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Connecticut Association for Marriage and Family Therapy
a division of the american association for marriage and family therapy

Inside

2013 CTAMFT ANNUAL CONFERENCE PRESENTER

Familiar Strangers: The Drama of Opposites and the Visible and Invisible

By Charlette Mikulka, LCSW

I've been fascinated with how human lives mirror and are a microcosm of the larger material and spiritual world. As a clinical social worker, my mind often perceives the world through the lens of emotions and relationships. I also see the yin and yang of the universe within family life. As many couples and family therapists have observed, for every intensely burning star in a relationship, there typically is a black hole, a family member whose emotions and sense of self get swallowed up and forgotten.

The inner worlds of family members with an anxious attachment style become imposing mountains. The inner worlds of those with an avoidant attachment style are dark caves or icebergs, with most of what's going on submerged. When I hear of hurricanes, floods and tornadoes, I think of the pursuer's surge of emotions, needs and complaints. When I hear of a drought, I think of the avoider's experience as a result of distracting, dismissing and ignoring. When our emotional distress is buried deep, we are a dormant volcano. When our emotional distress can't be contained, we are erupting hot lava. When we can't care anymore because it hurts too much, we become frozen tundra.

The "honey mushroom", what may be the largest life form in the world, is an underground fungus 3.5 miles across and taking up over 1,600 football fields. The safe or lethal mushrooms that emerge as

its fruit give us no clue as to how much is living underground. Likewise, whether our verbal expressions are carefree, rational, placating or irreverent, as someone detached from emotions and relationships, or relentless, nagging and noxious, as someone preoccupied with emotions and relationships, there are massive emotional worlds underneath that aren't seeing the light of day. Neither the heart that is encased in rock nor the heart that is raw and exposed feels safe enough to recognize or effectively disclose their deepest, most significant truths.

Family members may appear to be opposites, but just like the universe, polarized dyads are two sides of the same coin. While each partner's or sibling's coping strategies or positions may be glaringly different and provoke conflict or disconnection, their underlying essence,

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SAVE THE DATE

CTAMFT

CONNECTICUT ASSOCIATION FOR
Marriage & Family Therapy

in collaboration with

RIAMFT
Rhode Island Association for Marriage and Family Therapy

Annual Conference and Meeting
Thursday, April 25 – Friday, April 26, 2013

Mystic Marriott Hotel and Spa • Groton, CT

HEALING THROUGH FAMILY THERAPY

DR. KENNETH HARDY

"Brief Intensive Trauma-Informed Therapy"
Keynote Presentation - Thursday

"Innovative Interventions with Distressed Youth" *Workshop - Friday*

DR. ELIANA GIL

"Effective Use of Play Therapy" *Keynote Presentation - Friday*
"Expressive Therapy Strategies for Healing Trauma" *Workshop - Friday*

CHARLETTE MIKULKA, LCSW

"Identifying and Breaking the Trauma Reenactment Trance"
Presentation - Friday

PLUS:
Jayne Dean, LMFT
Shake Your Soul®: Yoga Dance - Thursday

Discover the union of body and spirit that is unique to yoga but with the play, joy and flow of dance!

President's Letter

Dorothy Timmermann, LMFT

Dear Members,

We all understand that change is inevitable and even though change has always been a part of life it seems that change is happening faster than ever before. Being able to adapt and respond effectively in a constantly changing world has become a necessary skill. How we respond to change is a funny thing. When we initiate change we may view it as stimulating and full of opportunities. When change is imposed on us, our experience is likely to be quite different.

"The Drama of Opposites" written by Charlette Mikulka, a presenter at our upcoming 2013 Annual Conference, helps to illustrate this point in family life. The changes and "growth" of our professional association also demonstrates this to us as a group. So what types of changes are we referring to now you may be asking yourself?

A significant change that has been determined by the Board to be important in adapting to the changing times, as well as being fiscally responsible, is the elimination of future printings of this newsletter. Communication platforms have shifted so significantly over the last two years and we believe that we can reach our members most efficiently and effectively in an electronic format. Even Newsweek magazine has recently announced that they will publish their final print edition December 31st, as they go completely digital in 2013. We have already been publishing a Monthly E-News and our plans include enhancement of this communications vehicle as we move ahead.

Another change that is underway is the offering of a new marketing/advertising program that provides an opportunity for members and other organizations promoting workshops and trainings to gain inclusion on our CTAMFT.org website and reach members via email with a Listserv package. This is in part due to diminishing income from individuals seeking MFT CEUs for workshops, a change that has been occurred over time due to many providers choosing to offer just NASW CEUs, which meet the requirements for MFTs as well. This new program will go into affect as of January 1st, 2013, and will include the limiting of Listserv postings that are advertising directly to members for workshops and trainings to those that have either contributed via applying for MFT CEUs or have taken advantage of the new marketing/advertising program.

A final note on change has to do with our 2013 Annual Conference. Following a year of engaging our neighboring divisions in discussion about collaborating for growth opportunities, the Rhode Island division has elected to join us in hosting an expanded offering. Our upcoming conference will encompass two days and feature multiple popular presenters including: Dr. Kenneth Hardy, Dr. Eliana Gil and Charlette Mukulka. There will be new social and networking opportunities along with special offers from the Mystic Marriott to enhance your visit and encourage overnight stays. We will also offer multiple ticketing options to accommodate various needs. Further details and registration will be available soon.

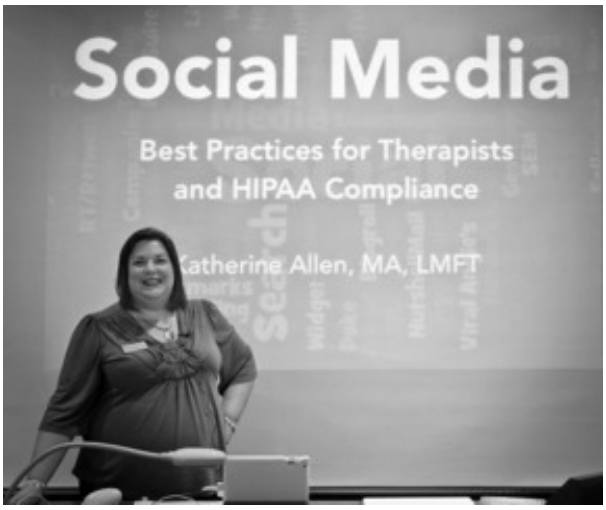
On a final note, I would like to remind members that one way to accept change more readily is to be a part of it and understand all that goes into the decisions that are being made on behalf of the organization. We are actively recruiting at this time for committee involvement and hope that you will consider getting involved. Some of our more active committees include: Membership, Annual Conference, Professional Development, Ethics, the Student Committee, Marketing Communications Committee and the Legislative Task Force. For further information please email us at manager@ctamft.org.

-Best Regards, Dorothy Timmermann, LMFT

Social Media: Best Practices and HIPAA Compliance

By Katherine Allen, LMFT

On Friday, October 12, 2012 CTAMFT sponsored a professional development workshop about social media and how therapists can learn to use it and technology to our safest and best ends. The online world is a big, complicated place and involvement in it is not optional. With all the many and varied ways this medium presents itself (web sites, blogs, email, Facebook, Twitter,



Pinterest, and who knows what's next), it's easy for a therapist to make mistakes with its use. But being informed and making accurate decisions as we engage in this online world is no longer something that we get to shrug our shoulders about and say, "who me? I'm just a therapist." HIPAA guidelines make it clear as day that each of us is mandated to be sure that we are using the tools at our disposal with safety and precaution when we use them to engage with our clients.

What is HIPAA compliancy regarding our communications with our clients? At its root, it basically means how well we are protecting their information, identities and presentations from anyone outside of the client/therapist relationship. So when we exchange emails with our clients, we have opened the door to the potential of outsiders gathering information about our communications. Even though we may have clients sign waivers releasing us from liability regarding electronic transmissions, it's still our duty under HIPAA to protect them to the best of our ability. That brings us to email types and qualities.

In the workshop, I asked the audience this question: when was the last time you received an email from your primary care practitioner, OB-GYN, or dentist? The answer: never. Nobody has ever received an email from one. Why is this? It is because HIPAA is not yet clear regarding email transmissions and rather than wandering into subpoena-land, they just don't engage in it at all.

As therapists, we have an entirely different type of relationship with our clients than medical providers do. Our clients really need to like us and feel safe with us for the process of therapy to be more effective. Yes, it's important for everyone to feel safe and well cared for by their doctors, but as therapists we spend more time with our clients than doctors do with their patients. It is understandable then that the desire and sometimes need for different kinds of communications is considered.

In the workshop I held up two envelopes. One was sealed, stamped, and addressed to me, having traveled through the US Postal Service to get from the sender to my home safely. The other was an envelope that was unsealed. Now let's think. If I have a safe email program and use it effectively, then I am sending the sealed envelope through the mail. It's not entirely foolproof. The mail truck could get in an accident, someone could break into my mailbox, or the carrier could mistakenly drop it. By and large, though, it gets from point A to point B without trouble or tampering. Now take the opened, unsealed envelope. Many email programs that are unfortunately used by therapists are of this type. Would you ever send confidential client information through the mail in an unsealed, open envelope? Heck no! Maybe you're not actually worried that someone is waiting and lurking hoping to pounce on that one unsealed envelope that slips by undetected. But hackers are thinking about that and they write code that never sleeps that searches for that one unsealed envelope.

So how do you ensure that your envelopes are sealed?

In a nutshell, if it's free it's unsafe. Any email that you don't pay for is basically an open envelope. I'm sure you're thinking "but I have a password and who would truly care enough about my teensy emails to really want them?" It's not that there are actual human beings looking at your electronic transmissions. However, by agreeing to use a service for free, you have agreed to let their computer programs "mine" information from your messages to create targeted advertising in exchange for the "free" service. Have you ever bought something from Amazon, say, a hammer? You fill out the contact information for the receipt and use your "open envelope" email account to receive the receipt. Now say the next day you are on Facebook and suddenly there are all of these ads for home improvement stuff along the right side. Your open envelope was mined for content to drive advertising. No big deal, you say, because you know what happened.

But let's change that a little bit. You email with a client about a tough time and instead of a secure, professional email you are using that same "open envelope" free email for

You Friended Who?

By John Suchocki, LMFT

Over the past few years I've noticed a trend in why couples have been seeking counseling at my practice. Accusations of emotional and physical infidelity have heightened with the advent of texting, social media sites, such as Facebook, and interactive smartphone applications. These communication methods are quick, easy, and convenient. Individuals may not understand the immediate or longer-term outcomes associated with communicating electronically with someone else via the web. However, the partners and spouses of these people may feel slighted by these virtual relationships (regardless of how innocent they may seem).

Infidelity certainly pre-dates the Internet. Although innovative technology can certainly help society, it has also created new ways (also quick, easy, and convenient) for individuals to cheat on their partners. Emailing and texting have become a norm in regards to basic communication. With those who are cheating, simple emailing can lead to sending inappropriate pictures and texting can lead to sexting. For the partner who is participating in this type of communication, a virtual emotional relationship may seem innocent or trivial. The individual may not ever see the person who he or she is communicating with. It could be an ex from years ago or someone that he or she just "met" online. Even though there may be no physical affair, these virtual emotional affairs can certainly lead to actual emotional or physical infidelity.

I've worked with couples in which one person communicates with an ex-lover online, "friends" someone who he or she just met, or chats with individuals during a smartphone application. Is this appropriate? Is this acceptable? I guess it depends on how that individual's partner feels. This is similar to a relationship in which one individual feels that his or her partner has a drinking problem. If partner A feels that partner B has a drinking problem but partner B doesn't feel as though he or she has a drinking problem, there is still a problem.

Because both individuals in the relationship may be utilizing these modes of communication, I feel that it is important to first assist the couple in identifying ground rules. Besides decreasing blame, identifying the couple as the client helps to define their shared goals in therapy (e.g., "we want to communicate better" versus "I want her to stop texting her ex-boyfriend"). These rules can include what they each feel is appropriate in regards to who they communicate with (and how they do it) as well as what would not be appropriate. This exercise is often helpful because people never really know their boundaries until someone crosses them.

Another intervention simply includes decreasing access to the electronic devices. For example, having agreed-upon "no smartphone times" or "no smartphone zones" can increase communication between couples without the commonly heard dings and buzzes that we have all grown used to. Perhaps a couple could increase communication by simply talking with each other without responding to text messages, updating statuses, or playing applications with complete strangers.

Texting and communicating via social networking sites and applications wasn't an issue 20 years ago. Although technology is supposed to help individuals and society, it can also lead to marital conflicts and create newer means for infidelity. Thus, these advances in technology and communication can also create new opportunities for MFTs. From a systemic perspective, working with these couples has been a fascinating experience, as the cell phone or smartphone often seems like a part of the family that is never more than an arms-length away.

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the correspondence. You mentioned help for suicidal feelings and resources for depression in the email message. Now, say this same client hasn't told anyone about his or her seeking therapy and a friend oversees their Facebook page and ads about depression or suicide help appear along the right side of the page. Sure, nobody purposefully or intentionally breached confidentiality but now this client has an uncomfortable moment to either avoid or explain which would not have happened if the email messages were protected from being mined.

Safe means remembering that nothing in life is free.

Some companies have begun to capitalize on this fear and uncertainty and are sending out unsolicited deals for encrypted, HIPAA-compliant programs that promote keeping you safe (for a monthly price). But the real truth of the matter is that it doesn't have to cost very much to employ smart and safe email programs. Don't fall for the ads that prey on your fear and lack of knowledge. We will be re-running the workshop as a webinar on the CTAMFT.org site soon and everyone can learn specifics of how to make their practice and clients HIPAA-compliant and keep you in control of the process.

Our practices are our livelihood and it is important that we take the necessary steps to keep them all running well so that as a whole, we are stronger and better able to help others than if we let each other flounder.

There is a great resource from the government that clearly spells out the practitioner's responsibility when using technology with client information. It is found at

http://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf

This guide explains the legal responsibility that every "covered entity", aka therapist, has to ensure and attest to in regards to the details of security protections, and whether you manage your technology yourself or if you pay for software, off-site programs, or EHR management systems. The legal responsibility falls individually on every independent practitioner's shoulders regardless.

Don't let this scare you away from using technology in your practice. As things stand today, it is the most effective way of building a reputation

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experience, and needs are harmonious. The more I work with couples, the more I find astonishing proof that partners are Emotional Twins, perfectly designed to empathize with the other…provided they look beneath their defenses. For example, I know a couple in which both partners had learned to dissociate from painful inner and outer worlds by leaving the earth and isolating themselves. She felt safest and happiest when she was scuba diving in the ocean, while he felt safest and happiest when he was piloting a plane in the clouds.

The majority of families are living on a buried emotional toxic waste site, a Love Canal. Our children are exposed to what radiates from poorly processed past and present

painful love relationships as they innocently play in the polluted puddles. The harmful and worthless defenses we rely on to deal with our difficult emotions play a major role in the psychological, physical, behavioral, and relationship disturbances that family members develop. And just like the Niagara Falls School Board's insistence on building near the unprocessed waste of Love Canal, we ignore the warnings, we minimize the potential harm, we blindly move forward thinking, "How bad could the damage be?" Our nation's overwhelmed and costly health care system is the answer to that question.

The yoga teacher wife of a couple I worked with returned from a blissful weekend retreat and within twenty minutes was enraged at her husband. She may have known how to find peace and a secure connection when alone with Life and the present moment, but she had no emotional skills to create such a bond with her life mate. What is not commonly known or appreciated is that, most of us are disconnected in our most important relationships, that is, with our own and our loved ones' hearts. This is of no small consequence. All that has mattered most to us in life is stored in our hearts and yet most of us don't have the safety, willingness or know-how to discover, manage and share what is there with the person we depend on at home. As a result, we are family and at the same time we are strangers with those who matter the most. How can we hope to know and guide our children when we ourselves are disconnected and lost?

Our hearts have so much to teach us, but without a safe holding environment - someone who can cradle and have compassion for both individuals' experiences - we are destined to reenact suffering in our homes and world. What is hidden harms. What is mindfully and carefully released is transformed. It feels so counterintuitive and dangerous, though, to move towards our pain and to validate the person who has hurt us. But it seems to be a universal law that the last thing we want to do is the only key that unlocks our shared prison. When our two heart stories are fully felt, owned and joined together, only then do they create the whole emotional truth which sets us free.

How wonderful it is then, and what promise lies ahead, now that therapeutic approaches are evolving to provide the heartfelt sensitivity, empathy and validation to coax the wise and loving but vulnerable heart-bird out of its protective thicket. Couples and family therapy that focuses on the heart helps us safely explore and share a secret garden within that we and our family members never knew was there: a place of wounds, losses, longings and love. By connecting with the deeper, tender emotions that our relationships provoke, we bring into focus the unity underlying and embracing our differences.

What is hidden harms. What is mindfully and carefully released is transformed.

Photographs taken by the author.

Treating the Relational Roots of Depression

By Tracey A. Laszloffy, Ph.D., LMFT

These days, it is impossible to watch TV or open a magazine and not see advertisements for anti-depressant medications. The upside of these ads is that they increase public awareness that depression is a common problem. It normalizes depression and makes it easier to talk about it openly. The downside is that these ads imply that the dominant cause of depression is biological, thereby leading to the conclusion that the solution (or cure) is medication. Because we live in a quick fix, instant gratification culture, the prevalence of prescriptions to treat depression is hardly surprising. However, it fails to contend with the reality that problems like depression often are rooted in conditions that extend beyond biology. Certainly there are cases where depression is a symptom of an underlying physiological disorder, but more often than not, it is a symptom of deeper difficulties that reflect the suffering that is created by strained relationships.

As MFTs, we understand that when the quality of our relationships suffers, we suffer (and depression is one symptom of that suffering). Just like a slice of cheesecake or a glass of wine can help us feel a little better for a moment, medication can help to ease the symptoms of this suffering. It can create a sense of "feeling better" in the moment, but this is just symptom relief; it is not a cure for what really hurts. Consequently, a comprehensive approach to treating depression must involve focusing on and helping to heal strained relationships.

Strained Relationships with Other People

When a relationship with a partner, parent, child, friend, or co-worker is strained, the stress that this produces can easily induce depression. A variety of factors can strain a person's relationships with others. These include unresolved conflicts, not feeling loved, valued, or respected by an emotionally significant person, having one's trust betrayed, being subjected to emotional, physical and/or sexual abuse, or being close to someone whose moods and behaviors are distorted by an addiction. Whatever the particular issues may be, it is important to recognize that if a relationship with someone that matters to us is strained, the resulting tension and hurt can be a primary root of depression.

Strained Relationship with the Social Context

Sometimes our relationship with the broader social context is strained by virtue of having membership in groups that are marginalized and oppressed. On the basis of gender, race, social class, sexual identity, religious affiliation, primary language, and/or mental or physical ability, people may encounter discrimination and devaluation that strains their relationship with the surrounding environment and society at large, thereby contributing to depression. For example, the relationship between poor people and their surrounding environment is strained by having to live in substandard housing within blighted neighborhoods and having to attend substandard schools and healthcare facilities. Moreover, because we live in a society that worships economic power and stature, the stigma and shame associated with poverty results in high doses of class devaluation and discrimination that further injures the relationship between poor people and society at large. Similarly, the relationship between women and minorities and the broader social context is strained by exposure to gender and racial devaluation and discrimination, which can induce depression. This reflected in the fact that women experience twice the rate of depression as men, regardless of race or ethnic background, while African Americans and Hispanics exhibit elevated levels of major depression in comparison to their white counterparts (Dunlop, Song, Lyons, Manheim and Chang, 2003).

Strained Relationship with Oneself

The most important relationship in each of our lives is our relationship with our selves. Those who struggle to feel self-love and self-valuation have a strained relationship with their self that can be a primary trigger for depression. Often times a strained relationship with the self is tied to tension in a person's relationship with others and/or with the social context. Strained relationships with people who are important to us can trigger a cascade of doubts about our self-worth, value, and lovability. Similarly, those who are subjected to devaluing and denigrating experiences based on factors such as race, class, gender, or sexual identity are at risk for internalizing this negativity. This can compromise the quality of a relationship one has with one's self, forming a fast track to depression.

Often times a vicious cycle develops between a strained relationship with one's self and engaging in self-destructive behaviors such as substance abuse, unloving sex, over- or under-eating, and/or aggressive or neglectful parenting. These kinds of harmful behaviors are both a reaction to not loving or valuing one's self. These behaviors may also produce shame and self-hatred that end up further injuring the quality of the relationship a person has with his or herself, and may increase the likelihood of depression.

Clinical Implications

Unless the primary root of an individual's depression is a biological disorder, then it is relational, and the solution must focus on healing strained relationships. This is why MFTs, as systemically trained, relationally based clinicians are especially well-positioned to work with clients who present

Measuring Healthy Relationships

By William Boylin, LMFT

Marriage and family therapists are frequently asked the question whether or not a relationship is a healthy one. Our clients want our opinion on whether their partner is good for them, whether they are soul-mates, and whether we can predict a long, healthy relationship. Obviously, therapists are not in the position to make such statements. Also, therapists are not immune to wondering if their own partner is good for them. How can we determine whether a current relationship is healthy? There is a viable way to assess a relationship to determine whether it is in fact healthy.

What seems insignificant in this problem is the concept of love. There are many people in life that one can love. Loving others is very easy to do. However, loving someone else seems almost inconsequential when it comes to whether the relationship is healthy. We fall in love for numerous reasons that have nothing to do with compatibility. People fall in love because of chemistry, because they are opposites of who we are, or even because they resemble a parent. Probably everyone has had the experience of loving someone who was unquestionably bad for them.

Usually when you ask how come someone is with their partner, most will answer because they love them. In substance abuse treatment, when counselors ask partners how come they are together, clients are first cautioned that they are not allowed to refer to love when answering the question. This often results in partners having difficulty answering the question. It is easy to say that you are with someone because you love them, but if you were to lay that aside, would you be able to give coherent reasons for being with your partner?

When I was a young man, my insecurity had a huge effect on my relationships. I was always afraid that my girlfriends would meet someone 'better' than I was. I was afraid they would meet someone who was better looking, more athletic, richer, cooler, smarter, or drove a better car. The result was that I would hold on to these relationships with a death grip, to keep from losing them. As you can imagine, no matter how much a girl likes you, if you hold on that tight, they will eventually run away, usually kicking and screaming.

Then, when I became engaged to my wife, I remember Carl Whitaker telling me, "you shouldn't get married, unless you can handle being all alone." He knew that marriages fail if you hold on to your partner too tight. This gave me a clue as to how to recognize a healthy versus an unhealthy relationship.

In a healthy relationship, your world grows. You are involved with your family and friends. You are involved in activities you enjoy, sometimes with your partner, sometimes alone. When you are in an unhealthy relationship, your world gets smaller. Your partner discourages you from seeing your family. They don't like your friends. They complain when you stay at work late. They may check your cell phone to see who you are calling. They may monitor your Facebook or Twitter accounts. They are constantly giving you feedback that you need to spend your time with them exclusively.

The next time your clients question whether their current relationship is a positive one for them, ask them if their world is growing or getting smaller. They will know right away whether they are in a healthy relationship or not.

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with non-biologically-based depression. While a range of MFT theoretical orientations and techniques can be utilized to promote relationship healing, there are several points that therapists should bear in mind when working with depressed clients.

1) Assessment. It is important to begin by assessing how a client's relationships with other people, the broader social context, and with his or herself have been strained. Therapists need to identify the specific issues that are the basis for whatever relationship strains may exist.

2) Discernment. Once the issues associated with a client's strained relationships have been identified, the next step is to discern the extent in which healing these relationship strains is possible. For example, a client who harbors some hurt with regard to a parent who was abusive when he was growing up may wish to heal that relationship as an adult. However, the opportunity to do so depends on the extent to which that parent is open to and interested in healing the relationship. If that parent desires a better adult child-parent relationship, a therapist can facilitate a process that includes addressing past wrongs and building a new connection based on mutual respect, honesty, and caring. However, if the parent manifests little or no interest in improving the relationship with the adult child, then the opportunity to promote relationship healing is obfuscated. In such cases, it is important for therapists to help clients accept and make peace with these limitations as a step toward healing themselves. When relationship repair is unlikely, the healing resides primarily in helping the client to forgive the other person and to make peace with choosing to accept the limits of what is possible.

3) Counteracting Devaluation and Promoting Radical Self-Love. Often, depressed clients have had experiences with devaluation. This occurs when one's dignity has been assaulted and defiled (Hardy and Laszloffy, 2005). Those who have been devalued struggle with not feeling good enough and with doubting their value and worth. Counteracting devaluation involves working with clients to take a stand of resistance against the demeaning

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MARWORTH

Upcoming Legislative Efforts

By Denise Parent, LMFT, CTAMFT President-Elect

CTAMFT has had several legislative goals over the past few years that will be receiving attention in the coming months.

MFT in the Schools

CTAMFT saw a fifteen year legislative effort realized last year as CT became the first state to certify School Marriage and Family Therapists. School MFTs provide services to families, parents and guardians in order to support the academic or behavioral functioning of a student and must meet a rigorous level of preparation including being licensed, as well as completing additional coursework in special education, child development, learning theories, and a 300 hour school-supervised practicum.

In spite of this advancement for MFTs, the legislation remains stalled at the implementation phase as the Department of Education struggles with logistical concerns about how MFTs fit into school organizational charts and budgets, which has dramatic implications for the careers of approximately 30 newly trained school MFTs. Specifically, concerns have been raised about whether it is possible to hire MFTs in addition to social workers, guidance counselors and school psychologists, or if individual schools or Superintendents can choose to hire an MFT in place of a school social worker.

CTAMFT will be convening meetings about furthering the employment vision and implementation of school MFT both on a practical and legislative level. If you are a clinical member who has created a successful relationship as a school provider, within a school system, or on a contractual basis through an agency, youth service bureau or private practice, please let us know your story and/or availability for contact by emailing manager@ctamft.org.

LMFTA

In 2009 the CTAMFT Board voted to initiate a bill to make a license available for Masters level graduates who are completing their 1000 post Graduate hours under supervision in their "Associate" or 'Pre-Clinicall Fellow" period. New graduates applying for this license would continue to be required to pass the National licensing exam and maintain adequate supervision. The "Associate License" or "LMFTA" license would increase marketability for graduates in agency settings, and open a shorter time line to be eligible for insurance panels when insurers require a waiting period post-license. The license would also allow for better regulation of practice by the Department of Health during the period between graduation and independent MFT practice.

This bill has been drafted based on a combination of the current LMFT statute and a bill that was passed for Social Workers for the same purpose. The bill has been stalemated, as has the Social Worker's implementation of their Associate license, due to the State budget cuts, the change in Governors and the fact that implementation of any new procedure has administrative costs attached. CTAMFT and their lobbying firm, Murtha Cullina, chose to wait on this initiative in 2011 after asking Health and Human Services Committee Co-Chair, Representative Ritter to introduce the bill. Given the budget climate and the short legislative session last year, this year was chosen to move forward in the new session. CTAMFT will need members support and advocacy as a bill is introduced. Legislative Liaison Susan Boritz is in the process of convening members across the state to be available to send emails, make calls or talk with key legislators as needed as this legislation travels through the House and Senate. If you haven't already let Susan know your are willing to help, email her at sboritz@aol.com.

How the Health Reform Law (Affordable Care Act, ACA) Will Affect MFTs in Private Practice

By Brian Rasmussen, PhD

Government Affairs Manager, American Association for Marriage and Family Therapy

How the Health Reform law will affect private MFTs is complex. I will confine this overview to the changes regarding Exchange plans and Medicaid.

Exchange plans (either State-based or under a federal fallback system, which would apply if a state declines to establish a state-based exchange; states' deadline for federal notification is 11/16/12) are expected to cover about 14 million now-uninsured persons in families with incomes between 133% and 400% of the Federal Poverty Level starting 1/1/14, which such persons receiving sliding-scale federal financial subsidies to enroll in one of these plans. Also at that time, states optionally may expand Medicaid from the state's current eligibility standards to all uninsured persons at less than 133% of the Federal Poverty Level (CT likely will expand).

The ACA provides that Exchange plans must cover 10 categories of services, including mental-health and substance-use services, and that those services must be covered at a "parity" level (as defined by the federal Wellstone/Domenici MH/SA Parity Act) with physical health benefits. In other words, if a specific Exchange Plan requires a 20% client copayment for an outpatient mental health visit, the plan cannot have a lower percentage copayment for a physical health visit.

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Principles of Working with High Conflict Divorce Couples

By Scott Huff, M.A.

For most MFTs, couples therapy carries the assumption that the couple has some interest in repairing their relationship. When the couple is already divorced and is experiencing high conflict, couples therapists may find themselves in an unfamiliar territory. This article, based on my experience and research as a high conflict divorce (HCD) therapist, lays out several principles that I have found important when working with HCD cases.

Principle 1: *Supportive co-parenting will produce the best outcomes for children.*

Research suggests that parental divorce, by itself, is not as detrimental to children as many people assume. Most children are resilient following a divorce. However, research makes it clear that exposure to parental conflict following a divorce increases the likelihood of psychological, academic, and social problems. At a minimum, HCD therapy should focus on developing skills to prevent overt conflict and triangulating the child. Better outcomes, however, will be achieved if parents come to recognize and support the other parent's role as a co-parent.

Principle 2: *Every parent has a right to be a parent.*

In HCD cases, clients will often make the case that the other parent should have little or no contact with the child(ren). As a therapist, you should remain committed to having each parent involved in the life of their child. This does not mean that visitation should always be split 50/50 or that joint custody is always best. What it means is that every parent should be able to have a personal relationship with his/her child, even if it is only under supervision due to a history of abuse or neglect. Similarly, if one parent has dominant decision making rights (due to court order or family tradition), that parent should seek and consider the other parent's input and keep him/her informed of important information.

Principle 3: *It is typically best to change behaviors and cognitions in service of changing emotions.*

My clients often ask me how they can compromise with their ex-spouse when they are still so distrustful and angry towards him/her. I explain that I see a loop between behaviors/cognitions and emotions. A client's hurt feelings feed his negative behavior which leads to a poor interaction and creates more hurt feelings. I have found the most success by focusing first on breaking the loop through improving communication behaviors and challenging negative assumptions. This involves enactments, skill-building (e.g. active listening), and process discussions. As behavior (overt hostility) improves, emotional healing and a reduction in covert hostility typically follow.

Principle 4: *Therapists must maintain well-controlled boundaries with clients and court professionals to maintain their effectiveness.*

In HCD cases, boundary maintenance is particularly important because the likelihood of triangulation is significant. A client may hang around after a session to speak with you individually so that she can tell you the "real story" about her ex-spouse. A client may threaten to stop coming to therapy if you do not change how you are working. A court professional doing a custody evaluation for your clients may ask your opinion about who is a better parent. In all cases, therapists must remain firmly committed to maintaining their professional boundaries with their clients and avoiding triangulation. It is typically enough to firmly tell clients and other professionals that doing what they are requesting is against clinic policy, violates the code of ethics, is not possible (e.g. knowing your clients' parenting skills), or is simply not the way you do things.

Principle 5: *Therapists must carefully manage the therapeutic alliance.*

Several important considerations go into the therapeutic alliance when working with HCD. Clients are often mandated by court and skeptical of therapy and the therapist. They may also treat the alliance as a zero-sum game, such that improving your alliance with one partner may come at the detriment of your alliance with the other. A balance must be struck between empathizing with each client's experience of the relationship and taking care to not agree with blaming statements. As clients share their stories, therapists should verbalize understanding of what clients are saying and validate the feelings they are experiencing, but must stay aware of the entire system.

Principle 6: *Therapists must remain skeptical of client reports.*

It should not be assumed that that client reports accurately reflect reality. This applies for behaviors (e.g. remembering the events of a conflict), cognitions (e.g. explaining one's motivation for getting a divorce), and affect (e.g. reporting their current mood). In all of these cases, there is a high likelihood that the client, either due to a lack of awareness or an intention to deceive, is not accurately reporting their position. This will most starkly be demonstrated when two clients disagree about the basic facts of an interaction. Rather than focusing on what clients are talking about, therapists should focus on how they are talking. The goal of therapy is not to find the truth, but to help clients talk about problems in a way that is mutually acceptable and leads to positive action.

An implication of this principle is that separating clients for individual information gathering sessions is unlikely to be fruitful. Doing so also presents possible problems with boundaries and alliances. This does not preclude separating clients to assess for violence or to introduce interventions that would be less effective if presented to both clients.

Principle 7: *Therapists must carefully monitor their own reactions*

It is critically important as a therapist to continually monitor your own reactions to the clients. If a therapist is emotionally reactive or favors one client's story over another, adaptations probably need to be made. Supervision is likely the best place to explore such difficulties.

The Importance of Developing Empathy Between Parents and Teens in Relational Therapy

By Anne Thompson, M.A.

Adolescence is a developmental period marked by transition and change. During adolescence a young person is striving to achieve autonomy, independence, and a greater sense of self. To parents, this process may feel like a loss. The unfamiliar new relationship with their teen is, perhaps, uncomfortable. Struggles emerge when parents attempt to maintain the same level of influence, involvement and control they had when their children were younger. Failure to adapt to changing developmental needs may inhibit growth, development, and differentiation of self for the adolescent, creating a power struggle that can last for quite some time. Empathy and psychoeducation may help to improve the quality of life for both teens and parents. MFTs are in a position to educate families on adolescent development and encourage active listening within the family. They can support parents need to maintain parental "control" while affirming and normalizing the distress an adolescent may feel about wanting to make their own decisions, perhaps while experiencing a pull to remain a "child." Empathy and mutual understanding promotes a less abrasive, less conflictual and healthier transition for the entire family.

Often apparent to parents and clinicians is the behavioral change that happens as young people push for individuation and self-reliance. What is often seen in this transition is adolescence appearing more defiant and resistant to suggestions or parental input. Brain development is the unseen vehicle responsible for many of these changes that families may not recognize. An adolescent has many regions of the brain reaching maturation at different times. Most notably, the prefrontal cortex, the "brakes" of the brain, associated with good judgment and impulse control is not fully developed until the mid-twenties, while other areas of the brain, such as the amygdala, serve as the "gas," and are responsible for risk taking and thrill seeking develop much earlier (Walsh & Bennett, 2004). This biological design helps teens to develop independence and autonomy but also creates vulnerability and increases risk taking that may necessarily prompt parents to step in, asserting more control. Parental control, monitoring, and supervision serve as protective factors in helping teens to avoid risky behaviors such as substance use (Bahr, Hoffmann, & Yang, 2005). The parent, in many scenarios, needs to provide the "good judgment" and decision making their child may have not yet developed ability to do on their own. One way to think of parental monitoring is to think of the parents serving as their child's frontal cortex or their "brakes" while it develops.

Developing empathy, understanding and awareness can help families achieve balance in their relationships. Parents who are too "in control" may not provide their adolescent room to explore, make mistakes, and learn to trust themselves and their own abilities. Not feeling understood, as well as feeling treated like a child can create low self-esteem in teens or create family conflict, among other outcomes. Parental anxieties and fears often dictate the level of involvement and how hands-on they are with their teens, sometimes "hovering" like helicopters over all of their child's activities as they may have when a child was younger. For some adolescents, high levels of parental involvement are welcomed but also become stressful when they are fighting for autonomy and are afraid to "let go" of parental guidance. There needs to be a balance in the relationship between letting adolescents gain new experiences while providing enough structure and support to help them to stay safe. Teaching families techniques such as active listening, facilitating and slowing down communication while working on mutual acceptance and boundaries is useful, as is enhancing mutual understanding of values and context, which can help with this challenging tightrope walk. Facilitating discussions around family expectations, roles, responsibilities, and needs serve as clarifying topics that can build empathy.

Working directly with parents to help them learn to "pick their battles," and help them to determine what experiences they will let their child manage on their own can help them to stay connected and "stretch" their authority to give room to the child for growth. Working to help adolescents learn how to express themselves in healthy and appropriate ways while negotiating for freedom with parents is also beneficial. Utilizing these techniques will promote empathy building and enhance psycho-education that provides a platform for developmentally appropriate and sensitive interactions between parents and adolescents.

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Inviting Culture Into the Classroom

By M. Selenga Gürmen, M.A. and Cameron Kiely Froude, M.A.

The American Association for Marriage and Family Therapy recognizes the importance of therapists providing culturally sensitive clinical treatment to diverse populations. Therapists must be well versed in recognizing contextual factors and inquiring about their impact. In fact, a competent therapist: "recognize[s] contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, and social context)" and provides "culturally sensitive approaches" (American Association for Marriage and Family Therapy, 2004).

Family therapy theories and approaches operate from a dominant culture perspective (Esmiol, Knudson, Martin, & Delgado, 2011). These perspectives guide the training of MFTs, and, by extension, influence how students learn to practice therapy. Recently, there has been an influx of culturally sensitive training models. However, research is lacking on the process by which students learn to attend to contextual issues (Nixon, et al., 2010).

The clinical training environment is a space where students can learn how to navigate issues around culture, race, power, ethnicity, and sexuality. Students can extend this knowledge to clinical work with families. Attending to power, privilege and social position in the context of the clients' worldview is critical to the therapy process (Winslade, 2009). Training from a culturally sensitive lens is one approach to providing students with the opportunity to explore critical cultural issues and power relationships.

Derald Wing Sue and David Sue (2013), authors of the textbook, Counseling the Culturally Diverse: Theory and Practice, propose the importance of students obtaining knowledge, skills, and awareness in their journey to becoming culturally competent. These three interrelated parts of the learning process include: (1) awareness of one's own assumptions, values, and biases, (2) understanding the worldview of culturally diverse clients, and (3) developing appropriate intervention strategies and techniques (p. 48-49). Traditionally, students passively learn information about underrepresented cultures by reading and memorizing, which they then utilize to answer factual questions on a test or in class. This approach is attending to the knowledge domain of learning. The domains of awareness and skills are lacking when training operates solely from a didactic framework.

Esmiol, Knudson-Martin, and Delgado (2011) discuss several conditions that facilitate students' development of a contextual consciousness. These include: "attention to power and privilege, integration of knowledge and experience, opportunities for self-reflection, and the role of teachers and supervisors" (p. 2). When the training environment meets these conditions, students are encouraged to examine the implications of their assumptions, privileges, and worldview. A compelling question, then, is how an educator can create these conditions and maintain them across time.

Current perspectives on culturally sensitive training suggest inclusion of experiential exercises into didactic training. Integrated learning approaches provide students with an opportunity to engage in a reflexive learning process. The classroom becomes a mirror by which students can examine the implications of their worldview, values, and assumptions in their relationships with others.

Understanding foundational theories and concepts of MFT is one of the core competencies as outlined by AAMFT (2004). Introducing models and theories can occur at the intersection of didactic and experiential learning. Learning about MFT theories is a useful point of departure from which to discuss implicit assumptions and values that students may hold. As with any model or theory, each MFT model has a set of assumptions that shape its perspective on a variety of issues that range from the definition of health and dysfunction to the way that families develop.

Students may be unconsciously drawn to the assumptions of one or more of the models over others. They may inherently privilege certain values. These unconscious assumptions may not yet be visible to the student. An important aspect of creating a culturally sensitive learning environment is to facilitate exercises that make visible students' invisible assumptions. One possible assessment tool for uncovering students assumptions about MFT models is the assumptions audit inventory (Rigazio-DiGilio, 2005).

The inventory includes a randomized list of the assumptions that are foundational to specific MFT models and approaches across therapy traditions. Students are instructed to rate assumptions on three criteria: (1) assumptions that they are immediately drawn to, (2) assumptions that they are not sure about, and (3) assumptions that they are definitely not drawn to. The results of the assessment illustrate students' implicit assumptions about the family therapy theories. This exercise provides a baseline of where students stand prior to their training.

Class time may be used to engage students in conversation about their assumptions. Students are encouraged to discuss the personal influences that shape their worldview and connect to the assumptions on the audit. Engaging in these conversations allow students to increase their awareness of their assumptions, values, and biases. Students' analysis of their assumptions creates space between the student and her values. When there is space between the student and his values, the student may choose the value he wishes to hold most salient at

a particular moment. Instead of students operating from their biases and assumptions, there is space for students to operate from a place of intentionality.

The assumptions audit inventory facilitates student learning in several ways. Students learn several pieces of knowledge including but not limited to: the frameworks, assumptions, and interventions of each model. They also learn that assumptions exist for themselves and their classmates. Students develop the skills to identify the implicit and explicit assumptions of each model and their personal worldview. Lastly, students gain awareness of some of their personal blind spots and how those blind spots influence their choices.

The described assessment is only one small part of students' training process that will prepare them to provide culturally competent clinical care. When students engage in an MFT curriculum that adheres to a culturally conscious approach, they are acquiring important skills that translate into clinical practice with underrepresented populations. Students may take the skills that they have learned in contextually conscious training and translate it into their work with culturally diverse families.

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CALL FOR POSTER PROPOSALS

2013 ANNUAL CONFERENCE

April 25-26, 2013

Mystic Marriott, Mystic, CT

Submission Deadline: January 15, 2013

The Poster Session Committee invites the submission of proposals for poster presentations during the 2013 CTAMFT Annual Conference. Posters will be prominently displayed during the Annual Conference. In addition, presenters will be asked to stand by their poster during the poster session to respond to comments and questions posed by conference attendees. A poster may be about research findings, clinical interventions, or any topic of interest to marriage and family therapists. Posters can include text, charts, tables, or other graphic representations suitable for conveying the message. We encourage posters that are creative and that address current issues in the field of family therapy. While the Poster Session is used to enhance the scope of information offered by the conference, posters that include work with children or families are encouraged. Anyone who plans to attend the CTAMFT Annual Conference is welcome to submit a poster as a way to enhance the conference experience. Teams of researchers or clinicians may submit posters if at least one member of the team will be present at the Annual Conference. Posters will be selected based upon the quality and relevance of the proposed presentation, with preference given first to CTAMFT members, next to individuals and organizations in Connecticut, and finally to out-of-state presenters. Accepted presenters will be notified by February 15, 2013 and must confirm their attendance by March 1, 2013. A complete Call for Posters Proposals can be found on CTAMFT.org. More information is also available by contacting:

Dr. Rachel Tambling, Poster Committee Chair
CTAMFTPosters@gmail.com

Social Media | Continued from page 5

and the most prolific way that clients search for assistance when they are in need. Having a secure website, email program, and a few ancillary social media platforms can be implemented easily, and can deliver both you and your clients great results. Like we recommend to our clients, let's lean into the discomfort and commit one hour per week to embracing and managing the tools that can help us all help more people more effectively. As I said in the workshop, if you have time to watch American Idol, you have time for this.

I recommend to those of you who enjoy learning on your own to review the following resources and explore the details behind the technology. It's dry stuff. Personally, I think that I am a much more entertaining presenter, but it's all there for the learning. Before diving into any one medium too far, read about each platform and see where you think you are comfortable biting off a small bite and slowly, see how it goes.

Katherine Allen, MA, LMFT is a Clinical Fellow of AAMFT, a Clinical Member of CTAMFT, and currently holds a position as a Director on the Board of CTAMFT. Katherine is also available to provide consultation for a nominal charge at your location for a private learning session on how to stay smart and safe. You can find Katherine at http://www.mft3.com.

A "Social Media" Webinar is in development along with other offerings from the Professional Development Committee. Keep updated by visiting CTAMFT.ORG

WEBSITES

- http://www.zurinstitute.com/socialnetworking.html
- http://en.wikipedia.org/wiki/Web_hosting_service
- http://en.wikipedia.org/wiki/Internet_Service_Provider
- http://en.wikipedia.org/wiki/Domain_name
- http://en.wikipedia.org/wiki/Domain_name_registrar
- http://en.wikipedia.org/wiki/Webmail
- http://www.splatf.com/2011/10/google-revenue/
- http://support.google.com/mail/bin/answer.py?hl=en&answer=1304609
- http://sethgodin.typepad.com/ (Seth Godin's blog)
- http://learn.linkedin.com/what-is-linkedin/
- http://allfacebook.com/

Health Reform | Continued from page 11

Per ruling of the federal Department of Health and Human Services (HHS), within this specified framework, each state will determine specific coverages for its Exchange Plans, using any one of four benchmarks such as the state's current highest-enrollment private small-group plan. (AAMFT instead urged uniform national standards.)

Exchange-eligible persons will choose from plans at four increasingly-comprehensive levels: Bronze, Silver, Gold and Platinum. Multiple payers will offer plans in each of these categories, but a specific payer might not offer products at all four levels. "Comprehensive" refers to factors such as client copays e.g. a Bronze plan may require a 30% copay and a Platinum plan only a 10% copay.

The law does not require Exchange Plans, which are nearly all expected to be offered under managed-care arrangements, to contract with any specific class of practitioner (e.g. MFTs) or to have an Any Willing Provider requirement (i.e. NO "any willing provider" rule that if MFT "X" is willing to accept Exchange Plan pay rates for MH/SA offered to other practitioners by e.g. CT Blue Cross Exchange Plans, that Blue Cross is compelled to accept that particular MFT, or any MFTs for that matter, as long as the Blue Cross has "sufficient" access to other types of MH/SA practitioners). This situation also applies to all other types of MH/SA practitioners, i.e. Plans have no compulsion to accept all or any Psychologists, CSWs, etc.

The one exception to this rule concerns Exchange Plans in states that now have certain "mandated benefits" such as an "any willing provider" mandate, AND where the state decides to apply any of those rules to its Exchange Plans, IF the state chooses to bear the entire added cost of the mandate(s). In other words, assume CT has an "any willing provider" mandate. If actuarial analysis estimates that applying this mandate would cost $11.57 per member (Exchange enrollee) per year, then the state would be required to pay all of that $11.57 annually for each Exchange enrollee. (All uninsured persons with Adjusted Gross Incomes between 133% and 400% of the Federal Poverty Level will be eligible for federal Exchange subsidies = ~15 million persons nationwide). So as a practical matter, it is very unlikely (though possible) that any state would choose to apply most or all of its benefit mandates to Exchange Plans.

A further issue arises in states such as CT, as clients often reside, work, and receive treatment in different jurisdictions. This is not different in concept than current employer-based health plans, but as Exchange enrollees will not have employer-based coverage, they will enroll in plans in their state of residence, which will not necessarily be where they choose to receive care. In the case of CT, some NY, RI, and MA Exchange-plan residents may wish CT MFT services, so CT MFTs (esp. near state borders) may wish to consider participating in those states' exchanges as well as CT Exchange Plan(s), and there will be somewhat varying rules between those jurisdictions.

There is no change from prior law regarding eligibility of MFTs for either Medicaid (i.e. private-practice MFT eligibility is still at state option) or Medicare (private-practice MFTs are still ineligible for Medicare Part B).

Relational Roots | Continued from page 9

messages they have internalized about their identity and worth. It also involves embracing radical self-love as an alternative position whereby a person chooses to intensely and persistently love the self and affirm ones innate value and worth. This process is especially important for those who have been subjected to a systematic devaluation (e.g., battered women, anyone with membership in a socially marginalized group, a person who was abused as a child).

4) Re-Channeling Rage. With regard to strained relationships, depression is rage that has been turned inwardly toward the self. Rage is a natural and healthy response to pain and injustice (Hardy and Laszloffy, 2005). While our society tends to be fearful of rage, this emotion can be used as an agent for growth and positive change. Therefore, identifying rage and helping to draw it out is essential.

The rage that underpins depression is tied to experiences with indignity and injustice and, as a result, the healing process must include: a) acknowledging the relational wounding and injustices that occurred; b) validating that it is reasonable to feel rage; c) fostering a space where rage can be safely vented and expressed; and d) helping clients to re-channel rage by taking concrete actions that serve as form of resistance to the conditions or situation associated with the wounding and injustices they have suffered.

5) Reclaiming Voice. Depressed individuals tend to have lost or relinquished their voice (which is their ability to express their thoughts, feelings and needs, and to be direct and assertive). Because depression involves a caving into oneself that is reflected in a loss of voice, the reclaiming of one's voice and speaking out is essential.

In Conclusion Unless depression is a symptom of a biological disorder, the primary treatment approach must consist of healing strained relationships that clients have with other people who are important to them, with the surrounding environment, and/ or with themselves. While MFTs can employ a variety of relationship healing theories and techniques, there are several key treatment points that therapists should bear in mind when working with depressed clients.

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Continuing Education Opportunities

An Instruction to Mindfulness Meditation
Date: November 2, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Treating Couples
Date: November 2 & 3, 2012
Location: Boston Park Plaza Hotel - Boston, MA
Sponsor: CHAPO-CME - Cambridge, MA
Contact: Judy Reiner Platt, Ed.D.
Phone: 617-503-8445
Email: cme@challiance.org
Approved for 14 CEU Credits

Accelerated Resolution Therapy (ART) Training
Dates: November 3 & 4, 2012
Location: Westfarms Community Room - Farmington, CT
Sponsor: Rosenzweig Center for Rapid Recovery
Contact: Laney Rosenzweig
Phone: 203-233-2523
Approved for 12 CEU Credits

Pieces of the Puzzle: Values, Boundaries, Burnout and Ethics
Date: November 5 & 12, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 12 CEU Credits

Helping Men Recover: A Trauma-Informed Approach
Date: November 7 & 8, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 12 CEU Credits

Biology of Addiction II
Date: November 14, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Bipolar Disorder: From Diagnosis, through Treatment and Into Recovery
Date: November 14, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Assessment of Acute Risk: Interviewing Skills for Clinicians, Case Managers and Helpers
Date: November 16, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Autism Spectrum Disorder
Date: November 16 & 17, 2012
Location: Boston Park Plaza Hotel - Boston, MA
Sponsor: CHAPO-CME - Cambridge, MA
Contact: Judy Reiner Platt, Ed.D.
Phone: 617-503-8445
Email: cme@challiance.org
Approved for 14 CEU Credits

Seeking Safety
Date: November 26 & 27, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 12 CEU Credits

Eating Disorders
Date: December 7 & 8, 2012
Location: Boston Park Plaza Hotel - Boston, MA
Sponsor: CHAPO-CME - Cambridge, MA
Contact: Judy Reiner Platt, Ed.D.
Phone: 617-503-8445
Email: cme@challiance.org
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Trauma Recovery and Empowerment Model (TREM)
Date: December 10-11, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
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Advanced Recovery and Empowerment Model (Adv. TREM)
Date: December 12, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Trauma Recovery and Empowerment Model (TREM)
Date: December 13, 2012
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Introduction to Dialectical Behavior Therapy
Date: January 9, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
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A Trauma-Informed and Gender Responsive Approach to Human Services: Changes in Understanding and Changes in Practice
Date: January 17 & 18, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32

Email: canderson@womensconsortium.org
Approved for 12 CEU Credits

The Perfect Storm: Gender, Culture and Eating Disorders

Date: February 22, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
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Using EMDR Therapy; the Adult Attachment Interview (AAI) and Attachment Theory with Parents

Date: March 2013 - TBD
Location: UCONN Stamford
Sponsor: Karen Alter-Reid, Ph.D. & Robin Gibbs, Ph.D.
Contact: Robin Gibbs
Phone: 914-686-9361
Email: robinegibbs@gmail.com
Approved for 12 CEU Credits

End of Life Issues

Date: April 12, 2013
Location: Hamden, CT
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Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Biology of Addiction, a Continued Conversation: Inhalants, Steroids, Marijuana and Designer Drugs

Date: April 10, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Healing Through Family Therapy – CTAMFT Annual Conference & Meeting

Date: April 25-26, 2013
Location: Mystic Marriott, Groton, CT
Sponsor: CTAMFT
Contact: Wendy Haggerty
Phone: 203-254-1748
Email: manager@ctamft.org
Approved for up to 9 CEU Credits

Men's Trauma Recovery and Empowerment Model (M-TREM)

Date: April 25-26, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 12 CEU Credits

Sexuality... A Common Trigger for Women's Relapse: A Sexual Health Approach to Working with Women with Histories of Trauma

Date: May 16, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

Sexual Health Recovery for Women with Trauma Histories: A Psycho-Educational and Holistic Approach

Date: May 17, 2013
Location: Hamden, CT
Sponsor: CT Women's Consortium
Contact: Colette Anderson, LCSW
Phone: 203-909-6888 ext 32
Email: canderson@womensconsortium.org
Approved for 6 CEU Credits

CT TF-CBT Learning Collaborative Training Dated: Various from November 2012 to November 2013

Location: CCSU – ITBD, New Britain, CT
Sponsor: Child Health & Develop. Institute of CT
Contact: Lori Schon
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in collaboration with

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Annual Conference and Meeting
Thursday, April 25 – Friday, April 26, 2013

Mystic Marriott Hotel and Spa • Groton, CT

HEALING THROUGH FAMILY THERAPY