JANUARY // FEBRUARY 2015

FAMILY THERAPY

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

THE MFT CAREER SPECTRUM

STUDENTS >>> YOUNG PROFESSIONALS >>> CAREER OPTIONS

FAMILY THERAPY MAGAZINE | JANUARY / FEBRUARY 2015 VOLUME 14, NO. 1

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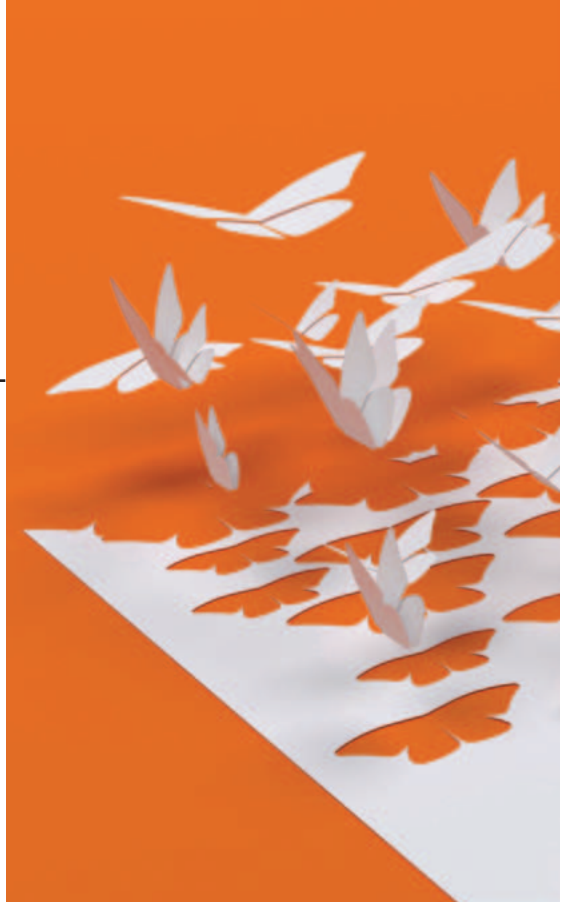

> “Therapists partnering with seriously mentally ill clients need to believe that recovery is possible.”

> One intern was greeted with "You're the therapist? Welcome to the psychosocial triage unit!"

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LETTERS TO THE EDITOR

We encourage members' feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

Twenty-five percent of this paper is post-consumer recycled material and preserves 17.49 trees, saves 7,429 gallons of wastewater flow, conserves 12,387,806 BTUs of energy, prevents 822 lbs of solid waste from being created, and prevents 1,618 lbs net of greenhouse gases.

Greetings and Happy New Year!

I AM PRIVILEGED to begin my term of office as president of AAMFT. As I think about how I came to be here, what immediately comes to mind are the people in this field from whom I have learned and by whom I have been inspired. Some have been master clinicians who have shared their approaches to working with individuals, couples, and families. Others have been extraordinary teachers with the ability to put into context philosophies and theories that undergird the field. Still others have been researchers who have impacted how I work with people because of their ability to not only do good research, but to communicate the results effectively. There have been and continue to be colleagues who challenge me to think, to consider views different from my own, and to be reflective about what I do and how I do it. What all of them have in common is integrity, passion for the field, and a deep respect for those around them.

It is with this integrity, passion, and respect that I hope to continue to serve AAMFT. Like my predecessor, I believe that dedication to transparency and generative governance are vital to our continued and growing success. I also believe that active pursuit of best practice in association management is critical to the long-term ability of AAMFT to serve our members well. In my judgment, these things contribute to a strong association, and they will be among my primary foci in the next two years. Having a strong, vital AAMFT with engaged membership is part of what will allow MFTs to increasingly have a voice in federal and local conversations about healthcare policy, and thus, serves the profession well. Likewise, investment in research that demonstrates the effectiveness of systemic and relational practice supports the profession of marriage and family therapy; research provides critical information needed to inform policy conversations, as well as the work done by clinicians.

Just as the association continues to grow and adapt in our rapidly changing environment, work settings for MFTs are also changing. Many MFTs who thrive on doing clinical work have developed specialty practices or work in specialty environments, as the articles in this issue illustrate. You will find MFTs in non-profits, integrated care facilities, family court and other settings affiliated with the legal system, and government agencies. In addition to changing work settings, hyper-specialization is increasingly pursued by MFTs and other mental health providers in response to increasing knowledge and demand. The range of specialties seems to be growing, and there has been a great deal of interest in specialty training expressed by AAMFT members. Staying on top of changes in the world of work for MFTs is crucial information for the AAMFT and is identified as a mega issue in the strategic plan.

Marriage and family therapists have a broad range of skills that prepare them to succeed in a variety of areas in addition to providing therapy or teaching and training. For example, entrepreneurial MFTs with an understanding of both business and systems may be ideally suited to provide consultancy services to small or family-owned businesses or associations. Marriage and family therapists who understand and enjoy action research may provide program evaluation for nonprofits or other agencies. Critical thinking skills, creative thinking, decision-making skills, strong communication skills, the ability to work as part of a team, and both personal and interpersonal skills are all transferable to a variety of settings and job responsibilities. Marriage and family therapists know how to think systemically and

"CHANGE, ESPECIALLY WHEN IT SEEMS RAPID, CAN BE FRIGHTENING, EXASPERATING, EXCITING, LOVED, HATED, OR SOME MIXTURE OF ALL OF THESE AND MORE."

understand the impact of actions in one part of a system on another part of a system, a critical component of strategic thinking. The ability to be culturally sensitive, think globally, and interact well with diverse groups of people continues to be important—in fact, the importance of these skills grows as associations and businesses respond to global markets.

The world continues to change, and some have indicated it changes more rapidly every year. Change, especially when it seems rapid, can be frightening, exasperating, exciting, loved, hated, or some mixture of all of these and more. The profession and practice of MFT will likewise continue to evolve, as will how we each respond as MFTs to changes around us. However, I believe the passion for the field and for the people and systems we serve will remain the same even as knowledge about how to best provide services grows.

For me, passion and knowledge are part of the heart and soul of MFT. The AAMFT has provided a place where I have been able to nurture my passion and increase my knowledge, and I plan to be part of an association that will keep pace with the changing needs of members and provide that same kind of place for others.

—Marvarene Oliver, EdD, LMFT, LPC

be informed & contribute be informed & contribute be informed & contribute be informed & contribute be informed & contrib

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Company Page
http://tinyurl.com/AAMFTpage

AAMFT Community
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Focus on exclusivity

M.A. in Marriage and Family Therapy at Chapman University

For more than 40 years, Chapman's MFT program has trained hundreds of master-level therapists. We're one of only seven programs in the state of California nationally accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

Unique to Chapman is the renowned Frances Smith Center for Individual and Family Therapy, at which all students complete one year of onsite clinical practicum. The center is composed of therapy rooms equipped with one-way mirrors, cameras and audio equipment used to record sessions for instruction and valuable real-world training. A play therapy room for child therapy and larger rooms for family therapy round out the innovative space.

The mission at Chapman is simple: to provide the highest caliber students with the academic and professional training to become competent, ethical, culturally sensitive and systems-oriented marriage and family therapists.

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The AAMFT Institutes for Advanced Clinical Education

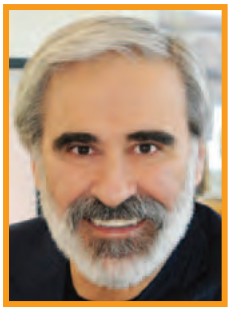
June 24 – 28, 2015 • Rome, Italy

Earn 15 hours of continuing education credit and learn from experienced domestic and international MFTs! Participate in the most advanced training for systemic and relational therapy available amidst the beauty and splendor of Italy.

Register online at www.aamft.org/institutes to secure your place and save $100 if you register by March 31, 2015.

AAMFT
American Association for Marriage and Family Therapy

Featured Presenters and Workshops
(June 24 – 28, 2015)



Treating Sex and Intimacy Problems in Highly Troubled Couples

Presented by David Schnarch, PhD

MFTs are uniquely positioned to provide much needed help for couples with severe relationship or personal problems, providing systemic intervention for delivering cutting edge sexual health care which is systemic to its core. This Institute offers a paradigm-changing view of human sexual desire, and a multi-faceted clinical approach for resolving sexual difficulties in difficult cases. Workshop format includes deconstructing case examples and intervention strategies, mind-mapping (Theory of Mind) applications, neuroplastic training activities, and spirited lectures and group discussions.

Going Further with Solution-Focused Work: Flexible Tools, New Paradigms, Refined Practice

Presented by Mark McKergow, PhD

This Institute will look closely at how Solution-Focused (SF) work is evolving. These developments include both trends towards even more minimal intervention, as well as connections to wider philosophical paradigms from Wittgentstein to extended mind to enactivism. The course will be a lively and participative event with stimulating inputs, collaborative discussions, and engaging activities. We will be using some video and transcription from actual sessions. Participants can also look forward to making progress with their own lives, workplace issues and relationships as we explore SF ideas in theory and practice.

Teen Voices in Family Therapy: A Multigenerational-Systemic Method of Intervention

Presented by Anna Mascellani, PhD and Maurizio Andolfi, MD

In this Institute the authors want to present a multigenerational-systemic method of intervention: instead of controlling children misbehavior through medications or with individual psychotherapy or counseling, they aim to create a therapeutic alliance with the adolescent and the family by working with them as a team and exploring relevant family events to link them to the presenting problem. The model of intervention that will be presented in this course is experiential with therapist playing an active role, being direct, authentic and empathic with the family, able to stay close the clients' pain and despair and on the other hand to respond positively to their hope and desire for change.

The Science, Art, and Ethics of Transcultural Therapy

Presented by Mary Hotvedt LMFT, PhD

This course is designed to give MFTs systemic ways of thinking about multicultural social models and working with clients affected by megatrends such as displacement, unemployment, overcrowded refugee camps, children orphaned by war and AIDS, institutionalized marginalization and violence against women. The needs and expectations, of these individuals and families present a multitude of challenges to social service and mental health fields, the practitioners often left to deal with issues not addressed adequately by governments. Participants will be introduced to several examples of intervention on behalf of clients; the examples will be drawn from several countries.

For more information or to register, visit www.aamft.org/institutes.

The AAMFT Institutes for Advanced Clinical Education

June 24–28 • Rome, Italy

Inner Voices, Family Dynamics and Therapy: Challenges of Sociocultural Patterns in Transition

Presented by Kyriaki Protopsalti–Polychroni, MA, CGP, ECP

This Institute will offer an opportunity to experience the "cultural milieu" orientation inherent in the approach of the Athenian Institute of Anthropos, the first center to practice Family Therapy in Europe. This approach is Systemic-Dialectic in nature and aims at multi-focal, multi-level interventions that honor and actualize "subjective cultural processes"- in terms of internalized perceptions, values, behaviors and patterns of relating - both in understanding individual functioning and family dynamics and in therapy.

By way of active participation in specifically devised experiential tasks/processes and through the simulation of specific family case examples, we will invite participants to embark on a group journey illustrating various dynamics of today's family within the context of complex sociocultural and global change.

Fundamentals of Supervision

Presented by Thorana Nelson, PhD

This 15 hour (interactive only) or 30-hour (interactive and didactic) intensive program is designed to fulfill course requirements for the AAMFT Approved Supervisor designation and satisfies the supervisory training requirements for many state laws.

Please note: To fulfill the complete course requirements for the designation, you are advised to select the 30-hour option and complete the online didactic prior to coming to Rome.

For more information or to register, visit www.aamft.org/institutes.

Hotel and Location

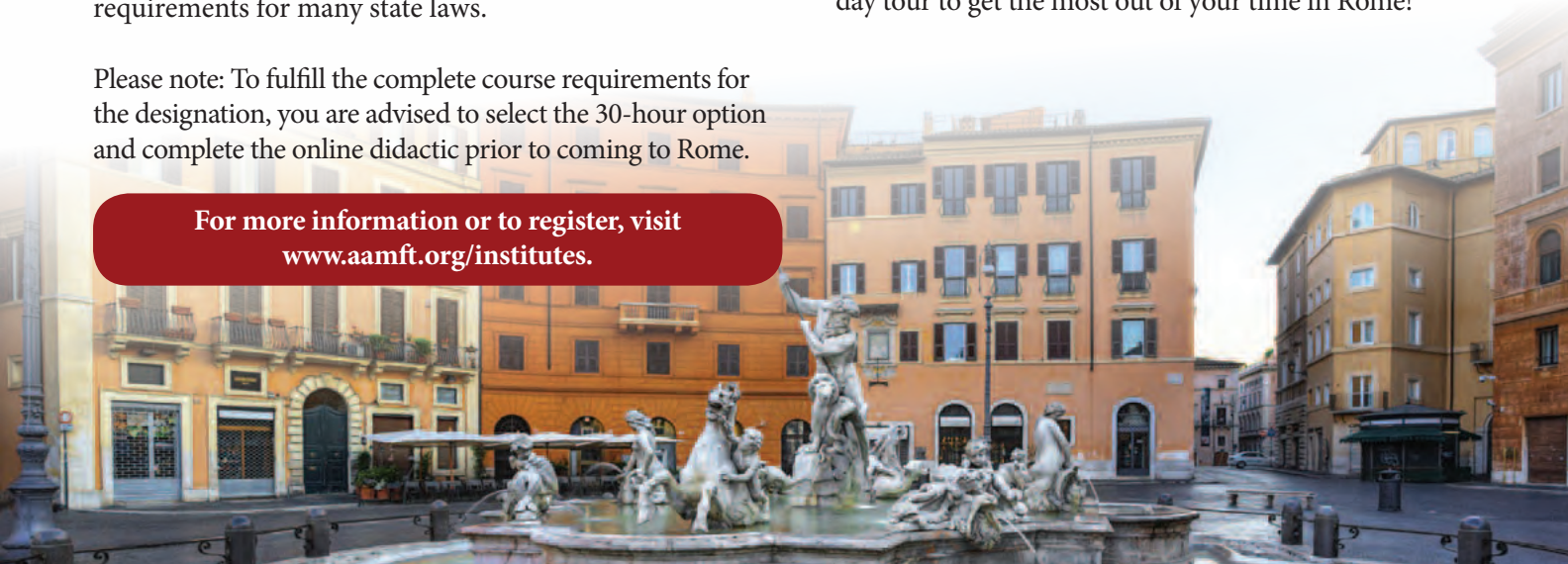
Our 2015 Institutes for Advanced Clinical Education is in the most exciting location yet! Receive instruction from the highest-rated presenters and soak up the local culture in the beautiful, ancient city of Rome, Italy. The Institutes are already a premiere event for our members to receive the most advanced training in marriage and family therapy available, and this June you have a once in a lifetime opportunity to experience it in a coveted vacation destination.

The Institutes will be held at the beautiful Atahotel Villa Pamphili, a park-like setting which is located minutes away from the Vatican and the city center for easy access to all local tourist attractions.

Visit the Institutes webpage at www.aamft.org/institutes to download the hotel reservation form.

Travel Information

The events will kick off on June 24 at 6:00 pm with a reception and orientation meeting to learn about the city and prepare for the week ahead. Course instruction will end on Sunday, June 28 at 12:30 pm. Join an amazing half or full day tour to get the most out of your time in Rome!



Registration

Four easy ways to register:
1. Online at www.aamft.org/institutes
2. Fax registration form to 703-838-9805.
3. Call 703-838-9808.
4. Mail form to 112 South Alfred St., Alexandria, VA 22314.

The registration fee includes handouts, a Welcome Reception, a continental breakfast on class days, and continuing education verification. It does not include books, lunch, dinner, transportation, and hotel accommodations.

Registration postmarked	by March 31, 2015	Regular
AAMFT Members	$495	$595
Non-members	$595	$695
Supervision – Interactive Institute ONLY (15 hours CE)		
AAMFT Members		$425
Non-members		$525
Supervision – Interactive Institute PLUS online didactic (30 hours CE)		
AAMFT Members		$595
Non-members		$695

Printed Name of Registrant:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Email Address:_____
Daytime Phone:_____ Fax: _____ AAMFT ID #:_____

Advanced Institutes Workshop Choices

Please select the workshop you would like to attend indicating a first and second choice.

	First Choice	Second Choice
Treating Sex and Intimacy Problems in Highly Troubled Couples	_____	_____
Going Further with Solution-Focused Work: Flexible Tools, New Paradigms, Refined Practice	_____	_____
Teen Voices in Family Therapy: A Multigenerational-Systemic Method of Intervention	_____	_____
The Science, Art, and Ethics of Transcultural Therapy	_____	_____
Inner Voices, Family Dynamics and Therapy: Challenges of Sociocultural Patterns in Transition	_____	_____
The Fundamentals of MFT Supervision		
Full course (15-hour didactic online + 15-hour interactive in Rome)	_____	_____
Interactive Institute only (15-hour interactive in Rome)	_____	_____

Total Registration Fee *(insert appropriate fee here)*: $_____

Methods of Payment

Payment in full, in U.S. funds, must accompany registration. Make checks payable to AAMFT. *(There is a $25 fee on all returned checks.)*

❑ Check ❑ VISA ❑ Master Card ❑ American Express

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Credit card billing address (if different): _____
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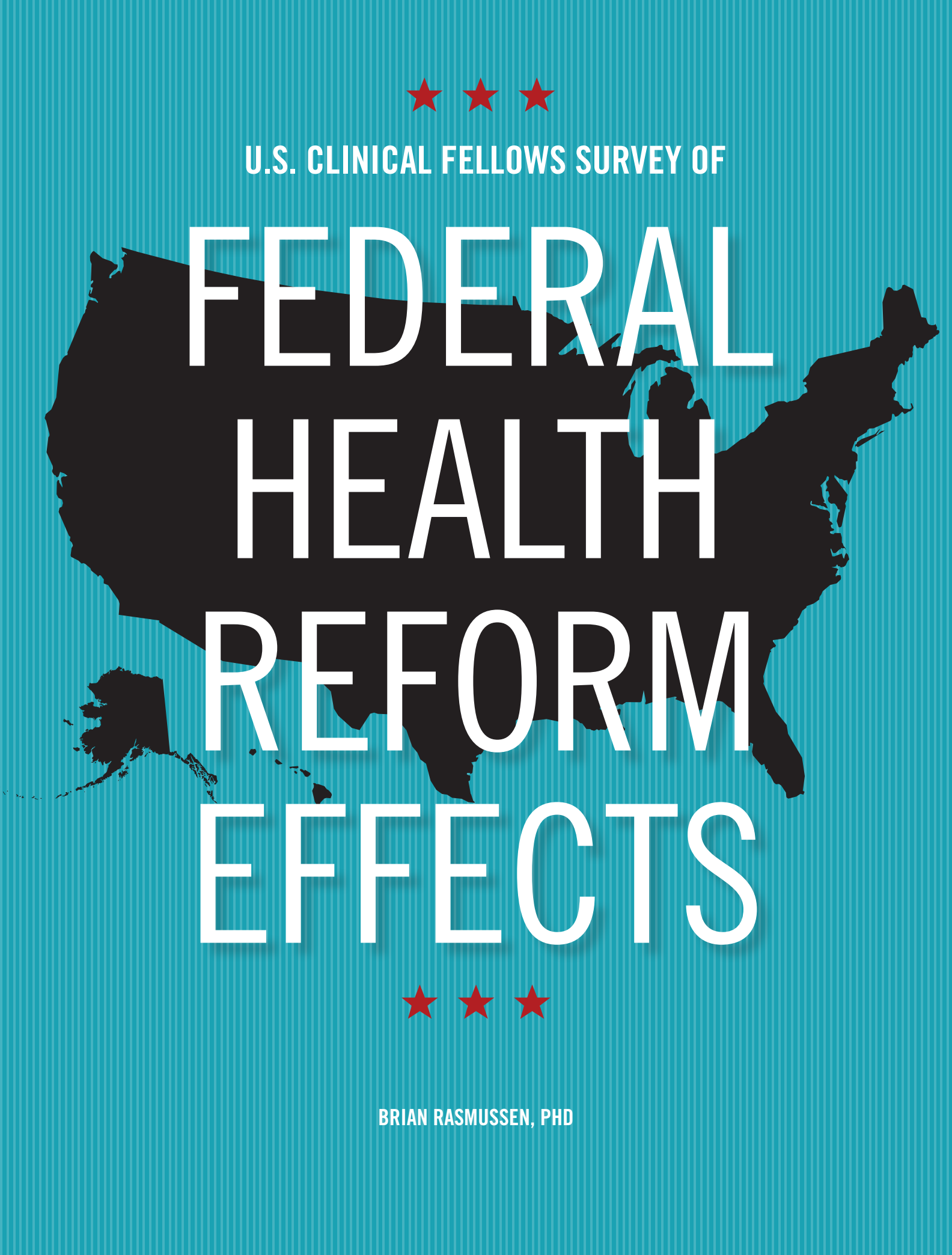
How did you hear about the AAMFT Institutes? *Please check one.*

❑ Email ❑ This brochure ❑ AAMFT conference ❑ AAMFT publication
❑ AAMFT website ❑ AAMFT division ❑ Non-AAMFT publication ❑ Previous attendee
❑ Word of mouth ❑ Other:_____



U.S. CLINICAL FELLOWS SURVEY OF

FEDERAL HEALTH REFORM EFFECTS

BRIAN RASMUSSEN, PHD

KEY FINDINGS

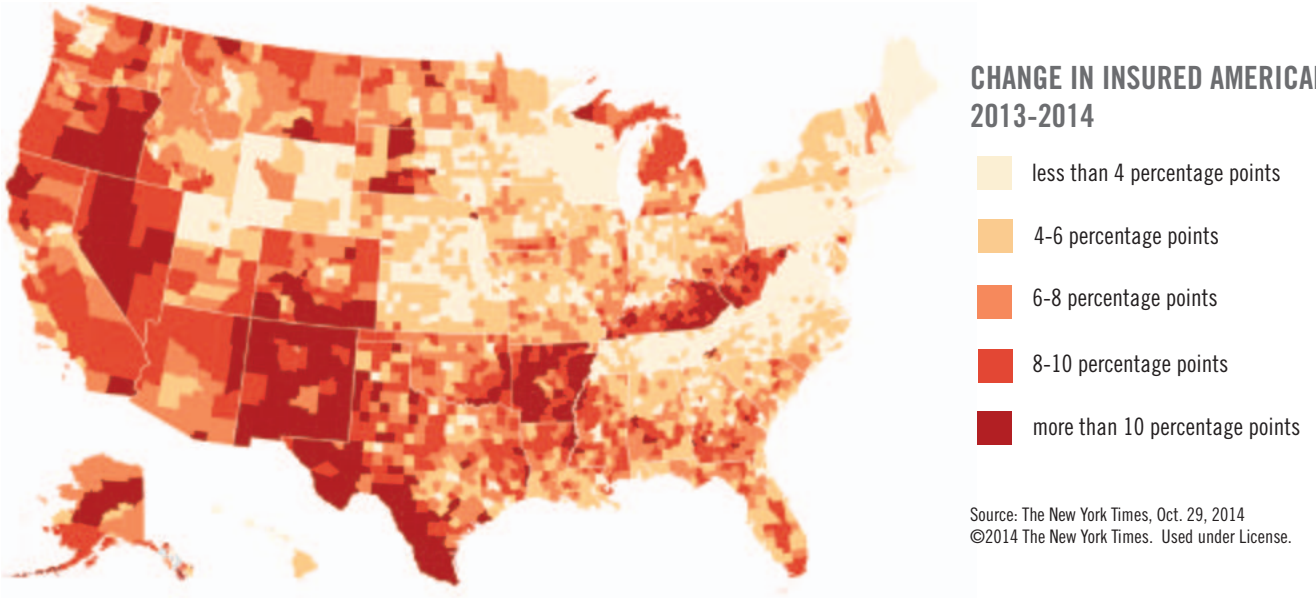
THIS SURVEY OF U.S. AAMFT Clinical Fellows currently in practice finds the federal health reform law (Affordable Care Act, ACA, also called Obamacare) overall to date has had relatively few positive, and relatively few negative, effects on responding Fellows. However, some Fellows report either highly positive or highly negative effects, and these effects may depend on Fellows' organization type (private office vs. facility-based) and State (or sub-State region) of practice. Facility-based Fellows are more likely to have ACA experience than private practitioners, and also more likely to report problems with ACA Exchange health plans at their facilities. A minority of private practitioners report either not being permitted to contract with ACA health insurance plans, or — if they have contracted with such plans — having administrative and/or pay-rate concerns. In a few cases, private practitioners say these concerns are jeopardizing their financial ability to stay in operation.

BACKGROUND AND SURVEY PURPOSE

The 2,700-page ACA law has many provisions, including establishing Exchange (Marketplace) health insurance plans available to all uninsured Americans, with the federal government subsidizing the premiums of people with family incomes ranging from 133% of the Federal Poverty Level ($31,721 for a family of 4 in 2014) to 400% of Poverty ($95,400 for a family of 4).[1]

In 2014, about 7.3 million people enrolled in Exchange health plans, which are offered in each State by one or more private insurers, such as Blue Cross plans. In 2015, it is expected that Exchange plan enrollment will grow to a figure estimated by the government at from 9 to 13 million persons. Early analysis of Exchange enrollees' insurance claims shows that on average they have more health (including behavioral health) problems than do privately-insured people.

About 7 million additional people enrolled in Medicaid in the 27 States that optionally expanded it (and also in the other States where they were eligible under prior law but had not previously enrolled). As shown below, the consequent reduction in uninsured people has been highly variable by State, and sometimes by Counties within a State:



Source: The New York Times, Oct. 29, 2014

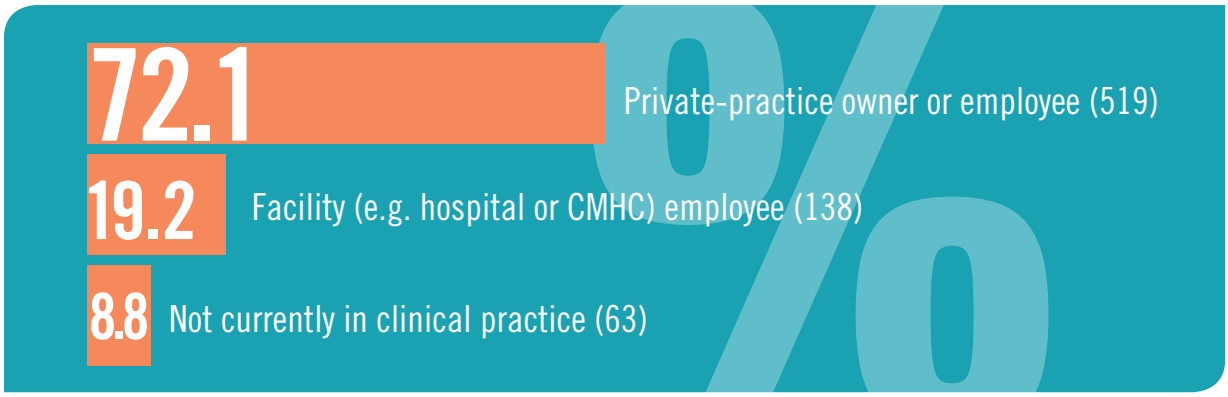
So Exchange plans offer a large and growing funding source for MFT services, but only if MFTs' clinical organizations—such as hospitals and private practices—are contracted with plans' managed care provider networks (non-contracted providers can render treatment, but may receive little or no payment from these plans). Prior reports have found that Exchange plans usually have "narrow" provider networks that often exclude small practitioners (such as solo offices) and tertiary-care institutions such as specialty hospitals. Some reports claim these plans' payment rates and administrative rules often are problematic.

In addition, Exchange plans' directories of contracted providers—even if publicly available—may be inaccurate, sometimes incorrectly including non-contracted providers, while other times failing to include contracted providers. Thus, enrollees already having relationships with behavioral providers, as well as those newly seeking behavioral treatment, may be unable to determine the network status of those providers, which could create financial problems for both those enrollees and their providers. The chief of the federal Centers for Medicare and Medicaid Services (CMS), which also oversees Exchange plans, recently said CMS will not address narrow networks or incorrect provider-directory data, instead leaving oversight to any states that wish to take action.

Thus, all 10,203 U.S. Clinical Fellows with valid email addresses on file at AAMFT were sent a survey on September 17, 2014, about their clinical experiences with the ACA, focusing on Exchange plans.[2] Fellows who did not respond to the initial survey request were sent two reminders. 720 Fellows completed the survey, for a response rate of 7%, typical for such surveys.[3]

Respondents were asked to specify type of site where they spend the majority of their clinical time: as a Private-practice owner or employee; a Facility (hospital or CMHC) employee; or Not currently in clinical practice. The site-type distribution is shown in Figure 1 below:

FIGURE 1. SURVEY RESPONDENTS' PRACTICE SITE TYPES. (% OF TOTAL RESPONDENTS)



Fellows not currently in clinical practice were thanked, which concluded their surveys, as only Fellows currently in clinical practice potentially have experience with the ACA law. Currently-practicing Fellows were directed to appropriate site-type (private-practice vs. facility-based) questions. Following are key results, first for private-practice, and then for facility-based, respondents.

[1] For background on ACA, see FTM July/Aug., Sept./Oct. and Nov./Dec. 2013 issues.

[2] ACA also permits States to expand their Medicaid programs for very-low-income people, but only 27 have done so, and private MFTs are not eligible providers in half of those States, so the survey did not address Medicaid expansion issues.

[3] It is possible that non-respondents' experiences differ from those of respondents. It appears private practitioners were somewhat more likely to complete the survey than were facility-based Fellows, suggesting ACA issues may be of greater concern to private practitioners. Missing and invalid responses to specific questions were excluded from all analyses. Sub-groups' totals may not add to exactly 100% due to rounding, or to multiple answers being permitted.

PRIVATE PRACTICE RESULTS

91.6% of private-practice respondents are the private practice's owner or co-owner, and 56.5% are in full-time (not part-time) private practice. The number of full-time-equivalent (FTE) behavioral therapists of all types averaged 2.3 with a range of 0.1 to 40. Because most private practices had 3 or fewer FTE therapists, the effect of number of FTEs on ACA experience was not reviewed.

California was respondents' most frequent state of practice, with 71 Fellows, but responses were received from every state except Delaware. Because the number of responses prevents meaningful state-specific statistics, respondents' states were arrayed into two categories: those where health insurers had—relatively early—imposed managed-care provider arrangements in metropolitan areas ("Early Managed Care States"), versus all other States.[4]

Most of the Early Managed Care States are in the Northeast, Industrial Midwest, or on the West Coast, have state-run (not federal) ACA Exchange (Marketplace) health insurance systems, and have majorities of state elected officials who are Democrats. Based on earlier Clinical Fellow and media reports, ACA experience of providers and consumers often varies by such characteristics, so this division allows detailed review of differences between these types of states.

Results for key questions are shown below, arrayed by 1) total private practitioners; 2) full-time vs. part-time practitioners; and 3) practitioners in "Early Managed Care" vs. Other States.

FIGURE 2. PRIVATE PRACTITIONERS' CONTRACTING WITH EXCHANGE HEALTH PLANS.

Q Are you now contracted with any health plans sold through the health reform (Affordable Care Act, also called ObamaCare) Exchanges?

56.5% No. (293 respondents)

28.9% Yes. (Count an HMO and a PPO exchange plan sold by the same insurer as two plans, but count e.g. MyState's Blue Cross PPO Gold, PPO Silver and PPO Bronze as one plan). (150 respondents)

14.6% I don't know. (76 respondents)

For private practitioners reporting at least one Exchange plan contract, the average number of contracts was 3.5, and the range was 1 through 18. Table 1 (on page 13) breaks out contracting experience by full-time versus part-time work status, and by practicing in an "early managed care" state versus another (not early managed care) state.

[4] Early Managed Care States, N = 254 (CA, CO, CT, DC, HI, IL, MD, MA, MI, MN, NJ, NY, OH, OR, PA, RI, WA, WI); Other States, N = 266 (all other states)

TABLE 1. PRIVATE PRACTICES' EXCHANGE PLAN CONTRACTING EXPERIENCE, AGGREGATE AND BY FULL/PART-TIME STATUS AND BY EARLY MANAGED CARE VS. OTHER STATES (N = 520).

Q Are you now contracted with any health plans sold through the health reform (Affordable Care Act, also called ObamaCare) Exchanges?:

	TOTAL	FULL-TIME PRIVATE PRACTICE	PART-TIME PRIVATE PRACTICE	EARLY MANAGED CARE STATES	OTHER STATES
NO	293	49%	66.2%	53.5%	59%
YES	150	34.9%	21.2%	33.1%	25.2%
I DON'T KNOW	76	16.1%	12.6%	13.4%	15.8%
TOTALS	520	100%	100%	100%	100%

Table 1 shows that full-time practitioners were more likely to have at least one Exchange-plan contract (compared to part-time practitioners), and that practitioners in "Early Managed Care" States also were more likely to have contracts than were those in other States. In Table 1 and the following Tables, the private-practice differences between Full- versus Part-Time Practice, and those between Early Managed-Care versus Other States, generally are statistically significant (chi-squares, $p < .05$).

Both these Table 1 effects make intuitive sense, because full-time practitioners, and those in Early Managed Care States, presumably tend to have more experience contracting with existing health plans sponsored by employers. So it would be expected that those private practitioners also would be more likely to have Exchange-plan contracts.

Private-practice respondents next were asked about their Exchange plan contracting experience, with answers detailed in Table 2.

TABLE 2. PRIVATE PRACTICES' EXCHANGE PLAN CONTRACTING EXPERIENCE, AGGREGATE AND BY FULL/PART-TIME STATUS AND BY EARLY MANAGED CARE VS. OTHER STATES (N = 520).

Q Which of the following is correct about contracting with Exchange plans (check all that apply, as your experience may vary by insurer)?

	TOTAL	FULL-TIME PRIVATE PRACTICE	PART-TIME PRIVATE PRACTICE	EARLY MANAGED CARE STATES	OTHER STATES
I have not contracted with any Exchange plans (i.e. I answered No to the previous question).	326	54%	50.8%	50.7%	64.8%
My private practice contacted the insurer(s), and they agreed to contract with us.	43	9.4%	6.8%	9.5%	5.7%
The insurer(s) contacted my practice, and my practice agreed to contract with them.	39	9.4%	5%	8.5%	5.3%
My practice already had "all product" contract(s) with the insurer(s), which added Exchange plans.	157	38.9%	18.5%	31.3%	24.2%

E RESULTS CONTINUED

ble 2 also shows that private
e full-time and who practice in early
s, are more likely to pursue Exchange
other practitioners. These results also
same reason as the patterns shown in

Based on previous anecdotal Clinical Fellow and media reports of problems contracting with Exchange plans, as well as denials of Exchange-plan contracts and reportedly inadequate pay rates, private-practice respondents were asked several questions, with results displayed in Tables 3 and 4, and Figures 3 and 4.

E PRACTICES' EXCHANGE PLAN CONTRACTING DENIALS, AGGREGATE AND BY STATUS AND BY EARLY MANAGED CARE VS. OTHER STATES.

s your clinical site contacted any insurers to request Exchange plan provider
tract(s), but such contract(s) were denied?

	TOTAL	FULL-TIME PRIVATE PRACTICE	PART-TIME PRIVATE PRACTICE	EARLY MANAGED CARE STATES	OTHER STATES
	492	92.6%	97.3%	93.7%	95.5%
	28	7.4%	2.7%	6.3%	4.5%
	520	100%	100%	100%	100%

in the two prior Tables, Table 3 shows
itioners, and those in early managed
newhat more likely to have contacted
, and to have requested contracts denied
by those insurers. Again, these practitioners likely are more "mature" in their business operations than are part-time practitioners and those in states where managed care is less a longstanding influence.

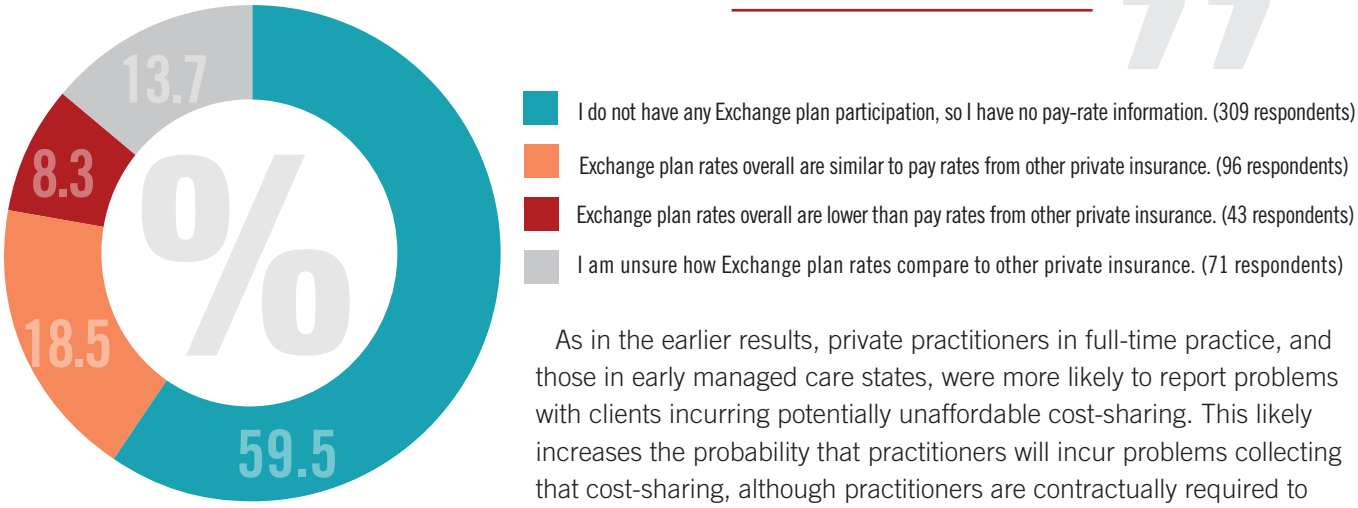
> Many exchange (plans) act as if clinicians are provider
> s, even make referrals and then don't pay because
> hose providers) aren't part of their narrow network. I
> own all Exchange plans—some of them I had to make
> l efforts. And some still act as if I am a (contracted)
>
> . – CALIFORNIA CLINICAL FELLOW "A"

Private practitioners who reported having any Exchange plan contracts also were asked, "About how many (or zero) new clients enrolled in Exchange plans has your practice treated since January 1, 2014?" The mean response was 2.5, with a range of 1 to 25.

> I have a small part-time practice along with my university teaching in psychology (and) my experience with the NY ACA plans has been positive. The plans have been managed well, have paid competitively, and I have been able to assist three individuals who previously had been unable to get health insurance due to preexisting conditions and, in one case, age. – NEW YORK CLINICAL FELLOW

FIGURE 3. PRIVATE-PRACTICE PAYMENT-RATE EXPERIENCE WITH EXCHANGE PLANS.

Please summarize the payment rates your clinical site receives from Exchange plan(s):



As in the earlier results, private practitioners in full-time practice, and those in early managed care states, were more likely to report problems with clients incurring potentially unaffordable cost-sharing. This likely increases the probability that practitioners will incur problems collecting that cost-sharing, although practitioners are contractually required to make collection efforts.

> I have found that clients who are on the Exchange plan are disappointed by the large deductibles. A few have abandoned the plan for other less costly plans, which I do not take as a provider, so we either negotiate a sliding scale or they pay for the session and submit for reimbursement. I have found a pretty large lag time in processing Exchange clients vs. regular (Insurance Co. name) clients. It's usually 2 weeks and Exchange can take up to 2 months.
> – CONNECTICUT CLINICAL FELLOW

FIGURE 4. PRIVATE-PRACTICE EXPERIENCE WITH EXCHANGE-PLAN CLIENT COST-SHARING.

Q Many Exchange plans require enrolled clients to pay high deductibles and other high out-of-pocket costs. Has your practice had any problems collecting Exchange-plan clients' cost-sharing payments?

57.8%: No. (300 respondents)

12.7%: Yes. (66 respondents)

29.5%: I don't know. (66 respondents)

PRIVATE PRACTICE RESULTS CONTINUED

TABLE 4. PRIVATE PRACTITIONERS' EXPERIENCE WITH EXCHANGE-PLAN ADMINISTRATIVE PROBLEMS.

Q Have you seen any of the following with any Exchange plans (check all that apply)?

	TOTAL	FULL-TIME PRIVATE PRACTICE	PART-TIME PRIVATE PRACTICE	EARLY MANAGED CARE STATES	OTHER STATES
Overly stringent pre-approval or medical review procedures	47	11.4%	5.9%	8.3%	5.1%
An insufficient number of visits being covered	35	8.4%	4.5%	7.7%	4.1%
Client(s) lacking knowledge about basic insurance procedures (e.g. HMO vs. PPO; deductibles)	129	31.5%	15.8%	25.8%	17.7%
Client(s) requesting/requiring the services of language interpreters.	5	1.7%	0%	.7%	1%
My clinical site has not treated any Exchange plan clients.	266	45.3%	59%	39.1%	50.7%
None of the above (no problems).	111	20.1%	23%	17.1%	20.4%

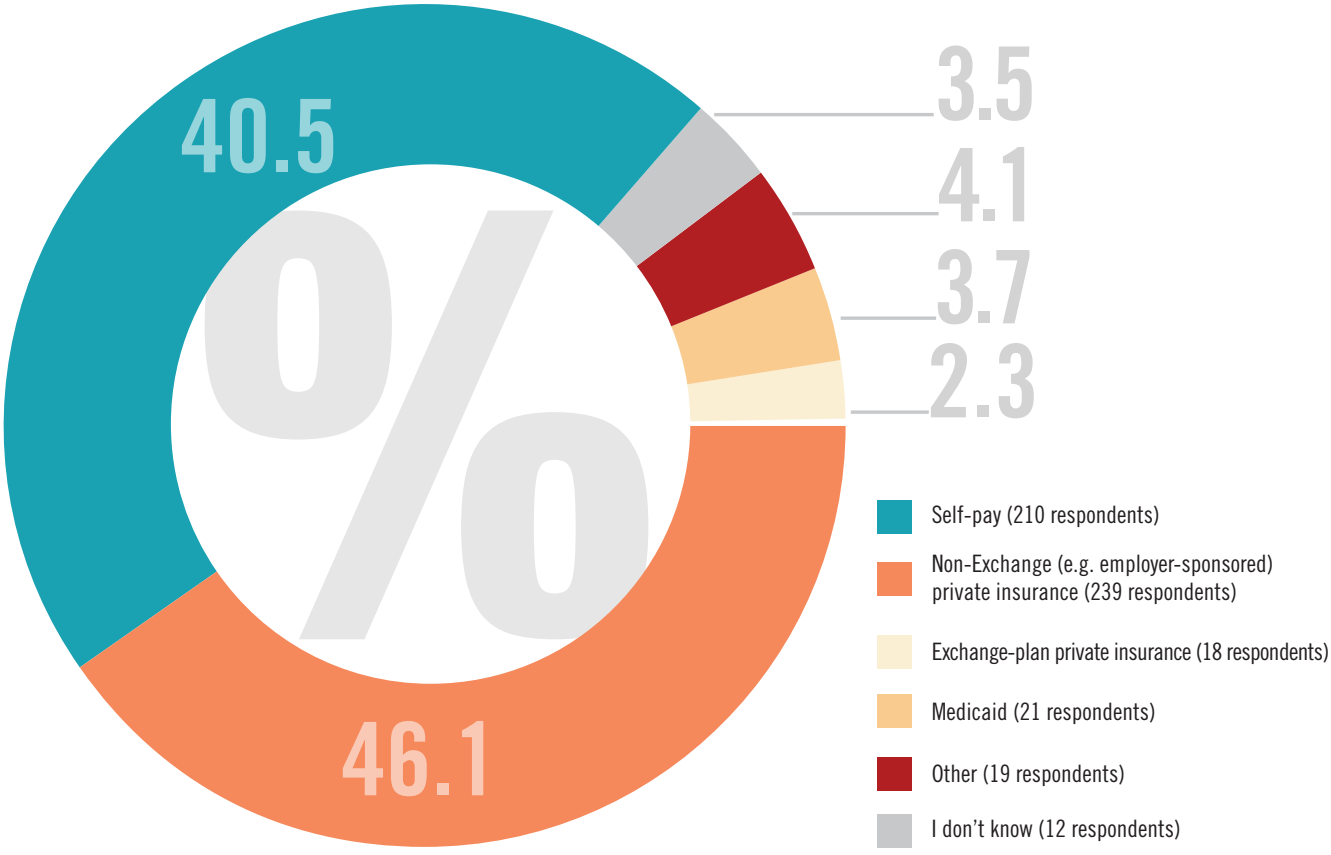
As with previous findings, private practitioners who are full-time or in early managed care states are more likely to report each of the several types of problems listed. This pattern of findings suggests that as private practitioners move from part-time to full-time, and as Exchange plans increase enrollments (move to resemble early managed care states), the probability of administrative problems with Exchange plans will grow.

> "We were given wrong information about the co-pay, wrong information about the client ID, and spent more time getting things straightened out than we were paid for! [The Exchange plan] is also the slowest in making payments of (all) the insurance companies....[Due to such problems with insurance generally] I was working 6 days/week to take home $20,000/year. I quit. **I'm closing down my business.**"
>
> – GEORGIA CLINICAL FELLOW "A"

> The vast majority of the clients I've had with ACA coverage are buying it through Blue Cross of Idaho via the exchange. My experience is that under the new plans offered in Idaho clients can generally access mental health care and simply pay their office visit co-pay. A number of these new clients are in plans that only require a $10 co-pay. So that's great for them. However, Blue Cross of Idaho requires an authorization every ten visits and its a fairly time consuming process. They are also (rumor has it) turning down authorizations if they don't meet Blue Cross' "medically necessary" criteria. – **IDAHO CLINICAL FELLOW**

FIGURE 5. PRIVATE PRACTITIONERS' MOST FREQUENT OVERALL PAYMENT SOURCE.

Please check the one type of payment source used most frequently by your practice's overall clients:

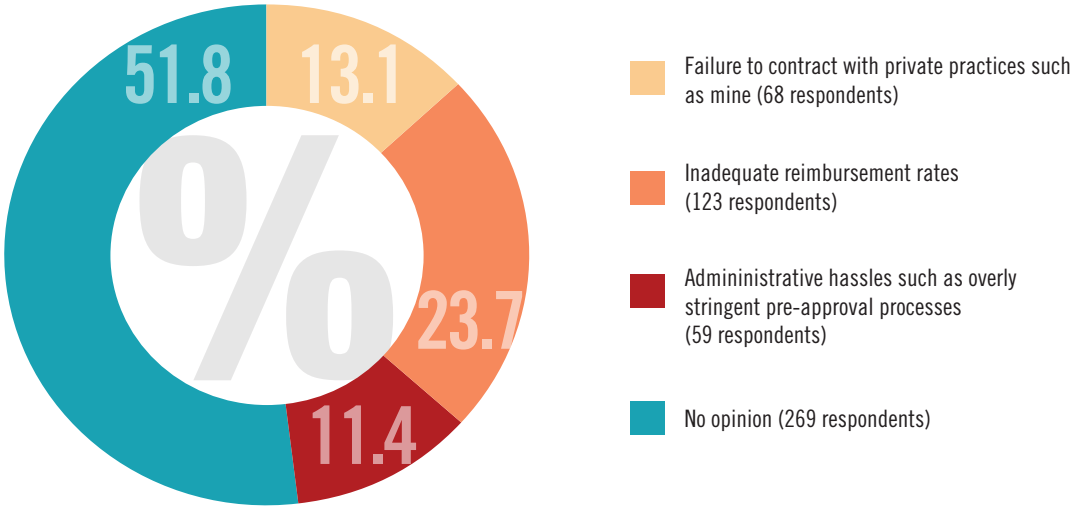


Private practitioners who work part-time are more likely to cite self-pay as their most frequent payment source, at 53.2% versus only 30.9% of those in full-time practice. As more consumers who previously were uninsured later obtain Exchange coverage, some of those consumers (particularly those with moderate incomes) may change from self-pay to Exchange coverage, thus potentially reducing the number who are willing to pay out-of-pocket.

OVERALL DISTRIBUTION OF FELLOWS' GREATEST CONCERN WITH EXCHANGE PLANS

FIGURE 6. DISTRIBUTION OF TOTAL RESPONSES AS TO PERCEIVED GREATEST PROBLEM WITH EXCHANGE PLANS.

Private practitioners also were asked to "Please check the one most important problem with Exchange plans that some MFTs have reported and that AAMFT should try to improve."



Although the majority of respondents had no opinion about the greatest concern with Exchange plans, perceived inadequate payment rates led the responses for those who did state any top concern. This was followed by plans' failure to contract with respondent's practice organization, and then by operational problems. That response pattern is similar to anecdotal media reports for other types of healthcare practitioners.

> "With the shortage of mental health professionals, LMFTs have a golden opportunity through healthcare reform to help solve the tidal wave of problems that will be caused by reimbursement being tied to [outcomes in integrated clinical settings]. We won't be able to take advantage of the opportunity or serve nearly enough people if we stay with the current thinking—'we are the highly trained experts—they will come to us'.... We need to be where the clients are... [and] we need to be there when they need it."
>
> – MINNESOTA CLINICAL FELLOW

FACILITY-BASED RESULTS

The number of respondents who work at facilities such as hospitals (rather than at private practices) was too small (N = 139) to obtain meaningful results for full-time versus part-time practice, and for early managed-care states versus other states. So only overall facility-based results are shown. Results for each question are shown as follows.

FIGURE 7. FACILITY-BASED PRACTITIONERS' SITE TYPE.

Please indicate the type of clinical facility where you most frequently practice:

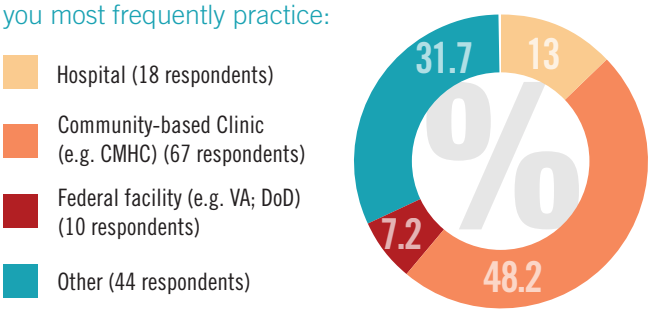


FIGURE 8. FACILITY-BASED PRACTITIONERS' EXCHANGE-PLAN CONTRACTING EXPERIENCE

Has the clinical facility where you most frequently practice contracted with any Exchange (Marketplace) health plans under the federal Affordable Care Act (health reform law)?

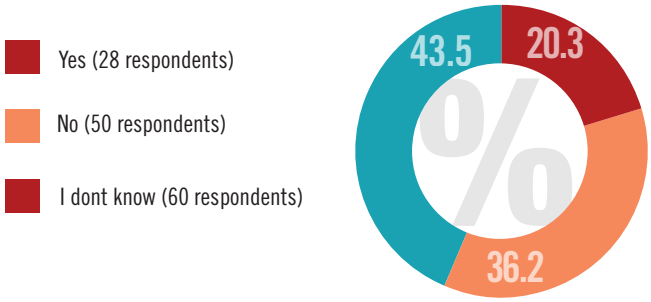


FIGURE 9. FACILITY-BASED PRACTITIONERS' EXPERIENCE WITH CLIENT CENSUS, PRE- VERSUS POST-EXCHANGE PLANS START.

What has been the trend in the number of clients treated personally by you at your facility since January 1, 2014?

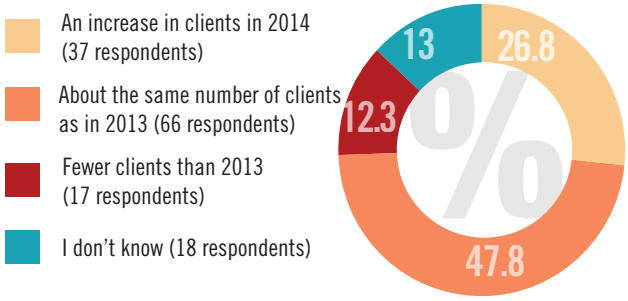


FIGURE 10. FACILITY-BASED PRACTITIONERS' EXPERIENCE WITH CLIENT AVERAGE TIME PER EPISODE, PRE- VERSUS POST-EXCHANGE PLANS START.

Please check one of the following concerning your average total time per client episode (e.g., total 60-minute visits per client) in 2014 compared to 2013:

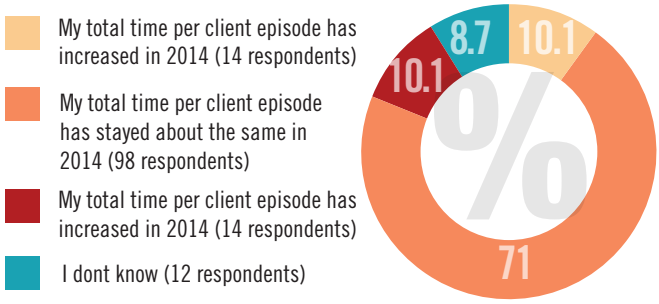
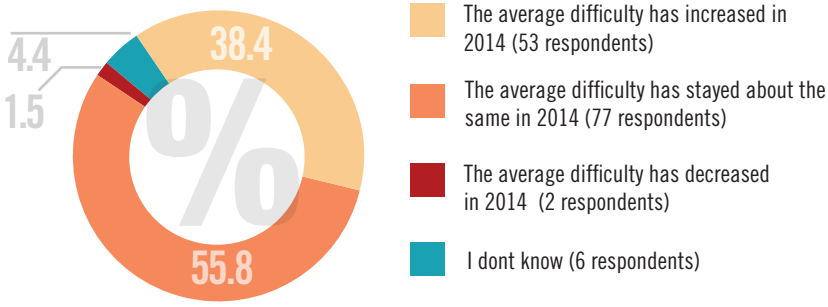


FIGURE 11. FACILITY-BASED PRACTITIONERS' EXPERIENCE WITH CLIENT AVERAGE DIFFICULTY PER EPISODE, PRE- VERSUS POST-EXCHANGE PLANS START.

Please check one of the following concerning the average difficulty of treating clients (clinical severity, paperwork burden, any language barriers) in 2014 compared to 2013.



FACILITY-BASED RESULTS CONTINUED

FIGURE 12. FACILITY-BASED PRACTITIONERS' EXPERIENCE WITH PAYER ADMINISTRATIVE PROBLEMS, PRE- VERSUS POST-EXCHANGE PLANS START.

Q Have you seen any of the following occur in 2014 at your facility (check all that apply)?

38.4%: An increase in overly stringent pre-approval or medical-review procedures by clients' insurance plans. (53 respondents)

27.5%: An increase in an insufficient number of treatment visits being covered by clients' insurance plans. (38 respondents)

12.3%: An increase in client(s) requesting/requiring the services of language interpreters. (17 respondents)

14.5%: An increase in the number of all behavioral therapists. (20 respondents)

7.3%: A decrease in the number of all behavioral therapists. (10 respondents)

6.5%: An increase the number of MFTs. (9 respondents)

6.5%: A decrease in the number of MFTs. (9 respondents)

40.6%: None of the above (no such changes) (56 respondents)

> I am **really, really happy** that [AAMFT is addressing this [ACA issue].
>
> – CALIFORNIA CLINICAL FELLOW "A"

DISCUSSION

Most private practitioners have very little to no experience with ACA Exchange plans. This is of concern because as Exchange plans increase their number of enrollees over time, private practices may well be "locked out" of contractual ability to treat Exchange enrollees for reasonable pay rates, thus losing a large potential revenue source.

Some private practitioners with ACA experience report few or no problems, but others report major difficulties. Types of reported problems are similar in nature to those with regular (e.g. employer-sponsored) health plans. And for some practitioners who are not contracted with ACA plans, there are adverse "spillover" effects, either losing referrals to contracted providers, or by plans' inaccurate administrative treatment of those practitioners as if they were contracted.

So Exchange plans, with their sometimes relatively low pay rates and high administrative costs, may exacerbate the already-tenuous financial situation of those private practices that are unable to rely on client self-pay as their main revenue source.

Facility-based practitioners' experiences differ substantially from those in private practice. Although only about 20% of facility-based MFTs report that their facility has any ACA contracts, these MFTs report higher rates of administrative problems. This facility-versus-private site difference may result from Exchange enrollees' greater awareness (and thus greater use) of facilities such as hospitals as opposed to private MFT offices. If that were true, it also may be that facilities such as hospitals are more likely to be contracted in Exchange plans' provider networks, resulting in a further, financial reason for consumers to be treated at facilities rather than private offices.

Usage of hospitals and other facilities by newly-insured Exchange enrollees may explain why 14.5% of facility-based respondents report increases in overall behavioral therapist staffing levels, versus only 7.3% reporting overall staffing reductions. Only 6.5% of these respondents report reductions in MFT staffing, and the same percentage report MFT staffing increases.

In summary, it appears from survey responses that the healthcare reform law has had little positive or negative effects on most Clinical Fellows. However, some individual Fellows report either highly positive or highly negative effects. AAMFT will continue to advise Congress and the federal Executive Branch on ACA positives and negatives, and will share these survey results with selected Congressional staff. AAMFT also anticipates fielding a similar survey in the future to allow comparison over time to the results reported here.

GO ONLINE
Members having comments or questions on the ACA may send them to **advocacy@aamft.org.**

WELL, I DEGREE

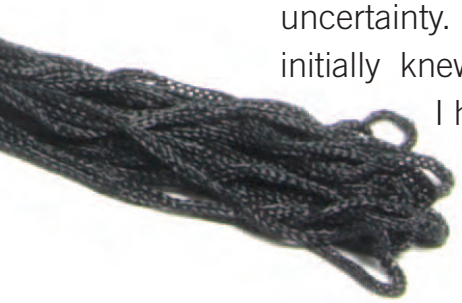
Brett Novick, MA

GOT MY AND LICENSE. NOW WHAT?

IT WAS 2000 and I was making the two-day trek back to my home state of New Jersey. Under one arm, my MFT degree, and in the other, a handful of visions, hopes and dreams of a successful career—while surrounded again by family and friends. When I arrived back home, I dreamed of an immediate, thriving private practice. I pictured (or more accurately *hoped for*) clients beating down my door as I comfortably settled back home after an eight-year hiatus in the Midwest.

I knew I was in trouble almost immediately as I returned to the East Coast. In the region I went to graduate school, the discipline of marriage and family therapy was firmly established. In contrast, the field in New Jersey was still in its relative infancy, and not quite as entrenched or recognized. I realized I was going to have an uphill climb when I applied for jobs as a "family therapist" only to be told, "We are looking for social workers for the position, not licensed marriage and family therapists." I had a young family and was feeling frustrated, worried, and saddled with a huge graduate student loan that was bearing down on me. I seemed to be a round peg trying to fit in a square hole everywhere I went.

As is often the case, my vision and reality were two very different paths, to say the least. Fortunately, 15 years later, I have begun to reach the precipice of what I envisioned. It was a path that was neither straight nor direct, and fraught with uncertainty. It required more skills than I thought I had, more creativity than I initially knew was needed, as well as more flexibility and patience than I thought I had. It meant making dumb, well-intentioned mistake after mistake, and I now wish I had not thought so myopically in my attempt to forge and blend a rewarding career path.



EVALUATING AND RE-EXAMINING THE DIRECTION OF YOUR CAREER CAN NEVER HURT.

I knew I had to cast a wide net; set myself apart. What this meant was being able to piece experiences and qualifications to blend several roles into a rewarding career. Since that point 15 years ago, I have had an opportunity to manage, teach, consult, and be in private practice, while simultaneously working in the public education system. Each of these duties helped to round and fulfill me, both as a person and a professional.

It is my sincere hope that these ideas help you to stretch beyond your "comfort zone" and into new areas and paradigms. Perhaps they may even help you steer clear of some of the "growing pains" I experienced as I forged a career. Regardless, evaluating and re-examining the direction of your career, or tweaking it to the direction you want can never hurt.

NEVER SAY "NO": Often, I was offered or sought per-diem opportunities with various agencies to do evaluations, assessments, or therapy. Working with each agency gave me opportunities to test the climate of each, put myself out there for potential job offers and expand my experiences outside of just traditional counseling experiences. Look for areas of potential growth and seek these out intentionally.

MANAGEMENT AND SUPERVISION ARE ALWAYS NEEDED QUALITIES: Look for human and/or social service agencies that are seeking managers, directors or coordinators. The experiences of management may lead to doors both in and out of mental health that you would not otherwise have access to in the future. Leadership and your knowledge of how people relate and behave are a dynamic, as well as marketable, combination.

Help your fellow therapists: If you are successful in an area in a particular aspect of counseling practice (such as marketing, designing great business cards, setting up a practice or website) offer to help others. Get your name and reputation out there and charge a fee for the service. Look for areas of need as you talk to your therapist peers. What do they need? What challenges do they face? Find a way to fill that void and you have a potential new revenue stream or even a possible career in its infancy.

LOOK FOR CERTIFICATIONS AND LICENSES THAT ARE PRACTICAL: If you are going to continue your education, look towards those fields that will expand your career options. Some of us tend to gravitate towards those certifications in which we're interested. That is fine, just be sure the education has some return value in expanding your career. Don't seek certificates that are not going to have practical financial return in your career (remember, trainings should be an investment).

NETWORKING SHOULD NOT BE UNDERSTATED: Being a part of associations, social media, and trying to be in the public eye as much as possible is vital. No one will market yourself better (or as well) as you can. Look for what others are doing and listen to their concerns. Can you fill a need in the community? Is there something you can do better? What is needed in the community that is not being provided? Asking these questions helps move your abilities to an opportunity-seeking entrepreneur.

CONSIDER TEACHING WHAT YOU KNOW: Remember, your skills are valuable to others, but not just in the therapy session. Consider teaching at the college level or offering workshops in adult education programs. Relationship, communication skills programs, or most social science programs fit nicely into our educational abilities. With martial discord at a continuing high, couples may find attending a workshop less threatening than traditional counseling.

HOUSES OF FAITH CAN USE YOUR KNOWLEDGE: Marriage is a religious institution. Who better than an MFT to offer assistance in a weekend marriage retreat? Review the format of the retreat agenda and see where you can interject your talents. If it is your cup of tea, consider starting your own couples retreat program.

LIFE COACHING—A NEW AREA OF CAREER EXPLORATION:

Counseling people who are in need and assisting in direction provides a great parallel for the knowledge necessary for the burgeoning field of life coaching. Life coaching shifts away from the medical model of mental health to a more mentoring based prototype. Instead of treatment plans and goals you are now looking at, taking a step back from the focus of a presenting psychological/family structure problem to life and career goals. A quick web search will find a host of sites that provide certification. Just be cautious; make sure the certification is reputable and of value. Look for a program that is accredited by the International Coach Federation. Additionally, be sure you understand the code of ethics, as well as job description of prospective life coaches, as this will differ somewhat from that of AAMFT.

INTERNET AND PHONE THERAPY:

Though I have never conducted therapy via phone or the internet, and find the practice fraught with potential issues, some therapists have found a niche in this area. If you want to consider putting out a shingle in this specialty, I encourage you to read, move cautiously, and check with local associations, licensing boards and peers. The advantage, of course, is the ability to assist people without having restriction of geography and from the comfort of your own home. The disadvantage is the loss of the personalization that is usually a critical aspect of therapy and concern about adequate service to clients.

SYSTEMS ARE SYSTEMS—MARKET THAT:

As an MFT, you have a particular set of skills in understanding the concept of how a system works. Systems, of all sorts (families, offices, schools), are all somewhat similar structures and you have a deeper knowledge to go beyond "content" in a situation versus simply "processes." An understanding in this theory can be an essential asset in companies. Further, you can take this skill and resource to offer effective teambuilding skills programs and retreats.

MAKE HOUSE CALLS:

Don't forget to consider in-home mental healthcare. Some therapists tend to shy away from this practice, as it can be an additional challenge to go into a family's environment that is chaotic, conflicted or (sometimes) dangerous. However, in-home therapy may be the place to meet the most challenging of clients and enhance your skills. Working for an agency or setting up your own business to work with families, children with developmental disabilities, or marital/pre-marital counseling may just be the jumpstart or supplement your career portfolio needs.

BE AN AUTHOR:

If you have something to say in a different way than anybody else, consider writing a book. Don't think it could get published? Consider self-publishing your book (see Gina Ogden's two-part series on writing and publishing in the July/August and September/October 2013 issues of this publication). Either way, writing and marketing your book can be a rewarding and fulfilling experience in the life of your therapy career.

VOLUNTEER:

As an MFT, you have a special duty to volunteer in your community. Volunteering in various areas in the community is not only rewarding, but helps you better understand specific needs within your particular community. Our communities need more advocates helping families grow and thrive.

Whatever direction you take in your career, leave all your options open. In this dynamic and fluid world, careers change in a heartbeat, and doors open and close quickly. Leaving all your pokers in the proverbial fire is a vital way to be able to have flexibility to assure there is always a side door and most options are not locked or slammed shut.

Brett Novick, MA, LMFT, has been working within school districts in New Jersey for the past 13 years. He has also worked in private practice, as well as a variety of community mental health settings, working with individuals, groups, and families. Novick was awarded District Teacher of the Year in 2007-2008 and New Jersey School Counselors Association Human Rights Advocate of the Year in 2008.

YOUNG PROFESSIONALS

THE RISING TIDE OF STUDENT DEBT

Benjamin E. Caldwell, PsyD

How much should it cost to become an MFT?

WHILE INDIVIDUAL COSTS OF GRADUATE EDUCATION CAN VARY WILDLY—some students go to smaller, grant-funded programs and never have to pay tuition, while others (often in private schools) pay $60,000 or more just in tuition for their degrees—the average cost of graduate education in all of the psychotherapy professions is rapidly increasing. For those who borrow to pay for their degrees, their debt loads upon graduation are much higher than prior generations of therapists.

THE MENTAL HEALTH PROFESSIONS ARE BY NO MEANS UNIQUE IN THIS. Cost increases have been occurring throughout higher education in the US. However, it is noteworthy that while tuition costs have been increasing much faster than general inflation in the economy, the master's level mental health professions have also been making degree requirements higher, compounding cost increases.

HERE'S ONE WAY TO THINK ABOUT THE CHANGES. In 1985, a master's level therapist typically needed a 36-semester-unit master's degree to become licensed. Let's suppose that Emily wanted to become a family therapist back then, so she went to Average Hypothetical University, where the cost of tuition happened to be $200 per unit. Emily would have paid a total of $7,200 in tuition to get the degree she needed to become an MFT.

If AHU has gone through the average US tuition inflation since then, today they are likely to be charging more than $1,200 per unit. Let's say Emily's daughter, Selena, who wants to become an MFT in 2014, decides to go to her mother's alma mater to get the degree required now, which takes a minimum of 60 units. Selena's total tuition cost will be more than $72,000. Of course, other prices have risen as well over the past 30 years; consumer prices have roughly doubled since 1985 due to inflation. But the cost of the education necessary to become a master's level therapist is more than 10 times what it was 30 years ago (Wadsworth, 2012).

And that's just tuition. It leaves out other expenses, and the much greater difficulty students now have obtaining financial aid. In professional schools, a majority of students receive no financial assistance whatsoever (Mulvey, Wicherski, & Kohout, 2010).

While there is no specific research on student debt among family therapists, many MFT students today need to borrow large sums of money to even attend graduate school. Their salaries upon graduation may not be enough to sustain the graduate and their family, particularly given that in most states the therapist will still need to complete years of supervised experience, often in jobs with relatively low pay, before they are eligible for licensure.

Across professions (excluding degrees in medical fields, law, and theology), those who borrow to complete master's degrees graduate with an average of more than $50,000 in debt, much of which comes from their graduate education (The College Board, 2013). Remember, too, that this is just the principal, or the amount borrowed—repaying a $50,000 debt on a 10-year schedule at 6.8% interest will actually require almost $70,000 in total payments (FinAid, 2014).

Though those are big numbers, you might understandably ask: How much debt is actually a problem? So long as our salaries allow us to make the monthly payments on our educational debt, does it really matter what the total numbers are?

I'll admit, I've been guilty of this kind of thinking on more than one occasion. I was lucky enough to get my doctorate when student loans were cheaper and relatively easy to come by; when I refinanced my student debt after graduation, I was able to do so at just over a 2% interest rate, which was common at the time. With a steady university paycheck, I now barely notice when my student loan payment is automatically deducted from my bank account.

Today's students don't have it so easy. Refinancing, when it is available at all, is usually at interest rates of 5% or more—that may not sound like much at first, but over the life of a $100,000 debt refinanced into a 30-year repayment schedule, the difference between a 2% rate and a 5% rate is more than $60,000.

The web site, FinAid, set up as a public service to help students and their families obtain aid and calculate debt repayments, estimates that you need an annual salary of more than $64,000 to be able to afford repaying a $100,000 debt at a 5% rate over 30 years.* If that interest rate were 6% instead, you would need a salary of almost $72,000.

Most master's level therapists, and many psychologists, simply don't make that much, especially when starting their careers. See below.

While the salaries for psychologists are significantly higher, they are the only professional group that requires a doctoral degree—and the added expense that comes with it. The average psychology program is more than 100 semester units, compared to the 60 required at the master's level.

Simply put, it is much harder today than it was even 10 years ago for a

Most master's level therapists, and many psychologists, simply don't make that much, especially when starting their careers.

According to the Bureau of Labor Statistics, these are the 2013 median annual salaries for full-time work in the four major psychotherapy professions:

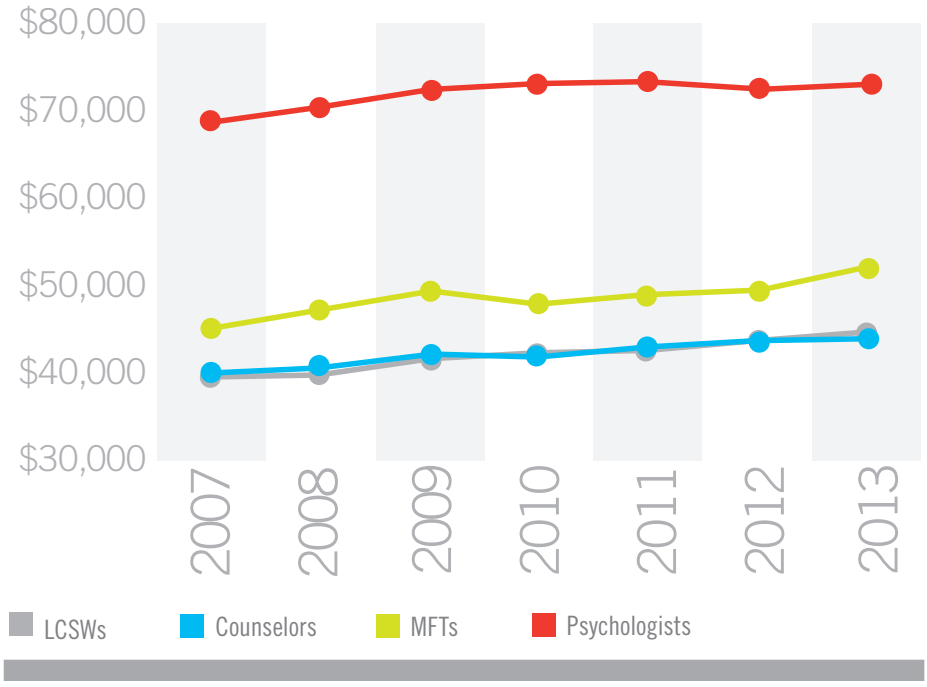
prospective therapist with a strong skill set and academic record, but few financial resources, to fulfill their dream of becoming licensed. Graduates of PsyD programs in psychology now report an average of more than $100,000 in student loan debt (American Psychological Association 2008). While hard numbers for the master's-level professions are challenging to come by, the average student borrower has racked up about $30,000 in debt before even starting graduate school (The Institute for College Access and Success, 2013). According to FinAid, the median MFT salary of $48,160 would be sufficient to pay off a $74,000 debt over 30 years at 5% interest. Total payments on that debt would amount to more than $143,000.

Educational debt is frequently mentioned as a key reason millennials are buying fewer cars and homes than prior generations (Christie, 2014). Many millennials say that their student debt factored into decisions to delay getting married (29%) and having children (43%). It might also be leading otherwise well-qualified students who would like to be therapists into other careers: Almost a third of millennials said that student debt had considerable impact on their choice of career fields (American Student Assistance, 2013).

A 2008 report on student debt among social workers begins with a simple and saddening quote from one of their survey participants: "Unmanageable debt, poor preparation in training for job negotiations, and low salaries in the social work profession make the social work profession untenable" (National Association of Social Workers, 2008). That same report showed that nearly a third of social workers had to rely at least in part on credit cards to finance their education. In spite of a nationwide shortage of social workers, the report concluded, "educational debt is pushing people away" from the profession. It seems likely that the same is true for family therapists and counselors.

The cost of the education necessary to become a master's therapist is more than 10 times what it was 30 years ago. However, there is good news regarding salaries:

According to the Bureau of Labor Statistics, salaries are improving for all of the mental health professions except Psychology, which has been effectively flat since 2009.



Source: Bureau of Labor Statistics. Data represents mean annual full-time wage.

Despite these data, responses to the educational debt crisis in mental health have been underwhelming. The professions and some governmental bodies have responded with efforts at student loan reimbursement plans and funded internships. While these programs are certainly helpful, they are generally tied to public service and awarded to only a tiny fraction of those who desperately need (and would qualify for) them.

For the professions to continue to place such a heavy financial burden on their newest and most vulnerable members is unconscionable. There is little, if any, evidence that increases in training requirements have made master's level therapists any safer or more effective in our work, raising questions about the necessity of those new requirements. Today's higher training standards, and their associated costs, may be doing more to keep people out of the mental health workforce than they do to improve the quality of that workforce.

Writing about the apprenticeship model in medicine, *Slate*'s Brian Palmer (2014) captured the same problem we now face in the therapy professions (I've taken the original quote and changed "physicians" and "doctors" to "therapists" here):

Over the past century, there have been additions to, but few subtractions from, the training process. […] The long process doesn't just weed out the incompetent and the lazy from the potential pool of therapists—it deters students who can't pay for so many years of education or who need to make money quickly to support their

families. That introduces a significant class bias into the therapist population, depriving a large proportion of the population of therapists who understand their background, values, and challenges.

Large-scale solutions to this issue are unlikely in the near future. There appears to be little political will to revisit educational and experience requirements for MFT licensure, particularly if the goal is reducing them. However, **on an individual level, there is much that an MFT can do to insulate themselves from concerns that starting an MFT career requires going broke first.**

The first step may be to simply give more weight to financial considerations when choosing a graduate program. As noted earlier, graduate program costs vary wildly. Some programs charge little to no tuition, while others have true costs of $70,000 or more. Students can and should gather as much information as possible from programs about their actual costs prior to enrolling, and should carefully consider whether it is realistic to take on that level of expense. Governmental programs that reduce or eliminate student debt in exchange for work in public service continue to expand, providing opportunity for those interested in public mental health careers. Students may be well-served by looking into such programs early, to make sure their education and experience meets all the requirements to participate.

** Assuming no loan servicing fees and applying 10% of the borrower's gross income to loan repayment, which corresponds with a debt-to-income ratio of 1.6. Most programs use higher thresholds (that is, you would need to be making significantly less than the numbers I use here) when defining economic "hardship" for the purposes of payment deferral eligibility.*

*** For the analysis here, I've used the BLS categories of Mental Health Counselors (21-1014); Clinical, Counseling, and School Psychologists (19-3031); Marriage and Family Therapists (21-1013), and Mental Health and Substance Abuse Social Workers (21-1023). These are the closest parallels to licensure in the BLS data.*

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STUDENT LOAN FORGIVENESS

Licensed MFTs are eligible for student loan forgiveness under the National Health Service Corps (NHSC) if the MFT:

- agrees to serve in a clinical capacity in a federally-designated Mental Health-Health Professional Shortage Area (MH-HPSA) site, and
- is selected by the federal Health Resources and Services Administration (HRSA), which selection is based on:
- the willingness of the MFT to work at an MH-HPSA site that is relatively easy or difficult to fill (rural sites are more difficult), as well as the MFT's desired amount of loan forgiveness (the less the amount of desired loan forgiveness, the more likely the MFT will be to receive an award), and
- the total available NHSC funds for the year in question.

Forty-four MFTs are receiving loan forgiveness as NHSC enrollees. Initial awards are for two years, and may be up to $50,000 total in loan forgiveness. Applicants may choose to fulfill an award by working either full-time or (for lesser loan forgiveness) half-time. Once the initial award is fulfilled with two years of service, NHSC clinicians may apply for additional loan forgiveness.

AAMFT and other healthcare professional groups continue to urge Congress to provide more funds for this program. Members interested in applying for NHSC loan forgiveness should visit http://nhsc.hrsa.gov/loanrepayment/index.html for applications, timelines, and other details.

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Why I Chose the Field of Marriage and Family Therapy

I spent my high school years and the beginning of college thinking that I wanted to be a geneticist, which is a far cry from marriage and family therapy. One year into my biology program at Purdue University, I was really unhappy with my studies. I didn't feel like my life was going in the right direction. I spent a semester in career counseling trying to figure out what my new major should be and the path my life should take. After extensive testing and speaking with a counselor, everything was pointing me in the direction of a helping profession working with people. After great consideration, I settled on psychology, a subject that had always scared me. However, deep down I knew I really wanted to help people.

I grew up in the Midwest with two happily married parents who have been together since high school. I only had one friend in elementary school whose parents got divorced. As I grew older and met more people and was exposed to more family styles and dynamics, I was shocked and disillusioned to learn that the divorce rate is so high. I couldn't imagine so many couples, families, and children having their lives torn apart by conflict and separation. There were (and are) tons of people in our country who were not as lucky as I was to have such an idyllic childhood with a happily married parental example. The divorce rate figures are really what stuck in my head throughout my psychology training at Purdue. I desperately wanted to do my part to help lower that statistic or at least keep it from rising.

During my senior year, I prepared to apply to graduate programs, as I knew I would need a master's degree and probably a doctorate degree in order to practice as a psychologist. On a whim, I decided to pick up a family studies minor which consisted primarily of child development classes, but as part of it, I enrolled in one course in marriage and family therapy. The MFT course immediately sparked my interest like none of my psychology courses had to that point. I loved learning about Gottman and his theories, and I did not want to put my textbook down. That semester I was also enrolled in a sexuality course with a professor who happened to be a former AAMFT Board Member who has served on the faculty of several MFT programs. Through conversations with her, I learned that marriage and family therapy is not just a subset of psychology. It is a very different systemic-focused discipline with a completely separate license to practice. I was immediately drawn to the idea of working with couples and families and not solely individuals.

The divorce rate figures are really what stuck in my head throughout my psychology training at Purdue.

I applied and was admitted to the COAMFTE-accredited MFT program at the University of Maryland, College Park. I loved learning the different models of MFT, especially emotion-focused therapy, cognitive behavioral therapy, and structural family therapy. During my practicum, I enjoyed working with couples the most, as I suspected I would. I graduated in 2007 and worked for a year as a substance abuse counselor before deciding to take a break from doing therapy. I wanted to stay connected to the profession I fell in love with during undergrad, so I came to work for AAMFT and have been here since. I like to think I am doing my part to help support the professionals who are providing much-needed marriage and family therapy to the public and to students who are just starting out on their professional journey.

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HOW TO MORE THAN JUST SURVIVE IN AN MFT GRADUATE PROGRAM:

SIX THOUGHTS FROM A STUDENT WHO MADE IT

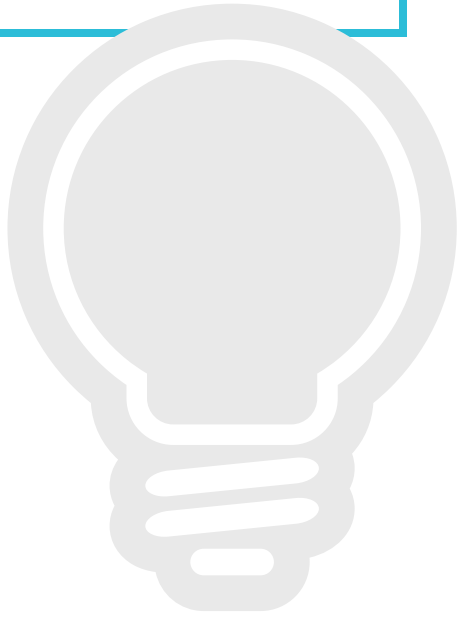
Cameron C. Brown, MS

1 Self-care Schooling in general can be draining, but layer on top of that, becoming the tool in therapy that can assist in enacting change with clients; it's exhausting. It took me until eight months into my program to realize that I was beginning to burn out. My life centered around the classroom and the therapy room. I was helping my clients achieve better balance in their lives, yet I was finding it difficult to find balance myself. I was running on empty and my class work, therapy, personal relationships, and sanity began to suffer.

I began focusing more on things that energized me and gave me purpose. These things are different for everyone. Recent literature highlights how exercise not only benefits us physically, but also psychologically (De Moor, Beem, Stubbe, Boomsma, & De Geus, 2006). Also, quality personal relationships with loved ones have been associated with higher self-esteem (Foster, Kernis, & Goldman, 2007) which may in turn energize us in those frustrating therapy sessions. Positive personal relationships can also assist us in being open to and receiving hard feedback (Kumashiro & Sedikides, 2005). For me specifically, I loved associating with fellow therapists, but I found that when I had close friends outside of my field, I was more able to step away from work and take my therapist hat off. Also, I began indulging in media and literature that was irrelevant to my field, but that I found interesting, entertaining, and relaxing.

2 Be open to difference Most MFT masters programs are very short (two to three years) and require hundreds of therapy hours. Although seemingly daunting, this really is not a large span of time to learn how to be an effective therapist, so go in with an open mind to new perspectives and ideas. Be open to what your instructors are offering you; they have been placed as instructors at your academic institution for a reason.

Just as in life, your program may expose you to thoughts, theories, lifestyles, or opinions with which you do not see eye to eye. You do not have to agree with these perspectives, but be open to them. I believe it can be detrimental to our learning and progression if we believe we know everything and are *always* right. I was once advised to be like a sponge during graduate school. Remember, you are paying good money to be there, so soak it up!



As many seasoned, licensed, or even simply graduates in MFT know, a masters in marriage and family therapy can be a beautiful, but grueling, experience. Becoming a therapist is rewarding on so many different levels, but also so incredibly hard. Before I began my masters program, I only heard about the rewards. I heard the usual phrases from family, friends, and peers: "You have a job that truly matters to people." "You get to go home from work knowing that you have made a difference." "There needs to be more of you [therapists] in our world." "What a rewarding career." What I did not hear from others is: "You will spend the next two years drowning in literature, writing pages upon pages of papers, and figuring out your own issues while trying to help others figure out theirs. It may be one of the most difficult degrees because it is simply not just learning, it is becoming." I miraculously made it through my masters in marriage and family therapy and below are **six things I learned along the way that not only helped me survive but ultimately thrive.**

3 Take advantage of supervision

I specifically recall my first supervision where I was being watched live by my supervisor and peers through a two-way mirror. I was terrified! I felt like an animal at a local zoo where visitors were watching me and thinking, "Aww, how cute, look at him try and climb that tree. Aww, he just fell down again. I hope he does not hurt himself." If anything, I felt like that mirror between my colleagues and I was a giant magnifying glass that showed all of my imperfections, inadequacies, and incompetency. I was vulnerable. It was exposing. The session ended and then came the flood of feedback from my colleagues. It stung. Walking out of supervision that evening I felt as if becoming a therapist was perhaps not meant for me. I did too many things wrong. I just was not good enough.

I struggled with these thoughts of inadequacies for the next couple of weeks until I brought them up with my supervisor. She chuckled and explained to me that her role was not just to sit back and watch me, but to really help me *become* a great therapist. She continued to explain that her feedback and suggestions were not meant to be personal attacks, but to open my eyes to specific ways to become a better therapist. I thought a lot about this and realized that the reason I am in an MFT graduate program is not just to get a piece of paper showing that I graduated, but to become a therapist.

Supervision and feedback can be tough. It can sting or be difficult to take in. Be open to it. Your supervisors earned that position for a reason. They have lots of clinical hours under their belts. Learn from them and their experiences. Be open to their points of view, even if it is hard to hear. You are in an MFT graduate program to become a therapist, right? Well, let them help you become one.

4 Self-of-the-therapist

Going into my graduate program, I did not have everything together and figured out in my life. If you or anyone you know has it all together or figured out, please get in contact with me because I want to know how it is done. My specific program focused a lot on self-of-the-therapist issues because of the belief that it is difficult to detach our personal lives from our therapy lives. There were specific things in my life that were hindering my confidence and effectiveness in the therapy room. Although your supervisors or instructors cannot be your own personal therapists, they can assist you in figuring out some of the issues in your life or point you to resources that can. I personally believe that we cannot ask our clients to do things that we cannot, or will not, do ourselves. Just as we would be frustrated with a client who runs from problems, do not run from yours; figure them out. What better time to sort out these issues than in a learning program?

5 Do not sell yourself short

During the first few hundred clinical hours of my therapy career I struggled believing in myself. I constantly found myself apologizing to my clients for less than great sessions (I do not even think I knew what a "great" session was anyways). ***Do not sell yourself short.*** Just because you are not married does not mean you cannot help a marriage, or just because you do not have children does not mean you cannot assist families.

First, we are usually harsher on ourselves than others are on us, which means that realistically, you are probably much better than you think. I know this is hard for me to say about you, the reader, because honestly, I have never met you and there is a high chance that we will never meet, so you will have to trust me when I say you know more than you think. You are the ones who have read endless pages about assisting marriages and families, the ones who have had hours of supervision with top-notch therapists, attended workshops about interventions, or attended AAMFT trainings and conferences. You are right; you do not know everything, but you will *never* know everything about therapy. Just because you are not a part of Mensa does not mean you cannot be an involved, dedicated, and effective therapist.

6 Pace yourself in becoming a great therapist

I guess you could say that I am a recovering perfectionist. I was the one who could not turn in a paper until it was revised 10 times, or cook a complex meal worrying it could turn out inedible. It has always been difficult for me to do things at which I'm not perfect doing. This mindset carried over into the therapy room. I struggled, and then became frustrated because I was struggling. This frustration led to feelings of inadequacy, which my supervisor quickly recognized. During a peak of frustration, my supervisor asked how many clinical hours I had done thus far. I told her about 30. After a small laugh, she said something like, "Well, you have not even done a full work week of therapy, and yet you have the expectation that you should have already 'arrived' as a therapist." This small comment totally changed my perspective about my process of becoming a great therapist. I needed to learn that becoming a great therapist was something that is a lifelong pursuit, not a skill like riding a bike, which one can pick up after a few tries and some scraped knees. I even bet that many of your supervisors and instructors, when asked if they have arrived as a therapist, would say they have come a long way from where they once were, but would admit they have not yet arrived. Be patient with yourself. An effective therapist is a developed skill (like basketball or cooking), which requires a great deal of time. I encourage you to never *arrive*, but continue to *learn* and *challenge* yourself as a therapist.

accepted into an MFT graduate program means that your faculty has faith that you will be an effective therapist and are willing to help you become one. They believe in you and you should, too. Take care of yourself, be open to difference, take advantage of supervision, face the issues in your life, do not sell yourself short, and pace yourself in your quest to become a great therapist. Despite how you may feel right now, you will make it through your program. I did and so will you.

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BEGINNING A CAREER IN

MEDICAL FAMILY THERAPY

The term "medical family therapy" has been around for decades now. Susan McDaniel, Jeri Hepworth, and Bill Doherty coined the phrase in 1992: "[W]e introduce the term medical family therapy to refer to biopsychosocial treatment of individuals and families who are dealing with medical problems" (2014, p. 2). They explained that this approach was more than just adding family therapy to traditional healthcare. It was a way of relating, and understanding relationships, differently; it called for breaking down silos of professional skills and allegiances, and building up partnerships based on mutual respect and shared goals for families. Today, the practice of medical family therapy and collaborative care is booming, and more and more MFT graduates are aiming to provide this kind of integrated care. But how do you do it? And where? And what does it take to become a "medical family therapist"? In this article, we take a look at the current climate of primary healthcare, the role of family therapists in that climate, and guidelines for joining the growing community of providers **who wouldn't practice any other way.**

Barbara A. Gawinski, PhD **Tziporah Rosenberg, PhD**

Background:

Primary care physicians, nurse practitioners, and physician's assistants—including those in family medicine, pediatrics, internal medicine, and obstetrics and gynecology—treat individuals and families from the cradle to the grave, enjoying long term, continuity relationships. They are "de facto" mental health providers (Regier, Goldberg, & Taube, 1978), often the first line of consultation and intervention for individuals and families in distress. Up to 60 percent of visits to primary care health professionals are for issues related to psychological or social/family concerns. These healthcare practitioners, with sometimes-modest training in the psychological or mental health systems, are treating patients with symptoms of depression, grief, loss, anxiety, family distress, substance abuse, violence, among others concerns. And they are often in the position of giving psychological and emotional support to patients confronting medical illness, new diagnoses, chronic conditions, and end-of-life issues. Most of us, as patients, expect this kind of support from our primary care providers.

Integrating family-oriented behavioral health professionals—family therapists, psychologists, psychiatrists, and social workers—into primary care settings expands the capabilities of primary care physicians. It makes perfect sense, and its success is reflected in the tremendous growth of medical family therapy and collaborative care practices. Why? Because professionals of all disciplines, as well as policymakers and third-party payors, see that interdisciplinary teams result in better care, better job satisfaction for the professionals, and, most importantly, better health for individuals and families. The "one stop shop" of the Patient-Centered Medical Home (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, 2007) is quickly becoming the gold standard of primary care, one critical piece of that model being a whole-person, biopsychosocial orientation.

George Engel's (1977) biopsychosocial model derives from general systems theory (Wynne, 2003) and demands that we are attend to health and wellness at each level (from the micro to the macro), including of course, the family and social/cultural systems. Unfortunately, not all family therapy training programs prepare graduates to work with the physical concerns of their patient families. Close to 1 out of 2 adult Americans has at least one chronic illness (Wu, 2000), so most MFTs work with people who are struggling with health and illness conditions in addition to their psychological and relationship concerns.

Despite a growing interest in and need for this type of practice, graduates from MFT training programs often complete their education with limited coursework and clinical training, unless they trained at one of the few programs with an explicit focus on medical family therapy (i.e., East Carolina University, University of Rochester). So how would an interested graduate of a less specialized program embark on this important work? It comes down to three main areas of focus: do your homework, network with like-minded others, and develop competencies.

Do Your Homework

Getting prepared for work in a medical setting as a family therapist is fascinating. Each encounter, be it with a patient, support staff, or medical professional, draws on several levels of knowledge, awareness, and fluency. Start with some good primers on the subject of collaborative care and the integration of systemic therapies and traditional healthcare. *Medical Family Therapy and Integrated Care 2nd ed.* (McDaniel, Hepworth, & Doherty, 2014) and *Family Therapy and Family Medicine* (Doherty & Baird, 1984) are two seminal works that set the stage for family-oriented care in the medical setting. *Models of Collaboration* (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996) is an excellent guide with useful strategies and suggestions for forming working relationships with others in a collaborative setting. While these texts offer solid background information and guidelines for practice, preparedness should also be informed by the growing body of literature dedicated to evidence-based practice, training models, and case studies in collaborative care. The journals *Families, Systems, and Health* and *Annals of Behavioral Medicine* routinely features these types of articles. For those seeking collaboration in a tertiary care or specialty setting (ie. bariatrics, cardiology, endocrinology, oncology), journals catering specifically to those specialties may also have pieces on "behavioral" or psychosocial medicine."

Network

Establishing yourself as a medical family therapist is all about relationships. Organizations such as the Collaborative Family Healthcare Association (http://cfha.net) and the Society for Teachers of Family Medicine (www.stfm.org) provide a home for family medicine professionals of all disciplines who are devoted to more integrated models of care and training. They also offer specialized conferences, meetings, journals, and trainings for those hoping to learn the requisite skills as integrative practitioners. These organizations also provide online forums, listserves, and small group memberships to allow for more exchange among members with common clinical and training interests.

The most esteemed and oldest models of medical family therapy and collaborative care exist in institutions where a physician or family therapist (or both) pioneered something new. The University of Rochester Medical Center (URMC) is the embodiment of this pioneering energy, having been the birthplace of the biopsychosocial model (Engel, 1977) and an early partnership between family therapy and family medicine (McDaniel, Campbell, Hepworth, & Lorenz, 2005). The URMC Institute for the Family offers a week-long Medical Family Therapy Intensive that highlights not only how the field has evolved but also cutting edge applications of integrative practice (www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/mfti.aspx). Experiences like this where family therapists learn alongside physicians, nurses, and other mental health professionals help to create stimulating professional relationships and networking possibilities among others interested in this type of care.

Developing Competencies

The Commission on Accreditation of Marriage and Family Therapy Education's (COAMFTE) core competencies establish the base skills needed for an MFT to practice independently and effectively. As the field of medical family therapy is still in its relative infancy (Linville, Hertlein, & Lyness, 2007), discussions continue around the set of core knowledge, skills, and attitudes for the medical family therapist. While it can be argued that all of the core competencies of an effective family therapist apply to the practice of medical family therapy, it is also true that collaborative practice and working with patients with health problems demands an additional skill set, including emotional responses to medical illness, common caregiver reactions, and collaborative skills with medical providers, to name a few. Developing skills as a medical family therapist can also be facilitated by consultation and supervision with a more seasoned medical family therapist either in your practice or elsewhere.

Becoming a Medical Family Therapist

Becoming a medical family therapist can occur in two distinct environments: well-established programs and settings with the "right ingredients." In the first, the idea of integration is well established. The practitioners, educators, and trainees all buy into the importance of attending to all aspects of a family's health and well-being. The practice walks the talk; medical professionals and family therapists work side by side, share space, patients, and often charts. They value the experience of a highly skilled team with diverse expertise when it comes to providing healthcare.

Environments with the "right ingredients" have possibility, but also need to be assembled and developed. The "right ingredients" include a physician or nurse practitioner champion (someone who's willing to push the envelope a bit and who has the respect and resources to do it), a culture of teams (recognition that good care requires a variety of professionals from a variety of disciplines), and a physical space that can accommodate the addition of psychosocial or behavioral services (though many a visit by a fully integrated medical family therapist is successfully conducted in an exam room).

Medical family therapists can also work from an off-site office if they make use of these principles in working with

families, their health concerns, and their health professionals. The skill set transcends physical practice setting, although collaboration with other healthcare professionals, especially off-site, will require a more concerted and intentional effort.

Once you've found the right setting, getting the job, so to speak, is about knowing what you know, and marketing yourself as a primary care mental health provider. A systems-trained, relationally-oriented therapist who both understands the effect of illness on families and can bring together potentially divergent perspectives is likely to be a good fit and an asset to any integrative and interdisciplinary healthcare team. Focused training through either a specialized medical family therapy degree, a certificate program, or a post degree coursework or conference can help to develop additional skills as well as foster a solid identity and competencies as a medical family therapist.

Conclusion

Those new to the field are entering at an exciting time. Opportunities to treat families in collaborative primary and specialty care settings are growing, as is the demand for well-trained, versatile, team- and family-oriented mental health practitioners. And those not-so-new-to-the-field, who began the movement toward integrated care, are not merely seeing the fruits of their labor. They are training the next generation of medical family therapists, vital members of the healthcare teams of the present and future.

We use the term "patient" synonymously with "client" given its universal use in healthcare settings.

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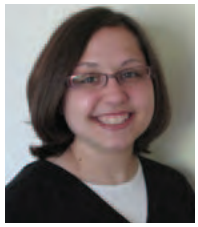

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TRAINING OPPORTUNITIES

University of Rochester Medical Center
Post-degree certificate: www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/mfti.aspx

University of Nebraska-Lincoln
PhD: http://cehs01.unl.edu/cyaf/grad/mftPhD.shtml
Post-degree certificate: www.unl.edu/gradstudies/prospective/programs/Cert_MedicalFamilyTherapy

Drexel University
Post-degree certificate: www.drexel.edu/catalog/certificates/medical-family-therapy.htm

East Carolina University
PhD: http://www.ecu.edu/che/cdfr/medft/

Seattle Pacific University
Post-degree certificate: www.spu.edu/depts/spfc/mdft/

Mercer University
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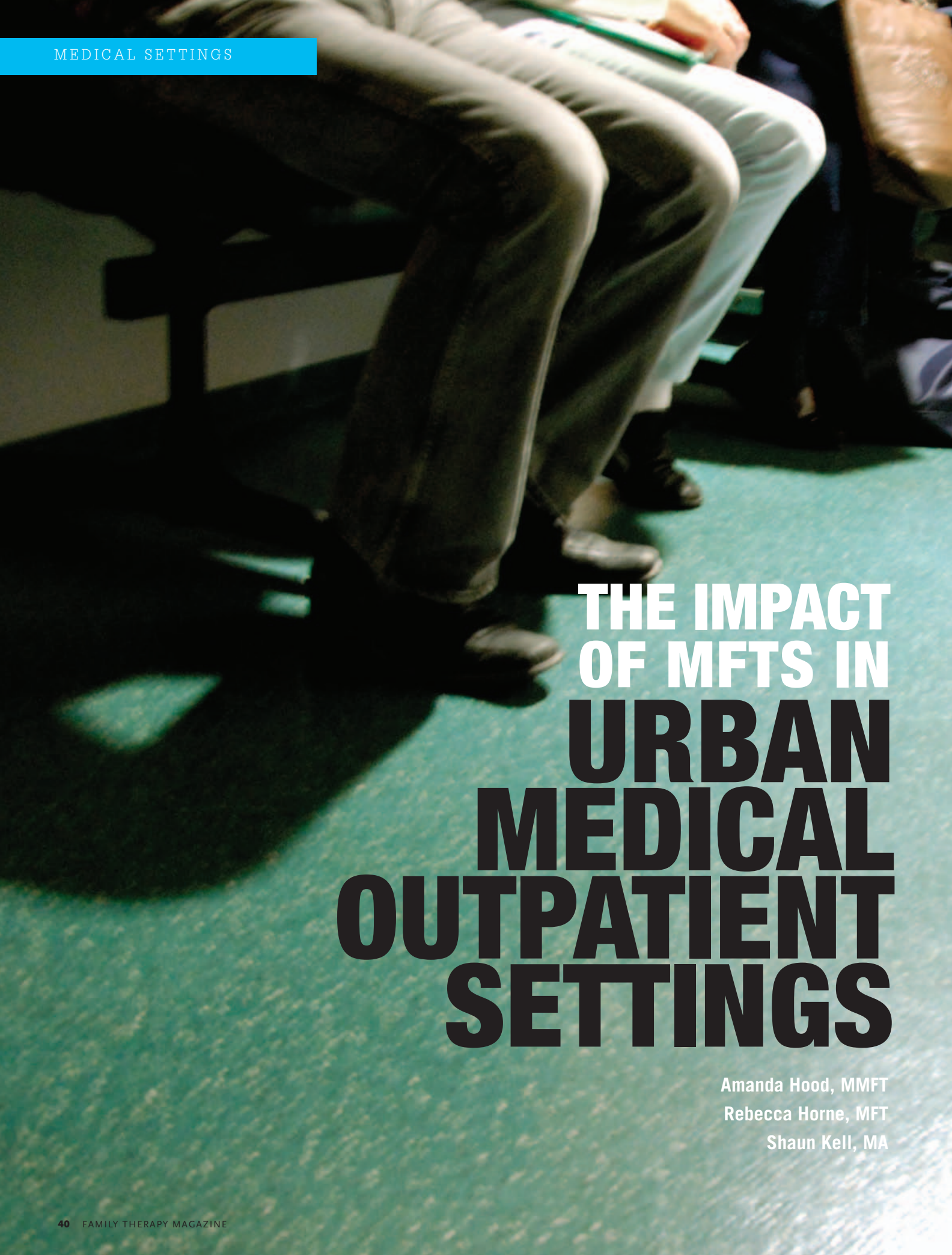

THE IMPACT OF MFTS IN URBAN MEDICAL OUTPATIENT SETTINGS

Amanda Hood, MMFT
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BECAUSE OF ITS focus on the importance of systems, marriage and family therapy is experiencing growth in medical settings. Therapists can become indispensable members of multidisciplinary teams who improve outcomes for patients. One reason MFTs fit so well in these settings is that they capitalize on something known as the "offset effect." "An offset effect occurs when people reduce their use of medical services following some type of therapy or behavioral health intervention. The premise is that with the help of therapy, people can deal with their life circumstances more effectively, therefore reducing stress or the possible tendency for emotional concerns to be expressed physically" (Law, Crane & Berge, 2003).

Specifically, MFTs positively impact patient outcomes as a result of their focus on biopsychosocial approaches. Because MFTs recognize that no one exists in isolation, they consider the context of the person as a whole within their series of embedded social systems. They are adequately trained to be aware of the need for and to provide social support to those who often lack support at the most basic level.

Knowing the benefits of integrating services to promote patient best interests and actually *doing* them are two very different things. Looking back on the way our successful program got its start came from finding a way to meet a need. The W.T. Anderson Health Center of the Medical Center of Central Georgia Navicent Health in Macon, Georgia, is a fairly typical low-cost urban clinic. Due to being overwhelmed by a needy patient population, the staff there was eager to have a mental health professional working with them.

Their patients face all the difficulties people do as they encounter chronic health diagnoses, acute illness, and/or general aging health decline. In addition to these expected difficulties, they also face the problems that come with poverty: unstable or substandard housing, lack of access to services, and lack of resources for food and other necessities. One seasoned attending internal medicine physician greeted the first intern by saying, "You're the therapist? Welcome to the psychosocial triage unit!" Like the residents, nurses, pharmacists, and support personnel, he was thrilled to have someone on staff to assist patients in coping with these challenges that too often get ignored in medical settings.

We discovered that the path to successful MFT acceptance and integration was found in fostering effective professional collaborations. The MFT must be seen as an integral part of the healthcare team, as well as patient advocate. We found that joining skills are helpful in fostering relationships with residents, attending physicians, nurses and other medical staff. This begins with educating the staff on the MFT clinic role and the potential benefits of referring. Part of integrating into the healthcare team is learning to be clear about what the MFT can offer patients as well as medical staff.

In our case, this relationship building began while residents were presenting patient histories to attending physicians. Being visible and available for consultations during this time leads to an interactive healthcare exchange and offers chances for MFTs to ask questions and offer insight from a systems points of view. Once rapport is established, most MDs welcome psychosocial information affecting patient health and appreciate the value of systemic causality.

Medical settings can also be quite fast paced. Learning time constraints and clinic workflows can assist the MFT in competent time management. Additionally, the norm in most clinics is to communicate about patients in a "quick fire" manner. The MFT benefits from learning to deliver relevant information to the medical staff in a linear, concise way and is often expected to offer impromptu suggestions and recommendations.

A new MFT in a clinical setting will also quickly realize that there is a structure and protocol in place, so knowing and respecting the clinical hierarchy is vital to MFT success in healthcare settings. Honoring the clinical chain of command will demonstrate the MFT as a team player and further solidify the collaborative role. This can be done by respecting time constraints, inquiring about medications and

Learning time constraints and clinic workflows can assist the MFT in competent time management.

perspectives of physicians, in addition to including nurses in consultations/recommendations that take place with the PCP.

While the main focus is on patient care and driving clinic medical outcomes, remembering that MFTs are both part of and consultant to the entire system is crucial. That is, we are not just "therapizing patients." MFTs know how to enter a room, read emotional and systemic cues, and change things, with the help of their colleagues. If we have earned the respect and built collaborative relationships, we can help MDs, nurses and patients communicate more effectively with patients and with one another.

As important as it is to solidify these cross-disciplinary relationships, they will never be fully utilized without obtaining funding for these collaborations. Inspiration and guidance for the funding process can easily come from looking at other areas where mental health professionals have benefitted hospitals. Because hospitals are currently under more financial scrutiny than ever, financial savings are perhaps more convincing than anything else. In the case of MCCG, the Transitions and Palliative Care department had employed professional counselors and MFTs for years to assist families in making difficult end-of-life decisions. They discovered that when they could demonstrate improved patient outcomes, they could solidify their place as viable members of the medical community. With that in mind, it becomes important for MFTs to identify particular health behaviors and

ONE INTERN WAS GREETED WITH "YOU'RE THE THERAPIST? WELCOME TO THE PSYCHOSOCIAL TRIAGE UNIT!"

biomedical outcomes that they can help improve. After evaluating conditions and situations that compete for highest cost areas needing improvement, it was determined that clinic patients were using the emergency room (ER) for problems better suited for their primary care physicians (PCPs). Obviously, this was a huge cost to the hospital. It cannot be underestimated that when communicating to the medical community, anecdotal reports of patient satisfaction and improvement must be backed up with concrete quantitative data. It was determined over time that in our situation, the most concrete way to measure our patient outcomes was to visibly reduce overutilization of the ER, as well as to identify biomarkers that could be reliably affected and measured. You may be thinking, how can an MFT positively affect HbA1c's (blood sugar level) and reduce ER visits? Well, it can be done.

One study that points to why shows that, "Social support refers to the emotionally sustaining qualities of relationships—a sense that one is loved, cared for, and listened to" (Umberson & Montez, 2010). Numerous other studies report the critical role that social support plays in both mental and physical health. Social support may even have indirect effects on health through enhanced mental health, by reducing the impact of stress, or by fostering a sense of purpose and meaning in one's life. In fact, supportive social ties may trigger physiological effects, such as reduced blood pressure, heart rate, and stress hormones that are beneficial to health and maximize a patient's ability to calm themselves and make better decisions overall (Umberson & Montez, 2010). These factors contribute to the reduction of many symptoms of both acute and chronic illnesses.

THE NORM IN MOST CLINICS IS TO COMMUNICATE ABOUT PATIENTS IN A "QUICK FIRE" MANNER.

Once the role of our MFTs was professionally integrated, it was found that by using some very basic therapeutic interventions, patient health improved. One of the methods used most often is motivational interviewing (MI) (Rollnick, Miller, & Butler, 2007). MI was originally developed as an intervention designed to target the ambivalence surrounding behavior change with problem drinkers. However, after much research and experimentation, it has been found helpful in a variety of settings, including healthcare. Motivational interviewing works on the premise that people respond to collaboration, empathy and engagement. "While MI is patient-centred in that it focuses on what the patient wants, thinks and feels, and it is the patient who does most of the talking, MI differs from other patient-centred approaches in that it is directive. That is, in MI there is the clear goal of exploring the patient's ambivalence in such a way that the patient is more likely to choose to change his or her behavior in the desired direction, and systematic strategies are used in order to achieve this" (Britt, Hudson & Blampied, 2004). The therapist wears the hat of facilitator as opposed to expert. The benefits of MI administered by a MFT include the fact that MFTs are trained to be master joiners, have attuned listening ears, are mindful of the stages of change and generally have the time for longer sessions than their physician counterparts.

Another interesting phenomenon that occurs when people begin to take ownership of their health thereby reducing their symptoms of chronic illness is that they make less frequent trips to the ER. We found that this marker has been the most influential in proving the benefit of an MFT in a medical setting. After all, money talks. In measuring the ER visits of the patients on the MFT clinic

MFTs are trained to be master joiners, have attuned listening ears and are mindful of the stages of change.

caseload over time, we have noted impressive results. Data have been recorded since May 2007 on ER over-utilizers. When a patient is added to the caseload, the MFT begins tracking the number of times he or she goes to the ER and produces a monthly report reflecting those figures. Based on the data recorded, the number of ER visits reduced by up to 81.29% with an average reduction within the past year of 79.44%. Obviously, these reductions are due to a combined effort between the MFT, AHC personnel and the PCPs. In February 2014, a poster on this project was presented at the Xavier University's Health Disparities Conference in New Orleans, LA, and in December another poster was presented at the 2014 Minority Health and Health Disparities Grantees' Conference in National Harbor, MD.

These findings highlight the success of integrating a behavioral health component into the traditional medical model. We have been able to positively affect patient relationships with their PCPs and decrease their need to seek medical care from ER facilities. As evidenced in the data, after working with the MFT, many patients exhibited a decrease in chronic illness symptoms, inpatient admissions and ER visits, while anecdotally reporting more satisfaction with their quality of life, as well. The data also suggest that targeting this population with the trained MFT reduces the overall cost and burden placed on the healthcare facility as a whole. In summary, despite it taking some time to get professional collaborations firmly established in environments that are typically slow to change, the benefits speak for themselves. MFTs are paving the way for integration to become the norm as opposed to the exception to the rule.

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MFTS PROVIDING

RECOVERY-BASED SERVICES

A REVOLUTION IS IN FULL SWING when it comes to the delivery of mental health services for people living with serious and pervasive mental illness. One decade ago, the U.S. Department of Health and Human Services issued a consensus statement on mental health recovery based on the New Freedom Commission on Mental Health's (NFCMH) (2003) recommendation that public mental health organizations adopt a recovery-based approach to severe and persistent mental illness.

Anne Odgers, MS

Those recommendations set in motion the recovery movement, one that seeks to inspire providers to release pre-conceived notions about a client's mental health trajectory, and find ways to support recovery. "In the past, mental health systems were based on the belief that people with severe mental illness did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course" (Anthony, 2000). Indeed, the change in pathological thinking that holds a person *once debilitated, always debilitated* has been slow to follow the exodus of psychiatric hospital beds. Those fortunate enough to find recovery-oriented services rather than incarceration, homelessness, or bare survival often fare much better than the mentally ill from past generations who were relegated to extended or life-long commitments to psychiatric institutions.

Marriage and family therapists (MFTs) in the public sector have exposure to a relatively broad client system of care, which can include services that create access to stable, affordable housing; provide therapy in the client's own environment; help clients access transportation, medication, treatment for addictions or physical health; assist in accessing financial and health benefits such as Social Security Income; and help to access wellness centers and peer support programs. Exposures to these community-based recovery services are more limited for therapists in private practice.

In addition to the broadening array of services provided, the very nature of actual therapy for people affected by serious mental illness is also being transformed by a recovery-oriented approach. With the recovery movement still taking shape, doctors and therapists continue to hear client voices in establishing treatment methods and goals and to integrate the medical and recovery models. "The paradigm shift includes moving beyond a focus on pathology and professionally directed treatments to observing and embracing the lived experience of consumers' recovery processes while offering support and encouragement as they rebuild their lives" (Davidson & White, 2007).

THE ECONOMIC IMPACT Annual inpatient hospital treatment costs savings are in excess of approximately $900 to $1,400/year

The term "recovery" itself has been the subject of some debate recognizing that people diagnosed with serious mental illness often do not experience complete remission of symptoms. As such, recovery is generally appreciated as a reduction in symptoms sufficient that a person is able to live, work, learn and participate fully in their community. "The U.S. Department of Health and Human Services (2004) has formally defined mental health recovery as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential." From the consumer perspective, an emphasis is placed on the person with a mental health diagnosis having autonomy in the journey of recovery. To them, a very important component is that they have a voice that is truly regarded and valued.

In the past 10 years, the recovery movement has been a catalyst for the implementation of many community-based services. Although considerable shortfalls in these services still exist, they do represent a significant shift in the delivery of services to those diagnosed with serious and pervasive mental illnesses. A recovery-oriented approach appreciates the degree to which a person experiencing serious mental illness may struggle to obtain medication, maintain gainful employment, get to and from appointments, access financial and health benefits and tend to other life needs. This has created a wraparound system of care that surrounds a client with services to support them in each of these areas.

One example of this type of service is assistance securing educational/employment opportunities and vocational training. Services such as job coaching have made a marked difference in clients' lives, increasing their productivity and capacity to make a living. According to research done at the University of Maryland, supported employment studies have shown significant treatment reductions in four outcomes: hospital stays and days, ER visits for mental health problems, and psychiatric crisis visits. This study found annual inpatient hospital treatment costs savings to be in excess of approximately $900 to $1,400/year (Salkever, Gibbons, & Ran, 2014).

One fundamental change from traditional therapy approaches is that of client agency, empowerment and self-determination. Unlike many models of therapy, MFTs in the recovery model join with the client on their journey of recovery, rather than assuming the role of expert or change agent (Gehart, 2012). Seriously mentally ill clients may have difficulty communicating ideas and creating space for them to partner and share equal responsibility for recovery

requires very intentional effort on the therapist's part. This involves a much more personal commitment to the client, one in which the therapist may have to redefine his or her boundaries as opposed to those held in regular practice.

Perhaps above everything else, therapists partnering with seriously mentally ill clients need to believe that recovery is possible. Mapping a person's sense of purpose and meaning helps both the therapist and client build hope in recovery. MFTs must hope against all odds in a client's capacity to recover if they are to deliver effective recovery-based therapy. "One's own and other's hopefulness has been identified as critical in launching the journey from despairing about a life situation to hoping for a better future" (Anthony, 1993; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Torrey & Wyzik, 2000). "… And for this reason, the establishment of particular hopes and aspirations can be seen as an initial step in the process of recovery (Deegan, 1996; New Freedom Commission on Mental Health, 2003).

Gehart (2012) identifies the following components of a strength-based approach to recovery: establishing a recovery partnership, mapping the landscape of recovery (sense of life purpose, belonging and intimacy, hope, strengths and resources, mental health history), recovery treatment planning, recovery-oriented interventions and ethical implications of recovery-oriented practices. A strength-based approach is crucial to the recovery model. Clients who have lived with pervasive mental illness often struggle to be aware of their strengths, and this is also true of some of the therapists from whom they may have previously accessed services. Helping a client to shift from a problem-oriented perspective to one of celebrating their strengths is key to building their

THERAPISTS PARTNERING WITH SERIOUSLY MENTALLY ILL CLIENTS NEED TO BELIEVE THAT RECOVERY IS POSSIBLE.

hope and confidence that recovery is possible. This type of therapy can be quite challenging with the seriously mentally ill client. Regularly highlighting even the smallest client accomplishments and strengths is a significant goal for therapists practicing the recovery model.

Mapping a sense of client belonging and working with them to identify and connect with community is another important aspect of recovery-focused therapy. Mapping mental health history, current reality, treatment options, goals and recovery plan are all highly collaborative processes in which the recovery-oriented MFT strives to encourage clients to exercise as much agency as possible. This and other facets of recovery work require curiosity, mutual inquiry and creativity.

MFTs wishing to build a career in recovery-oriented services need to be aware that recovery-based practices raise ethical and boundary questions beyond those created in traditional service models. Recovery-based service embraces sessions that occur outside of the office and in the client's own home and community. Recovery-focused services can also expand the therapeutic relationship to include case management, advocacy, mentoring and even friendship. "With each consumer, therapists must demonstrate their humanity before a recovery partnership can begin. The therapist's sincere investment in the consumer's welfare includes the ethical mandate to do no harm and extends to do whatever it takes to meaningfully assist in the journey of recovery. Thus, a more personal and human level of commitment is required than is common in traditional family therapy practice" (Gehart, 2012).

According to *Mental Health: A Report of the United States Surgeon General* (National Institutes of Health, 1999), stigma is the most formidable obstacle to further progress in the arena of mental illness and health. Even extremely high achievers living in recovery hesitate to disclose their disabilities because of stigma. The negative impact of this self-stigma on a person's recovery journey cannot be overstated. Therapists have the capacity to help clients explore this impact and open new avenues of support in other settings.

MFTs need to be aware of opportunities to connect clients to resources when appropriate. Peer advocates and providers are one such opportunity. These are people who are hired because they have a mental health condition and a history of involvement in the mental health system. Peer advocates and providers improve the quality and access to services and help others navigate the system of care and mental health services. The creation of roles, such as that of peer advocates, are one way the recovery movement has helped

clients develop meaningful roles and relationships in their communities, sometimes reducing the need for long-term therapeutic relationships with a therapist.

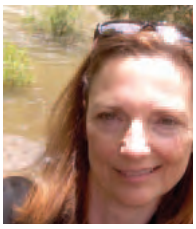
Evidence reveals that telling our stories is instrumental to the healing process and increases confidence and coping ability. Many consumers have found that giving voice to their experiences with mental illness has liberated them and created a new paradigm for these experiences. They are advocates effecting change in perceptions of mental illness rather than "patients." Effective recovery-oriented therapists will be equipped to help clients gain courage and see the value of sharing their stories, and also be linked with programs that support/train clients in this effort and provide opportunities for them to tell their story in the community.

MFTs need to get plugged in to the system of care so they know what resources are available and can help their clients access them. For example, consider a private practice MFT who is seeing a person who has had a psychotic break while in college. He is covered by his parent's insurance plan. This person might have a goal of getting a job. The MFT who has links with a supported job coach program will be able to offer that service. Supports of this nature increase self-confidence because they help the client to understand that they can handle the challenges of dealing with a serious mental illness and still work towards their goal of having a job. With the help of a job coach who can be called on for guidance and support if she or he has anxiety or some other crisis during the day, the client is guided into the work force in a manner that greatly increases confidence and the likelihood of success. Private practice MFTs working with the recovery model need to be informed and ready to link clients with the public mental health system that can offer these service. The same is true for accessing housing, Social Security Income, and other resources necessary for the stability necessary for recovery. There are numerous agencies that can help clients, but the disjointedness creates a different problem. Navigating resources and services often proves overwhelming to seriously mentally ill clients. Truthfully, this effort can be cumbersome for even the most high-functioning person not living with mental illness! MFTs in the recovery model help clients holistically with every part of their lives.

MFTs also use evidence-based therapies for the severely mentally ill that are proven to work in a recovery framework. Cognitive enhancement therapy is one that combines traditional therapy with pragmatics and job coaching. Clients with schizophrenia spend a year in treatment participating in both individual and group therapy. This

is evidence-based treatment that is showing good outcomes for people with schizophrenia.

The role of the MFT in recovery from serious mental illness is at once exciting and challenging. What could be more inspiring than partnering with someone to help them regain lost functioning and relationships as they recover from the devastation of a severe and persistent mental illness? For those who embrace the challenge, there is plenty to learn and varied tools to assist in the MFT's endeavor to help clients in their journeys from illness-dominated identities to lives marked by meaning and wellbeing.



Anne Odgers, MS, holds an MFT degree from Loma Linda University. She is a strong advocate for people with brain disorders as a member of the Board of Directors of the California Pomona Valley affiliate of the National Alliance on Mental Illness. Odgers is a Student Member of AAMFT.

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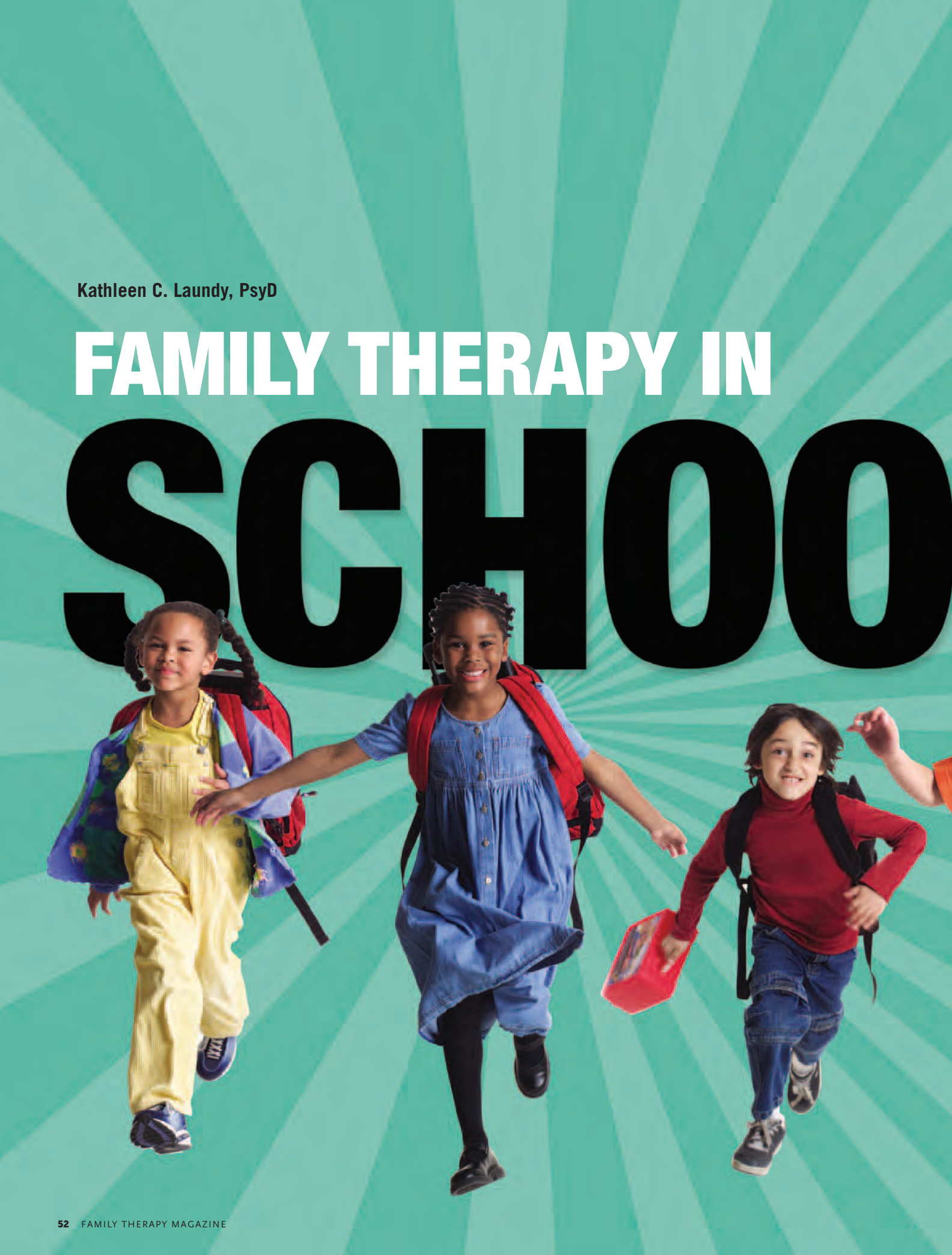
Kathleen C. Laundy, PsyD

FAMILY THERAPY IN SCHOO



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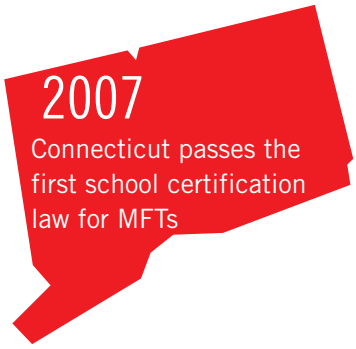
NOW THAT LEGISLATION IS BEING ENACTED to certify school-based marriage and family therapy (MFT) practice across the United States, it is important that we develop training and supervision models to prepare students for employment in schools. As an example, the following will examine the school certification experience in Connecticut as one frame of reference for school-based practice, offer a systemically-based model for service provision, and provide training and supervision ideas for MFTs who wish to pursue certification in schools in other divisions.



Connecticut certification law and regulations

In 2007, Connecticut passed the first school certification law for MFTs in the U.S. Connecticut State Board of Education Regulations currently require applicants to meet the following specialized training and experience requirements for school MFT certification. Applicants must be licensed by the Department of Public Health, pass a Praxis Exam (required of all educators), fulfill a minimum of 300 of hours of supervised experience in public schools, and complete graduate coursework in special education, developmental, learning and school-based systems theory. Following the success of the school certification legislation, Central Connecticut State University (CCSU) created a training track to prepare MFTs for school certification. The graduate coursework required involves taking approximately three more courses than the traditional MFT sequence of graduate training coursework, and obtaining practicum/internship experience that must occur in a school setting. For MFTs who are already licensed and wish to pursue school certification, that training track is also available to them. Upon completion of their classwork and school practicum experience, postgraduate MFTs receive a certificate of completion that affirms their eligibility for school certification.

MFTs come to the field of education with a wide range of background experience in schools. Some may have little direct experience themselves in schools, but have had family members who have benefited from special education services. Other MFTs may have formerly worked as teachers or paraprofessionals. Still others may be licensed postgraduate MFTs providing school services as private contractors while completing advanced MFT training to prepare for careers in education. But all MFTs need coursework, field placement and supervision in order to become familiarized with the uniqueness of school system practice and the regulatory requirements to practice as certified multidisciplinary team members in education.

School-based MFT history

Our Connecticut school certification and training history developed from collaborative work with primarily two Connecticut school districts. Six years prior to certification, the first training opportunity was created through invitation from a suburban Connecticut school district. Westbrook Schools requested that MFT students be placed in their schools as a way to provide more mental health services to their system. CCSU began a pilot placement there to provide clinical services and supervised school experience to MFT students, with Westbrook assuming supervision costs. Three years later, the town documented significant cost savings. Utilizing Educational Reference Group (ERG) comparisons from 2003-2005, Westbrook determined that it spent substantially less money in out-of-district residential placements than other towns with comparative demographics. Savings were attributed to early, preventive multidisciplinary team interventions, which decreased the need for emergency services. Since MFTs provided many of these services, this invaluable data supported efforts to obtain school certification. That collaborative effort resulted in the creation of a Youth Service Bureau in the town, where a close partnership between the school system and agency has been developed. Over 25 MFT students have now trained in Westbrook and have graduated into school-related careers.

The second collaborative training opportunity came from Naylor School, a K-8 urban school in Hartford with established educational ties to CCSU. When Naylor learned about MFT school certification, they requested MFT services from CCSU. Because many of their students' families could not travel far for mental health services, Naylor requested that MFT services be provided at their school. Naylor leaders recognized the need to partner actively with their students' families to boost student attendance and achievement. In return, they offered to host the practicum seminar there to help immerse MFT students in their school milieu. Over 30 MFT practicum participants have obtained training and supervision at Naylor, and other seminar students and post-graduates are now completing their supervised experience in several more schools.

MFT contributions to school-based clinical practice

MFTs make three unique and timely contributions to school systems. First, as school certified mental health professionals, MFTs join counselors, nurses, school psychologists and school social workers on school teams to help remove constraints that inhibit student learning and achievement. All of these professions have some graduate training in individual, group, family and community work, and thereby can offer what we call "necessary redundancies" (Laundy, 2013) in their skill set. An example is partnering with allied mental health

colleagues to offer social skills and other specialized group experience to students to boost their coping skills and readiness to learn. Having started as a profession and practice to provide more systemically based mental health services to families, MFTs have a strong multidisciplinary heritage and membership. They are well equipped to "play well in the sandbox" with other mental health professionals. The turf constraints of our "necessary redundancies" are more easily navigated by clinicians with a history of multidisciplinary affiliation.

Collaborative skills help transform school professionals into potent, efficient mental health team members, and such multidisciplinary teams represent a service model that has operated successfully in inpatient and outpatient hospitals, clinics and agencies in healthcare for many decades. Research we conducted after certification (Laundy, Nelson & Abucewicz, 2011) suggests that, although school mental health professionals and special education teachers know more about how special services teams can work in schools than administrators and general education teachers do, there is much work to be done to create more effective and efficient mental health teams in schools. It is not a coincidence that the first cohort of MFTs who became school certified in Connecticut had experience in school-based health clinics that partnered with community agencies to provide multidisciplinary services and programs to children and families in school settings.

Second, training in the multiple levels of individual, family, group, community and cultural systems makes MFTs valuable assets to educators. Based on No Child Left Behind (NCLB) federal legislation, education policy across America is shifting away from highly individualized special education for specific students towards providing more systemic and scientifically-based ways of educating all children. School psychologists refer to this trend as developing "multi-tiered systems of support" (MTSS) to children across elementary, middle

MFTs provide a unique contribution through their expert family-strengthening skills

and high school (Cowan, Vaillancourt, Rossen, & Pollitt., 2013). Systems-based education, a cornerstone of all MFT training, equips MFTs to provide an array of clinical services on such school multidisciplinary teams as Child Study, Planning and Placement (PPT), Response to Intervention (RtI), and Positive Behavioral Interventions and Supports (PBIS). It enables MFTs to join educational colleagues on many systemic levels with greater ease. Schools are integrating proven general and special education (SPED) practices earlier and more effectively into regular education, in order to prevent unnecessary labeling and better reach and teach all children. The intent of the RtI Initiative is to raise reading and other academic scores within general education, early in students' careers before more serious psychoeducational problems develop. MFTs are versed in evidence-based systemic practice, and therefore are well equipped to provide timely and value-added service to school teams on several levels and dimensions.

MFTs provide a third unique contribution through their expert family-strengthening skills. These skills help build family-school partnerships to foster more effective Individual Educational Plans (IEPs) for children, especially those with protracted special needs. Due to medical advances and other variables, chronic health problems have escalated and are being more frequently diagnosed in the U.S. In the past two decades, however, healthcare has become increasingly inaccessible to many children and families, particularly those who face chronic health, financial and cultural constraints. Symptoms often show up in schools, and children need to be healthy in order to learn. The family-strengthening clinical skills of MFTs are increasingly needed in schools in order to address children's chronic disorders that have long-term health and educational implications. The systems view that is the foundation of all MFT training can efficiently incorporate the child and the whole family over the course of the chronic disorder as well as the student's school career.

HOW FAMILIES COMMUNICATE, PROBLEM SOLVE AND ORGANIZE THEMSELVES REPRESENTS THE CORE OF MFT TRAINING

Since some learning disabilities are often inherited across generations, it is an advantage that MFTs are specifically trained to work with generational patterns. Too often, parents are wary of schools because their *own* learning needs were misdiagnosed as children and negative perceptions linger. MFTs are trained to address these processes, and can strengthen families to participate more fully in school meetings. As mentioned, mental health colleagues trained in counseling, nursing, school psychology and social work may also receive some training in family systems. But how

families communicate, problem solve and organize themselves represents the core of MFT training, and is quite useful when applied to child and family health over time to promote learning and educational achievement.

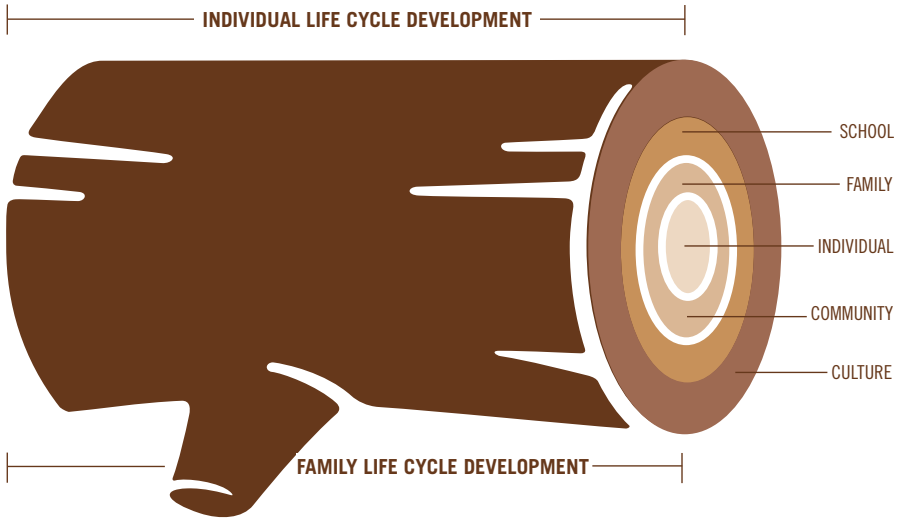
We have developed a paradigm to apply these various elements to MFT work in schools. The Longitudinal Overview of Growth in Systems (LOGS) is a model to conceptualize various levels of a child's functioning over the course of her or his school career. LOGS, illustrated below, is more fully detailed in Building Collaborative School-Based Mental Health Teams: A Systems Approach to Student Achievement (Laundy, in press).

The model incorporates medical and other family therapy "meta-theory" into the metaphor of a log. The bark of the long end of the log represents a student's individual and family life cycle, and the cross section of concentric rings through the middle of the log represents individual, family, school, community and cultural dimensions of a child's functioning. The LOGS Model helps place problems in systemic context, therefore grounding clinicians to design more proactive interventions. It also helps prioritize the sequence of interventions that need to be established for clinical work over time with families.

For instance, our MFT training program in Westbrook has supported the growth of one student with Asperger's syndrome who received his diagnosis as a young child in elementary school. Our MFT trainees and school colleagues have worked with the child, his family and school across his school career to negotiate the difficult transitions across elementary to middle and high school. MFT services have included parent, teacher and family consultation, as well as individual and group social skills training. His team has succeeded in keeping this young man in school despite his serious behavioral symptoms, and has empowered his family to work in closer concert with the school team. Cost savings have been realized through decreased need for emergency administrative meetings. Collaborative family and school relationships have prevented costly litigation and residential placement. That student successfully graduated from high school with the support of his family and school team.

The goal of education is to teach children in the "least restrictive environment" (LSE), and the role of the MFT at one point may be to boost parental support of a child's Individual Educational Plan (IEP). At another time, the MFT may design a group with a multidisciplinary colleague for a student to encourage the development of social skills. MFTs are also being utilized to design measures to track student progress. The LOGS Model offers a systemic framework to address all determinants of a child's functioning across time, and illustrates versatile opportunities for MFTs to support a child's education.

LONGITUDINAL OVERVIEW OF GROWTH IN SYSTEMS (LOGS) MODEL



Effective MFT school supervision

Supervisors need a specific and unique set of skills in order to supervise MFTs in schools. First, they need to know how to adapt a systems orientation to education. Supervisors should recognize that MFTs and all allied professionals are initially regarded as "guests" in schools, where the major goal is education and good mental health is an essential prerequisite for learning. Supervisors need to help supervisees learn to participate in collaborative school teams to foster supervisees' growth, as well as secure a respected position for school MFTs. At CCSU we provide MFT faculty supervision to students placed in school systems. We also enlist supervisory support from a school professional who is trained in another mental health profession as a way of building collaborative multidisciplinary relationships and appreciation of the unique and overlapping skills that mental health professionals provide.

Next, familiarity with systems-based school theory, developmental and learning theory, regular and special education history is necessary in order

ACCESSING SUPERVISEES' STRENGTHS TO SUPPORT GROWTH IS A GOAL OF ALL SUPERVISION.

to support student learning. Supervisors become better able to mentor supervisees in more knowledgeable ways if they are oriented about school systems. Some of this data can be accessed through state departments of education Web sites and from local schools.

Finally, accessing supervisees' strengths to support growth at varied stages of training and development is a goal of all supervision. Supervision of MFTs in schools is no exception. In order to support supervisees with varied backgrounds, we find it useful to supervise in groups, where diversity of experience is apparent and appreciated. Group members can model varied ways MFTs can join children, families and school colleagues to provide services.

For instance, one of our Naylor students is young and bilingual. She has endeared herself to students and young families because of her enthusiasm and command of languages. Another student is a post graduate with teenagers of her own. She has designed a support group for grandparents raising grandchildren. She also has a background in art, and she has made invaluable contributions to "marketing" MFTs with flyers and a newsletter announcing MFT services. Their varied skills work synergistically.

Connecticut now ensures that schools have access to a full range of behavioral health services by certifying school MFTs. Many more states are initiating similar legislation. It is timely and necessary to provide MFTs with training and supervision opportunities so they can function effectively in education as certified practitioners across the country.

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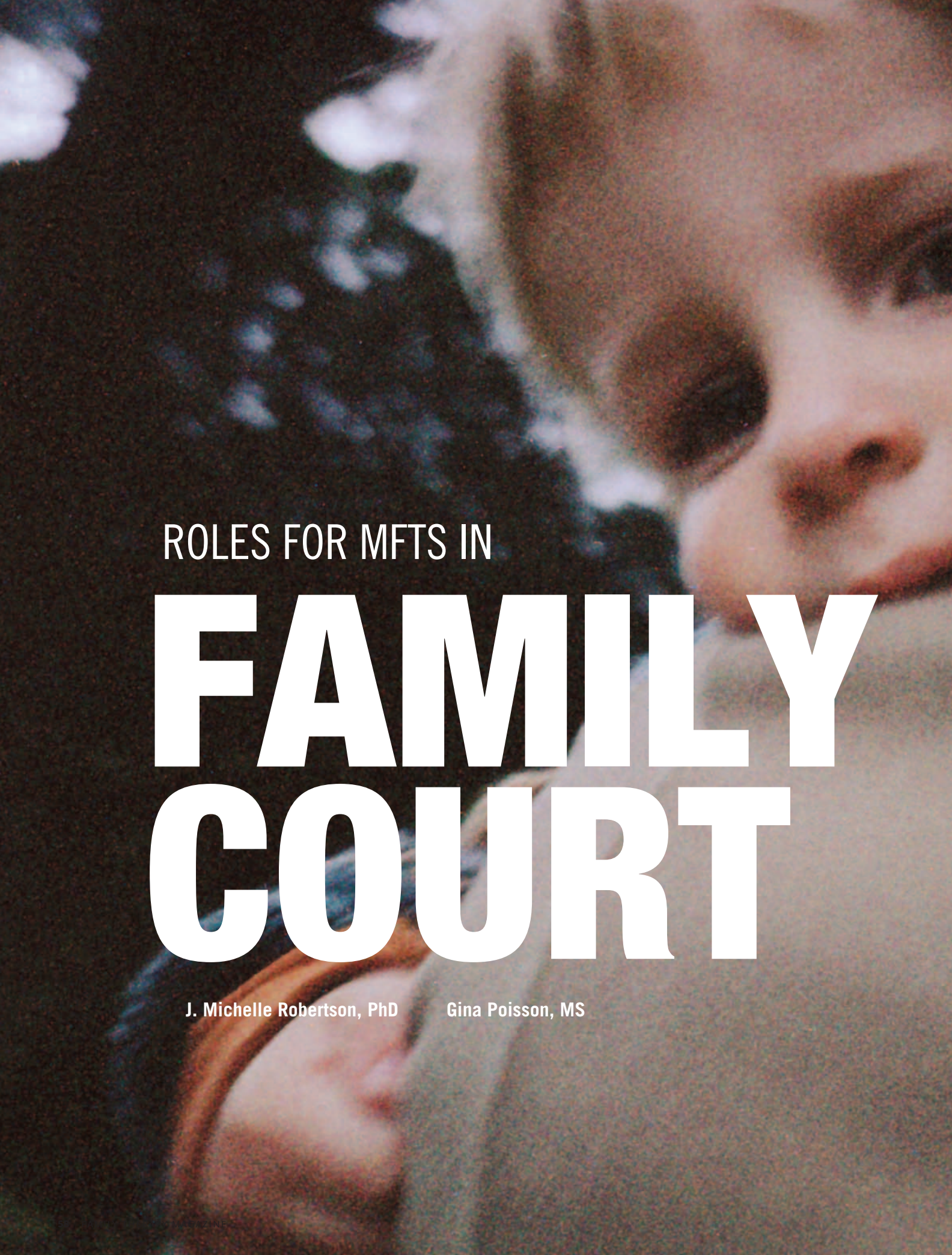

ROLES FOR MFTS IN FAMILY COURT

J. Michelle Robertson, PhD Gina Poisson, MS

FEW THERAPISTS SEEM INHERENTLY DRAWN TO THE COURTROOM. In fact, mental health professionals who purposely seek out work involving testimony and legal recommendations are often greeted with a look of astonishment and some variation of, "You do that on purpose?!" or, "You must need therapy yourself!" We have experienced this type of response repeatedly.

While the business of providing evaluative services to families involved in legal matters generates various responses from professionals, those doing this work find themselves passionate about it. In doing this work ourselves, we encounter increasing numbers of other marriage and family therapists (MFTs) curious about custody evaluations and how they can become involved in this service delivery. By walking through our own experience, we offer practical information to those considering how to expand your own business opportunities.

WE MUST LEARN THE CULTURE OF THE COURTROOM SO WE CAN EFFECTIVELY COMMUNICATE WHAT WE WITNESSED AND WHAT OUR EXPERIENCE TELLS US THIS MEANS.

What Services Can I Offer the Family Court System?

There are a variety of services MFTs can provide to court-involved families, and the most obvious involves divorcing or divorced families with children. Therapists can construct workshops focusing on topics of divorce that are aimed at children, parents, and even grandparents. In some areas, judges will require attendance before granting divorce or custody motions. Since these types of services are rarely attached to a forensic evaluation and would therefore present no ethical dilemma, workshop attendees frequently request continued family therapy services with us. Their requests remind us that not only can the workshops generate income and provide an important service, but they can also serve as a referral source to our own practice.

Beyond the workshops, the greater work lies with families involved in custody disputes in need of a true systemic evaluation by a clinician trained in family and relational dynamics. These types of cases are difficult for judges who must sort through layers of information from "he said/she said" type testimony, unending opposing counsel witnesses, and various forms of individual psychological evaluations that offer limited—if any—information regarding the best interest of the children or either parent's true capacity to provide secure, reliable physical and emotional care for the children. While these forensic-type evaluations cannot be a feeder to our practice like the workshops (see 3.14 of the AAMFT Code of Ethics; also review 7.5. 7.6, and 7.7), they can be stand-alone services that generate income while providing a valuable community service.

What is a Custody Evaluation?

After seeing a need in our own area, we began to formulate a service offering that would provide judges with substantive evaluative information to answer the question, "What is in the best interest of the children?" In the next section, we will provide an overview of the lengthy process we went through to develop our service delivery, titled Alternative Custody Evaluations (ACE). It proved to be a useful process that lead to the development of a specific service that was needed in our area. ACE, our systemic plan, has these essential features:

1. Structured sessions involving both parents, relevant support persons and children
2. Four to six sessions of direct contact (each two hours in length)
3. Use of co-evaluator format to minimize individual bias and obtain more relational data
4. Heavy assessment focus, with added psycho educational information where needed
5. Substantial written report with recommendations for custody utilizing intentional evaluation of:
   a. family-of-origin dynamics, including history of parent's relationship
   b. evidence of co-parenting capabilities
   c. emotional and relational capacity with children
   d. practice contextual issues related to the care of the children

Through observation of the interactions of parents, significant others, support persons, and children, the ACE approach provides a systemic evaluation that allows us to observe the many influences that sabotage parents' capacities to relate well to one another and provide care to their children post-divorce. We gather a summative and dynamic picture of the family, and then offer our clinical impressions and recommendations to the family court system for review and, often, implementation. If you are interested in more information about the details of ACE, please feel free to contact us directly.

What Do I Need To Know If I am Considering This Type of Work?

As you consider your interest in providing custody evaluation services to your local family court system, we have outlined the steps we took to establish our service. As with any new practice venture, getting started requires that you assess your professional strengths and weaknesses, canvas the existing service delivery landscape, and construct the delivery to fit the evident needs.

Personal and Professional Education. First, consider 3.6 of the AAMFT Code of Ethics: "While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work….[and]

practice in specialty areas new to them only after appropriate education, training, or supervised experience." We encourage you to attend local workshops for divorcing parents and kids, conferences and workshops devoted to court related issues, and seek permission to observe various family court proceedings. Immerse yourself in the professional literature available on custody evaluations, divorce, and visitation issues. State statutes and regulations exist in governing these issues, and you must be aware of those as well.

Another consideration with this line of work is your own exposure to and comfort with providing recommendations and professional testimony. One of our local family court attorneys recently conducted a seminar on how to testify in court and offered a valuable statement for therapists to consider: "You can only report on your experience of the situation and what you have witnessed—period." This statement provides any person testifying the assurance that they need not step beyond the scope of therapeutic understanding into the world of the unknown or world of assumption. The statement serves to communicate to the vast majority of those who greet the thought of diving into court-related services much like they would welcome diving into a pool of piranhas to take comfort in knowing this: we do know what we know. And we must learn the culture of the courtroom so we can effectively communicate what we witnessed and what our experience tells us this means.

Existing Services and Professional Networking. Second, find colleagues who are experienced in offering court-related services. These services are being provided all across the country, and it is unnecessary to fully re-create the wheel, in most circumstances. In fact, ACE was adapted from a service delivery by author Robertson in a prior employment setting. Once you identify professionals doing similar types of work, invite them to lunch and learn more. If possible, ask to shadow them. Depending on their openness, you may make multiple contact attempts before you can effectively assess the existing services. In this networking effort, be open to the possibility of a partnership in the making. As mentioned, we work in a co-evaluator team; therefore, finding a partner may be helpful to your credibility and improve the quality of your service.

Surprisingly enough, your competition may well include family law attorneys. Many attorneys in our area also provide mediation, evaluation, and management type roles with families. Every state differs, so be sure to learn your court's requirements for completing evaluations, offering recommendations, and gaining approval for court-related workshops, like parenting classes and anger management. Otherwise, your main

competitors are therapists just like you. Get to know who they are and the extent of their services; maybe you offer something they do not.

Understanding the Family Court System. The third and most difficult consideration is to become educated about the inner workings of the family court system(s) with which you will work. Remember that every city, county and state may use different terminology to describe the services offered and the role of the court employees involved in the court system; therefore, it is important you learn the language used in your area. There are many questions you must ask and answer, including the following:

- Who assigns the court cases (i.e., who runs the court docket)?
- Who are the family court judges? Do they rotate to the appointment of family court? If so, how often do they rotate? What is their approach to working with families?
- To whom are court cases assigned, and what are the determining criteria?
- Where do the courts struggle in servicing families? How can I make my services known?

Who is Responsible for the Family Court Docket? It is important to determine how the family court docket is handled. Specifically, you are interested in who assigns cases and schedules the court docket. Once identified, contact that person or office. In our county, all cases are assigned by the Court Dispute Coordinator, who reviews the family court cases to determine what services are needed and by whom. This is the same person who manages the family court docket. In your conversation, identify your credentials and experience, state the services you are most interested in offering (such as custody evaluations), and ask for an opportunity to meet and explore the need for additional service providers or even a different type of service delivery. Your ultimate goal is

OUR SINGLE BIGGEST ADVOCATE GROUP HAS BEEN OUR JUDGES

to identify areas where the system is lacking and develop an approach that will address the need before your first meeting with the judge(s). Identify your strengths and adapt an inquisitive demeanor so as to communicate that while you can offer services, you are also interested in learning more about what they have determined as a true need for the families being served.

Who are the Family Court Judges? Understanding the appointment of judges to family court can be somewhat challenging since different counties employ different practices. In our county, judges are elected to serve the county and have the option to rotate through family, civil, and criminal courts every January. Since new judges may enter family court every year, we must acquaint ourselves with all elected county judges, as they all eventually rotate through family court. Regardless of how judges are elected to serve, attorneys can be a valued resource to educate you about each judge's personality, professional style, experiences (both in and out of the court room), and his or her various methodologies. More often than not, the judge has been a practicing attorney, and some former colleagues may still be in practice in the area.

Despite some incredibly busy docket schedules, we have found judges to be open to meet with us and discuss their philosophical stances regarding their work on the bench. As we have prepared for various presentations the last two years, we have invited judges to meet with us over lunch as well as requested meetings in their chambers. We have yet to meet a disinterested judge. On the contrary, we have been incredibly impressed with their eagerness to educate us about their courtroom ethics, assumptions about families, and their wants and needs from mental health practitioners in testimony and recommendations. Our single biggest advocate group has been our judges.

How are Cases Assigned in Family Court? Most courts have a filtering process whereby family cases are categorized by level of conflict and need. Families who barely register on the conflict radar will most likely resolve their disputes outside of court through mediation, general psychotherapy services, or divorce workshop education. However, families who cannot reach agreements utilizing available services will likely be ordered to complete a more structured means, involving attorneys and court-appointed managers to oversee parenting plans, evaluations, and other specialized services.

Among those needing court involvement, the low conflict cases, typically noted by the absence of abuse allegations, addiction, and repeated court appearances, tend to be assigned to less invasive, less expensive services, such as educational workshops, court-ordered mediation, or other services intended to create parenting plans and visitation schedules. High conflict cases, typically noted by the presence of abuse allegations, addiction, and repeated court appearances, tend to be assigned to more highly structured,

more expensive forensic services offered by mental health practitioners to determine final resolution to the ongoing conflict. In these cases, judges want services that will provide finality to the conflict. Whatever the processes in your area, become familiar with what criteria is used and determine if your services will be geared to meet all levels of conflict or one specific level.

How Do I Make My Services Known?

After the rather exhaustive review of the professional literature, existing services, networking opportunities, and the legal system, you should have an informed plan of how you can meet the identified needs of your community. Using good, basic marketing strategies, create a professional packet to advertise your services. Include the following information:

- Credentials and contact information
- Description of services provided
- Time commitment for families
- Cost and explanation of those costs
- Description of the final product (i.e., written evaluation with recommendations)

With your defined service, the next step is to open communication with the court system—judges and attorneys alike—about how your services will make a difference to area families. Be prepared to explain how your services are similar to and different from what is currently being offered. You can make yourself visible in the community by hosting an open house or offering to speak at the various family court continuing education meetings throughout the year. Meet one-on-one with key figures such as judges, dispute coordinators, docket managers, and attorneys. It can be a long process, but as with all services offered in the private practice realm, a great service is useless if no one knows about it.

In conclusion, our hope is that you recognize how your systemic training has valuable implications for work in many areas outside of traditional therapy, and no area is in greater need of MFTs than family court. While we are not naturally drawn to the culture of the legal system, our MFT training is desirable, as well as underutilized in family court. In our own work, we have discovered there is a reward in knowing that we have invested our training skills into family systems in desperate need of fair resolution to ongoing conflict. And, as a bonus, it has effectively expanded our business opportunities.

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See Standard VII in the new Code of Ethics for guidance on working in forensic contexts.

ethics + legal matters

THERAPISTS PRESCRIBING PETS?

Emotional Support Animals

Alli Spotts-De Lazzer, MA

MOST PSYCHOTHERAPISTS CAN'T PRESCRIBE medications, but *can* "prescribe" dogs, cats, birds, miniature horses, guinea pigs, pot-bellied pigs, and other species to clients in need of Emotional Support Animals (ESAs). These animals offer support or comfort for psychiatric disabilities and, when so designated, are permitted in some no-pet areas. Though the notion of therapeutic animal companionship isn't new, a recent, significant rise in the use of ESAs for people with mental health conditions has been reported by the *Wall Street Journal* (Witz, 2013) and the *New York Times* (Wang, 2013), among others.

The first time a new-ish client asked me to write a letter designating her pet an ESA (often referred to as a "prescription letter"), I didn't know if it was within my scope of practice, let alone competence. I am animal-friendly and a pet owner, but I had no training in using animals as therapeutic interventions. From a clinical perspective, I could see that this pet's presence could help reduce this client's anxiety and depressive symptoms. At the same time, I strongly suspected that being granted an ESA might hinder this particular client's therapeutic progress toward autonomy. I was also uncertain about the permanency of the psychiatric disability label in her records and about its consequence on my client's beliefs about herself. Furthermore, what effect would this letter request—especially if denied—have on our new-ish therapeutic alliance?

Philip Tedeschi, executive director of the Institute for Human-Animal Connection at the University of Denver—one of the few schools in the world providing formal training combining mental health and human-animal connection—said, "It's not surprising that clinicians have not been exposed. The field has been growing and changing rapidly." Of 16 therapists I informally polled, 11 had been asked to write these ESA letters. Seven had agreed, four declined, and none reported feeling well versed in the process. Discussions in live and online therapists' groups echo a call for clarifying information regarding ESA letter requests—to begin with, is an ESA a service animal?

Contrary to popular perception, an ESA is not a service animal as defined by the Americans with Disabilities Act (ADA); therefore, an ESA cannot go everywhere with the client (Disability Rights California, 2011). ESAs are allowed where regular pets are permitted and, usually, in no-pet housing, with no security deposit required; in addition, they can often fly, free of charge, in airplane cabins. ESAs require no distinct training—unlike trained service animals whose tasks are specific, performable, and relate directly to mitigating a person's disability (e.g., for someone with Post Traumatic Stress Disorder, a service animal might confirm that all doors are locked). An ESA is expected to provide disability-related comfort or benefit (e.g., the animal's presence might help calm a person's disabling anxiety). A prescription letter is what typically shifts a new or existing animal from pet- to ESA-status.

Though research on how animals affect human health and development has provided a wide range of conclusions (Dizikes, 2011; Ensminger & Thomas, 2013; Herzog, 2011, Tedeschi, Fine, & Helgeson, 2010; Wang, 2013), for many pet owners, the quality of life improvement that animal companionship offers is self-evident. You can find reports of successful ESA experiences both in the news and by asking prescribing colleagues. Furthermore, some ESA owners view their ESAs as effective alternatives to using medications for ameliorating their mental distress (Wang, 2013; Witz, 2013). Since licensed mental health professionals *can* prescribe pets as client resources, whether you *should* becomes a consideration.

At present, there are few case studies, coherent decision-making strategies, or other ESA-related guidance for therapists. For this article I've consulted experts, clinicians, and current literature to help you formulate your own strategy for deciding your policy on prescribing ESAs.

Data and policies on this issue are accumulating and evolving. Someday, cumulative information will offer more explicit guidance, but in the interim, the following four questions can help you begin to sort out your stance on writing ESA letters. (1) "Am I professionally competent to write these letters?" (2) "Does an ESA serve my client's treatment, symptom(s), and diagnoses—and what are my justifications?" (3) "Does my client have a psychiatric disability?" (4) "Am I familiar enough with the laws, ethics, procedures, and constraints inherent to these letters to be maximally helpful?"

Scope of competence and use of animals in psychotherapeutic treatment

Federal laws state that licensed mental health professionals can write the letters prescribing that air travel or housing accommodations be made for their clients, and some clinicians seem to view ESAs as practical options for effective treatment, with little to no concern about scope. One clinician I interviewed expressed a theme of those who were in favor of prescribing. She stated, "I think we know the emotional state of our clients better than physicians, teachers, etc. I think depending on the case it should be considered as an option."

Clinical psychotherapeutic training does not usually include the topic of using animals as therapeutic interventions. Another therapist I spoke to used the following comparison: "After all, a trained equine therapist could prescribe or use horses, but for most therapists that would be outside of the scope of competence." In an interview, Philip Tedeschi pointed out the importance of therapists receiving training to effectively support their clients with their animal-helpers—he warns that if animals are not well-prepared and matched for their companion-statuses, the human-animal intervention can become contraindicative (e.g., resulting in unpredictable or dangerous animal behavior and increased anxiety in both human and animal).

Among those who participated in discussions about ESAs, many sought learning opportunities such as courses, workshops, or literature focused on the use of animals in therapy. Philip Tedeschi and Lisa Peacock, an Animal Assisted Intervention workshop instructor in Los Angeles, conferred that some animal-related Continuing Education courses (e.g., Animal Assisted Therapy [AAT]) can be helpful for growing scope of competence if they include relevant aspects such as scientific evidence, theories supporting the therapeutic use of human-animal bond, animal behavior, interventions, training, and so on. You can find these trainings by doing investigative research online; though many such workshops still do not include specifics on ESAs. Media sources can also point interested clinicians to relevant developments in the field: a recent article in the *Wall Street Journal* highlighted research supporting the effectiveness of assistive animals specifically in treating autism and PTSD (Wang, 2013). If you search the web for ESAs and related topics, you'll likely find that a variety of animal organizations list mental health benefits of animals or reference research studies and pertinent stories. Use your judgment when checking out the legitimacy of the information and organizations. Lisa Peacock recommended the following books on the therapeutic benefit of the human-animal bond: *Why the Wild Things Are: Animals in the Lives of Children*, by Gail Melson (2005), and *The Possibility Dogs: What a Handful of "Unadoptables" Taught Me About Service, Hope, and Healing*, by Susannah Charleson (2013).

It is important to note that a small number of therapists specified that writing ESA letters was out of their scope of practice. Reasons given included: prescriptions were perceived as a physicians' job; unfamiliarity with the subject and its application in professional practice; concern for managing animal welfare and safety issues (e.g., What if air travel distresses the animal?); and the perception of functioning as a disability evaluator if not trained in such.

One student reached a $40,000 settlement with her university after suing for the right to keep her ESA guinea pig in her dorm room.

Disability required for ESA letters

A psychiatric disability is required to justify writing an ESA letter. Though state and federal laws can vary on disability regulations, a person with a disability is defined by the ADA as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment" (U.S. Department of Justice, 2009). Training focused on mental health disabilities isn't standardized or required for all mental health professionals, which can leave a sizeable knowledge gap concerning which and how diagnoses in the *Diagnostic and Statistical Manual* (DSM) (2013) qualify for disability status.

Some therapists will find it sufficient to consider a client's symptoms and DSM diagnosis and then ask themselves if those meet the requirements of disability's definition. One colleague expressed feeling "confident writing a letter" if she "knew a client well enough" and could deem him or her "disabled enough." Another therapist who wrote an ESA prescription reported having no knowledge that a psychiatric disability is a requirement for an ESA letter. Yet another professional viewed "disability" as merged with "diagnosis" in ESA literature. Finally another therapist responded with, "No way. I'm not trained in disability evaluations."

> “New or evolving developments in the practice of psychotherapy can inadvertently pull a therapist into the legal realm.”

Laws, ethics, procedures, and considerations

ESAs are not primarily governed by the ADA since they are not service animals, but are covered by federal regulations, the Air Carrier Access Act and the Fair Housing Act along with other antidiscrimination laws. Plus, for both the prescriber and the ESA owner, a letter used for housing has different requirements and procedures than one used for air travel. Specifications continue to change and evolve, so a clinician needs to keep up if involving oneself in ESA letters.

On the other hand, according to an article by the California Association of Marriage and Family Therapists, if you don’t feel “competent or comfortable with providing such a letter, you are not legally required to do so” (Tran-Lien, 2013, p. 4).

If considering writing a prescription letter, you should protect your clients and yourself by remaining aware of what needs to be said in the document, as well as the legal and ethical constraints. Though sample ESA letter templates can be easily found online, no single version is guaranteed to work. John Ensminger, an attorney and national consultant on skilled dogs and their handlers, and J. Lawrence Thomas, a senior level neuropsychologist, offer guidance in their article, “Writing Letters to Help Patients with Service and Support Animals” in the *Journal of Forensic Psychology Practice* (2013). Here are some basics. A letter should be on letterhead and include the professional’s license information; it should state whether the person for whom the therapist is writing is a patient; it should specify that the patient suffers from a condition in the DSM (though the actual diagnosis need not be mentioned); and it should state that the animal alleviates or ameliorates an effect or symptom of the person’s condition. Additional suggestions include communicating whether the therapist has witnessed the animal’s interactions with the person, and whether the animal was recommended and obtained specifically to improve a symptom of the condition. The authors offer further recommendations to help therapists work within both laws and ethics while supporting their clients with ESA needs.

As evidenced in the article by Ensminger and Thomas (2013), when legal disputes over ESAs erupt, the letter generally becomes evidence. Therefore, the prescribing therapist can be subjected to extra-territorial duties, such as supplemental letter writing and legal testimony. ESA cases are easy to find in the news: Grand Valley State University student Kendra Velzen reached a $40,000 settlement with the university after suing for the right to keep her ESA guinea pig in her dorm room (Huffington Post, 2013); Orange County, California, had two cases in which landlords were sued for refusing to allow tenants with disabilities to keep ESAs. Settlements were reached in the amounts of $185,000 and $200,000 (AOA of California, Inc., 2013).

Therapists who incorporate these letters into their practices should also be prepared for unexpected scenarios with complicated ethical considerations. For example, a client close to terminating therapy may request an ESA prescription, and the letter is generally valid for one year for air carriers. So a therapist opted to write an expiration date into the letter. Some therapists feel uneasy about recommending an animal whose behavior is unknown to them. This is complicated, as the therapist cannot be expected to evaluate an animal’s public safety, and there is no required training, national certification, or registration process for ESAs (Ensminger & Thomas, 2013). In an interview, John Ensminger suggested that a therapist might be well served by including a clause in the letter that indicates public safety awareness and may offer liability protection (e.g., “Therapist cannot speak to the behavior or training of the animal”). Untrained or aggressive ESAs have been repeatedly cited as problematic in the news and blogs (McCarthy, 2010; Muth, 2013; Witz, 2013). Sometimes, a therapist might have knowledge that the requested ESA has behavioral issues. In these cases, Philip Tedeschi recommends, “I would refrain from writing such a letter. The emotional support offered by a pet is also available. If an animal is inappropriate for the public and potentially aggressive or escalated it is unethical to suggest the animal be utilized that way and if is likely to further complicate the clients activities not improve functioning.” Furthermore, a therapist may encounter a client who initiates therapy with the sole purpose of attaining ESA privileges for his or her pet instead of comprehensive treatment. One therapist chose to manage this by requiring a three-month minimum assessment period.

Conclusion

Some psychotherapists do not develop policies about ESA letters until presented with a request. In my case, after much consultation and research, I decided that the ESA letter was out of my scope of competence and explained so to my client.

Thankfully, the therapeutic alliance remained intact. Another therapist who agreed to the letter said, "I think it [denial of the letter] would have put some strain on the alliance, but it never occurred to me, as I actually thought it would be helpful for her to have the pet [in no-pet housing]."

New or evolving developments in the practice of psychotherapy can inadvertently pull a therapist into the legal realm, and it behooves therapists to pay extra attention to both the standard of care and existing laws and ethics that apply. John Ensminger predicts that the increase in published opinions from trial courts will eventually reveal that therapists' involvement in ESA court proceedings is far more commonplace than is presently recognized in the psychotherapeutic community. A therapist not well versed in the mix of supportive animals and therapy will likely benefit from taking applicable trainings (if available), studying pertinent literature, and consulting with colleagues and experienced professionals familiar with assistive animals and the corresponding professional laws and ethics. As always, document your decisions.

Although licensed mental health professionals *can* prescribe ESAs, it is both a personal and professional choice as to whether you *should*. As with any evolving psychotherapeutic issue, we won't know the explicit rules or consequences until examples are made that publicly set the standards.

One final note: I received a phone call as I was finishing this article—the person wanted to know if I could write a letter to her landlord that would allow her to keep her puppy living with her in no-pet housing...

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GROW YOUR BUSINESS THROUGH

Online Content Marketing

Josh Kalsbeek, MA

HAVE YOU EVER FELT that the success of your private practice is dependent on other people? Do you want to grow the influence of your practice? It can be incredibly frustrating feeling like your livelihood depends on someone else choosing you. It can be easy to buy into the idea that you must wait for others to give you their approval that you, and your work, are good enough.

The problem is that we are rarely chosen if we are not proactive. Typically, as therapists, we are proactive in growing our clinical skills. Or we are proactive in doing direct marketing and networking with other professionals. But are there other options?

The following describes how you, as a therapist, can choose to do more than wait to be picked. You don't have to wait for other people's permission and you don't have to do what everyone else is doing.

One of the best ways you can take initiative and market your business is through content marketing. Content marketing in its most simple definition is delivering valuable content to an audience. Content marketing online is a simple concept: engage people online, for free, providing valuable content.

Content can be many things: blogs, a video series, ebooks, surveys, worksheets, or online communities.

The most important aspect of content marketing is creating valuable content.

This material is beneficial to your audience. It helps them. It gives them a reason to keep coming back for more. They will naturally even want to share it with friends who might benefit.

Engaging in content marketing can be effective, whether you are running a private practice, lead a non-profit, or are pre-licensed.

This is not simply one more thing to be doing, nor it is an easy path. It can be very frustrating. But it can be incredibly rewarding.

You are creating a place where people can connect with you and get the help they need.

People who have been helped, inspired, and encouraged by free content online will trust you and be more likely to purchase a product or pay for your services.

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Joshua Kalsbeek, MA, is an MFT intern and founder of Therapy Pioneer. He is a therapist, adventurer, entrepreneur, and business coach.

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8 Reasons to do content marketing

1. Content marketing will develop your **authority as an expert.** This develops trust for potential clients or customers. In order to successfully do content marketing, you typically need to choose a specialty, some specific niche where you can help solve people's problems. The content you create helps people see that you are knowledgeable. This can help you increase your fees, or help justify the cost of paying for your services.

2. Your business will become a **unique brand.** You will stand out with content marketing. You will develop your own voice, your own way of engaging the world with your skills. It can help you create a powerful brand for your business that is recognizable, helps people, and grows your business. Doing content marketing well requires you to think about your audience and how to refine your message to them. This helps you shape how you present yourself to the world.

3. You have the opportunity to **develop and influence your own community** and are not as dependent on someone else to send you clients. You can become a leader by teaching. Through teaching, using whatever method of teaching you choose in your content marketing, you provide real help to referral sources such as doctors, lawyers, and other clinicians that they can recommend to their community.

4. **You will help people**. Your content will help other clinicians benefit their own clients. Your content will help people who never become a paying customer. This is a good thing. They can recommend you to others who do become paying customers. Having the platform of content marketing enables you to have greater reach to simply do good in the world. It amplifies your voice.

5. You can develop **multiple streams of income**. Your business does not have to be limited to providing therapy in a room with four walls. You can develop multiple streams of income using the skills and knowledge you have as a therapist, and learning how to effectively engage with people through content marketing. Books, online courses, and speaking engagements can bring additional income besides doing therapy.

6. You can **express yourself creatively** outside of doing therapy. Whether that is using your writing skills, public speaking skills, or your ability to think of new ways to serve your community. Content marketing can be a way you can engage in fun, creative, and inspiring activities.

7. You can begin before you are licensed. **There is no need to wait.** You can use your pre-licensure time as a runway to develop your content marketing so you can grow your network and launch your private practice.

8. **It leads to new opportunities.** Content marketing can lead you to new clients, speaking opportunities, interviews, and help you get hired in new jobs. It shows that you take initiative. Content marketing becomes a visual resume; it shows the world who you are and how you can help.

SHOULD THERAPISTS RETHINK THERAPY?

Attention Span: The Virtually Re-structured Brain

Suzanne B. Casey, PhD

IN A 1943 ADDRESS, Winston Churchill observed, "We shape our buildings, then they shape us." Like society at large, we, as therapists, and our clients are increasingly dependent upon innovative, technology-assisted communication systems (Kaplan, Wade, Conteh, & Martz, 2011). Most of us have adjusted our routine business and social interactions to accommodate the incredible opportunities offered by the technology-driven systems of communication around us. These efficient and enjoyable digital interactions are gaining momentum in our lives, and we purchase more and more personal devices to keep up with them.

Countless articles enumerate the less-desirable changes brought about by virtual communication technologies. Conversely, innumerable articles appeal to us to remember to blame people, not technology, for the misuse of digital tools. These views are instructive regarding the points they address.

However, what's a therapist to do with this information? How do marriage and family therapists view a client's attitudinal and behavioral changes while in session? Do we ask them to take time away from their devices and pursue face-to-face relationships? Do we happily join them in cyberspace and extol the virtues of online interactions?

Perhaps a more useful idea is to look at what is going on in the therapy room. For MFTs, Churchill's statement rings particularly true. As virtual technologies continue to shape and reshape the way all of us think and interact, therapists may decide to adopt a systemic approach toward the client who has been changed by the regular use of virtual technologies. To achieve this, the therapist would purposefully:

- cultivate a non-judgmental approach toward the client
- notice existing patterns of thinking and behaving, and
- utilize the momentum of viable change agents in constructing creative interventions designed to help the client reach desired goals.

But before we can effectively utilize the changes that have already occurred within our clients, let us first identify some of them. What are some of the ways we've been reshaped by the technologies we've built? According to researchers, six mental, biological, and behavioral changes are noteworthy. One of the most profound of the changes has to do with our attention spans.

Attention span

Prensky (2001) states that those born before 1990 remember how we managed our daily routines without using email services, social networking sites, text messaging, instant photo and video sharing, and other interactive technologies. Reading was a solitary venture, television programming concluded each night at midnight, and it was considered rude to call someone after 9:00 p.m.

In 2015, however, we can focus 24-hour attention on a seemingly endless array of screens that usher us through the looking glass toward links, prompts, beeps, buzzes, email, texts, instant messages, calls, videos, virtual worlds, interactive books, interactive movies, and interactive games. On one social web site, cybercitizens collectively form a cyberstate with a population one billion strong (Kaplan et al., 2011; Smith, 2012).

These fun, fascinating, invigorating, somewhat controversial expenditures of time and talents have become firmly entrenched in our lives. As these new interactions alter older, existing patterns of interaction, changes necessarily occur in other parts of our system as well. One of these changes involves our abilities to focus intently for prolonged periods of time on one thought or idea. As a result, our attention spans are shorter than they used to be.

In the previous century, it was believed the brain, once formed, could not change. In 1913, neuroanatomist and Nobel laureate Santiago Ramon y Cajal proclaimed the malleable brain of a child became fixed with the years, hardening into something like concrete by adulthood (in Schwartz & Begley, 2003). Experts of the past claimed that once it was rigidly formed, the unchangeable adult brain followed a slow, downward trajectory toward degeneration and death (Doidge, 2007).

Today, neuroscientists know the brain retains its ability to change and adapt to new situations throughout life (LeDoux, 2002; Wexler, 2006). This ability, *plasticity*, allows the brain to react to new challenges by developing neural connections uniquely suited to those tasks. For example, when persons of any age learn new math skills, take violin lessons, or acquire additional linguistic abilities, the brain restructures existing branches of neurons in order to accommodate the new patterns of thinking and behaving. These new patterns of neuropathways, necessary for

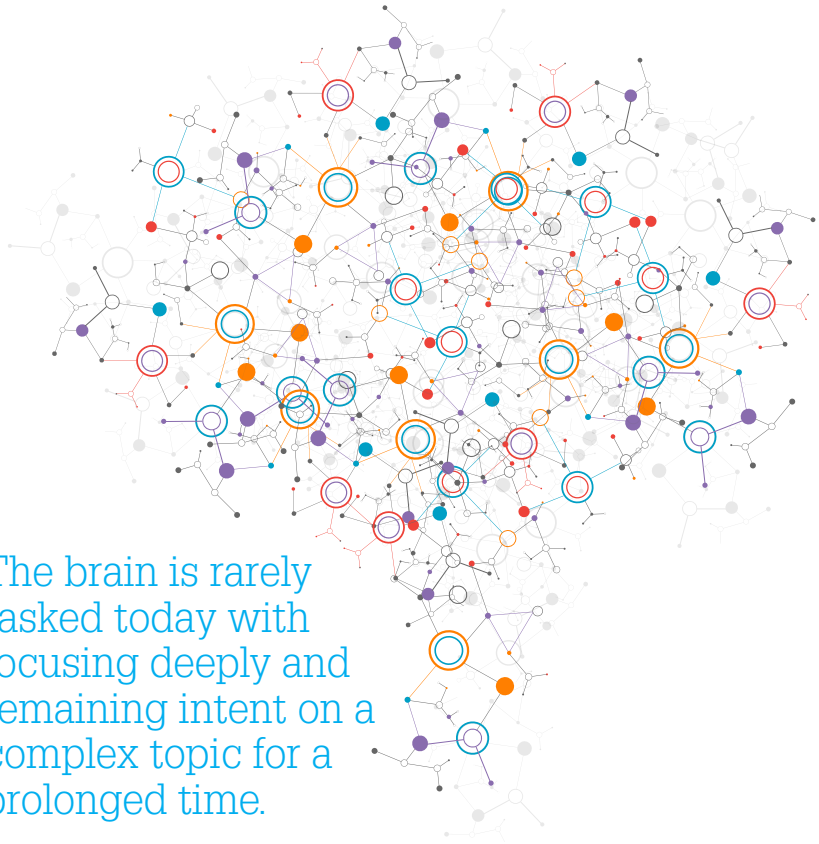
mastering the skills for performing the task at hand, grow deeper with regular use (Doidge, 2007).

Electronic communication devices present the brain with an unending array of learning opportunities. When a person purchases a new mobile phone, the brain responds to the need for increased levels of mental and physical dexterity suited to that device. To become proficient at navigating the numerous applications on the device, the brain creates neuropathways specifically designed to attain those desired levels of mastery (Shrestha & Lenz, 2007).

For example, we get better at sending text messages because our brains form neural branches specifically designed to meet the new challenge. When we practice sending quick, accurate text messages by typing on our mobile phone's miniscule keyboard, the brain methodically restructures itself in order to improve those skills—especially when it perceives them to be urgent and important (Doidge, 2007; Tapscott, 2008). For most waking hours, we remain alert to incoming texts, email notifications, social network updates, and numerous other bits of information—regardless of where we are or what else we are doing (Jessberger, Aimone, & Gage, 2008; Nielson, 2006). The brain is continuously challenged to make numerous rapid executive decisions.

There are, however, drawbacks. Merzenich (2008) and Gould (2007) observed that the brain, though plastic, is not elastic. It does not snap quickly back into former shapes to swiftly recover little-used neuropathways. Rather, the brain's neuropathways wax and wane with use and disuse. Very much like pathways in a jungle, well-worn paths become broader and more easily accessible, while little-used paths narrow and are soon overgrown.

There is a price for plasticity. As human brains adjust to become proficient at making rapid decisions and more skilled at shifting attention from one task to another, former mental and physical skills may wane (Trafton & Monk, 2008).



The brain is rarely tasked today with focusing deeply and remaining intent on a complex topic for a prolonged time.

When we want to listen to a lecture or read a long passage of text or think deeply about something, we may find ourselves inclined to remain attentive to our devices and attuned to (and even wishful for) their interruptions. Some of the skills we developed long before mobile phones, tablets, and laptops entered our lives may now be lost and no longer available to us. But aren't our ever-efficient brains working hard for us?

Yes, the brain works constantly to adjust to our needs. Yet, its energy stores are not limitless. Whenever the brain shifts focus, it also expends energy, incurring what Jackson (2008) called *switching costs* (p. 79). These switching costs make the brain pay an energy toll each time it switches from one task to another.

When a person surfs the Internet, decides to click a link, feels the buzz of an incoming text, checks the message, decides not to respond, returns to the web site, hears the ping announcing an incoming email, changes screens to read the email, formulates the response, returns again to the web site . . . the brain pays for each switch in attention with minute withdrawals from its own energy supplies.

To maintain its efficient functioning, the brain diverts valuable energy resources away from less urgent functions and directs them to demanding, task-switching operations. The brain is rarely tasked today with focusing deeply and remaining intent on a complex topic for a prolonged time. The infrequently used neuropathways used for deep concentration begin to wither and fade. Further, these little-used branches of neurons actually trigger automatic pruning processes within the brain, which trim away the fading neuronal branches (LeDoux, 2002). Gradually, those waning neuropathways and the skills they once enabled cease to exist. This allows the brain to divert its energy to skills deemed more necessary for survival.

Thus, we find it becomes harder to maintain focus and attention on the lecture we are attending, the face-to-face conversation we are having, a work meeting, special meal, the visit with Aunt Martha, and the movie we are watching.

Indeed, these activities now rarely receive the brain's undivided attention. Rather, the brain now excels in dividing its attention, re-routing energies so that we may quickly respond to an unending array of aural, visual, and kinesthetic prompts.

The brain that is tasked with communicating through virtual communication devices is, in turn, sculpted and shaped by the technologies it endeavors to master. In poetic recursion, the biological brain that originally designed interactive digital technologies is, in turn, reprogrammed by those very technologies. Our beloved virtual technologies subtly shape our remarkable human brains to fit technology-shaped grooves (Conner, Egeth, & Yantis, 2004).

What does all this research on brain plasticity mean? How does it affect a therapist's daily practice? It is possible that therapists and clients may present to therapy with different capacities for deep concentration. Therapists born before 1990 (Prensky, 2001) may retain a large portions of their former abilities to ponder quietly and intently some difficult existential concept. They may still be able to give prolonged and serious thought to developing a personal conviction on deep philosophical questions. Those born after 1990 may have no awareness of what it is like to engage in these solitary mental activities. Younger clients may have never experienced uninterrupted periods of quiet introspection and deep concentration. In fact, they may consider an extended period of uninterrupted silence to be a frightening or otherwise undesirable circumstance.

A thoughtful awareness of technology-shaped attention spans helps therapists understand that clients may not be stubbornly refusing to stay on topic for 50 minutes during the session or to read the recommended book. In fact, some of today's Rhodes Scholars admit they have little patience for prolonged solitary reading experiences and confess that they see no advantage to reading an entire book (Carr, 2011; Lanier, 2011). This could mean that the brightest, most motivated clients may engage their own superb mental processes in ways that differ wildly from that of the therapist.

To overlook, minimize, or ignore the recent changes in mental processes of clients (and many therapists) poses enormous risks to those who would be helpers and to those seeking help. A clearer understanding of some of these differences in no way threatens or diminishes a therapist's professional and personal effectiveness. To the contrary, it sharpens, equips, and emboldens the professional to serve the needs of others more effectively.

Should clients practice thinking deeply for prolonged periods of time? Should therapists insist that their clients develop new skill sets if they want to engage the therapist's services?

Ah, now...that's another subject altogether.

Look for my next column in an upcoming issue that will further explore the intersection of technology and communications.

Suzanne B. Casey, PhD, is a licensed marriage and family therapist and holds a specialization license in technology-assisted distance counseling services. Her most recent research examines ways in which a client's online relationships may yield insights for unique therapeutic interventions. Casey serves on the board for the Arkansas Association of Marriage and Family Therapists and is a Clinical Fellow of AAMFT.

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noteworthy

COAMFTE Approves Two New Programs and Renews Two More

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) met November 7-8, 2014 in the AAMFT offices in Alexandria, VA. The Commission granted initial accreditation to two MFT master's programs at Our Lady of the Lake University, one in Houston, TX and the other in San Antonio, TX. The Commission also renewed the accreditation status for the MFT master's programs at Nova Southeastern University and Syracuse University.

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November-December: Advanced Clinical Institutes

member benefits

Belonging to AAMFT allows you access to outstanding benefits and professional development resources at www.aamft.org.

Policy and Advocacy: AAMFT is the primary advocate for the profession, and the primary force for advancing the practice of marriage and family therapy. Our staff and leaders meet regularly with legislators and policy-makers to persuade them that family therapy works and that family therapists should be accepted throughout the health care system. To view the latest legislation updates and to learn how you can take action, please login as a member at www.aamft.org and click on the Legislation and Policy link.

TherapistLocator.net: This free online therapist directory is a public service of the AAMFT. Clinical Fellows and Members receive a free listing that they can personalize with practice and biographical information and their photograph. The AAMFT regularly advertises this service to the media and the public. Visit www.therapistlocator.net to learn about this valuable service.

Job Connection: AAMFT Job Connection is a free service that provides access to employers and jobs in the behavioral healthcare field. Post your resume, browse and view jobs based on their criteria. Learn more at http://jobconnection.aamft.org.

FamilyTherapyResources.net: This online resource includes AAMFT publications, events and articles, tapes from AAMFT conferences, and books by AAMFT members. AAMFT members can view and print out complete magazine articles for free. Members are also invited to add their books and products to the list of resources at no charge. For further information, visit www.FamilyTherapyResources.net.

Continuing Education: The AAMFT offers several opportunities for MFTs to earn continuing education credit, including an Annual Conference in the fall, as well as yearly Institutes for Advanced Clinical Training. AAMFT members also can earn continuing education online. AAMFT members receive discounts on all continuing education opportunities. For more information, visit www.aamft.org.

Online Store: The AAMFT provides an online store that contains must-have publications and products. Visit the online store to find to a variety of consumer updates, excellent resources, and AAMFT logo souvenirs. AAMFT members receive discounts on all purchases made at www.aamft.org/store.

Professional Liability Insurance: AAMFT membership gives you access to comprehensive liability coverage and rates, specifically designed for your practice. Call CPH and Associates for more information at (800) 875-1911 or visit their website at www.cphins.com.

Health, Disability, and Group Term Life Insurance: Mercer Consumer provides AAMFT members with a list of plans from which to choose, depending on individual needs. To find the right plan, call (800) 621-3008 or visit http://aamft.healthinsurance.com.

Legal Consultation: AAMFT Clinical Fellows and Members who need consultation on legal matters relating to their professional practice of marriage and family therapy can consult with the AAMFT legal representative free of charge. To make an appointment to seek legal consultation please call (703) 253-0471, email ethics@aamft.org, or visit www.aamft.org and click on Legal and Ethics Information.

Free Ethical Practice Information: The AAMFT offers comprehensive ethical advice and resources based on the AAMFT Code of Ethics. Marriage and family therapists can obtain FREE informational ethical advisory opinions, plus training and resources to protect and inform you about how to maintain an ethical practice. To reach this benefit visit www.aamft.org and follow the Legal and Ethics Information link.

Division Membership: The AAMFT divisions advocate for members at the state and local level and offer a variety of networking opportunities. Access the division directory and find out how you can get involved at www.aamft.org.

Online Networking Directory: AAMFT members have exclusive access to the membership directory located at www.aamft.org. Use the directory to make referrals, develop a peer supervision group, locate students to supervise, or find the perfect supervisor for your internship.

Publications: AAMFT members receive free subscriptions to the Family Therapy Magazine, AAMFT's bimonthly publication, the quarterly Journal of Marriage and Family Therapy (JMFT), and twice per month Family Therap-eNews distributed electronically.

Discounted Web Hosting: from TherapySites.com (www.therapysites.com/AAMFT). This web hosting company provides therapist websites that bundle all the tools you need into one all-inclusive package. The service is designed to give you everything you need to make your online presence a profitable investment for your practice including: Personalized domain name, integrated email service, easy-to-use editing tools, website hosting, unlimited pages, HIPAA compliant technology, client forms, appointment requests, website statistics and many other services.

Discounted Credit Card Processing: The AAMFT has collaborated with with TSYS Merchant Solutions (formerly First National Merchant Solutions) to help provide additional cost savings for members. Some of the benefits of the program include: Discounted group rates on Visa, MasterCard and Discover transactions, dedicated account management team, additional merchant processing services, including debit card acceptance, an interest-bearing account, and check verification/guarantee services, free online statements and account access and much more. An additional benefit of this service is an account management system that allows you to set up automatic client billing, the ability to obtain insurance pre-authorizations and setting up recurring payments.

FAMILY THERAPY

The American Association for
Marriage and Family Therapy, Inc.
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Clinical Case Consultations

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