessions, and wrongful convictions.

To protect against the possibility of suggestibility, there is a dire need for advanced education and trainings on suggestibility for professionals working in criminal justice and mental health contexts. Foremost, these professionals must be familiar with the developmental needs of children. Any interaction should begin with the professional reassuring the child that their job is provide information and the professional is simply there to learn what happened. Additionally, the professional should rely on screening instruments to assess the risk of suggestibility when appropriate. In combination with these steps, open-ended questions that avoid implicit and explicit cues in non-stressful settings can maximize the accuracy of the reported memories of children.

SUGGESTIBILITY IN CHILDREN: A NEED FOR INCREASED AWARENESS, TRAINING AND UNDERSTANDING AMONG CRIMINAL JUSTICE AND MENTAL HEALTH PROFESSIONALS CONTINUED

JERROD BROWN, PHD

Author Biography:

Jerrod Brown, PhD, is an Assistant Professor, Program Director, and lead developer for the Master of Arts degree in Human Services with an emphasis in Forensic Behavioral Health for Concordia University, St. Paul, Minnesota.

Jerrod has also been employed with Pathways Counseling Center in St. Paul, Minnesota for the past fifteen years. Pathways provides programs and services for individuals affected by mental illness and addictions.

Jerrod is the founder and CEO of the American Institute for the Advancement of Forensic Studies (AIAFS), the Editor-in-Chief of Forensic Scholars Today (FST), and a Youth Firesetting Prevention and Intervention (YFPI) Mental Health consultant for the Minnesota Department of Health (MDH). Jerrod is certified as a Youth Firesetter Prevention/Intervention Specialist, Thinking for a Change (T4C) Facilitator, Fetal Alcohol Spectrum Disorders (FASD) Trainer, and a Problem Gambling Treatment Provider.

Jerrod has completed four separate master's degree programs and holds graduate certificates in Autism Spectrum Disorder (ASD), Other Health Disabilities (OHD), and Traumatic-Brain Injuries (TBI). Jerrod has published numerous articles and book chapters, and recently co-authored the book Forensic Mental Health: A Source Guide for Professionals (Brown & Weinkauf, 2018) with Erv Weinkauf.

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COUNTERTRANSFERENCE: WHEN THERAPIST EMOTIONS SPILL OVER INTO THE THERAPEUTIC RELATIONSHIP

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

Mental Health Professionals spend their days investing and pouring into the lives of others in efforts to help them improve their overall quality of life. These efforts often include helping individuals, couples, and families wrestle with difficult emotions that at times spill over into the therapy room. Effective therapists cultivate the skill of identifying and considerately addressing these transference emotions, with an appreciation for the fact that these feelings are often influenced less by the therapists themselves, and more by past experiences with other individuals in the client's life. Therapists also need to learn to be less inconvenienced by these emotions spilling over into the therapeutic process, and instead appreciate that not only may it be a sign that the therapeutic relationship was subconsciously deemed safe enough to be expressed in that relationship, but also that it can be an opportunity to address those legitimate emotions in a safe environment in hopes that by doing so, the client can learn to more effectively express and address their emotions outside of that therapeutic environment in their daily lives.

Unfortunately, while mental health professionals focus their efforts on identifying and addressing client transference expressions, they often miss the signs of the impact of their therapeutic efforts on their own feelings. And if not sufficiently acknowledged, feelings have the potential to sneak up and sneak out in the form of an unhealthy emotional expression and may unfortunately have a negative impact on the therapeutic relationship and the efforts to support clients.

Despite this possibility, all hope is not lost. There are practical strategies therapists can employ to address therapist countertransference, reduce the likelihood of unhealthy countertransference expressions, and repair the therapeutic relationship in the event of unexpected countertransference spilling over into the therapeutic relationship.

Look For it

In order to address countertransference, you need to see it; and as with many of life's subtleties, you are more likely to see it if you are looking for it. For example, if you find yourself having difficulty empathizing with a client, it would be beneficial to consider whether the client is truly too difficult to empathize with or whether your past experiences are getting in the way of your ability to put yourself in their shoes. Similarly, if you find yourself unusually anxious, angry or uncomfortable with a client – after ruling out any legitimate safety concerns and considerations – it would be beneficial to consider whether there are personal emotions that are influencing your perspective on your client in an unhelpful way. Without being preoccupied with it, therapists can continually ask themselves whether past experiences are influencing their perspective – in positive or negative ways.

THERAPISTS ARE PEOPLE TOO; WE HAVE POSITIVE AND NEGATIVE EXPERIENCES THAT IMPACT OUR PERSPECTIVES AND EXPRESSIONS THAT NEED TO BE ADDRESSED AS WELL.

Own it If you discover personal emotions that are causing difficulty for you in your efforts to empathize and professionally connect with your client, avoid the common professional tendency to either dismiss the emotions as irrelevant, or to judge yourself for not perfectly compartmentalizing your feelings or for having feelings that need to be wrestled with.

Therapists are people too; we have positive and negative experiences that impact our perspectives and expressions that need to be addressed as well.
(continued on next page).

COUNTERTRANSFERENCE: WHEN THERAPIST EMOTIONS SPILL OVER INTO THE THERAPEUTIC RELATIONSHIP (CONTINUED)

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

Process It

The sooner you identify and own your countertransference, the sooner you can process it. Whether you process it on your own through professional journaling, obtain professional support via consultation with trusted colleagues, or seek the support of personal therapy, your client will benefit from having the best you.

Countertransference is not a negative thing. Therapists are real people too. We have lives, and past experiences that can have a lasting effect. We need not judge ourselves for having feelings. Rather, we need to make every effort to get ahead of them – through identification, self-acceptance, and processing – in order to reduce the likelihood of our clients being negatively impacted by them. That effort can be just one of the many gifts that we give our clients – often a gift they will never even know we gave them.

Lambers Fisher, MS, LMFT, MDiv, is an AAMFT Clinical Fellow, and a Licensed Marriage & Family Therapist, with over 15 years of experience counseling individuals, couples and families from a variety of cultural backgrounds. Lambers' training experience includes facilitating national seminars and guest lecturing on topics related to multicultural awareness and diversity, as well as being an Adjunct Instructor and Supervisor for aspiring mental health and other helping professionals. You can find him at www.lambersfisher.com

LAMBER FISHER, MA, LMFT, MDIV

MENTAL HEALTH DAY ON THE HILL

IF YOU ARE INTERESTED IN GETTING MORE INVOLVED IN LEGISLATION, CONTACT ERIN & TAMARA AT LEGISLATIVE@MAMFT.NET

MISOPHONIA: KNOW WHAT IT IS AND HOW TO HELP

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

We all have certain sounds that irritate us, but for those with misophonia the body's response is far beyond that of irritation. With misophonia the body's fight or flight response is triggered by certain sounds. It is an automatic response that doesn't involve any cognition and the sound/trigger makes the body feel as if it is being assaulted. I know because I have struggled with misophonia since my tween years.

It started with my mom's gum chewing when I was 11 or 12, then went to chewing sounds by both my parents, then my high school best friend's gum chewing, then my college roommate's habit of eating M&M's throughout the day, and so forth. These trigger sounds instantly invoked feelings of intense anger, disgust and anxiety along with a strong urge to flee or lash out.

The worst part was not knowing why this was happening to me. No one else seemed to have this problem, which led me to feeling embarrassed and ashamed about it. The few times I brought it up to family or close friends it was treated as being comical or something I made up. I wanted therapy or some sort of help for it, but my requests weren't taken seriously. I don't blame my parents or friends for not being more supportive because at the time there was no name for it, they knew of no one else having this problem, and the way the symptoms manifest is confusing.

WITH MISOPHONIA THE BODY'S FIGHT OR FLIGHT RESPONSE IS TRIGGERED BY CERTAIN SOUNDS

I hoped it was something I would grow out of but when it continued to persist and worsen with each passing year, I had to accept it was going to be a part of my reality for the rest of my life. As someone pursuing a career in psychotherapy (and wanting to "job shadow" and work on my stuff) I saw a number of therapists with different skill sets over the course of my 20's. At some point in the therapy process I would have the courage to bring up my aversion to certain sounds and was repeatedly met with bewilderment, blank stares and/or amusement…along with some empathy but no helpful insight into what it was (most considered it a form of anxiety). Then it occurred to me one day to do an internet search about my hatred of chewing sounds (this was before "Google it" was commonplace) and lo and behold there were forums a mile long of people struggling with the same thing! I spent hours reading the posts that first night. I laughed a lot because I totally understood where these people where coming from as they described their rage about sounds that are insignificant to the average person and how they would like to respond if there were no consequences (i.e. think adult tantrum). Knowing that I wasn't alone was so validating and gave me hope.

Within a few years the condition had a name – misophonia. And when my son went in for some therapy five years later and I mentioned having misophonia during the family history portion of the intake process, it was the first time I encountered a therapist who knew what it was! I was thrilled word was spreading!

Fast forward to 2013 and the Misophonia Association was formed, which among other initiatives puts on an annual conference. And research is being conducted to better understand the cause of misophonia (hopefully leading to a cure)! Studies are showing there is a brain basis for misophonia and that misophonia is a neurological disorder. (continued on next page).

MISOPHONIA: KNOW WHAT IT IS AND HOW TO HELP CONTINUED

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

There is no diagnosis for misophonia in the DSM, but a group of psychiatrists in Amsterdam who have been researching the condition have proposed the following diagnostic criteria:

1. The presence or anticipation of a specific sound, produced by a human being (e.g. eating sounds, breathing sounds), provokes an impulsive aversive physical reaction which starts with irritation or disgust that instantaneously becomes anger.

2. This anger initiates a profound sense of loss of self-control with rare but potentially aggressive outbursts.

3. The person recognizes that the anger or disgust is excessive, unreasonable, or out of proportion to the circumstances or the provoking stressor.

4. The individual tends to avoid the misophonic situation, or if he/she does not avoid it, endures encounters with the misophonic sound situation with intense discomfort, anger or disgust.

5. The individual's anger, disgust or avoidance causes significant distress (i.e. it bothers the person that he or she has the anger or disgust) or significant interference in the person's day-to-day life. For example, the anger or disgust may make it difficult for the person to perform important tasks at work, meet new friends, attend classes, or interact with others.

6. The person's anger, disgust, and avoidance are not better explained by another disorder, such as obsessive-compulsive disorder (e.g. disgust in someone with an obsession about contamination) or post-traumatic stress disorder (e.g. avoidance of stimuli associated with a trauma related to threatened death, serious injury or threat to the physical integrity of self or others).

So how can you support a client who presents with these symptoms?

1) Know what misophonia is in a general sense (finish reading this article and you can check that off or go a step further and watch "Quiet Please" listed in the resources below).

2) Make sure your client knows they are not alone and there is a name for their condition.

3) Share the below resources with your client. Help your client better understand the condition.

4) Encourage your client to exercise frequently and take time to do activities/be in settings that are calming to their nervous system.

5) Brainstorm coping strategies and ways to modify their environment to minimize triggers and the effect of triggers (ex. strategic placement of white noise machines).

5) Help the client in managing the emotions that come with misophonia (shame, rage, anxiety, grief). The following treatment approaches have shown to be effective with some misophonia sufferers: CBT, DBT, mindfulness, hypnosis, somatic work, EMDR, Alpha Stim and Neurofeedback. You may need to refer your client to someone who specializes in one of these treatments for misophonia-specific support, along with professionals in other fields who understand the condition such as chiropractors and audiologists.

6) Do systems work! In particular, work with anyone the client lives with (whether it be parents, a spouse, roommates, etc.) to help them better understand the condition and support the client in coping (along with validating their experience – misophonia is tough to live with!).

If you are an educator: Classroom settings are one of the most challenging settings for those with misophonia because of snacking, gum chewing, pen clicking, etc. Create a safe environment for students with misophonia to be able to let you know they have the condition and offer/brainstorm possible modifications so the student can better focus on what is being taught versus the sounds in the environment.

(continued on next page).

MISOPHONIA: KNOW WHAT IT IS AND HOW TO HELP CONTINUED

LETTERS TO THE EDITOR – OUR GREATEST TOOL: THE THERAPEUTIC RELATIONSHIP

Making my condition known to all of you (especially considering my role with MAMFT) is another big step in my journey of combating misophonia. I hope it results in more and more clients feeling understood when they present with misophonia in therapy.

One of the reasons I hold back from telling people about my condition is that I don't want people to feel anxious about eating around me. Fortunately, my misophonia isn't on the severe side and my triggers are generally with those I spend a lot of time with. Gum chewing is the exception. It always triggers me. So now you know to not chew gum around me. The same goes with Oprah if you ever meet her.

Resources

Film: Quiet Please

Misophonia Facebook page: Stop the Sounds

Research Article: The Brain Basis for Misophonia

MN Audiology Clinic (source for white noise generators): Audiology Concepts

Book: Understanding and Overcoming Misophonia: A Conditioned Aversive Reflex Disorder

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SARA BIDLER, MS, LMFT

Daisy Camp

For your ever-expanding life!

Full Day Divorce Retreat:

Wise Women Divorce Better...

The emotional, financial & legal essentials

May 11th, 2019 from 8:45am-4:45pm

Cost: $60 until 1 month prior, after $85 *(Scholarships available)*

Daisy Camp is a one of a kind retreat that provides financial, legal and experienced advice from qualified professionals that help women who are going through divorce transition. Coupled with the business seminars, inspirational and self care sessions, which help enable women to navigate the business and emotional realities that come from a divorce proceeding. Price includes program, lunch and beverages.

Upcoming Divorce Workshops:

Suggested donation of $25, scholarships are available!
Workshop details and more info at www.DaisyCamp.org

Divorce Choices:
Understanding Your Options

(Edina) April 10th, 5:00 - 6:30pm
& July 17th, 5:00 - 6:30pm

Empower Yourself:
Intro to Divorce Law & Process

(Woodbury)
April 24th, 6:30 - 7:30pm

Dollars & Sense:
Understand your financial future

(Edina) June 13th, 4:30 - 6:00pm
& August 1st, 11:30am - 1:00pm

Daisy Camp, a non-profit organization, helps women facing divorce by:

- Providing reliable financial, legal, and practical information from some of the leading professionals in our community.
- Creating a safe and confidential environment where women can step away from their busy lives and reflect on the next steps in their journey.
- Developing a community of women who help each other find strength, inspiration, and even fun, during difficult times.
- Making generous scholarships available to assist woman enrolling into a Daisy Camp retreat or workshop.

3300 Edinborough Way Suite 550, Edina, MN 55435 | Phone: 952-405-2060 | Daisy@DaisyCamp.org | www.daisycamp.org

MAMFT Greater MN Conference

Breaking Trauma's Silence: Our Country's Awakening to Sexual Health

May 3rd, 2019

Earn 6 CEUs! Approved by MFT and SW Boards

Join us this spring in Moorhead for the biennial MAMFT Greater MN Conference!

Markie Twist, PhD, LMFT will be our keynote speaker and will present:

If You Can't Talk About Sex, You Probably Shouldn't Be Having It: Sex Talk as Sexual Health

In this Keynote, the presenter will open with a comprehensive definition of sexual health, and note the barriers towards attaining such health. One of the biggest barriers to sexual health is the larger oppressive societal framework in which we all exist, which keeps many of us silenced and shamed from engaging in comprehensive, sex positive dialogue and discussion. Thus, the presenter will detail mechanisms through which clinicians can assist individual, couple, family, and relational system clinical participants to break through sexual silence and sex negativity in order to gain in sexual health and wellness. Such mechanisms will include tools for discussing and negotiating consent, provision of related assessments like the sexuality- and gender-focused genograms, and tips for assisting clinical participants in being empowered to engage in lifelong age-appropriate sex talks. Following the keynote, workshops will be provided by local therapists on the following topics:

- *Consent Violations in Loving Relationships-Healing through Pleasure*
- *Let's Talk Pleasure*
- *Taking Sci Fi Out of Sex: Uncomplicating Sexual Issues in ASD*
- *The Double Bind of Sexual Violence*
- *BDSM: What It Is, What It Isn't*
- *Working with Trauma in Global Family Therapy: The Need to Repair the Cultural Worldview when Healing from Sexual Assault*
- *Transforming Adverse Life Experiences*
- *Turn On! Arousal Explained for Every Body-The Therapist Version*

The conference will be held at the Courtyard by Marriott Moorhead. Rooms can be reserved at the discounted rate of $99 by calling 218.284.1000 and mentioning the MAMFT room block. A limited number are available.

There are many opportunities for marketing your business at the conference!

For more information on all of the above and to register go to:

www.mamft.net

HE SAID SHE SAID: SWAN SONG

KEN STEWART & BRIER MILER

She said

Well, we knew it would have to happen someday. The ending I mean. We knew the time would come when we would say goodbye to He Said/She Said. What started as an impulse to try writing a column together turned into a journey that lasted more than 15 years. So it seems important to honor all those years together and how different it will be without a looming deadline challenging us to come up with yet one more topic.

As in any goodbye, we are saying farewell to the columns that were misses as well as the hits, farewell to the moments when we actually wrote into brilliance, and to those not infrequent times our words fell flat. Right in front of our colleagues too. But I think that's been some of the greatest reward of this experience, Ken, the risk-taking. I'm grateful we risked showing up. Like our clients do all the time. As in our work with clients, every column was not a masterpiece, just like every session is not a miracle. But sometimes a single sentence that you've written has lingered in my mind for years, much like I know my voice will linger in the heads and hearts of the clients to whom I am now also saying goodbye. I will go with them, just as they will stay with me, the everyday miracle of attachment.

He said

When I was a beginning therapist, I was desperate to learn all the therapeutic techniques I could get my hands on. Having just a superficial idea what psychotherapy was, I thought that clever moves and directives were what it was all about. And there were plenty of cool 'techniques' that were quite effective if I didn't turn to them too often: enactments, reframing, shifting chairs, whacking tennis rackets on pillows as you screamed your anger, talking to your [mother/father/sibling/abuser] in the empty chair, speaking for the client in imagined encounters, and on and on. Structural and Gestalt therapy were replete with techniques guaranteed to stir things up and rearrange things. Some I don't use anymore because I've moved on to other ideas and other approaches. Although I still rely on enactments – asking clients to talk directly to each other instead of about each other. And reframing – providing alternative ways to describe situations or people or events – can often have a powerful impact. And of course, there are the specific trauma therapies of EMDR and Brainspotting. You can take the beginning workshops in both of them and be proficient for 90% of your clients. But you will want to take the levels 2, 3 and 4 (and maybe more) to hone your technique and master the more challenging situations. It never ends. I am 73 years old and have been practicing for 43 years – and I am still taking courses and still learning.

She Said

Me too, but our courses are different. Every Monday morning I go to a studio and paint with oils. The teacher's guidance, the mixing of paint on palette and then onto canvas, the chatter of other students, the satisfaction when something looks "painterly"... this is what draws me these days. And a monthly writing group I've been in for almost ten years, where our teacher points us inward to find our voice in order to put it on the page. I want to write more about therapy, even as I am stepping away from providing therapy and even as I say goodbye to THIS writing about therapy.

Writing this column with you has been a great experience. So, it's not surprising that as I write this, I am remembering other wonderful opportunities I have had in my career – over two decades of graduate teaching, mentoring and supervising many gifted family therapists, helping build MAMFT and the strong presence of MFT in our state, getting to touch and be touched by the lives of my clients. Wise and generous colleagues and mentors of my own.

Early in my career I heard it said that in a "goodbye" is every goodbye. As I have wrapped up with clients through the years, I have felt that - the presence in the room of their other losses (and my own). I've had to bid farewell to many of the family therapy pioneers during my career, and even if I never met them I feel their absence. I miss their bright enthusiasm and their conviction that family therapy is revolutionary. One of the less well-known (but no less impactful) pioneers was Charles Barnard, who started the MFT program at UW-Stout, one of the first graduate programs in the country. I am ever grateful to Chuck for his influence and the opportunities he gave me, first as a student and later as a part of the teaching/supervising team. His death almost 10 years ago adds a personal loss to my goodbye, but I celebrate the fact that his influence is very much alive.

I guess that's my hope, as I wind down a career that has filled and sustained me for almost 40 years – that my clients have felt that I felt and loved them, that our work together added value and meaning to their lives, that my colleagues have experienced my contributions as enriching and empowering, and that my influence will linger even as I pass on.

I hope my voice will go with you all.

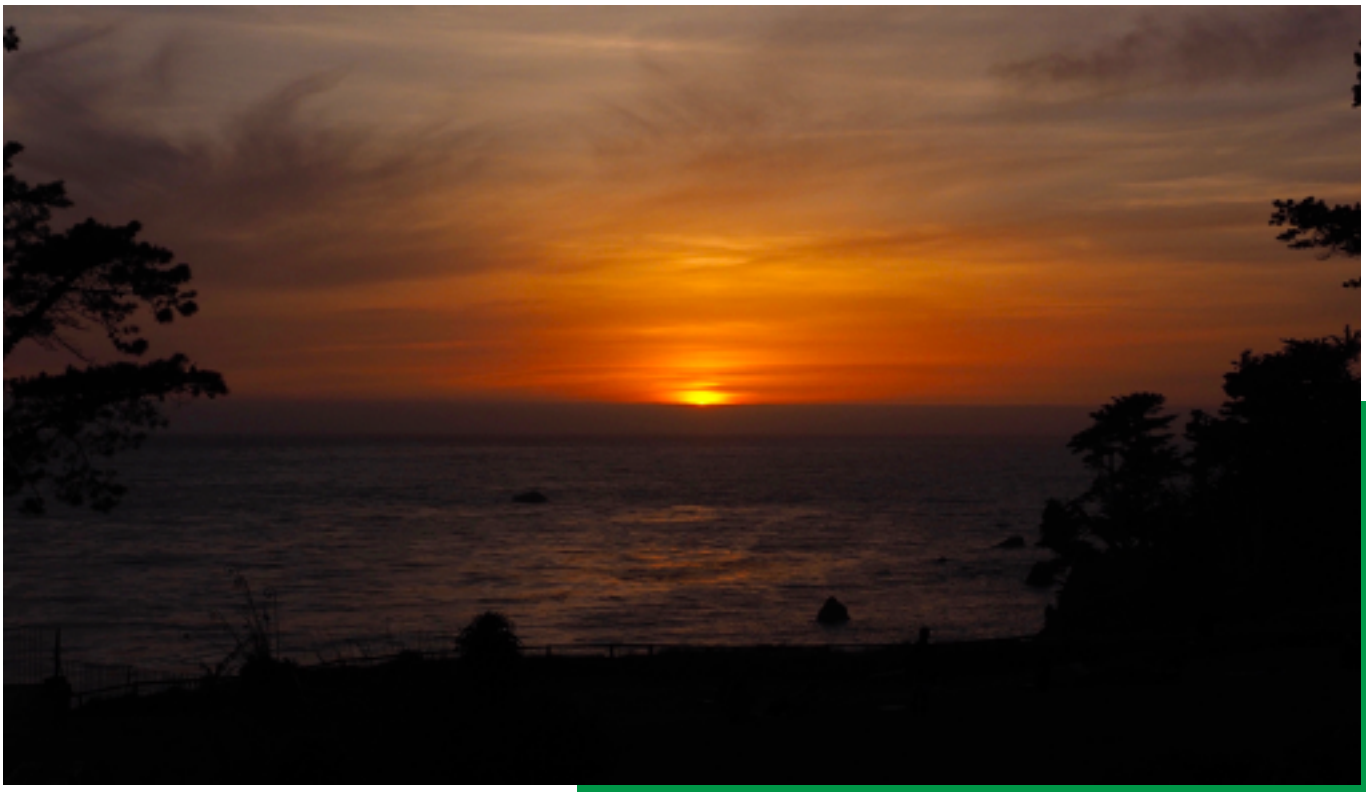
HE SAID SHE SAID SWAN SONG CONTINUED

He said

When I began my practice in 1975, I created a workshop to promote my practice and called it – "Endings and Beginnings – Who is ever ready?" I suggested the idea that most of our lives we live in rhythms of endings and beginnings. One of the most important things we must learn is how to say goodbye in order to say hello. If you can't let go, if you stubbornly hold on to your own version of nostalgia, your own 'splendor in the grass or glory in the flower' you will stay stuck. Instead of finding strength in what remains behind as Wordsworth promises, you will live your life looking in the rearview mirror. Sheldon Kopp (and the poet, Dylan Thomas) said it is the 'refusal to mourn.' We must not refuse to mourn. We must mourn our losses, mourn what cannot be recovered, and move on. Our memories form and reform our identity. Our memories are molded and remolded with each telling. Our stories get slightly altered according to the purposes of our storytelling to the particular audience listening to us at the time. Telling a story to my students may be different in telling the same story to my family.

What lies behind in this professional life of mine from a green beginner in April of 1975 at age 29? Three years of Gestalt Therapy training, five years of intense encounter groups – from being a participant to becoming a trainer; nearly four years of marriage and family therapy supervision. Countless workshops with Carl Whitaker, Sal Minuchin, Virginia Satir, Murray Bowen, Gus Napier, to Sue Johnson, Besel van der Kolk, Laurel Parnel, Harlene Anderson, Francine Shapirio, and David Grand. Every year some 2-day or 5-day intensive training that shaped my work, expanded my skills, and made me a more effective psychotherapist. It has been a journey from not-knowing, to knowing, to wisdom. Now I would call my approach "Collaborative Wisdom Therapy" – an approach that empowers the knowing of my patients, that generates transformative dialogues, and finally, that uncovers the hard-earned wisdom of those that seek me out for conversation.

I am honored to have been along for the ride.



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