MAMFT News

THE NEWSLETTER OF THE MINNESOTA ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

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SPRING 2018

LETTER FROM THE EDITOR

Happy Spring MAMFT,

What I love about following our quarterly newsletter-posting schedule is that it encourages me to think more about the change that comes with each season. I am reminded to appreciate the cycle of change and newness. I hope you are all enjoying longer days, more hours of sunlight, warmer temperatures, the melting of snow, and Girl Scout cookies (I recently discovered there's gluten free Girl Scout cookies!)

Check out this edition to keep up to date with the changes we are making at MAMFT. Spring in Minnesota isn't always that glamorous, but maybe on one of those late March or April snow days check out some reading recommendations from your colleagues.

Thank-you to all those that contributed to the Spring 2018 Edition. Thank-you for continuing to support connectivity, relationship and relevant dialogue within our MAMFT community. Whether you are a Marriage and Family therapist, mental health practitioner, a student, social worker, psychologist, a helper or healer, MAMFT invites everyone to join in continuing to make MAMFT vibrant in Minnesota.

Best,

Christine Dudero, MA LMFT
Newsletter Editor

PRESIDENT'S COLUMN
IF YOU BUILD IT, THEY WILL COME

According to the popular movie from 1989, "If you build it, they will come." I can't help but recall that phrase when I think about MAMFT. Many years ago, a few hardworking people had the desire to connect, to form relationships, and to bind together as professionals doing relational work. Now that we find ourselves a month and a half into our independence from AAMFT, I want to take a moment to reflect on the hard work of so many that made independence possible. This was certainly not an overnight decision and required a lot of behind the scenes efforts from so many.

The word **pioneer** means trailblazer, pathfinder, innovator, and leader. I was able to have lunch today with a group of pioneers. The Council of Past Presidents met for the first time and I found myself very privileged to meet with a group of Past Presidents that have all walked in similar shoes that I find myself walking in now. These people definitely were/are pioneers. They all provided leadership and guidance to the association in its various stages of development. As a parallel, I had different relationships with them in various stages of my professional career. From school program leader, supervisor, colleague, fellow board member, conference travel companion, instructor, and fellow collaborative board meeting attendee, they have all played a part in my development as well. It is for this reason that I'd like to talk about the roots that this association was built on so many years ago.

Relationships. This should not be a surprise that the association was started at a time where relational therapists had to defend the work they were doing. The value of relational therapy was being called into question. Licensure was not even an option in many states. Our association was started because some key people felt that ***Relationships Matter***. We find ourselves surrounded by relationships every day. Our clients have relationships, we have relationships or connections with our clients, we have relationships with colleagues and mentors, and our professional identity also binds us together in relationship.

When I joined the association many years ago, it was from the advice of Ginny D'Angelo. At the time, she was my practicum advisor. She did not tell me to join because it was cheap. She did not tell me to join because I would get discounts at conferences. She told me to join because I would be welcomed into a community of likeminded professionals that can offer guidance and support, a home, of sorts. It was because of my relationship with Ginny that I felt compelled to join my professional association. It was my home. I want it to feel like home to you as well.

Relationships are not always perfect and sometimes relationships are really hard, so I am fully aware that some people may not feel as at home in the association as I do. To that I would say, the board is invested in making this a home for many professionals regardless of licensure, age, gender, political or religious views, or race. We are actively working on building bridges in our professional communities so that others might begin to feel welcome at the table.

Please join MAMFT as we continue to build relationships and carry on the torch that was started so many years ago. Maison, casa, guriga, bahay, tsev, Zuhause….. welcome *home*.

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

MY ROAD TO INCREASING COMMUNITY ENGAGEMENT

I've recently joined the Elections Committee, which is a group of MAMFT members responsible for vetting and recruiting for our board. In hoping to energize others to consider becoming engaged with the board or a committee, I thought I'd share a bit about my own process toward joining the Elections Committee.

Two years ago a co-worker told me about an open position on the MAMFT Elections Committee. At the time, other obligations, combined with little involvement in MAMFT activities kept me from running for a position. This year, everything lined up. When I again learned of an open position I decided to take on the three-year commitment for a few different reasons.

The first reason has to do with connecting with like-minded and supportive peers. When I was in my MFT training program at St. Mary's I learned from my teachers, who had been in the field for many years, that throughout their careers they'd met with the same set of colleagues in a peer consultation group. In this group, they grew as clinicians through mutual support and shared knowledge. I always appreciated this approach and I've learned to seek peer support and consultation on my own. Joining the MAMFT elections committee was partly out of my desire to continue broadening my connections in the field.

Another reason I decided to run is because I believe in sustaining our professional community. I've learned that **in Minnesota we have one of the largest state associations.** I appreciate and recognize our good fortune at having a large and vibrant MAMFT community. Joining the elections committee helps me to engage and support more fully.

Being on the committee also helps me feel more aware of and involved in the exciting changes since MAMFT has become independent from AAMFT. Prior to being on the committee, I took more of a passive, sideline approach to being a MAMFT member. This is changing as I take a more active role.

Now that I've started my term on the Elections Committee, I have learned more about what happens on the board, including the level of commitment people have for their positions. What I've learned helps me to appreciate how much goes into running the board. One example of board-sponsored activities is low cost/high CEU trainings. I've registered for the Somatic Experiencing training in May. It's *free*! Smaller and less committed boards would be unable to make these opportunities available.

For me, becoming a committee member was typical for how this process will go for future incumbents. It began with learning more about the commitment from the existing Elections Committee members who initially told me about the position and attending a board meeting. The committee then helped me through the process of writing out my elections statement by providing questions to think about. Once I had written responses to the questions, the Elections Committee helped by honing my thoughts into a cohesive statement. Finally, the statement was put on the MAMFT website, which was then released to the greater membership who later voted.

Those of us on the Elections Committee will be talking to MAMFT members in the upcoming months as we look to fill spots that are opening up both on our committee and on the board. **Consider for yourself what it might be like to be part of this team!**

Lucy Grantz, LMFT is a therapist and art therapist who works with children, ages 6 and up, adolescents and adults. Lucy works at Natalis Counseling and Psychology, a mental health and counseling clinic in St. Paul. The focus of Lucy's work is on increasing understanding in relationships in order to improve well-being. She is also working on a sub-specialty in OCD treatment for all ages.

RURAL LIFE OF AN LMFT:
A PLACE WHERE EVERYBODY KNOWS YOUR NAME

Dual Relationships? Double Relationships? Boundaries? Competency? Ethical Dilemmas? It's hard to know the black and white line of these things, when you are practicing in rural MN. When I go to the local coffee shop to grab a cup of coffee, odds are that my barista is a current client, previous client, a friend, or a family member of a current/previous client. When I go to a restaurant to eat with my family or friend's odds are the hostess, bartender or waitress is one of these as well. If that person was a hostile client or didn't like your services, odds are you are not going to want to drink that coffee or eat that food. When I go to Walmart, Target or the local grocery store, odds are you will run into a client or two. As many of us know, our clients are not shy; they will approach to say hi and chit chat about what is going on in their life since they last saw you. Sometimes you don't want your male client staring at that box of tampons sitting right on top of your cart, but that's life as a practitioner in rural MN. This is a normal phenomenon that happens on a regularly basis, not something that happens once a year.

Where does the community go for help? It's not practical or feasible for low income, poverty ridden families to take an entire day off of work every week to be able to travel outside of their community to see a provider that doesn't know their family name or a family friend. Further, many individuals in rural MN struggling with mental health, do not have the luxury of a vehicle or public transportation so they are dependent on volunteer drivers, their own two feet, the city bus (if the community has one), or friends/family to bring them to appointments. I have client's that travel 50 miles one way for an appointment because there are no providers closer to them for services. I have client's that walk 5 miles one way to get to an appointment because they have no other form of transportation. Although some are allowed volunteer drivers through their insurance, many turn this away for the simple fact of a dual relationship. I understand! Who wants the person that gives them communion at church to be the person driving them to their chemical dependency treatment? They are already ashamed enough of themselves, they don't want to put themselves in the place of public shaming.

Dual relationships are impossible to avoid at times in rural MN. After all, where does the Pastor go when he is struggling with marital issues? He calls you. Where does the Doctor go when their teenager's behaviors have become out of control? They call you. Where does the Dentist go when they are struggling with grief and loss? They call you. How about when your local co-rec volleyball or softball league needs a sub player for the week and one of your teammates finds someone that is a previous or current client? You smile and play the game. Or when the opposing team has a current or previous client playing with them and you accidently spike the ball in their face or pitch a ball into their leg? It puts a whole different dynamic on just living your life when you are rural practitioner. When you go to the gym, and you are mid-sweat only to look to your left and see one of your client's that pushes boundaries sits down on the machine next to you and starts chatting about therapy related stuff. When you go to your cousin's wedding, and several clients are sitting in the room…of course they see you. This might put a damper on your own personal enjoyment of what is meant to be a beautiful event. When you go to your friend's baby shower and another client is there that you never knew was friends with your friend. This might put a damper on this intimate moment. This is the kind of stuff that happens on a regular basis in a rural practitioner's life that grad school never teaches them how to deal with.

….Stay tuned for the next newsletter and follow up to rural life of a practitioner!

P.S. I would love to hear about what types of rural dilemmas you have found yourself in!

Email me at charlinebengtson@yahoo.com and share your stories.

My name is Charline. I'm a Licensed Marriage Family Therapy. I provide therapy and counseling services for individual, couples, groups and families in a safe, confidential, and respectful environment that facilitates growth and healing. I have been practicing in the Willmar & Paynesville area since 2010. I expanded my services to the Alexandria community in 2017.

When I'm not at the office or researching current mental health trends, I can be found with my family and friends enjoying the great outdoors.

SEX WORK AS LABOR:
RESPECTING AUTONOMY OF THERAPY CLIENTS WHO BUY & SELL SEXUAL SERVICES

Assuming therapy clients who pay for sex have traits of sexual narcissism and feel "entitled" to women's bodies is based on harmful myths and stereotypes about those who pay for sex. As systemic mental health providers, being curious about the needs the client is getting met when they pay for sexual services is key– is it an emotional need? A physical need? A need to express a type of sex that is not "allowed" in the relationship" All or none of the above?

If seeing a sex worker is breaking a relationship agreement the client has with their partner, they may not be getting a need met in their relationship or may be unable to assert their needs. Examining the systemic function the behavior of paying for sexual services plays usually reveals more about our clients' needs and wants in their relationships and sex lives. This information helps us set collaborative goals that may or may not include the client paying for sex.

Conversely, the antiquated notion that women should only have sex with men "for free" is based on male entitlement to women's bodies and grossly gendered ideas of emotional and sexual labor.

This notion is also based on gendered assumptions about women and sexuality – namely that women who engage in sexual behavior in exchange for money are either deviants or victims, as the stereotype of women who have any type of sex is that their sexual behavior must be "intimate" or "emotional". Gendering sex in this way is inaccurate and harmful – as it often results in female-identified people being expected to provide sex and intimacy "for free" and discounts emotional and sexual labor as a valuable type of work.

Viewing sex work as a legitimate type of work is an effective way to move past these false assumptions. From a labor perspective, selling a sexual service is akin to selling other types of emotional, physical or intimate services – which therapists and other helping professionals (including somatic body workers, surrogates, etc.) engage in themselves and already view as a service that can be provided for "free", or be provided for a fee.

When it is assumed that all sex workers are exploited, trafficked, or otherwise coerced, worker agency and autonomy are ignored along with the personal choice our clients have to decide what to do with their sexual labor. This anti-sex work position is inherently anti-feminist and unethical, as our therapy clients and the people they relate to have autonomy and agency and are already making informed decisions which we as clinicians are to respect.

Depathologizing and destigmatizing sex work are both important parts of my work at the Minnesota Sexual Health Institute. I see therapy clients who are current and former sex workers, clients of sex workers, couples struggling with relationship and boundary issues, and individuals engaging in out of control sexual behavior. If you are interested in consulting with me about a sex worker-specific case, I am happy to offer my time and expertise in this area.

Katie Bloomquist, MS, MA, LAMFT
Vice President, Sex Workers Outreach Project - USA

Minnesota Sexual Health Institute
www.mnsexualhealth.org

Katie is a sex therapist and LAMFT in Minneapolis providing systemic psychotherapy for individuals and couples in the LGBTQI+ and sex work communities who are struggling with mental health, relational and sexual health concerns. She is kink and poly-positive and competent and is affirmative of ALL consensual unconventional sexual behaviors. She has several sex work research publications and presents academically on the sex workers rights movement, sex work stigma and the minority stress of sex work at sexual health and therapy conferences. She is currently developing a training for therapists and human service providers aimed at reducing clinician bias against sex workers and increasing cultural competency. She runs a therapeutic support group for current and former sex workers in Minneapolis at the Minnesota Sexual Health Institute.

WHY SHOULD I JOIN MAMFT?

As of this writing (end of February), 500+ individuals have decided to come alongside other relational healers in the area and join the newly-independent MAMFT! That's amazing! Let's keep going!

The real reasons why folks choose to join MAMFT are many and garden variety. We all come to the organization with different backgrounds, histories, areas of expertise, and lenses through which we see the world. And that is part of what makes coming together so great! We really are stronger together. *Relationships Matter.*

The strong start to the first 2 months of our new organization shows that 500+ people agree, relationships matter! First and foremost, I think, that is what one gets from being a part of MAMFT. *You really do get out whatever you choose to put in*. It won't be handled to you on a platter or in a cute MAMFT-branded water bottle. (Though I would like one of those!)

You will not find **networking** to be a benefit if you never step up to take part in a networking-related event. **Training** and ongoing learning opportunities are not only required for our licenses, but help us to serve our clients with up-to-date knowledge and competence, and MAMFT has several exciting trainings coming up this year – but you have to come to them to get the benefit!

These are just two examples of how getting involved in your professional association can positively impact your career and connections to others.

On a lighter note, you know those times when folks say _____ is "cheaper than your daily latte habit" or whatever sort-of guilt-inducing, self-awareness-raising comparison.. here is your very own, related to a few of the MAMFT membership levels and the wonderful food that comes from Chipotle.

Clinical Fellow – a low rate of 11 steak burritos!

Pre-Clinical Fellow – whoa, only 3 orders of chicken tacos!

Student – 2 – that's right – a mere 2 carnitas bowls!

Retired – 3 barbacoa salads, not bad!

You don't have to tell me how often you go to Chipotle, and I won't tell you how often I go to Punch Pizza! Both are walking-distance from my office. But look at those numbers! Deep breaths – you don't have to cut your Chipotle habit to pay for MAMFT, it's just for comparison!

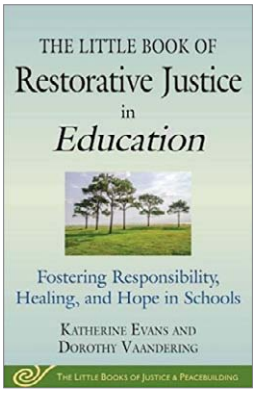
In the end, really, it's not about dollars or burritos, it's about *connections*. Want to find a new job? *Connect with others to find out what's out there*. Need a supervisor for licensure? *Connect with other Pre-Clinical folks to find out who's good (or bad!)*. Looking to offer a consult group? *Connect with other therapists who are interested in the same topics and are in need of consult*. The combinations are endless – just like when you're in line to order at Chipotle.

You get to choose what goes into your MAMFT burrito, whatever suits your tastes. Everyone's 'reason' burrito will be different, but that's part of what makes this community so great!

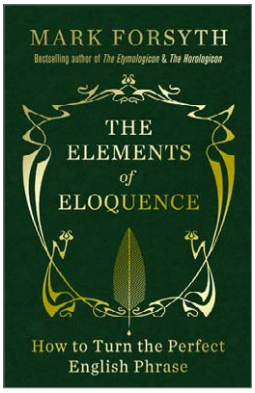
Cheers to tasty food and more importantly, connections.

Tamara Statz, MA, LAMFT
MAMFT Pre-Clinical Representative

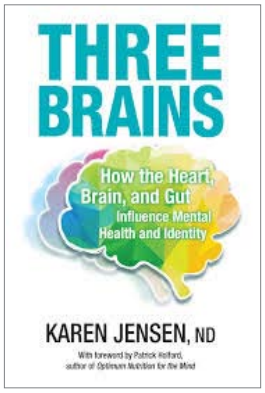
PRE-CLINICAL READS



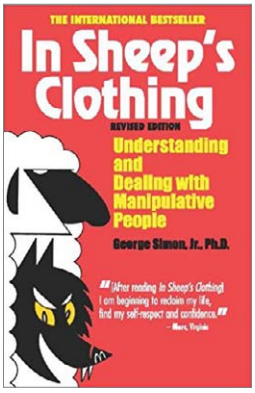
THE LITTLE BOOK OF RESTORATIVE JUSTICE IN EDUCATION



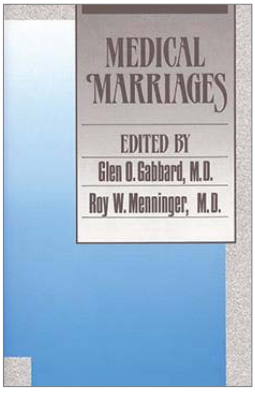
THE ELEMENTS OF ELOQUENCE



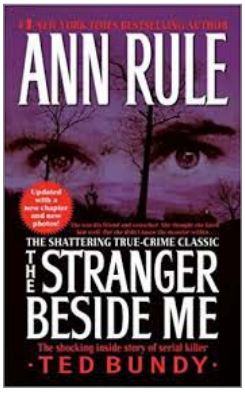
THREE BRAINS



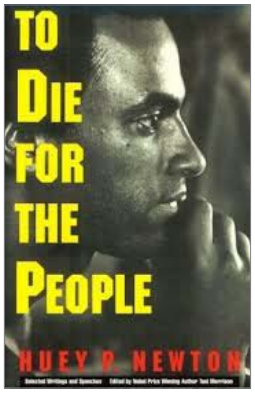
IN SHEEP'S CLOTHING



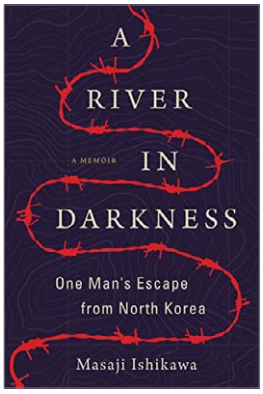
MEDICAL MARRIAGES



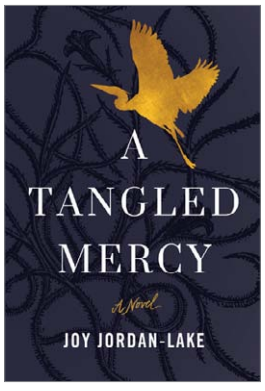
THE STRANGER BESIDE ME



TO DIE FOR THE PEOPLE



A RIVER IN DARKNESS, ONE MANS ESCAPE FROM NORTH KOREA

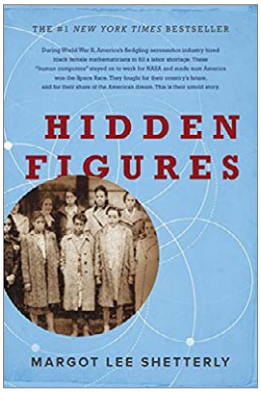


TANGLED MERCY

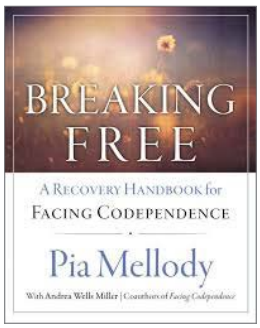
PRE-CLINICAL READS

TIPS FOR LIVING

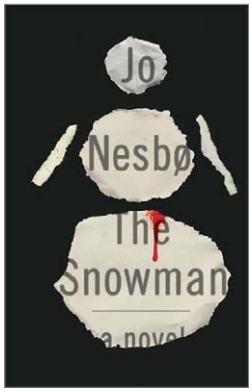
THE GENDER GAME SERIES



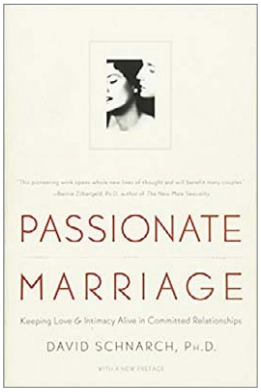
HIDDEN FIGURES



BREAKING FREE A RECOVERY HAND BOOK FOR FACING CODEPENDENCY



THE SNOWMAN



PASSIONATE MARRIAGE

MAMFT GREATER MN SPOTLIGHT
INTERVIEW QUESTIONS

Name:
Terri Ross

Credentials:
LMFT

Education:
Bachelor of Arts in Psychology, Child Psych. Minor from the University of Minnesota Minneapolis, Master of Arts in Marriage and Family Therapy from St. Mary's University, Minneapolis.

Place of employment/What do you do?
Terri Ross Family Connections, LLC in Faribault, MN.
I started my Private Practice in 2015 after working professionally in a school setting.

Why do you do what you do? What motivates you?
I have worked in child protection, and as a parent mentor for the prevention of child abuse as well as for a private adoption agency placing waiting U.S. children into permanent adoptive homes. I want to help people (re)-process the events that happen in their lives. I use Cognitive Behavioral therapy, Art and Play therapy to help children and families try on new thinking lenses to feel differently and be able to choose their behavior. I provide a safe space for couples to air their grievances with each other and learn new skills. What motivates me; The good feelings I have when people are feeling better, leaving my office in a better mood than when they entered. That motivates me to keep doing what I do.

How did you get into this field?
While working for a rural county in child protection I was able to receive education from Dr. Charles Bernard from Stout University, Wisconsin on in-home family therapy. The training helped me to help families stay together and provide children with permanency. He inspired me to pursue my education to become an LMFT.

What do you know now that you wish you had known as a beginning therapist?
My role is to help people find ways to feel better about themselves, by thinking outside the box. People need to feel hope and trust in their own powers to feel better. I've learned that people are all different and unique. Some have more acceptance and tolerance of others.

How has a client impacted you?
Admiring the work ethic and hard learning curve of a father out of prison who became a single parent to his children.

How do you practice self-care and keep balance in life?
I go to plays, music venues, sit out in the sun, garden, listen to music and have recently been challenging myself with Sudoku. I love to go to the ocean.

If you weren't a therapist what would you do instead?
In another life I think I'd love to be a farmer.

What are people surprised to learn about you?
I've been married nearly 38 years and have 12 grandchildren.

What are some of your hobbies?
Reading, canning salsa and raspberry jam, cooking, playing piano and caring for my horses, cats and a dog.

Favorite quote?
Life is what we make it. Always has been always will be.

Ultimate bucket list item?
To learn to hang glide

Best book recommendation?
"The Four Agreements"

What is your involvement with MAMFT and why do you choose to be involved?
I want to be more involved on the MAMFT Greater Minnesota committee. The MAMFT provides great training opportunities for pre and clinical members. They do a great job of promoting unity, respect and professionalism in what we do.

Terri Ross, LAMFT

"I Am Not Sick, I Don't Need Help" – *Xavier Amador, PhD. (Vida Press, 2012)*

For the last 20 or so years, brain research has helped us understand that the serious mental illnesses of schizophrenia and bipolar disorder are diseases of brain function. During the century before the "Decade of the Brain (the 1990's)", these rare and frightening mental diseases were blamed on bad or inadequate mothering (the "schizophrenogenic mother"), thanks to the early theories of Freud and subsequent generations of psychology, puzzling over the cause and treatments of such life-altering and permanent mental illnesses.

In his wonderfully personal and helpful book "I Am Not Sick," Dr. Amador explains that the primary feature of these severe mental illnesses is the core belief that the sufferer is "not sick." In medical terms, this disbelief in their illness is called "anosognosia" (ã-nõ'sog-nõ'sê-ã). Sufferers may be homeless, talking to voices in their head, unable to sleep or put together a clear sentence, believing that aliens have made inroads to their cells, but to these ill brains, the beliefs and thoughts are as real as sunlight and gravity.

If you have ever been in a relationship with someone who has become mentally ill and whose illness has this feature of anosognosia, you know that trying to convince them to get to the hospital for treatment or to take their medication is a futile, frustrating, and relationship damaging exercise. But this is how almost everyone attempts to get their loved one's the help they need to be safe and recover.

In his best-selling book, Amador explains the model of engagement that he has developed over 30 years of living with his older brother, who was a schizophrenic, and working as a professional forensic psychologist and therapist. He walks the reader through this counter-intuitive but effective model that listens, understands and collaborates with the sufferer, who, in the end, must participate in their care in order to get better.

He calls this program "LEAP," which stands for Listen, Empathize, Agree and Partner. Utilizing the tools familiar to therapists of Client-Centered/Active Listening, Cognitive-Behavioral, and Motivational Interviewing models, Dr. Amador provides tools, examples, and scripts as examples of learning to use this strategy with loved ones who need help.

I read this book as a way to help one of my clients, whose loved one is beginning to demonstrate marked personality changes, delusions and strange behaviors. As we talked about how to be helpful short of calling 911, this book has become a welcome addition to my library and therapeutic models. If you continue to wonder how, as a family therapist, you can actually help these patients and families, I urge you to get this book or log onto his website, LeapInstitute.org.

Lynne Silva-Breen, MDiv, MA, LMFT
Lynne has a private practice in Burnsville, and is the current Treasurer of MAMFT.

COUNSELING ADULTS AND COUPLES

ON THE AUTISM SPECTRUM

A couple comes into your office complaining of problems with communication and conflict resolution. Sounds pretty routine, right? You know what to do because you've seen this scenario many times. However, after a few sessions you begin to see that something is very different about this couple.

One partner, say it's the husband in this case, is relatively okay with the relationship and can't understand why his wife is making such a big deal out of things. The wife complains of feeling lonely and disconnected from her husband. She is tired of doing everything to keep things running in their household. She complains that her husband is disengaged from the family focusing mostly on himself and his own interests. He can't seem to remember to do simple tasks and promises to help but doesn't follow through. When she reminds him of things he's promised to do he reacts with extreme anger. He won't discuss it with her, he shuts down and goes into his own little world. The wife is left feeling frustrated and all alone. Because she's afraid of his anger she stops asking him to do thing.

In your counseling sessions the husband promises to be more attentive to his wife's needs and is given specific examples of what he should do. He says he loves her and will do anything to save his marriage. The wife is learning to be more assertive, asking for what she wants and needs.

When the couple returns to their next session you ask, "How did you do with your homework this week?" The husband looks at you with a blank stare, and asks "Homework, what homework?" The wife says she has been working on being more assertive. Her husband has no idea what he was supposed to do differently. He continues to get angry and distance himself from his wife and family. He says, "I'm damned if I do, and damned if I don't…so I've stopped trying'. He feels attacked in the session and blamed for all the problems in the marriage.

This scenario plays out week after week until the couple finally stops seeing you.

The husband in this case could very possibly have ASD, Autism Spectrum Disorder. In the past when it was called Asperger Syndrome, it didn't seem as severe as calling it autism. Unfortunately, when the DSM 5 came out in 2013, there is no longer an Asperger Syndrome diagnosis. Instead, everyone is lumped into one big diagnosis of Autism Spectrum Disorder. There are different levels of care required, but most people only hear the word autism. The negative stigma of having autism is still there for many people who think, "I don't have autism… Isn't that when kids are non-verbal, flapping their arms and having meltdowns?" The answer is yes… and no. Because autism is on a spectrum there are many different ways it manifests itself in people. Some people with ASD may be very impaired and need 24 hour care, others may be highly functional.

The husband in this case could be very high functioning and well regarded in the workplace possibly as an engineer or an IT expert. People may think he's a little quirky but they would never think he had autism. Nor would he.

Having a partner with ASD presents many unique challenges. The longer you try to counsel this couple as neruo-typical, the more frustrated they will become. I have counseled many clients who have tried traditional counseling without knowing one had ASD. They overwhelmingly have reported that the counseling did more harm than good.

Knowing some of the signs and symptoms of ASD could be very useful when deciding how to work with a couple like the one in this example. Unfortunately, most therapists and counselors have no idea what to look for.

Here are some things you might hear in session that could help you assess whether you should continue working with a couple, or refer to a specialist.

"Unfortunately, most therapists and counselors have no idea what to look for."

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WIFE'S ISSUES

- I feel lonely, disconnected from my husband.
- I have to do everything to keep the household running.
- I think he loves me but he doesn't know how to meet my needs.
- He lacks empathy.
- He is inappropriate in social situations.
- He was very attentive when we dated. He changed as soon as we got married.
- He doesn't comfort me when I'm sick or stressed.
- He can't remember anything.
- He doesn't like to go out with friends or family.
- He has no friends.
- He doesn't want to have sex.
- He doesn't make eye contact.

HUSBAND'S ISSUES

- I don't understand why my wife is unhappy.
- I'm okay with the way the relationship is.
- If she could just be happy everything would be fine.
- She nags me all the time about doing things around the house.
- I don't like to be around her family and friends. Why can't she just accept that?
- I'm dammed if I do, and damned if I don't. I can't please her.
- She's the one with the problem. If you could fix her anger everything would be fine.

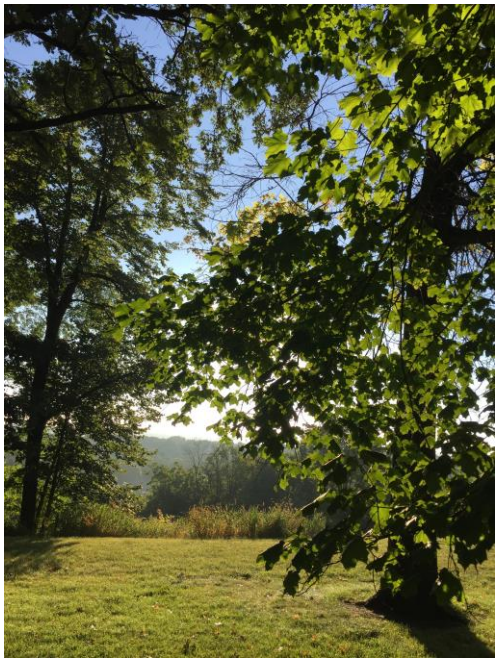
People with ASD have had it their entire life. Reference the criteria in the DSM 5 and ask questions about the client's childhood. Did he have friends growing up? Did he have a special interest? How did he like school?

If you feel your client may have ASD, seek advice from someone who specializes in

ASD in adults.

Mary Einarson, LMFT, specializes in helping individuals and couples with ASD. She is the founder of Spectrum Counseling in Plymouth. She will be presenting a workshop for therapists on April 27, 2018.

GREATER MN TRAINING OPPORTUNITIES!



We are looking for…

- Trainers to present 3-6 hour trainings in Rural Minnesota. We are also open to multi-day trainings if you are interested in staying for a few days! Some reimbursement/compensation offered.
- Venues willing to host trainings in Rural MN for free, with space that holds 30 or more individuals.
- Go to www.mamft.net/events-training/greater-mn-trainings/ for topic suggestions and more details!

Upcoming Greater MN Trainings:

- April 23rd: An Introduction to Radically Open DBT (St. Cloud)
- April 27th: Autism Trends in MN Multicultural Communities: Engaging and Supporting Culturally Diverse Families of Children with Autism (Alexandria)
- May 25th: Trauma Healing: Neurophysiological Frameworks for Working with Trauma (Owatonna) SOLD OUT

Questions? Contact Megan Oudekerk at president@mamft.net.

MN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY
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GREATER MINNESOTA PROVIDERS,
WE ARE COMING TO YOU!

This year we are kicking off a training series and social events that are being coordinated in multiple regions, outside of the Twin Cities metro area. **Members of MAMFT will be able to attend for free**. The trainings will be either half-day or full-day trainings and social events are being set up for after the trainings as well. You can find the training seriend under the Greater MN Trainings on the MAMFT.net website.

Here's a sneak peek:

- In April, Multicultural training will be held in Alexandra.
- In May, Introduction to Somatic Experiencing training will be held in Owatonna.
- In April, Radically Open DBT in St. Cloud.
- In September, The Principles of Pleasure: Four Important Skills to Help Therapists Work with the Good Stuff in Rochester.

You can invite social workers, clinical counselors, or psychologists to register too, as these events are for any practitioners in behavioral and mental health fields.

To continue our efforts to expand events throughout Minnesota, let your Greater Minnesota Committee know:

- What training topics or additional events you feel is a need in your region

  Such as:

  - Trainings on disorders, crisis, relational, identity, cultural, professional practices, etc.
  - Panel discussions i.e. ethics, professional boundaries, different modalities of treatment, etc.
  - Consultation groups for pre-clinical, licensed, or other specialized certification models
  - Social events for behavioral and mental health providers

- Which training topics that you would be willing to present outside of the metro area

  Such as:

  - Ethics & code of conduct of MFT's in rural practice
  - Dissociative Identity Disorder
  - Working with rural culture
  - Principles of private practice - Navigating logistics, insurance, etc.
  - Navigating the legal system in child custody
  - CEU's for supervisors
  - Your own topic

- If you can be a liaison with the committee for your area

  We need people who know:

  - Venue sites
  - Restaurant/food options
  - Entertainment
  - Other behavioral and mental health businesses in your region

Please provide your feedback through our Greater MN Committee page on the MAMFT.net website, or at my e-mail address below.

Looking forward to seeing you in greater Minnesota!

Cassandra Brix, M.S.
Cassandra.Brix@gmail.com
Greater Minnesota Committee At-Large Member

TRAUMATIC-BRAIN INJURY (TBI):
FACTS MENTAL HEALTH PROFESSIONALS NEED TO KNOW

Traumatic-brain injury (TBI) is a serious disorder that can result in a host of short and long-term deficits. Individuals impacted by TBI often struggle not only to cope with the primary disability of a brain injury, but also with an array of secondary deficits and limitations. Traumatic brain injuries (TBIs) have been linked to emotional problems (e.g., anger), behavioral problems (e.g., impulsivity and aggression), substance use, and poor decision making. As a result, individuals with TBI are typically in need of community-based services, including services provided by mental health professionals. When TBI is not properly understood and managed by mental health professionals, problematic outcomes can arise. As such, mental health professionals should be familiar with TBI to maximize the effectiveness of services provided to clients. To this end, this brief article reviews multiple key points about TBI that all mental health professionals need to know.

Adaptive Functioning Deficits.

Adaptive functioning deficits commonly occur among some individuals impacted by TBI. A person's adaptive behavior is composed of their practical, social, and mental capacities to deal with everyday challenges and problems (e.g., personal hygiene, personal finances, navigating social interactions. Some individuals with TBI may be dependent on the support of family and social services due to deficits in adaptive functioning. As such, mental health professionals are encouraged to assess the individual's adaptive functioning capabilities and determine what supports and services are needed to best support the impacted individual.

Anger and Frustration.

TBI can result in the individual having less patience and developing a shorter temper characterized by easiness to become angry or frustrated. As a result, the likelihood of these behaviors, particularly in new or challenging situations, may increase as a function of TBI. As a result, it is imperative for the impacted individual to participate in community-based programming that addresses these challenges and deficits.

Anxiety and Depression.

Anxiety (e.g., general anxiousness or panic attacks) and depression are common after a TBI. These feelings could be the direct result of damage to the brain or the indirect result of the struggles of dealing with and recovering from the injury. As a result, individuals with TBI need a calm and stable environment to aid in their recovery.

Attentional and concentration impairments.

The attentional and concentration impairments of TBI can have a range of devastating consequences. This includes the lack of comprehension of instructions and questions that can result in poor outcomes during inpatient and outpatient treatment settings. These issues are only exacerbated when treatment providers lack an awareness and understanding of TBI.

Cognitive deficits.

TBI can have ranging impacts on an individual's cognitive capacities. Cognitive deficits resulting from TBI can involve information processing, attention, concentration, memory (i.e., short- and long-term), spatial orientation, and abstract thought. As a result, the individual with TBI could have issues solving problems, initiating activities, and completing tasks without assistance. These identified deficits are often best served through TBI-informed community-based or inpatient treatment settings.

Confabulation.

Another issue that may be common among some individuals impacted by TBI is confabulation. Confabulation is the creation of a false memory or partially false memory that the individual believes to be true and can sometimes occur because of filling gaps in recall with one's imagination or environmental cues. Confabulation is particularly likely in situations with professionals who ask leading questions or pressure the interviewee. Inspirations for confabulation can be drawn from social media and social companions or can result from a combination of biopsychosocial factors. Mental health professionals must be prepared for the possibility of confabulation when interviewing and assessing someone who has sustained a TBI.

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Emotional and Behavioral Problems.

Traumatic brain injuries (TBI) commonly bring about alterations in emotions and behaviors. For example, emotional changes can include feelings of anxiousness and depression along with mood swings. Alternatively, behavioral changes might include less socially conscious actions and increased impulsivity and disinhibition. Such emotional and behavioral changes could be the result of brain trauma or the stress resulting from the brain trauma. Family, peers, and community-based treatment professionals will be key in limiting the damage of the emotional and behavioral changes caused by the TBI.

Importance of Screening.

The symptoms of TBI vary widely as a function of the area(s) of the brain that were damaged in the incident. Complicating matters, individuals who suffer from a TBI are often injured in other areas of their body. As a result, the screening and assessment process must disentangle if the impairment is a result of the TBI, a physical injury to another part of the body, or both.

Interpersonal Communication Impairments.

Interpersonal communication impairments are commonplace after TBIs. Such impairments can manifest themselves in several ways, including the art of conversation, where the individual may have difficulty listening to and comprehending others. Beyond this, individuals with TBI may have issues with detecting social cues, maintaining eye contact, and unintentionally violating the norms of personal space. As a result, others may come away from interactions feeling as though the individual with TBI was not sensitive to their needs.

Memory Deficits.

Individuals who have sustained a TBI frequently experience memory deficits that may impair their ability to appropriately understand and comprehend various aspects of the treatment process. As such, community-based supports and services that utilize TBI-informed approaches may result in longer term positive outcomes. The memory deficits of TBI can result in several issues. Individuals with TBI can forget agreements and commitments, not recall previous actions, have difficulty learning new skills and rules, and behave erratically. These issues can be very troublesome in structured treatment settings. Additionally, memory impairments may manifest as being capable of successfully completing a task one day but forgetting the task the next day - it is important to understand that this may not be within the control of the individual.

Mental Health.

TBI can be comorbid with many mental health issues including mood disorders (e.g., depression), anxiety, trauma (e.g., PTSD), affective dysregulation, personality changes, substance use, and changes in personality. All of these co-occurring issues may worsen when TBI has not been accurately identified and treated. As such, mental health professionals play a crucial role in the treatment of individuals impacted by TBI and co-occurring mental health problems.

Referral and Additional Testing.

Missed and misdiagnosis of TBI is common. As a result, many children, youth, and adults are unable to take advantage of advanced medical and psychological treatment and services, which could render a better quality of life. If mental health professionals suspect the presence of TBI, a referral for a full TBI assessment is recommended.

Physical Symptoms.

TBI can result in many physical symptoms including pervasive headaches and migraines, physical weakness and coordination problems (e.g., numbness, dizziness, clumsiness, and balance issues), sleep issues (e.g., drowsiness and insomnia), sensory impairment (e.g., loss of sense of smell, taste, and vision), and chronic pain.

Missed and misdiagnosis of TBI is common.

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Social Adjustment.

Traumatic brain injury can have a deleterious impact on an individual's social adjustment, which in turn can limit the individual's relationships with caregivers and professionals. This is especially the case when supports and services are not in place.

Victimization.

TBI has been linked to decreases in executive function and cognitive processing speed. Troublingly, research has reported that victimization mediates the association between executive function skills and acceptance by peers. As such, factors linked to TBI may increase the risk of victimization by peers.

Treatment.

Mental health professionals without specialized training in TBI may struggle to adequately treat individuals impacted by TBI. It is suggested that mental health treatment providers become TBI-informed. It is important to remember that Individuals impacted by TBI may require specialized treatment approaches given their cognitive, neurological, and social deficits. Early and accurate diagnosis of TBI and effective treatment and management can help limit and protect against some of the disabilities caused by TBI.

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) and the Journal of Special Populations (JSP). 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). Email address: Jerrod01234Brown@live.com

POWER & THE (DEVELOPING) FEMINIST THERAPIST

Introduction

Feminism, as an intellectual movement, has transformed the postmodern ideals of deconstruction and subjectivity in ways that transmute the traditional sense of the individual viewing it as a static body bound by objectifying polemics, to an amalgam of a being composed of subjective experiences. As the various disciplines of the humanities and human sciences have adopted and adapted feminist thought, psychotherapy practices have grown in ways that are able to escape the sterility and objectification of the medical model; able to hold the multiplicity of individuals while still being able to hold onto the object reasoning that is necessary to achieve a sense of psychosocial functionality. For developing therapists like myself who come from a feminist, intersectional background and are driven by social justice, there is a fear of losing social progress by upholding the status quo our clients bring into therapy.

As I have developed intellectually over the years, feminist theory has given me a lens to see the world that has proven to be invaluable in not only determining my place within society, but within the reified and caste-like nature of the world. The antagonistic nature of arbitrary differences, the -isms of racism, sexism, colonialism, etc., are based upon not only a systemic form of hatred, but also a primal form of hatred that is rooted in an existential death anxiety. To dismantle the aforementioned systems of oppression, those that are propagated by the subjugation of the female and minority bodies and minds through patriarchal institutions, we must focus on the concept of power.

The core values of Marriage and Family Therapy (MFT) and feminist ethics

The field of MFT has changed in accordance with the contemporary ideologies of both scholars and laypeople alike, encompassing feminist concepts that push the boundaries of what it means to be a competent therapist. As Prouty, Lyness and Lyness (2007) have highlighted, feminist ideology creates a framework for which therapists can aspire to while they engage their clients, mental health focused institutions, and the overall population. As a result, the principle understanding of competency mandates the expansion of a therapist's skill codified through Principle 3.6 of the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (2015), while also taking into consideration the difficulty in comprehending or upholding multiplicity through the process of introspection and boundary setting by therapists through Principle 3.10. The point of contention that arises for many therapists, myself included, is the inner conflict around how multiplicity manifests itself within the therapist and within their practice.

The possibility of multiplicity

Within philosophical literature, Michel Foucault's conception of power and knowledge have greatly influenced debates around gender, identity, and language, propelling the paradoxical nature of multiplicity beyond traditional political notions while heavily influencing the works of feminist scholars (Butler, 1990). I believe the Foucauldian conception of power greatly lends itself to a holistic, albeit dualistic, understanding of the culpability of the effects of multiplicity on a therapist. To highlight the difficulties of multiplicity, I focus on a major piece of contention among feminist and, subsequently, queer theorists through the use of the words 'gender queer.'

For many, to be 'gender queer' and/or to identify as 'gender queer' is an intrinsically political act that reclaims the power that is stymied by the words, 'gender binary,' it's antithesis. By logic, intentionally and/or unintentionally claiming the antithesis of gender binary further codifies the very power structure feminist thought is looking to dismantle (hooks, 1981). As a result, two common responses arise: reject or accept (Foucault, 1981; Butler, 1990). What one finds in rejecting the aforementioned feminist logic is the discrediting of people of color, of women's bodies, and of culture, all while creating an air of ambivalent and object sterility (Deveaux, 1994). However, if one accepts, they will find that there is the possibility to de-legitimize the power of the privileged binary identities by placing sole power and responsibility in the conceptions of each individual.

To make abstract the concept of gender through multiple identifiers paradoxically lessens the power of each of these words while exponentially increasing the profundity of their main purpose of signifying gender. By the very nature of identity, subjectivity must always supersede objectivity to achieve a multiplicitous identity. As a feminist therapist, achieving competency and comfortability appears to stem from being able to hold conflicting and even contradicting identity points within all aspects of existence.

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Competency

To know one's self: the good and the bad, to find strength in discomfort, and knowing how to use those moments as growing, boundary pushing opportunities, is tantamount to competency. To have various capacities for introspection or, what I call "introspectivity", is critical in being able to foster one's skills in understanding and upholding multiplicity. Within practice, introspectivity informs the therapist of not only their limitations, but their possibilities as well. Knowing that there may be points of contention between the therapist and client, a good therapist is able to use their subjective experiences in objective ways that are not necessarily concerned with the moralization of a client. Developing a truly sophomoric attitude is critical in sustaining growth in a field that is marred with both holes of the illogical and monoliths of logic. This non-confrontational approach is rooted in an attempt to see that not all things are purposefully oppositional, but have occurred and continue to occur because of terms of survival.

In the case of the terminology 'gender queer,' it is not necessary to enforce the opposition to the gender binary, rather encourage multiplicity that should be the key. I believe it is absolutely necessary, especially in the case of the European language family (i.e. German, Spanish, Russian), to have polarizing discourse so that one can convey the perceived nature of things within said paradigm. These national and official languages came into use because of political means and exercises of power throughout the millennia of human existence (Chomsky, 1968). In this respect, one cannot simply stop the use of political or gendered words as they are embedded permanently into the construction of the various linguistic components including syntax and grammar. As Chomsky et al. (2002) suggest, I too believe that just as the common understanding of the politic of language has been lost to time, so too will the semantic meaning of discursive language if there is enough time.

Conclusion

To be feminist is to be political and to be a feminist therapist is to be a political therapist, one centered on depoliticizing the individual. One strategy is to uphold and fortify identity politics, as Phelan points out:

"Identity politics must be based, not only on identity, but on an appreciation for politics as the art of living together. Politics that ignores our identities, that makes them "private," is useless; but non-negotiable identities will enslave us whether they are imposed from within or without (1989)."

It is my belief that a feminist therapist should be concerned with putting the lifeblood of meaning back into the words of our clients through transforming the politic of their language into a language of art and true expressionism. True feminist therapy is being able to harness the non-acknowledged power of our clients to transform and empower them to be their true, unobscured self. Often, this goes in terms of asking the unasked questions, those that seem 'taboo' or more about the therapist than the client. Ultimately, by asking those taboo questions and engaging equitably through conveying the humanity of the therapist, a true feminist therapist can emerge.

Casey Skeide, Student Representative

Casey is a Marriage and Family Therapy Master's Candidate at Saint Mary's University of Minnesota - Twin Cities and a practicum intern at Anicca: Adolescent Day Treatment. Casey specializes in Gender and Sexuality, Dysfunctions of Identity, as well as the application of Existential and Narrative Psychotherapies. With a background in Sociolinguistics and Asian Studies, Casey is inspired by the abilities of story telling and language as a means to construct and empower.

References

American Association for Marriage and Family Therapy. (2015, January 1). AAMFT code of ethics. Retrieved from http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx

Butler, J. (1999). Gender Trouble : *Tenth Anniversary Edition*. New York: Routledge.

Chomsky, N. (1968). *Language and mind*. New York: Harcourt, Brace & World.

Chomsky, N., Belletti, A., & Rizzi, L. (2002). *On Nature and Language*. Cambridge: Cambridge University Press.

Deveaux, M. (1994). Feminism and Empowerment: A Critical Reading of Foucault. *Feminist Studies*, (2). 223.

Foucault, M., & Gordon, C. (1980). *Power/knowledge: Selected interviews and other writings*, 1972-1977. New York: Pantheon Books.

Hooks, B. (1981). *Ain't I a woman: Black women and feminism*. Boston, MA: South End Press.

Prouty Lyness, A. M., & Lyness, K. P. (2007). Feminist Issues in Couple Therapy. *Journal Of Couple & Relationship Therapy*, 6(1/2), 181-195.

Phelan, S. (1989). Identity Politics: *Lesbian Feminism and Limits of Community*. Philadelphia: Temple University Press.

HE SAID/SHE SAID

SHE SAID:

Here we are again, Ken, beginning a conversation about… relationships, relationship therapy, our clients, our colleagues, our mentors, our supervisees, mentees and students. Our community, our world. Ourselves. We started this conversation over fifteen years ago, and I find myself reflecting on how much has changed. Remember when we were all going to party like it's 1999, that is when we weren't freaking out about the possibilities of Y2K blowing up all the technology…? It seems so quaint now. I met you when I joined the MAMFT Board in 2000, and it wasn't long before you asked me to join you as co-editor of the newsletter, which you deftly created on your Mac, got printed and mailed out. Sara Wright co-edited the newsletter with you before me, and before that Bean Robinson was Sara's co-editor. I remember when they asked me and Ginny D'Angelo to write a review of a workshop by a young up-and-coming family therapist named Ken Hardy.

It seems impossible that I have known you since before 9/11, because that seems like a lifetime ago now. It changed so many things. Remember when we could go out to the gate and send off our loved ones as they boarded their plane? Remember when kids didn't have "play dates," when parents just told them to go out and play? Grandparents recently told me in a session that their son, who lives in Edina, believes someone would call the police if he let his 8-year-old walk unaccompanied to the park at the end of his block. Of course no one would be surprised if that same child spent the average seven hours a day looking at a screen. It's a whole new context for families these days.

Likewise our MFT association. I enjoyed the last newsletter, reflecting on the history of our vibrant Minnesota division of AAMFT as we move into fully independent status. Finally we can belong to MAMFT without having to join the national association, something people have requested for years. It was good to see the new faces on the Board as well as the names of past MAMFT presidents going back to the mid-80s - including both of us. I appreciated the passion expressed by new President Megan Oudekerk and others about our thriving family therapy community both in the Twin Cities and in GREATER Minnesota, and Lucas Volini's reflections on some of the courageous innovators who are our MFT ancestors. I hope people are going online and reading the newsletter. Christine Dudera is doing an excellent job as Editor.

I guess it's just as another sign of age that I wish I could still hold it in my hands.

HE SAID:

Now that the Newsletter is only online (saves a lot of money), how many members read it compared to those who read the printed version before? Just wondering. We get the Star Tribune and the New York Times newspapers, the Strib, daily, the Times, Sundays. I like the printed word on paper. Sure, I access both newspapers online, but I still prefer the printed version with coffee cup stains, crumbs, and a full layout. And, we still have a landline. We have friends who gave up their landline and now it seems impossible to reach them on their cell phones; it seems easier for people to ignore calls on their cell phones – if they even *talk* on the bloody phones anymore instead of #~%*+ texting! Sheesh! Changing times. More and more I feel like some curmudgeon. Of course, I was born in 1945 in the Truman Administration.

So, there you are. Budgets shrink, organizations morph, but people are still folks – with worries, difficulties, misunderstandings, infidelities, and anxieties. We're still needed. And, I still enjoy my therapy practice and I think I provide value to my patients – they're still coming back.

You and I go back a long way. We have history. I tell my students and supervisees that when they're stuck, get more history, more of the story. I still hold by that simple idea. Of course, being stuck in therapy can be due to many things – the wrong frame for the problem, the wrong questions because of the wrong frame, inadequate information because of the wrong questions, or misleading information because it's too narrow a focus – back to needing more of the context, more of the story.

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That's how we like to distinguish ourselves as family therapists – the wisdom of the importance of the system. But, we've even transcended that notion of the "family system". Now we know it's the individual and family story – the evolving *narrative* (thanks to Michael White and David Epston, and Harlene Anderson and Harry Goolishian). Or it's the insecure attachment (thanks to Sue Johnson and John Bowlby). New metaphors and theories that are useful and open up more possibilities beyond the ones we've used before. Good. As the hymn goes, "New occasions teach new duties, time makes ancient good uncouth." New metaphors, new theories, new ways of seeing and doing are ever evolving and we are better for the most part.

We can still question what we know and how we know it – that kind of epistemological wisdom it still very much alive and well. Thank God (or 'the universe' or 'higher power' or our 'rational minds').

SHE SAID:

Enjoying the printed page, the crinkle of the newspaper as you hold it in your hand - as opposed to the convenience and accessibility of reading the NYT online - makes me think about the virtual world we, and our clients, spend so much time in now. Are we mindfully choosing it? Are we considering what is getting lost? This is where our work, as relationship healers, seems more crucial than ever before. Trust, attachment, empathy – these are not to found online. There is nothing virtual about love. It's the real deal.

People seem to be spending less and less time with their own thoughts. So much simpler to pull up our newsfeed, follow our favorite #twitter-ers, fall down the rabbit hole of Facebook. Could it be that one day, maybe in the not-so-distant future, people will be unable to recognize their own thoughts? Not know what they believe, separate from others, not know their own ideas, their own intuitions? This is Big Brother at its scariest, and we stand at the threshold of what once seemed like fantastic science fiction.

The relationship with Other and the relationship with Self - these need our attention, compassion, care and love more than ever. Maybe we don't need the Newsletter in hard copy. But I'll choose the hard copy, the landline, of relationships every time.

HE SAID:

Flesh and blood versus virtual reality – muscle and blood or pixels and code, hummm. I see people walking in airports or down the street looking at their bloody phones instead of what's around them. In Germany they have warning signs printed just before the crosswalks because so many people are looking down at their phones instead of up and around. Good grief. It may be a millennial thing, but it affects other generations as well.

Relationships that we can touch, smell, see in moment in front of us – that's what matters most. But, if we can't, friends and family are at a distance – in Afghanistan or Japan, Florida or Maine, we can be in touch via Skype or Face Time – the next best. So, we have alternative methods, thanks to the digital age, of being in touch. But each new technology has its marvels and it's downsides. Same for about every new technology – the technology can enhance and connect, or numb and disconnect. Pay attention. What is the temptation and price of convenience?

Brier Miller & Ken Stewart

PUBLICATION INFORMATION

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EDITOR

Christine Dudero
editors.mamftnewsletter@gmail.com

We encourage members or non-members alike to make submissions (clinical essays, reviews, letters to the editor, etc.) on any relevant issue or in response to MAMFT NEWS content. All submissions will be edited for length, clarity, readability, grammar, spelling, biased language, and appropriateness to the mission of MAMFT NEWS. 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 at www.MAMFT.net Questions or concerns may be addressed to the MAMFT News Editors at the email listed above.

PLEASE NOTE Submission deadlines for 2018

ISSUE	SUBMISSION DEADLINE
Spring	January 30
Summer	April 15
Fall	July 15
Winter	October 15

Submission of an article does not guarantee its publication. No materials will be returned. All materials for publication should be submitted via the website at www.MAMFT.net

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Minnesota Association for Marriage and Family Therapy
Relationships Matter