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Couples Therapy

GUEST EDITOR **Scott Wolfe, Ph.D.**

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FEATURED ARTICLES

ASSOCIATION NEWS

COLUMNS

About the Maryland Psychologist
The Maryland Psychologist is published four times a year by the Maryland Psychological Association. Deadlines for article submissions are as follows: December 1 (Winter), March 1 (Spring), June 1 (Summer), September 1 (Fall). Letters, opinions and articles are welcomed. Please keep letters to 250 words maximum. We regret that we cannot publish or respond to all letters. Those selected will be subject to editing for length and clarity and for balance of views on the issue. Feature articles, brief research papers, or case studies should be limited to four pages double-spaced. Authors are responsible for their reports being in accord with APA guidelines regarding use of research participants, confidentiality of clients, written presentation, and similar issues. Send all material to *The Maryland Psychologist*, 10025 Governor Warfield Pkwy, #102, Columbia, MD 21044 or pr@marylandpsychology.org. Questions? Call Megan Smith at the MPA Office 410-992-4258 or 301-596-3999 or e-mail members@marylandpsychology.org.

NOTE: Names in bold within articles denote an MPA member. The opinions stated herein do not necessarily reflect the position of the MPA Board of Directors. Letters to the Editor and letters from the Editor do not necessarily reflect the views of the Maryland Psychological Association. Institutional/ Corporate subscriptions to The Maryland Psychologist are available for $100 per year.

President's Message

R. Patrick Savage, Jr., Ph.D.

Dear Fellow MPA Members,

Continuing with the theme of my last column, MPA is experiencing a period of seismic change and abundant opportunity. By now you are likely to be aware that the heart of our organization, Executive Director Judy DeVito, will be leaving us next year. She has been the heart and driving force of MPA for the past 10 or so years. If you follow the list serve, you know that Judy was honored by her colleagues at APA's annual Leadership Conference. She received the **2014 Award for Outstanding Staff Member of a State, Provincial, or Territorial Psychological Association**, from Division 31—The APA Division of State, Provincial, and Territorial Psychological Association Affairs. If any of you have had the opportunity to work with or get to know Judy, you are aware that this recognition was long overdue. Judy has helped build MPA into one of the nation's premier psychological associations. While we are saddened by Judy's impending departure, we are also hard at work preparing for the transition to new leadership at MPA. A Succession Task Force, chaired by Joshua Cohen, has been authorized, formed, and is already hard at work readying MPA for this significant change in leadership. As Judy has often reminded us, this is an opportunity for MPA to engage someone who will lead us into the future, although that has been hard for most of us to accept. Also keep your eyes peeled for upcoming announcements about some form of celebration to mark the incredible leadership that Judy has provided to all of us.

Many of us attended APA's State Leadership Conference, an opportunity to gather with fellow psychologists around the country, Canada and US Territories, to learn about the newest trends in association management, psychology, health care, and issues confronting psychology on the national stage. We have brought back tools to continue to move our association forward as well as having had the opportunity to meet with our representatives on Capitol Hill to voice our views on a variety of issues affecting the practice of psychology within Medicare. This effort is one part of psychology's legislative effort to educate and influence the opinions of elected leaders to include psychology in health care policy as well as to educate them of the value that psychological treatment and psychologists bring to health care and more importantly to the lives of people. In summary, while MPA faces many challenges over the next several years, we also learned that we have much to be proud of and have already been implementing many of the ideas and programs designed to help you, our members, promote the health and well-being of psychology both now and in the future.

I was chagrined to realize that I had conveyed what I thought was a truth to you in my last column that I have subsequently realized is not quite as accurate as I would like. I have a saying with my clients…"I will tell you the truth as best I understand it, but reserve the right to change the truth as I am exposed to or seek new information." During our time at SLC Judy DeVito, **Laura Estupiñan-Kane**, and myself attended two workshops on Strategic Planning that were outstanding and informative. We were exposed to some additional information that has resulted in a step backwards, rethinking and a redesign of what I thought was our completed Strategic Plan. Rest assured we are hard at work and hope to have the newly designed plan completed by our June meeting and forwarded to you, our membership, for comment. The truth as I know it now….

On the legislative front, MPA has experienced an extraordinarily successful year spearheaded by its Legislative Committee chaired by **Ed Shearin**. Through two years of hard work by the members of that committee in combination with the incredible energy and commitment of our lobbyist Julia Worchester, our consultants, and our executive director, MPA was able to pass a very significant piece of legislation. HB641/SB803, known as Client Privilege, enables you to protect yourself from the psychological and physical harm that threatening clients have the capacity to inflict on you. Starting June 1, 2014 you will have the ability to use information obtained during the treatment of a threatening client to protect yourself

from harm. In the event that you might want or need to obtain a restraining order or file charges against a threatening client, you may do so after June 1, 2014 without violating your client's privilege of confidentiality and running the risk of a complaint being lodged with the Board of Examiners, a hearing, or possible sanctions for violating ethical codes and standards of practice. As I mentioned on the listserv, this legislation arose from the experience of several of our members who made their concerns known to MPA's leadership, who then worked to change an unintended consequences of previous legislation.

Passage of the Client Privilege alone would be cause for celebration. But there is more. As a result of the tragedies that occurred at Penn State; Columbine, CO; Aurora, CO; Fort Hood, TX; Sandy Hook, CN; Columbia, MD; and Murrysville, PA, issues involving the intersection of mental health and violence, from child abuse to shootings, have been moving to the forefront of many legislative initiatives in Maryland. Unfortunately but understandably, many of these initiatives appear to be based more on emotion rather than an adequate understanding of the many factors that lead to an explosion of violence by that very small percentage of persons who act out. While some change is certainly needed, many of the proposed "solutions" are not well thought out and were apparently created without an awareness of laws and procedures that are already in place to deal with many of these issues. This past year in Maryland we have addressed laws that could have: forced outpatient treatment and medication on certain individuals, criminalized aspects of child abuse reporting, placed additional burdensome educational requirements on psychologists, allowed legislators to begin determining which forms of therapy are legal and which are not, and criminalized sexual relationships with one's own patients. You will hear more about these issues in more detail from both **Ed Shearin** and Julia Worchester.

As these issues have become more prominent in the legislative agenda we have begun to experience tactics being employed by others that we find distasteful and outside of our past experience. These tactics appear to have been designed to get legislation passed by significantly bending the facts. As a result of one position we took this year on a particular bill, a video was produced and information forwarded to legislators and the press that implied that MPA was in some way supporting the sexual exploitation of clients/patients by their therapist. I want to be clear with you, our membership, that MPA does not, has not, and will not encourage, endorse or support therapists having sexual relationships of any kind with the clients/patients whom we treat. Period! This is the position that MPA and your Board of Directors has consistently taken and represented to our legislators, despite the claims of others who are attempting to get unnecessary additional regulations passed in Maryland.

On the brighter side, after two years of hard work, relationships with the Board of Examiners of Psychologists have significantly improved despite the very different positions that MPA and the BOEP took upon introduction of Legislation last year to regulate Psychological Associates in Maryland. Without going into detail, the leadership of both organizations has worked hard to find a compromise position that would protect the public without putting undue burdens on either the psychologists who utilize the services of Psychological Associates or the individuals who choose to become Psychological Associates. We were able through the efforts of leadership on both sides to achieve this goal. I am pleased to report that there has been open, direct and respectful communication between the leadership of both organizations which I believe will serve well the profession of psychology.

Folks we are being challenged in ways that I have not experienced in my time as a practicing psychologist. The opportunities to mold the practice of psychology abound during this time of change. The future of psychology and MPA is in your hands to forge it as you will. I see plenty of suggestions on the listserv about a variety of positions or activities in which MPA should become involved. Your leadership is thrilled to hear these ideas and the expressions of concern that each of you as our members has about the future of MPA. There is one small problem…. MPA needs each of you to give of your time and talents in some way to forge the future of psychology. Those of us in leadership and participating on MPA's committees are small in number, volunteer our time to our profession, and hence only have a limited amount of time to devote to these efforts. If the results of this year's legislative effort are not enough to convince you that we can make a difference, nothing will. If we speak in an intelligent, thoughtful and concerned manner for ourselves and the people we serve, people will listen. You can make a difference; the future of psychology is in your hands, and I invite you to participate actively. Give any of your committee chairs, Judy, or your officers a call or an email and offer some of your time and talent to forge your profession. The gratification and camaraderie that you receive back is worth the time and effort.

All my best to you the members, who make all of this possible through your continuing support of MPA. At OCI we will celebrate the ending of a long MPA tradition, as we move the organization forward to meet the challenges of the nature of practice today. Ψ

HERE & THERE

Judith C. DeVito
Executive Director

Writing this particular column is bittersweet. In preparation for a photo display at the upcoming Ocean City Institute, the last one in a long line of conferences, I have been browsing through stacks of photographs that capture over three decades of continuing education "at the beach." Starting out as the Pre-Convention Institute in 1982 (at which time the Convention was in June), it had a name change in 2001 that has remained—the Ocean City Institute (OCI). Looking at all the smiling faces in the photos (and at numerous volleyball games!) it is clear that for the families of psychologists in the early years, OCI was a time for relaxation, meeting up with old and new friends, and sharing the excitement of being part of a burgeoning clinical profession. Families looked forward to the boardwalk food and arcade games, miniature golf, and thrilling rides at the end of the pier. These pictures depict a generation of great promise and, as we know now, of promises fulfilled. You have become seasoned clinicians and leaders in psychology on state and national levels. For some, you now enjoy a well-earned retirement. A few of the children in the photos are now practicing psychologists themselves.

So, while we value and cherish the past, we also recognize the heavy current socio-economic pressures on families and practice (especially early career psychologists), that prevent participation at OCI. MPA is committed to ensuring that great CE is an option for all members. We are also committed to taking the best features of OCI—in-depth learning, experiential workshops, relaxed training—and bringing those features to more members in multiple events and venues that are also accessible to more members.

I do hope that you attended this final OCI. I also hope that you and many other members join me in anticipating the new and valuable ways that our Educational Affairs Committee will develop continuing professional education for psychologists in Maryland.

Speaking of new, I hope you have had a chance to visit the MPA website lately. You'll notice there is a new MPA Career Center implemented by our talented PR Coordinator, Bethany Wetherill, which expands the employment reach to the national level for job seekers and employers. Our own local MPA classifieds are still available on-line and in *The InPsyder*, as well as in *The Maryland Psychologist*. We now have one more resource to serve our members in a wider way.

How about the additional on-line practice resources containing meta-analyses on myriad psychological subjects and issues? The Professional Practice Committee (**Wendy Buzy**, **Peter Smith**, and **Brian Corrado**) under **Julie Bindeman's** leadership worked hard to bring this to you—in a great practice resource format updated by Bethany.

Have you checked out the on-line MPA Bookstore developed by **Catherine Busch** that features books written by MPA members *and* books that MPA members have recommended on the listserv? It links with Amazon for convenience—and anything you order through the MPA site, including items other than books, helps MPA. Look for much more on-line convenience coming your way.

We're also very proud of the work that Chair **Mary Alvord** and the Public Education Committee, **Jonathan Dalton**, **Shreya Hessler**, **Jana Martin**, **Jim Dasinger**, **Gloria Vanderhorst**, **Julie Bindeman**, **Jessica Samson**, **Judith Glasser**, **Amy Van Arsdale**, **Jaclyn Halpern**, **Angela Priester**, and Con**nie Blizzard**, have done over the last few months. Have you wondered how MPA is reaching out to the public about psychology? How about by writing blogs and creating educational videos for the MPA website; by volunteering at the YMCA's Healthy Kids Day in two locations; by planning for upcoming outreach at the 50+Expo and farther afield in underserved areas. Committee members also appear in print and electronic media keeping psychology and psychologists front and center.

The Membership Committee with **Lisa Freeman** (chair), **Cathy Brookman**, and **Michael Adler** have been working on marketing and videos for our website that will promote MPA membership, and also educate the public on what psychologists do.

A very exciting development is a technology makeover for our MPA conference room. This means a better sound system, camera pickup, and monitor. Not only will it make MPA distance learning and programming a more quality experience, but participation in governance through MPA committees within MPA will also be more enjoyable and feasible for all MPA members no matter where they live. We are already garnering a wide audience of early career members from

Here & There *continued from page 5*

Cumberland to Salisbury who, with the ECP Committee and chair **Linda Herbert's** leadership, tune into the terrific ECP learning webcasts.

So more changes are coming and some have already arrived. MPA is dynamic and is moving with the times to do more through better technology and on-line services. As **Pat Savage** mentioned in his President's column, one of those changes will include my retirement next year. I said this was bittersweet and it is very hard to actually see this in writing! I will save reminiscing for later on, but suffice it to say that right now I am getting such a kick out of seeing the changes we have long sought coming to fruition. It is a great way to begin the transition year—knowing that MPA and its members are well prepared for the future. This association has maintained a tradition of excellence for over 58 years and will be well-placed to carry that forward under new executive leadership. More later! Ψ

GUEST EDITOR'S INTRODUCTION

Couples Therapy

SCOTT WOLFE, Ph.D.

Historically, national surveys have found that about 80% of therapists in private practice in this country report that they provide couples therapy as a clinical service. However fewer than 15% of therapists report ever having a graduate course in couples therapy or an internship in which they learned couples therapy under a supervisor who specializes in it. I am happy to report that in recent years this is changing dramatically.

The last two decades have seen an enormous growth in couples and relationship research which has led to the development of several research based and evidence based couples therapy approaches. Gottman method couples therapy and emotionally focused couples therapy are two of the most notable of these approaches. These approaches now offer training programs and certification of couples therapists in their particular methods. Of course for many years certification has existed in sex therapy (a subcategory of couples therapy) by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). Graduate programs are also responding by adding couples therapy courses. With all of these developments in the couples therapy field is now approaching levels of excitement and the enthusiasm that the various schools of family therapy and general systems theory enjoyed much earlier.

The enormous growth in our field owes much to Susan Johnson's ground breaking efforts to bring emotion into relational work (Emotionally Focused Therapy). She did this single handedly when the field in the late 1980s was almost exclusively favoring behavioral and systems approaches and was not interested in emotion. She applied John Bowlby's attachment theory to adult romantic relationships and famously argued that marriages are not bargains. They are bonds.

John Gottman's four decades of research on relationships is the other major milestone in the growth of the field of couples therapy. His seven major longitudinal studies which followed over 3000 couples for periods of twenty years or more essentially define what we know scientifically about relationships. John collaborated with his wife Julie Gottman, also a psychologist, and together they translated and sculpted these research findings into an effective clinical method (Gottman Couples Therapy) to help ailing relationships. Their approach is the other major approach that focuses on emotion.

This special issue of *The Maryland Psychologist* is dedicated to couples therapy, explores ways couples therapists, now armed with better research and better clinical methods, are expanding their practices by applying their skills to new populations. In this issue some of our area's finest and most experienced couples therapists share with you their experience and enthusiasm for working with couples and applying their skills to new and different groups.

Our first article by **Nancy Hafkin** and Sharon Covington focuses on helping couples who are facing infertility. Nancy and Sharon specialize in infertility counseling and teach a year long seminar for clinicians in this area. In their article they first introduce us to an array of assisted reproductive technologies that are now available to couples and then they outline the psychological consequences of infertility for the couple and for the woman undergoing assisted reproduction. Finally they discuss three major goals for the treatment of couples who are facing infertility and the psychological process that needs to take place for healthy adjustment.

The next article by **Cara Jacobson** discusses the use of couples therapy when one partner has been diagnosed with an eating disorder. Trained as a couples therapist and having completed a postdoctoral fellowship at the Sheppard Pratt Eating Disorders program, Cara is uniquely equipped to do this specialized type of couples work. She first discusses the importance of countertransference and the need for the couples therapist not to align with one partner over the other. She shows how the couple's dynamic of the identified patient and their caretaker partner can lead to hyperfocusing on the disorder and thus avoiding processing their painful feelings and concerns. Finally she explains that eating disorders act in many ways as numbing agents to protect these individuals from

negative emotions and how this understanding can help guide the work of the couples therapist with these couples.

Next **Barry Bass** writes about low sexual desire which is one of the major presenting problems couples report who consult with a sex therapist. He is Professor Emeritus of Towson University. Both a Maryland licensed psychologist and a Diplomate in Sex Therapy certified by the AASECT, he practices in Towson Maryland. He argues that couples coming in with one partner self diagnosed with low sexual desire often need to reframe their concerns as being one of avoidance. He discusses how the therapist can best help the couple by helping them talk about their sexual needs and the conditions needed for arousal. Finally he concludes that what is needed is not necessarily more sexual desire but indeed less sexual avoidance.

Kathryn Rheem is a certified EFT therapist, supervisor, and trainer. She has worked extensively with combat related trauma and the impacts of high stress on couple dynamics. In her article, Kathryn helps us understand how emotionally shutting down is a naturally occurring response for the deployed soldier, especially those returning from combat, as well as the spouse who has remained at home. The task of the couples therapist is to provide a safe place for the couple to learn to open up and share emotionally with each other. Kathryn's article also creates a safe place for the clinician reader who wants to learn new and better ways to help military couples.

Our next article is written by Barry McCarthy. He is a Professor at American University who has written extensively on sex and sexuality and regularly presents at national and international conferences. One of his most recent books is Rekindling Desire which he co-authored with his wife E. McCarthy. His article for this issue of *The Maryland Psychologist* focuses on integrating sexual desire and a new couple sexual style with the treatment of extra-marital affairs (EMA). He begins by dispelling several myths and misconceptions about the sexual life of couples in committed relationships and then he begins to outline his new approach to recovering from EMA with an emphasis on sexual recovery and the development of a new sexual style for the couple. His approach begins with a four-session assessment of the couple with two of the four sessions as individual meetings with each partner. His approach calls for 10-25 couples sessions over a three to twelve-month time period with relapse prevention sessions every six months for two years. This new approach to EMA is especially noteworthy for its inclusion and emphasis on sexual recovery and its focus on an individualized relapse prevention plan.

Patricia Gibberman and I wrote the next article in which we explore ways to bring relationship education workshops to couples who are interested in relationship enhancement or relationship repair. Traditionally most of us have helped couples only through couples therapy but studies have shown that it takes the average couple six years to make a couples therapy appointment once they have indentified that they are having problems. So it makes sense to find ways to get to many of these couples earlier. Some couples use relationship education in conjunction with couples therapy and some use it as a way of testing the waters before they decide to enter therapy. A list of the most popular couples workshops is presented. Relationship education is just another way to help couples and at the same time to expand your practice while using your skills in a new way. Patricia Gibberman and I have been presenting the Gottman Weekend Couples Workshop: The Art and Science of Love four times a year for over five years. We are both certified Gottman method couples therapists, workshop leaders, trainers and supervisors who were trained directly by John and Julie Gottman. Patricia practices in Faifax Virginia and Scott practices in Columbia Maryland.

Next **Robert Brown** shares with us an instrument he developed to aid couples therapists in developing a self assessment of their own competency in their clinical practice with couples. As we expand our practices to new populations it is important to continue to expand our skill base and knowledge base in these new areas. This self assessment instrument operates as a checklist which allows us to assess areas of strength in our work with couples and areas we need to improve. **Robert Brown** is well known by so many in the Maryland Psychological Association (MPA) community. He is a former president of the MPA, past chair of the Maryland Board of Examiners of Psychologists, and a former professor at the University of Maryland. He practices in Columbia Maryland where he sees couples and individuals.

Richard Ruth has graciously focused his regularly appearing column Dynamically Speaking on same-sex relationships and the very important and sensitive concerns of LGBT clients coming out, then and now. Richard shares with us his personal story and explores how views have changed in our profession, in our culture, and in our homes. It is a remarkable article. I am sure it will inspire all who read it as it did me.

Finally, last but not least, we hear from three doctoral students and MPAGS members, **Lauren Battaglia Dumont**, **Tiffany Duffing**, and **Corey Molzon**. They share with us their thoughts and reflections on what it has been like for them to begin doing couples therapy this year. They discuss what they have learned about their couples and about themselves as novice couples therapists. Hope still lives. Ψ

Couples Therapy and Infertility

NANCY HAFKIN, Ph.D. AND SHARON N. COVINGTON, M.S.W.

During their relationship, one in ten couples is affected by infertility, defined as the inability to become pregnant or carry a pregnancy after one year of unprotected sex. These couples are dealing with the problem during a time when three major developments are impacting their journey: The availability of more effective treatments, the change in population demographics, and greater media attention and public awareness. Fifty, even thirty years ago, a couple unable to conceive primarily faced adoption or remaining childless as their only alternatives. Today, medical treatments facilitate parenthood through an alphabet of options: assisted reproductive technologies (ART) such as in vitro fertilization (IVF), intrauterine inseminations (IUI), intracytoplasmic sperm injections (ICSI); and third-party assistance with donated egg (DE), sperm (DI), or embryos (ED), and/or women who act as a gestational carriers (GC) for a pregnancy. In addition, this technology towards parenthood is available to a range of individuals and couples seeking biologic parenthood (married or committed couples, gay or lesbian couples, single women and men) who previously would have been without treatment options to have children. Yet these heralded changes seem paltry when a couple faces the grief of repeated pregnancy loss or failure to conceive with no known reason.

Most couples spend much of their life trying not to get pregnant. When difficulties conceiving occur, it creates a crisis which develops into a chronic stress on the individuals and their relationships the longer it continues. For many, infertility is not a discrete event but an evolving process initially experienced as a potential threat or loss, both real and imagined. As it continues, the evolution is into real threat: repeated loss of hoped-for conception or a miscarriage; invasive and expensive medical treatment; problems in relationships with friends and family; a future without children; and on and on. Infertility becomes an emotional rollercoaster that is unpredictable, negative, uncontrollable, and ambiguous. It provides the perfect petri dish for stress.

We know that the strain of infertility can remain in a relationship many years after resolution. The shock, disbelief, anger, shame and guilt can evolve into feelings of diminished self-esteem, chronic bereavement, anxiety and depression. Treatment means a new world of medical technology and jargon, an invasion into a couple's sex life, cyclical treatment demands, financial pressures, work absences, and the possibility of significant disappointment. Most infertility patients enter counseling to obtain symptom relief, develop better coping mechanisms, deal with issues of stress and loss, and/or obtain assistance with decision-making. A mental health professional who has specialized training in the field of infertility counseling is the ideal choice here, since the couple needs competent information, crisis intervention, support, an opportunity to learn coping skills, a place to grieve, and assistance making decisions. Infertility counseling is a highly specialized area, due to constantly advancing medical technology combined with complex psychological and ethical issues, and clinicians working with infertile couples need to be well-versed, educated, and trained (Covington & Burns, 2006).

The psychological consequences of infertility can be emotionally devastating, and women undergoing assisted reproduction are at greater risk for psychological distress, particularly if treatment is unsuccessful. Factors contributing to grief reaction following unsuccessful IVF or protracted treatment include pre-existing psychological illness, length and extent of medical intervention, previous reproductive loss or trauma (e.g., multiple miscarriage, stillbirth, termination for medical reasons), and social isolation. Adjustment and anxiety disorders are the most common, with depression likely in infertile women who had a history of depression.

Theoretical approaches to treatment usually include a combination of psychodynamic psychotherapy, cognitive-behavioral therapy, strategic/solution focused brief therapy, crisis intervention, and grief counseling. Objectives in counseling are influenced by three factors: Culture, clinician's degree of experience with infertility, and the infertility treatment itself. Since many infertility patients present for focused help, short-term intervention is often the approach.

A careful assessment of each member of the couple and of the overall health of the relationship can guide the clinician in treatment planning. Infertility-specific standardized measures of marital functioning are few. More general measures of marital functioning often lack sensitivity to infertility concerns. Those with good reliability, validity and norms for comparison can prove useful in determining the severity of relationship complaints, individual distress, and offering leads for further inquiry. The Fertility Problem Inventory (1999) assesses the extent to which infertility problems have strained the couple's overall relationship and FertiQol, a recently developed tool available online (www.fertistat.com) measures quality of life of infertile individuals.

An understanding of gender differences is essential (Petok, 2006). Considerable evidence indicates that men and women are affected differently by the experience of infertility. Women are more likely to worry that something is wrong long before seeking treatment, more likely to initiate discussion with partners, and more likely to assume personal responsibility for the failure to conceive. Women report higher levels of distress than men on measures of anxiety, depression and self-esteem. Men are more likely to cope using denial, distancing, or avoidance.

Infertility in the remarried couple is complicated by dynamics of stepfamily formation and by the fact that it is playing out at a time in the life of the family that is most likely to be volatile and unstable (Hafkin & Covington, 1999). The parties likely have markedly different levels of investment and motivation for having a mutual child. This may become even more difficult if the ensuing child will not be genetically related. The "unshared loss of infertility" may cause guilt, resentment and anger.

Counseling goals include facilitating the couple's management of treatment, increasing awareness of treatment implications, addressing conflict, reducing stress on the relationship, encouraging active decision making, and improving communication not only within the couple, but between the couple and the medical staff. A key issue is the learning of new skills, such as the capacity to regulate emotions under difficult circumstances.

A second goal is to facilitate the management of infertility as a couple: Identifying differences in motivation for having children, differences in reaction to infertility and coping style, and problems in communication. A capable couples counselor will need to employ all his/her skills in assisting a couple in identifying and conveying feelings accurately, expressing complaints constructively, and developing better conflict resolution skills.

The third goal is to assist with infertility strains on the couple, to support the work of grieving and to identify alternatives and new life perspectives when parenthood has not been achieved. Ending treatment is a long and difficult process, complicated by the fact that members of a couple are seldom in agreement about the decision. Rarely is timing simultaneous. Research shows that often the decision has to do with emotional energy, not finances, as couples become exhausted by repeated loss and by the number of other decisions that must be put on hold while in treatment. The consequence of protracted infertility on the couple's sexual relationship can be significant and long term, wreaking havoc on intimacy, and needs to be addressed whether or not treatment has been successful.

There is a psychological process that needs to take place for a successful adjustment after infertility: Finding meaning to what happened, gaining mastery over the events and regaining control in life, and enhancing the sense of self. Or, if medical treatment is unsuccessful, mourning the loss of a genetically related child, and refocusing or moving past the infertility to adoption or child-free living. Counseling can assist a couple in reviewing their infertility experience, cognitively and emotionally, and can provide a witness to the loss. Ψ

Nancy Hafkin, Ph.D., and Sharon Covington, MSW, have been providing individual, group and couple psychotherapy in Montgomery County, Maryland for over thirty years. They co-lead the Infertility Counseling Study Group, a ten month (September-June) training opportunity for clinicians. Nancy and Sharon can be contacted at www.covingtonandhafkin.com.

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Eating Disorders in Couples Therapy

CARA JACOBSON, Psy.D.

When I first began graduate school, I, like many other young females, took an interest in the dynamics of romantic relationships. I focused on couples therapy throughout graduate school and completed my dissertation on factors that longitudinally maintain romantic relationships. After immersing myself in the research and beginning to conduct couples therapy, I realized that it was more than just a passing interest and that I eventually wanted to focus on couples in long-term outpatient therapy. In order to seek a broad range of experiences, I completed a postdoctoral fellowship at the Center for Eating Disorders at Sheppard Pratt Hospital. When I moved into private practice after my fellowship ended, I assumed that I would see couples and also treat individuals with eating disorders but I did not realize that I would find myself treating couples with eating disorders. I never expected that these two populations would fit together so well. The unifying theme I have found in treating both populations is the use of avoidance as a tool in dealing with relationship conflict, insecure attachments, self-destructive tendencies, body image concerns, and trauma.

There are several factors to consider in couples therapy when one partner suffers from an eating disorder. The first factor I regularly attend to, assuming that no one is an immediate health risk, is to be aware of my own countertransference reactions towards people who suffer from eating disorders, whether these are positive or negative associations. I often check in with myself during my work with couples to make sure that I am not

aligning in one direction with either partner due to my own assumptions. It is important to be aware that those individuals who choose partners afflicted with eating disorders often identify themselves as caretakers. This creates a dynamic in which both partners become hyper-focused on the eating disorder as an attempt to avoid their own individual feelings and experiences. Because of this, I actively work to eradicate the dynamic of the "identified patient." Clients who struggle with eating disorders are quick to develop a 'sick identity' and are described as such by professionals. This is, in part, due to the medical model and while it is a helpful conceptualization, it also holds the threat of clients developing unhealthy and pathological identities. While the majority of the following article will be focused upon understanding the partner who suffers from an eating disorder, I would encourage clinicians to be aware of counterbalancing interventions and maintaining a health-focused environment.

We know that conflict in a romantic relationship can prove to be one of the most painful experiences in life (Bowlby, 1980). Because turmoil between partners will inevitably create distress, it is important to note the relationship between distress and eating disorders. One way in which we can conceptualize eating disorders is to view them as numbing agents. Theories suggest that people who struggle with eating disorders use the effects of disordered eating to numb themselves from negative emotions or to protect themselves against emotional distress. Restricting food intake to the point of malnutrition can create feelings of emotional numbness, whereas bingeing, purging, over-exercise, and the use of other eating disorder symptoms also help with emotional avoidance. It is important to keep in mind that the partner with the history of the eating disorder may use eating disorder symptoms to cope with difficult emotions and that the partner in the caretaker role may focus on his or her partner's eating disorder symptoms to avoid his or her own tough emotional situations. For example, in a couple that I currently treat, the male partner would prefer not only to force feed his wife, but also to use our time in sessions to discuss her eating disorder symptoms in depth rather than focus on his own abusive past. I find it helpful to remind couples of this pattern and not only to encourage both partners to work on identifying and labeling their emotions in the moment, but also to teach the couple how to

self-soothe and how to soothe each other when distressed. I generally have several conversations with my couples about Gottman's idea of flooding, and ways to deescalate from conflict in order to help the partners face and express their emotions in calm and safe ways, without doing things to enable or reinforce the eating disorder symptoms (e.g., force feeding).

People who struggle with eating disorders are more likely to have trouble creating secure attachments. Attachment processes have consistently been found to be insecure in eating disordered populations (Ward, Ramsay, & Treasure, 2000). Therefore, interpersonal difficulties may be present in the romantic relationship in the form of dependency, low self-esteem, people-pleasing tendencies, and the avoidance of conflict. I have observed that clients with eating disorders identify as being fearfully attached and tend to waver between being absolutely terrified of dependency and being completely emotionally and physically dependent on their partners. One of the most protective factors against the development of an eating disorder in adolescents is parental encouragement of autonomy (Huon & Strong, 1998). I tend to apply this construct to couples and work towards developing autonomy and comprehensive identities outside of the romantic relationship…so that the partners do not need each other, yet want to be with each other. One of my long-term therapy goals is to facilitate the couple in striking a balance between healthy autonomy and healthy dependency.

Research shows us that self-harm and self-destructive behaviors are high in comorbidity with people who struggle with eating disorders. These clients often believe that they are not worthy and that they deserve to experience punishment. This often translates into destructive acts against the relationship such as affairs, physical or emotional aggression, or isolating themselves in their emotional pain. I often transparently conceptualize different destructive tendencies in the romantic relationship as being "symptoms of the eating disorder." Individuals with eating disorders commonly experience intense self-loathing and internalizing rather than externalizing anger. We clinicians know that the problem with internalizing anger is that it often manifests through self-destructive acts or gets bottled up and disproportionately released against partners. Because of this, I use Marsha Linehan's emotion regulation work from dialectical behavioral therapy constantly with this population, with specific awareness to applying mindfulness to emotions, as well as working to decrease emotional suffering and increase positive emotions.

Other factors which often surface during work with this population are sex and body image. Eating disorders inevitably affect confidence levels and sexual desire, both physiologically and psychologically. We also know that people who struggle with eating disorders have body image concerns. I rarely directly address body image concerns in individual or couples work because it becomes clear that focusing on body image often contributes to the avoidance of tough emotional pain. Because of this, I have found time and time again that when we work through underlying issues (past traumas, bullying, parental neglect, losses, etc.) body image concerns dissipate. It is important to note that these concerns do not disappear completely, but they no longer interfere with the individual's daily functioning or in the romantic relationship. If there is a history of sexual trauma, which we know is highly comorbid with eating disorders, it is paramount to explore and work through that history or it may cause the couple to develop a pattern in which they unintentionally relive that trauma with one another. You can see how in the couple I referenced earlier, force feeding can serve not only to help each partner avoid emotional pain, but can unintentionally recreate trauma dynamics. For the aforementioned wife, who has been a victim of childhood sexual abuse, force feeding retriggers the unhealthy victim/perpetrator dynamic. It is important to help couples ease back into sex by using techniques like sensate focus and to make sure that the partner who suffers from the eating disorder feels safe and in control. I also find it extremely helpful to teach the couple new language around discussing past traumas, and to model for the partner without the history of trauma how to listen empathically and respond to his or her partner as discussion of trauma ensues.

Eating disorders often develop when people have problems expressing emotions and have no other way to speak. Keeping this in mind helps me in both my individual and couples work to assist these clients in finding their voices. This is particularly helpful in working with couples so we can encourage them to verbalize their struggles rather than act them out or take them out on the relationship. Throughout my work, I have often found clients with eating disorders to be some of the most insightful, intuitive, and intelligent people. I find my work with couples intriguing and rewarding and combining both populations creates for rich and vibrant therapy. Ψ

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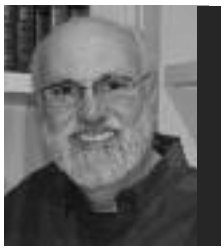

Is Low Sexual Desire a Misnomer?

BARRY A. BASS, Ph.D.

One of the major reasons individuals in committed relationships seek the services of a sex therapist is to address their self-diagnosed problem of low sexual desire. These low desire couples typically arrive at my office in agreement about one basic fact—that the low desire partner is the one with the problem. Many sex experts attempt to bypass the issue of having only one member of the couple designated as the "identified patient" by reframing the issue as a "desire discrepancy" problem, one about which both partners can then claim ownership. Regardless of who gets the diagnosis—the individual or the couple—everyone seems to be in agreement that the problem is one of *desire*. That is, one or both partners has lost *interest* in sex.

The other point of agreement for these couples surrounds their recollection regarding the quality of their early sexual encounters. Falling into one of two categories, there are the couples who describe a time, earlier in their relationship, when sex was satisfying, passionate, and frequent. And then there are the couples who describe their earliest sexual encounters with one another as having been filled with awkwardness and anxiety, but who, in spite of some amount of avoidance, were nevertheless able to muddle through—at least for a while.

By the time either type of couple finds their way to my office, virtually all sexual contact has either ceased or become perfunctory and unsatisfying. They will often describe their sexual feelings toward their partner or spouse by using phrases such as, "He or she feels more like a brother or sister to me than like a husband or wife." But what is most relevant is that both kinds of couples—those who right from the beginning of their relationship describe their sex life as having been problematic as well as those who once had a sex life they would have characterized back then as "passionate"—now describe themselves as having lost their desire for sexual intimacy with their partner.

It's also noteworthy that although both kinds of couples are rarely engaging in any partner-related sexual *behavior*, they describe their problem as one of generally low sexual *desire* rather than one of low desire for sex with their particular partner or even as a problem of low sexual *frequency*. That is, these individuals do not see their infrequent sexual behavior with their partner as the primary problem requiring attention but instead see their infrequent sex as a symptom of, or the result of, another more serious problem, mainly one of generalized low sexual *desire*.

However, it is my observation that these individuals' self-diagnosis is rarely the most helpful way to conceptualize the issue about which they are concerned. Yes, it is true that these couples are rarely connecting with one another in sexual ways. But not *engaging* in sex is not the same as not *desiring* sex. A student may not speak up to a teacher who he feels is treating him unfairly, but that doesn't mean the student doesn't desire to do so. He might simply want to avoid the potentially negative consequences of speaking up. Likewise for these couples. Avoiding sexual contact shields them from having to confront their concerns about how poorly things might go, were they to attempt a sexual encounter.

The distinction between desire and avoidance becomes even more clear when these individuals are asked about sexual behavior that does not involve their partner. The majority (but not all) of those individuals presenting with complaints of low sexual desire, are typically masturbating at the same frequency as they had before their desire for sex with their partner had diminished. They consistently report in private meetings with me that they have experienced minimal change in either their desire for or their frequency of solitary sexual gratification. And then there are others who report high frequency of sexual desire and sexual frequency with individuals other than their partners. (Treatment of those individuals is beyond the scope of this paper.)

Thus, what is most often the case with low desire individuals is not that they don't desire sexual contact with their partners, but rather, that they are *avoiding* sexual contact with them. Once the presenting problem is redefined as one of avoidance rather than one of desire, our therapeutic strategy then changes from one of trying to discover the reasons someone might no longer be interested in sex to uncovering the reasons why, in spite of continuing interest, he or she, nonetheless, is continuing to avoid all partner-related sexual contact.

It might be worth noting here, that most individuals are more comfortable attributing their infrequent sexual behavior to a loss of desire and are likely to balk at the notion that the real issue might be one of avoidance. My hypothesis is that clients presenting with sexual complaints are more comfortable

with a diagnosis that minimizes personal responsibility for the problem. According to this reasoning, low "desire" implies that the problem may have a biological as opposed to a psychological cause and might therefore be somewhat out of the client's control. Thus, if my problem can be construed by me as "out there" in the physical realm over which I have little if any control—such as my having a hormone deficiency, but which might be easily fixed with the right medicine—as opposed to "right here" in the psychological arena—such as my anxiety and worry about sexual performance—over which I might have somewhat more control but which might require more work on my part, my tendency would be to adopt the "out there" explanation for my behavior.

Reframing low sexual desire as intentional sexual avoidance in some way forces the individual to acknowledge that he or she might have some choice in the matter. (This same phenomenon comes into play when I treat men with erectile dysfunction who appear *disappointed* to learn that there is no biological or physiological reason for their problem. These men were hoping they could "blame" their dysfunction on something outside of their own control.)

In brief, when the problem is one of avoidance, the solution is likely to require that we assist our clients in helping them to discover the reasons for their avoidance and to assist them in changing their pattern of avoidance. When the issue is one of desire, the problem is more ambiguous and the solution less obvious.

What I have discovered in working with individuals with self-diagnosed low sexual desire is that there is typically one of two different reasons for their sexual avoidance. First are the couples whose avoidance revolves around their inability to identify those conditions that would likely lead them to find sex a relaxing, enjoyable, or exciting experience. For this group of individuals their anxiety and worry about their sexual performance interfere with their ability to maintain their equanimity, thereby preventing them from discovering what conditions they require in order to become aroused with their partner.

However I have found that there is a second type of individual who comprise the majority of those arriving at my office with the self-diagnosed condition of low sexual desire. These are the folks who know exactly what conditions would make for an exciting and pleasurable erotic experience. What's missing for this group is not knowledge but the courage to ask for what they want.

In this second group are the men who worry that their sexual preferences would be seen as unacceptable by their partners. More than one man has expressed a desire for a mode of sexual expression they fear their partner would see as either too passive or too erotic. They are reluctant to admit to and/or share with their partners the kinds of sexual fantasies and behaviors they know would lead to hot and exciting sex. These include some that are rather benign such as the wish for sex to happen in places other than in the bedroom and others require more planning and cooperation on their partner's part such as the hope that their partner might share with them her (or his) private sexual fantasies. It's likely that these individuals are already imagining these "unacceptable" scenarios during masturbation but have, up to now, been unwilling to ask their partner to participate with them.

Likewise numerous women have shared with me in individual therapy sessions that they prefer sex in ways they fear will be perceived by their partners as either too uninteresting or too "kinky." For example, these women tell me that they don't like the way their partner kisses but don't want to hurt his (or her) feelings by asking for something different. Other women report the wish that their partners would spend more time giving them oral pleasure rather than they, the women in my office, being the ones expected to perform oral sex on their partners. When I ask these women why they don't simply ask for what they want, they reply with some variation on, "I'm afraid to ask for that" or "He'd lose respect for me" or "I'd be so humiliated if he told me he didn't enjoy the taste or smell of my genitals." Because they don't ask for what they want, they can't then get their conditions for good sex met. And because they don't ask for those conditions to be met, they continue to avoid engaging in the kind of sex they typically share with their partner but which they know, from past experience, they are unlikely to find very satisfying. The result is that instead of asking for what they want, they deceive themselves into believing that they don't want any sexual contact and that they have lost all sexual desire.

In summary, individuals who define their problem as one of low sexual desire are rarely, if ever, without sexual desire. In the right setting and under the right conditions and with the right person, these men and women are capable of experiencing high levels of desire leading to high levels of sexual satisfaction. The barrier to that satisfaction is most often their unwillingness to acknowledge to their partner, without embarrassment or shame, the conditions they require in order to become sexually aroused. Consequently, what will ultimately be needed in order to fix the problem is not more sexual desire, but less sexual avoidance—or, to say it another way, more sexual courage—the courage to ask for what these men and women really want. Ψ

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Couples Therapy with Military Couples

KATHRYN RHEEM, Ed.D., LMFT

When Steve, the consummate soldier, came home from his tour in Afghanistan, his next position in the Army was at a desk on base. With his brothers still deployed or getting ready to redeploy, Steve felt out of place in an office environment and quickly grew bored at his desk job. Nothing came close to the adrenalin rushes he experienced and loved while down range. He felt like a "mouse in a cage" and hated that he no longer felt like a soldier, the professional identity that so suited him and one for which he trained so diligently. Dealing with overwhelming boredom, Steve and a colleague fell into an affair. It was the discovery of the affair which brought Steve and his wife to couples therapy.

Couples therapy with couples who have deployed, particularly those who have experienced combat, needs to focus on helping partners learn to open and share emotionally with each other. In order for partners to feel safe turning to each other, one of the primary therapeutic goals is to create an environment of recovery between the partners (first in the therapy room and then at home). Clinicians play an important role in helping our clients heal. We have a bright flashlight that we can shine on places our clients habitually avoid and make it safe for them to focus on what had been the dark places. But, when partners are experienced as a healing resource by each other, their love for each other is much stronger than the light of a clinician's flashlight. Their love has the strength of a stadium floodlight. They can become each other's best resource for coping with all each of them has faced.

Turning to Each Other

Rather than problem solving or exploring the past, helping partners learn to share their vulnerabilities with each other is the overarching goal. When vulnerabilities are shared, these moments become bonding moments that strengthen the couple's relationship. Strengthening the couple's bond inoculates them against future relationship stress and disconnection.

The Process of Turning to Each Other

In the first sessions of couples therapy, the clinician metaphorically "comes alongside" each partner in order to see the landscape from where each partner stands. The clinician creates safety by normalizing and validating the client's experience, reflecting the emotions that are starting to be shared and works intrapsychically in order to access more primary emotions, since vulnerabilities are embedded in primary emotions. As clinicians work with and distill our client's emotions and vulnerabilities, we help each partner make contact with their deeper feelings. Touching and working with emotion provides internal order and creates coherence. Connecting with and then staying in contact with the deeper, stronger emotion is necessary before asking one partner to share vulnerabilities with the other partner. New or emerging emotion is chaotic, often disorienting, and floods our brains. The clinician stays close to the client's inner-world in order to join the client in their emotion, lead the way through the emotion, and structure a process that creates transformation for each partner and ultimately the relationship.

In these early sessions, the clinician is working with each partner, although the other partner is in the session. As this process is happening with one partner,

the clinician has an eye on the listening partner to monitor responses and reactions. Reactions need to be processed moment-by-moment in order to maintain safety for continued exploration. As the clinician is working with each partner, seeds are being planted about sharing these deeper emotions and vulnerabilities with each other. While the partner is in the room and listening to the partner's process with the clinician, it is important that each partner take the risk and share vulnerabilities directly with each other. Since emotion is the messenger of love, turning to and sharing with the partner is the start of restructuring their bond in order to strengthen their love. Neurologically, so much is exchanged when partners see each other's faces and eyes. Sharing with the clinician is an important start, but nothing replaces the transformation of sharing openly with each other.

Processing Barriers to Sharing

For couples who have been distressed or disconnected or for couples, like many military couples, who traditionally don't share emotionally, turning to each other and sharing vulnerabilities will feel risky. It is risky, particularly when the one you love has turned away from you and confided in another, as Steve had done. When risks and fears of sharing have not been processed experientially, they often present as barriers or blocks in sharing. Clinician should expect these barriers and then know what to do in those moments: evoke the risks that each partner feels, often fears, and work experientially with those risks. Fears of sharing are a common and expected part of the process of learning how to share vulnerabilities with each other.

Working with Military Couples

Stereotypically, sharing emotionally has not been seen as a strength in military culture. This makes sense and is a positive adaptation for going into combat and other stressful situations. The ability to shut down emotionally is one of nature's best survival strategies. This is true for both partners: the one going down range to fight the enemy and the one staying home to protect the home front. Once at home and no longer living and working in harm's way, however, this ability to shut down can become a barrier to connection. Upon homecoming, or in the moments of re-connection in day-to-day life, the ability to share emotionally is a new skill that must be learned, and is often learned in couples therapy in order to reconnect, repair a connection, or simply connect to get the soothing and comfort all humans need. This new skill—to share emotionally with a safe partner—is framed as a new strength. Every military service member learned new skills to deploy and be successful in combat. Just as important, particularly when returning home, every service member and partner needs to learn the skills of reconnecting at an emotional level in order to have their relationship become a safe haven, the safe haven that offers protection and comfort from the storms and stresses of life. Ψ

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Integrating Affair Treatment, Sexual Desire, and a New Couple Sexual Style

BARRY McCARTHY, Ph.D.

There have been impressive clinical and research advances in couples therapy over the past decade. Unfortunately, this has not generalized to the specialty areas of sex therapy, sexual desire, extra-marital affairs, and the differences between the couple's relational style and sexual style. The same myths and misconceptions I learned as a young psychologist are still dominant in 2014. These include that sexual problems are a symptom of an individual or relationship problem and once that is resolved sex will take care of itself; that the key for sexual desire is increased intimacy and communication; a hierarchical approach to treatment focused on the core problem first (depression, alcohol abuse, trauma), then relationship issues, and finally sexuality; not dealing with sexual desire directly because of fear of violating professional boundaries and ethical concerns; and that once resolved, sex problems will not reoccur. None of these clinical assumptions has been empirically supported and, in fact, for most couples are untrue and harmful. These are professional myths, and myths die hard.

Sex therapy is best understood as a sub-specialty of couples therapy. A helpful clinical adage is that sexuality has a complex, paradoxical role in a marriage (or partnered relationship). The healthy role of sexuality is small, but integral, contributing 15-20% by energizing the bond and reinforcing feelings of desire and desirability. The paradox is that dysfunctional, conflictual, and especially avoidant sexuality has an inordinately powerful negative role, 50-75%, draining intimacy and threatening relationship stability (McCarthy& McCarthy, 2014).

The new mantra in the sex therapy field is desire, pleasure, eroticism, and satisfaction (Foley, Kope, & Sugrue, 2012). Desire problems are the major sexual concern that impacts relationships and brings couples to sex therapy. I advocate for marriages which are satisfying, secure, and sexual. The best estimate is that about one in five marriages are non-sexual (defined as having sex less than ten times a year-less than once a month). Interestingly, the number of non-sexual partnered relationships among couples who have been together more than two years is even higher-perhaps one in three. Contrary to "common sense" belief, the most common time to become non-sexual is the first five years of marriage, especially the first two years. Also, contrary to media reports, when couples give up on sex it is almost always the man's decision (especially after age 50) because he has lost confidence in erections, intercourse, and orgasm.

Many couples therapists report that dealing with extra-marital affairs (EMA) is one of the most challenging clinical problems. Again, contrary to media reports, the most common time for an EMA is early in the marriage, especially the first five years. Snyder, Baucom, and Gordon (2007) have presented an empirically-based, clinical model for assessment and treatment of EMA which challenges the traditional clinical lore, especially that EMAs are usually a symptom of a marital problem and that most affairs result in divorce. EMAs are an excellent example that sexuality is multi-causal, multi-dimensional with large individual, couple, cultural, and value differences.

This paper will focus on three issues: (1) treatment of EMA with a specific focus on sexual recovery, (2) the crucial role of rebuilding a strong, resilient sexual desire, and (3) developing a new couple sexual style post-EMA.

The four session assessment model (McCarthy& Thestrup, 2008) has proven of great value in assessment and treatment planning. The first session is conducted as a couple to reinforce the message that intimacy and sexuality is a couple issue as well as to assess motivation and understand what they've done in the past so that mistakes are not repeated. This is followed by individual psychological/relational/sexual histories to understand individual and couple strengths and vulnerabilities. The fourth session is the couple feedback session (usually ninety minutes) which bridges the assessment and treatment phases. There are three focuses in this session: (1) a genuine individual narrative for each spouse about psychological,

relational, and sexual issues generally and the EMA specifically, (2) a therapeutic plan/agreement about goals and a time frame (most typically six months to process the role and meaning of the EMA, make a marital decision, and sexual recovery from the EMA); (3) assign the first psychosexual skill exercise to be done at home (usuallly the trust position) (McCarthy& McCarthy, 2012). The message is that half the therapy occurs in the clinician's office and half in the privacy of their home.

Therapy sessions usually begin on a weekly basis, with the hope that in 4-6 weeks therapy will transition to every other week. Ideally, couples sex therapy would involve 10-25 sessions over a three month to a year period, and include relapse prevention sessions at six month intervals for two years after the formal termination of the couples therapy. Of course, "booster" sessions could be scheduled when needed. The goal is to reinforce changes and to promote growing healthy couple sexual desire.

The therapy approach is based on an integrative couple psychobiosocial model which addresses all relevant psychological, biological/medical, and social/relational dimensions. Rather than a hierarchical approach, we utilize a "both-and" approach to issues of sexual desire. This includes developing a coherent understanding of the EMA, rebuilding the trust bond, and making genuine meaning of the EMA which is accepted by both the involved and injured partner. The majority of marriages survive an EMA: the easiest is the male high opportunity/low involvement EMA and the most challenging is the female comparison EMA. The organizing therapeutic concept is to help the individuals and couple make a "wise" relational and sexual decision rather than the traditional emotional, short-term decision. The Snyder, Baucom, Gordon (2007) model emphasizes a three phase approach: (1) slowing down the emotional process, self-care, not acting impulsively or dramatically; (2) making meaning of the EMA following an interpersonal trauma/PTSD model, including genuine forgiveness; (3) making the decision either to recommit to a healthy marriage or agree to a "good divorce." Our contribution to this model is the emphasis on sexual recovery from the EMA and an individualized relapse prevention plan (McCarthy & Wald, 2012).

It is crucial for the clinician and couple to be aware that you cannot compare EMA sex with marital sex. Like pre-marital sex, EMA is typically a romantic love/passionate sex/idealized experience with the special charge of breaking boundaries and secrecy. The motivating, empowering comparison is to couple sexuality before and after the EMA. The challenge is to create a new couple sexual style which promotes sexual desire and satisfaction in a healthier manner than before the EMA. The couple sexual style involves maintaining your own "sexual voice" (autonomy) while balancing that with being an intimate sexual team who integrate intimacy and eroticism into their lives and relationship (McCarthy & McCarthy, 2009). A strong message to the couple is they cannot change the past, although they can learn from the past. In the present and future they create a couple sexuality which promotes strong, resilient sexual desire.

Another crucial component of this treatment model is to develop an individualized relapse prevention plan. The great majority of couples (perhaps 80-85%) choose a clearer, stronger commitment to a monogamous marriage. This new agreement includes awareness of personal, emotional, and situational vulnerabilities; an agreement to process this high risk situation with the spouse rather than impulsively acting to revert to a secret sexual life; and if there was an EMA incident it would be disclosed within 72 hours. Typically, the cover-up and lying has a more negative impact than the EMA itself. It is crucial that the clinician ensure this is a genuine emotional agreement and commitment, not a politically correct or socially desirable approach.

For couples who choose a non-traditional way to organize their relational and sexual lives, a relapse prevention agreement is even more important. First, the couple need to be clear about what they value about each other and their bond. Second, they must be specific about the circumstances and types of EMA which are acceptable; for example, some couples find triadic sex or closed swinging allow erotic freedom and alternatives. The third dimension is what type of EMA is not acceptable; the most common exclusions are falling in love with another person or a comparison affair.

A core guideline in sex therapy is to recognize that "sexually one size never fits all." Competent sex therapy recognizes the inherent variability and flexibility of individual and couple sexuality. Rather than pretending to be value-free, the clinician takes a pro-sexuality stance in affirming that sexuality is good, not bad; that sexuality is an integral dimension in being a female or male; and the clinician encourages each individual and couple to experience sexuality as a positive 15-20% role in their lives. The clinician affirms the mantra of desire, pleasure, eroticism, and satisfaction. Ψ

Barry McCarthy, Ph.D. is a professor of psychology at American University who has written over 100 professional articles, 26 book chapters, and 12 books. His latest book is *Rekindling Desire*, 2nd Edition (2014).

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Relationship Education Workshops:
How to Expand Your Practice by Teaching Couples the Skills to Repair and Enhance their Marriages

SCOTT WOLFE, Ph.D. AND PATRICIA GIBBERMAN, LCSW

James and Belinda separated last summer after James had an affair. The affair ended and after months of separation, and despite the hurt that was caused, they both missed each other quite a bit and began to talk regularly on the phone. James finally convinced Belinda to give him a second chance and they started couples therapy to see if they could reconcile. Their couples therapist recommended that in order to help them make more progress they should attend a couples workshop in addition to their weekly sessions with her. They agreed.

Before marrying each other, Peggy and Lawrence's first marriages ended in divorce. They decided early on in their relationship that to keep their connection strong and to avoid another divorce they would commit to doing something every year that would focus on nurturing their connection. This year they decided to attend a weekend couples workshop.

Sarah is unhappy in her marriage with Bob and she has been after him for years to attend couples therapy. However, Bob would always refuse which only made Sarah more unhappy. It was only after their youngest went off to college that Bob finally agreed, reluctantly, to attend a couples workshop, but not couples therapy. His fear of Sarah leaving him, now that their kids were out of the house, was his primary motivation. Sarah was hopeful that this could be a start for them in finding a closer connection as they entered into empty nesting. However, underneath, Bob was unsure if he could satisfy Sarah's need for closeness, since he didn't feel that much of a need for it himself. Bob ended up finding the workshop "not too painful"

and at the end of the workshop he was more open to meeting with a couples therapist. Sarah left feeling more hopeful.

These are the kinds of couples who attend couples communication workshops and relationship education programs. As a couple registers for a workshop, most programs require an individual phone interview with each partner separately to screen out couples with ongoing severe characterological domestic violence, major psychopathology, and untreated substance abuse. Appropriate referrals are given if the workshop is not a good fit for any couple.

Some couples are looking for enhancement to make a good enough marriage even better and to avoid the possibility of divorce in the future. Others are in search of relationship repair and struggle to find a deeper more secure bond which at one time was there for them but over the years may have dissipated. Even couples who never had a secure bond, and who have no idea how to create one, can learn through a workshop that there is a path to creating secure connection. These couples may already be in couples therapy and use a workshop to learn the skills of better communication to augment the work they are already doing on deeper issues with their couples therapist on a regular basis. Finally, there are other couples where one or both partners may be wary of entering couples therapy either due to stigma or to their fear that such a venture could end up making things worse. These couples may be more open to attending a weekend couples workshop which can introduce them to research-based relationship skills in a relaxed, comfortable environment without stigma or the sense of being patients in therapy. They listen to lectures, see demonstrations of research-based skills, and then

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2014 Sine Die Report: Maryland General Assembly

JULIA PITCHER WORCESTER, LEGISLATIVE CONSULTANT, LAW OFFICE OF J. WILLIAM PITCHER

THE CONCLUSION OF THE 432ND SESSION OF THE Maryland General Assembly, known as "Sine Die," occurred at midnight on Monday, April 7th with its usual fanfare and release of confetti. In this session, the General Assembly proposed and considered 2,693 legislative bills and resolutions. Since this was an election year session, there was some political posturing but relatively few controversial issues. Governor O'Malley was successful in passing his minimum wage proposal, in decriminalizing small quantities of marijuana, and in expanding and strengthening the ability to dispense medical marijuana.

The story line throughout the session was the failure to successfully implement the Maryland Health Benefit Exchange (MHBE) website known as "Maryland Health Connection" (http://marylandhealthconnection.gov). This resulted in finger pointing and scapegoating that featured all three democratic candidates for governor: Lieutenant Governor Anthony Brown, Attorney General Doug Gansler, and Delegate Heather Mizeur. A joint oversight committee was formed. In addition, Department of Health and Mental Hygiene (DHMH) Secretary Dr. Joshua Sharfstein was summoned to testify before Congress. The website turned out to be so broken that before the conclusion of the legislative session, the site was abandoned altogether and the state will seek to implement the Connecticut framework using new software at a cost of an additional $30-50 million.

All members of the Maryland General Assembly are up for reelection this year, and the statewide offices of Governor, Lt. Governor, Attorney General, and Comptroller will be decided this fall. The Primary Election will be held on June 24, 2014 with the General Election on November 4, 2014. In most cases, the winners of the Primary Election for the General Assembly Senate and House Delegate seats will determine the final candidates. In most cases, the winner of the primary election is likely to be the winner of the general election because districts are drawn to "lean" Democratic or Republican; even more so in the latest statewide redistricting.

This report is a sampling of the subject matter and issues addressed during the 2014 Legislative Session.

MPA PROACTIVE LEGISLATION

HB 641/SB 803: Courts & Judicial Proceedings – Communications Between Patient or Client and Health Care Professional – Exceptions to Privilege

POSITION: Strong Support
OUTCOME: Passed

In its second year of introduction, MPA was successful in bringing together a coalition of providers included in the bill to pass landmark legislation which will add an exception to the client privilege statute in cases where the mental health professional is barred by confidentiality but is the target of threats, harassment, or stalking.

The bill includes: psychiatrists, psychologists, licensed social workers, licensed clinical professional counselors, and psychiatric mental-health nurses, all of whom will benefit by this evidentiary tool in cases where the safety of the mental health provider has been compromised.

The bill passed unanimously through both chambers and was signed into law on April 14, 2014. The law takes effect on June 1, 2014 and will be applied prospectively.

PRIORITY ISSUES

HB 33: Criminal Law – Professional Counselors & Therapists – Conduct (Lynette's Law)

POSITION: Oppose
OUTCOME: Did Not Pass

This bill that, if passed, would criminalize sexual contact between therapist and patient was first introduced in 2013 and was written for counselors only, a result of an incident of therapist abuse involving an LCPC who had a prior criminal record in another state and then engaged in a sexual relationship with a patient in Maryland. He had been licensed in Maryland with no background check or discovery of his prior record. Subsequently, after charges were brought, he voluntarily surrendered his license to avoid prosecution. The victim is the champion of this bill. Consequently, the Counselors Board strengthened their background check and fingerprinting procedures. As the law stands right now, any sanction of a mental health professional for engaging in sexual relations with a client is handled by the state professional licensing board through adjudication and determination of penalty such as suspension or revocation of a license. During the 2013 legislative process, however, the bill was amended in scope to include all mental health providers (psychiatrists, psychologists, social workers, and psychiatric nurses). Though the bill was

successfully killed in the Senate, it was reintroduced in 2014, once again drafted to target LCPCs and Marriage and Family Therapists (MFTs).

MPA had numerous discussions about whether to enter into a debate about legislation that didn't directly affect psychologists this time around. But, if history repeated itself and the bill included the amendments previously proffered, the associations representing mental health professionals would have to organize an opposition strategy at the last minute. The decision was made in consultation and conjunction with the Maryland Psychiatric Society (MPS), the National Association of Social Workers—Maryland Chapter (NASW-MD), and the Maryland Nurses Association (MNA), to work together to oppose the bill on principal as bad policy. The language of the bill was also so broad with regard to "sexual contact" that it could lead to misinterpretation of behavior with innocent intent, such as a hug, and leave mental health professionals open to the risk of erroneous accusations of sexual abuse.

As a testament to collaboration with colleagues, MPA, in conjunction with the abovementioned associations, worked daily to keep the legislation from moving forward. Unfortunately, due to the nature of the election year and political pressure, the House Judiciary passed the bill in committee on Crossover Day. We were successful in keeping the bill locked in the Senate until the final hours of Sine Die when a last minute committee hearing was scheduled. This sent the various lobbyists scrambling to testify and shore up votes to bring the bill down. That testimony was successful and the bill never passed.

NOTE: *MPA will be working with other associations over the summer to have a strategy in place should the bill be introduced in 2015.*

HB 113/SB 225: State Board of Examiners of Psychologists Psychology Associates Registration

POSITION: Support
OUTCOME: Passed

A priority for the Board of Examiners of Psychologists (BOEP), this bill will allow the Board to register a psychology associate who meets the pathway criteria detailed in the legislation.

MPA offered its support for registration rather than the licensure status that the Board originally sought. MPA encouraged the Board to make every effort to prohibit independent practice for registered psychology associates in the future. MPA will also be working with the Board on the implementation of the regulations such as CE requirements, supervision, etc.

HB 150/SB 694: Health Occupations – Maryland Behavior Analysts Act

POSITION: Support
OUTCOME: Passed

The Maryland Insurance Administration (MIA) has finalized new regulations that will require coverage of autism benefits, including applied behavior analysis (ABA), for many private plans as well as state employees. The new requirements will apply to individual, fully funded small and large group plans, the state employee health plan, and coverage purchased through the Maryland Health Exchange. The coverage includes a minimum of 25 hours weekly of ABA up to age 6, and then 10 hours weekly through age 18. In addition, psychological care and speech, occupational and physical therapy for the treatment of autism are covered.

The regulations require ABA practitioners to be licensed by the state, so this bill was introduced to coincide with the implementation of the new regulations. HB 150/SB 694 will license Board Certified Behavior Analyst (BCBA) practitioners under the purview of the State Board of Professional Counselors and Therapists.

MPA offered support for the bill in conjunction with the insurance regulations that any practitioner receiving reimbursement should be regulated by the state. MPA also submitted minor technical amendments to prohibit BCBAs from practicing psychology, diagnosing mental or physical disorders, or conducting psychological testing. Another amendment was also added to allow for licensed psychologists who specialize in ABA or who are dually certified in ABA to be protected and allowed to use the terms "behavior analysis" or "behavioral analysis."

OTHER LEGISLATION OF INTEREST

HB 779: Maryland Health Care Commission – Health Care Provider-Carrier Workgroup

POSITION: Support
OUTCOME: Passed

The bill, which was enacted, provides that the Maryland Health Care Commission shall convene, on a regular basis, meetings between representatives of health insurance carriers and providers. The goal of such meetings would be to "iron out" issues that may otherwise become bills in the Legislature. Delegate Hammen believes that such regular meetings may result in more agreements between the parties and fewer disagreements. While he may well be right, only time will tell whether his belief is correct.

NOTE: *MPA may be able to utilize this workgroup once established for future insurance related issues and provider credentialing.*

Continued on page 10

2014 Sine Die Report

"Assisted Outpatient Treatment"

HB 592/SB 620: Mental Health – Approval by Clinical Review Panel of Administration of Medication – Standard (Passed)

HB 606/SB 67: Mental Hygiene – Standards for emergency Evaluation & Involuntary Admission – Modification (Failed)

HB 767/SB 831: Public Health – Mental Hygiene Law – Assisted Outpatient Treatment (Failed)

HB 1267/SB 882: Dept. of Health & Mental Hygiene – Outpatient Services Programs Stakeholder Workgroup (Passed)

A trio of bills were introduced this year by the National Alliance on Mental Illness (NAMI) to mandate involuntary treatment in the community (HB 767/SB 831), to loosen the standards for involuntary commitment to a psychiatric facility (HB 606/SB 67), and to make it easier for physicians to medicate individuals against their will once committed (HB 592/SB 620). The latter was the only bill to pass of the proposed package.

All three of those bills were strongly opposed by the Mental Health Association of Maryland (MHAMD), MPA, the Maryland Psychiatric Society, and the American Civil Liberties Union (ACLU) on the grounds that passage of this expansive statute would be a significant step backwards in addressing mental illness while increasing institutionalization of the mentally ill through the use of involuntary commitments and psychiatric medications.

In response, legislation was introduced by the MHAMD to provide an alternative, non-coercive approach to engage this population (HB 1267/SB 882). The language as proposed was stripped and replaced by a stakeholder process to be developed by DHMH to consider what best serves individuals with mental illness who are at high risk for disruptions in the continuity of care.

NOTE: *HB 1267/SB 882 does not specify the members of the stakeholder group to be convened. However, MPA has been invited to participate in the stakeholder group meetings. We will continue to monitor the developments of that group.*

HB 395/SB 702: Health Care Malpractice Claims – Definition of "Health Care Provider"

POSITION: Support
OUTCOME: Failed

House Bill 395 changes the coverage of the Maryland laws relating to malpractice claims so as to include certain "health care providers" (pulled in Psychologists by way of adding the "State Board of Examiners of Psychologists") who may be sued for medical malpractice.

When the present malpractice system was set up, many of the current "health care providers" did not exist. For example, "nurse practitioners" and "physician assistants" were not yet licensed provider groups and, hence, they are not covered by the malpractice law. Expanding the definition of "health care provider" draws many providers under the Health Care Malpractice Claims subtitle of the Courts and Judicial Proceedings Article. This means that a medical malpractice claim must be adjudicated under procedures which require a plaintiff to file a certificate of a qualified expert and a supplemental certificate attesting to noncompliance with standards of care. The bill pulled in "licensees" by licensure board rather than specifying the provider. Because of the wide range of providers licensed under each board, many who are never subjected to high dollar malpractice suits, the bill failed.

HB 802/SB 198: Maryland Medical Assistance Program – Telemedicine

POSITION: Support
OUTCOME: Passed

This bill specifies that, to the extent authorized by federal law, coverage of and reimbursement for health care services delivered through telemedicine must apply to Medicaid and managed care organizations in the same manner that they apply to health insurance carriers. Subject to the limitations of the state budget and to the extent authorized by federal law, DHMH may authorize coverage of a reimbursement for health care services that are delivered through store and forward technology or remote patient monitoring. DHMH may specify by regulation the types of health care providers eligible to receive reimbursement for health care services provided to Medicaid recipients.

HB 1009/SB 789: Civil Actions – Noneconomic Damages – Catastrophic Injury

POSITION: Opposed
OUTCOME: Failed

This bill, the principal initiative of the Maryland Association for Justice, would have tripled the current Maryland cap on noneconomic damages. The current cap in any case involving "catastrophic injury" is $745,000 (25% more in a wrongful death case) and would have been moved to over $2 million in a case which could be defined as a "catastrophic injury." An analysis of the definition of "catastrophic injury" in the bill indicated that almost all medical malpractice cases filed in Maryland would fit that definition. *(The current cap only applies to physicians in Maryland; another bill, HB 395/SB 702 would have added in other providers to the cap but that bill failed).* Since the cap on noneconomic damages applies in all cases, not

just medical malpractice, most of the injured people who appeared before the Senate and House Committees testifying on these bills had suffered injury in non-medical situations. In most cases the victims made very compelling witnesses. At the end of the day, however, the testimony of the physicians, hospital community and the business community thwarted any favorable actions on these bills.

HB 1127/SB 884: Health Insurance – Incentives for Health Care Practitioners

POSITION: Opposed (as written), Support (with amendments)
OUTCOME: Passed with Amendments

This piece was an initiative of the health insurance industry and particularly United Healthcare. It changed the Maryland "bonus" law which regulates the types of incentives that health insurance carriers may build into a provider's contract. It was clear that the existing Maryland bonus law was worded in such a way that perfectly acceptable bonuses might be forbidden.

The amended bill specifically stated that any bonus could not be a "disincentive" for medically appropriate care and that any bonus arrangement between a health insurer and a provider was to be in writing and have a clear description of the bonus rules. Moreover, a provider could not be forced, in his or her contract, to agree to such a bonus and would have the right to file a complaint with the Maryland Insurance Administration if the bonus was medically inappropriate. The amended version received the support of the provider community.

HB 1363/SB 832: Health Care Provider Malpractice Insurance – Scope of Coverage

POSITION: Monitor
OUTCOME: Failed

This bill would have allowed a medical malpractice insurance policy to include coverage for the defense of a health care provider in a disciplinary hearing (i.e., licensing board) that arises from the practice of the health care provider's profession—by repealing the provision prohibiting such coverage. The bill also makes a conforming change by repealing the provision that allows a separate insurance policy to be purchased to cover this kind of defense.

Currently, malpractice insurance carriers can provide a defense attorney for the health care provider if the provider is sued for malpractice but can't provide an attorney for the provider if the provider is undergoing a disciplinary action (legal proceeding) by the provider's licensing board. Expanding the coverage of malpractice insurance may have been be a positive for a health care provider, provided the expansion didn't significantly increase the cost of malpractice insurance.

SB 607: Health Occupations – Child Abuse and Neglect – Training

POSITION: Opposed
OUTCOME: Failed

This bill would have required each individual who is licensed or certified under the Health Occupations Article to receive, prior to licensure or certification, ninety (90) minutes of training in the identification and reporting of child abuse and neglect. All licensees would have been mandated to complete the required training despite working in a setting that does not involve children. This training would be repeated every four years. If an individual failed to receive this training, the respective health occupation board could have taken disciplinary action against the individual.

MPA, along with many other associations, opposed this bill as unnecessary and an administrative burden on the licensure boards. There has been an increased push to criminalize failure to report child abuse, with penalties that include jail time up to one year and monetary fines of $1,000 per conviction. This has been a concern for many provider groups and we should continue to stay vigilant in watching for future initiatives.

Other similar bills introduced this year (all failed):
- HB 1053/SB 210: Child Abuse – Failure to Report – Penalties and Task Force
- HB 1193: Task Force to Study Implementation of Strategies for Preventing Sexual Exploitation of Clients by Health Professionals
- HB 1344: Task Force on Preventing Child Sexual Abuse
- HB 1389: Task Force on the Prevention of Child Abuse and Neglect

NOTE: *MPA will begin to engage legislators by educating them about the current reporting laws for health care providers, emphasizing that to criminalize (i.e., add jail time) to the law could result in providers over-reporting to law enforcement and DSS—both entities that are already overburdened and understaffed which won't result in the intended goal.*

WRAP UP

MPA's input is very valuable to the legislators and they want to hear from you, the experts, when considering health care legislation. As your lobbyists, we will be your eyes, ears, and advocates on the ground in Annapolis. We encourage you to come to Annapolis and contact your legislators and tell them how you feel about issues that are important in Maryland. Ψ

Relationship Education Workshops *continued from page 19*

participate in practice exercises to make their marriages better along with other couples like themselves. This serves to normalize things quite a bit and we know that at the end of workshops one-third of workshop attendees request a referral to a couples therapist for follow up.

The last two decades have seen an enormous growth and maturity in the field of couples therapy. Owing to the contributions of giants in the field such as John Bowlby, John Gottman, and Susan Johnson, couples therapy, once subsumed under family therapy as a small area of study, now has found its own separate identity and has garnered its own share of academic respect. Interestingly enough, a hidden secret of many of us who categorized ourselves as family therapists back in the heyday of the family therapy movement was that we were primarily seeing couples anyway, because the couple is the unit that is often the most critical for healthy family functioning.

Several of the more prominent and popular methods of couples therapy, most of which are research or evidence based, have developed educational couples workshops which showcase and apply their methods to enrich, enhance and repair relationships (see inset from Halford, 2011).

The purpose of this article is to highlight marriage and relationship education and to encourage couples therapists to expand their practices by offering services to couples in this new, exciting and evolving way.

These workshops translate relationship theories and therapeutic interventions used by each method into discrete skills or conversations that couples learn and practice during the workshop and take home with them. Thus, each workshop's curriculum requires additional training to be certified or approved as a workshop leader/presenter for a particular relationship workshop format. Training time for becoming an approved presenter varies. Some programs require as little as a one or two day training program and do not require a degree or license in a mental health profession. These programs are thus open to clergy, teachers, educators, and others as well as clinicians. Other programs require you to be a licensed mental health professional and be a certified therapist in a particular couples therapy method such as Gottman Method (Gottman & Silver, 1999), Emotionally Focused Therapy (Johnson, 2008), or Imago Therapy. These requirements are in addition to completion of the actual training for learning to present the workshop.

Couples Psychoeducational Workshops

Adapted from (Halford, 2011)

The Art and Science of Love
(John & Julie Gottman–Gottman Couples Therapy)
gottman.com

Hold Me Tight
(Susan Johnson- EFT)
iceeft.com

Imago- Getting the Love You Want
(Harville Hendricks-Imago Therapy)
imagorelationships.com

PREP-Prevention and Relationship Enhancement
(Howard Markman)
prepinc.com

Relationship Enhancement
(Bernard Guerney–Relationship Enhancement)
Relationshipenhancement.org

Seven Principles Program
(John Gottman in collaboration with David Penner-Gottman Couples Therapy)
Gottman.com

The divorce rate in the United States remains high, hovering around 50% for first time marriages, and second marriages fare even worse with a 60% rate of failure. The traditional way to reach these couples and to help them work out their difficulties and stay together has been couples therapy. However we know from the research that couples, once they recognize they have problems, wait an average of six years before they schedule an appointment with a couples therapist. In the meantime negative cycles and patterns of interaction such as pursue-withdraw or attack-defend become rigid and entrenched. Couples lose their ability to dialogue, discuss, and connect, and they move into gridlock, flooding, escalations, and finally disengagement. They may lose their emotional connection and bond and continue to slide down the cascade of dissolution and divorce.

Marriage and Relationship Education is another tool that is available for trained couples therapists to be able to reach these couples earlier before negative patterns become so entrenched. As we all know, an ounce of prevention is worth a pound of cure. Ψ

Scott Wolfe, Ph.D. and **Patricia Gibberman, LCSW** are certified Gottman couples therapists, senior Gottman trainers, and workshop leaders. Scott practices in Columbia, Maryland and can be reached at scott@swolfephd.com. Patricia practices in Fairfax, Virginia and can be reached at pgibbermanmsw@gmail.com.

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Self-Assessment for Competencies in Practicing Couples Therapy

ROBERT A. BROWN, Ph.D.

Many practitioners, particularly those who graduated some years ago, received no formal training in couples therapy. Much of our training has come from isolated workshops by noted therapists; these workshops do not offer systematic, broad training in research, theory, and practice. The increasing amount of research and theory in working with couples means that training in personality theory, psychopathology, and individual therapy simply is not adequate to prepare one to work effectively with couples.

The list of questions below is aimed at helping you self-assess your competencies in understanding and treating couple distress. It is not specific to any particular theoretical or practice orientation. The list is not all-inclusive and may vary between highly specific and overly general. However, I hope it will be useful in helping focus your peer discussions and other learning experiences (readings, CE, etc.) in areas that will fill some remaining gaps in your knowledge and skills for assessing and treating couples.

Self-assessments are notably unreliable as outcome measures of training effectiveness. In fact, professionals who are the least competent in a particular area are the most likely to rate themselves highly. But this is not a test - it is aimed at you assessing your strengths and weaknesses as a couples therapist to inform yourself as to your knowledge and practice gaps. If you are not honest with yourself, it will not be useful.

If you decide to use this self-assessment, you may rate each item using the following scale:
5 = I know a lot about this topic
4 = I know a considerable amount about the topic
3 = I know a moderate amount about the topic
2 = I know a little bit about this topic
1 = I know next to nothing about this topic

1. Ethical and Professional Issues

____ A. The unique ethical issues involved in working with couples.
____ B. How to develop a written or oral contract with my couples that includes the basic elements of informed consent and, if applicable, meets the HIPAA guidelines.

2. Psychopathology, Couple Maladjustment, and Assessment

____ A. A conceptual framework within which to analyze relationship distress, including the assessment of interaction patterns. This is not to suggest that there is consensus on any one particular system, but only to ask whether you have an overall diagnostic framework or a general scheme that helps you conceptualize the major dimensions that characterize functional and non-functional relationships.
____ B. The relationship between partners' individual histories and current couple interaction.
____ C. The relationship between individual pathology(ies) and couple distress; e.g., depression, alcohol abuse.
____ D. Assessment questions or devices to assess individual and dyadic maladjustment and appropriateness for couple therapy.
____ E. The individual and couple characteristics associated with good and poor prognoses.
____ F. The biopsychosocial aspects of interpersonal relationships; e.g., the presence of chronic illnesses and their interaction with socially sanctioned gender roles.
____ G. Integrating the results of my individual and couple assessments and pinpointing issues that need to be dealt with.
____ H. Formulating goals and a specific treatment plan for and with my clients based on my assessment.

3. Treatment of Couple Distress

____ A. The treatments for couple distress that currently have the most research support and their basic treatment techniques.
____ B. Many of the basic treatment techniques involved in empirically supported couple therapy, such as establishing and maintaining the working alliance and a collaborative set, creating a safe environment, engendering hope, increasing positive exchanges, training in communication/problem solving, managing and resolving conflict, fostering compliance with interventions, managing anger and destructive verbal and nonverbal

behavior, teaching self-soothing strategies, fostering a sense of safety so that partners can reveal their vulnerabilities to one another, dealing with crises, or other techniques that may be specific to your theory of couple maladjustment and treatment.

____ C. The most common psychotropic medications and their potential effects on a couple's relationship.

____ D. Dealing with or referrals to give on issues that involve special areas of expertise, e.g., finances and budgeting, dysfunctional sexual relationships, career choice/performance/management, having fun, spiritual life, parenting, normative life crises, the influence of past trauma, blended families, chronic illness.

4. Special Topics/Special Populations

____ A. How gender affects couple relationships (e.g., communication, decision-making, power, conflict resolution styles, etc.) and how I can work with these issues.

____ B. Working with diverse couples (e.g., older couples, gay/lesbian/bisexual couples, devoutly religious couples, ethnic minority couples, couples of varying socioeconomic statuses).

____ C. The basic physiological and psychological ingredients of functional and dysfunctional sexual relationships and the principles of sex therapy, and when I can work with sexual problems and when I need to refer.

____ D. The varied dynamics of extra-relationship emotional and sexual relationships and how to work with the couple on them.

____ E. Some of the alternative ways of working with couples in which one member wants a divorce and the other does not. How to proceed if both want a divorce.

____ F. Dealing with interpersonal violence, including when it can be dealt with in joint therapy with the couple and when people need to be worked with individually.

____ G. Termination—when and how to consider it, how to deal with the couple around it.

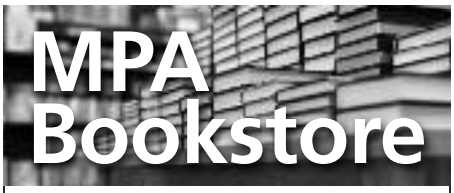
____ F. A biopsychosocial framework that can be useful in working with couples with chronic illnesses/disabilities.

____ G. Working with couples' loss and grief issues; e.g., death of a child.

____ H. Issues that involve a couple's larger interpersonal system; e.g., relationships with in-laws, friends, the workplace.

____ I. Community resources for couples with respect to such issues as interpersonal violence, parenting skills, health issues, budgeting and financial management, grief work, job/career concerns, blended families, chronic illnesses, or other common problems that couples face. Ψ

Robert Brown, Ph.D., ABPP is a past president of MPA, past chair of the Maryland Board of Examiners of Psychologists, and is Emeritus Faculty at the University of Maryland. Furthermore, over the years he has coordinated two Postdoctoral Institutes in Couples Therapy for the Maryland Psychological Association. He practices in Columbia Maryland where he sees couples and individuals.



MPA is proud to announce the launch of a new **MPA bookstore through Amazon Affiliates**. The bookstore is filled with books authored by and recommended by MPA members, and contains a variety of books appropriate for clients and psychologists. A small percentage of sales generated will benefit MPA.

The bookstore can be accessed through the homepage of the MPA website, or directly at www.marylandpsychology.org/psychologists/books.cfm.

We hope that this will be a useful tool for you in locating materials for yourselves and clients!

JAY I. LEVINSON, PH.D. HONORED IN VIENNA, AUSTRIA

On May 17, 2014, while attending and speaking at the Viktor Frankl Institute's 2nd International Congress on Logotherapy and Existential Analysis: the Future of Logotherapy, in Vienna, Austria, **Dr. Jay I. Levinson**, a 35-year member of MPA, was doubly honored and recognized for his outstanding scientific and clinical work in logotherapy and existential analysis and the propagation and application of logotherapy. Dr. Levinson was awarded an Honorary Membership in the Vienna Medical Society, and was made an Honorary Lifetime Member of the International Association of Logotherapy and Existential Analysis at the Viktor Frankl Institute in Vienna. The experience was all the more moving and humbling, as Dr. Levinson explained, since his presentation and the bestowing of honors was held at the Vienna Medical School's Billroth Library, one of the same lecture venues used for pioneering work by Freud, Adler, and Frankl (who was Dr. Levinson's mentor and for whom he worked for over 20 years).

Dr. Levinson was invited as a plenary speaker to present a paper entitled, "Bereavement and Logotherapy: A New Perspective on Grief." In attendance were clinicians and researchers from around the world, as well as Dr. Levinson's wife, Lori, and daughter, Gabi. In his acceptance speech, Dr. Levinson thanked the Institute, and his family for their support. He also encouraged others to continue to build on Viktor Frankl's work, as was his fondest wish, to help the many in need. His time in Vienna was highlighted by a visit with Frankl's widow, Elly Frankl, when, after many years, Dr. Levinson enjoyed reminiscing in person with her about their time together with Viktor, a real treat beyond regular phone calls.

The members of MPA extend their sincere congratulations to Dr. Levinson on receiving this singular honor and recognition of his lifetime achievements.

Dynamically Speaking

Richard Ruth, Ph.D.

LGBT Couples—Then and Now

While I was an intern, the hospital where I trained revolutionized its intake form. For the first time, there was a space to sketch in a genogram. The problem was, the space, two inches by three, had room enough for mom, dad, and their two children—but not the complex, multigenerational, extended families we were treating, most from collectivist and not individualist cultures. So some of us drew outside the lines.

But there were limits to our imagination—for me, some of them agonizing. None of my supervisors or colleagues had a clue what I felt as I considered the genogram boxes—that the then-revolutionary discovery, that individuals are essentially contextualized by their family experience, as yet had no space for the family I dreamed of creating. Social conditions being what they were at the time, I did not think I could ever really have a family of my own making. In the world I lived in, there were no models I knew of; in my clinical training, there had been no guiding theory. At the internship I loved, it did not feel welcoming, or even safe, to be out. Achieving that sense took me more than two decades after internship.

I now live and work in an age far different from what I ever envisioned possible. My male partner and I have been together for almost twenty years, civilly and religiously married for eight. The jurisdictions where I practice now recognize my marriage, and—in some ways, even more astoundingly—I am covered under my partner's health insurance. To my students, heterosexual and LGBT, their professor is an old married guy.

Most readers of this column are not LGBT (though MPA is a welcoming home for the not-tiny minority of us who are). But something all practicing psychologists have in common is that we live and work in conditions far different from what we once imagined and evolving so rapidly we can barely keep up.

It is exactly that dynamic that frames my reflections on work with LGBT couples. It has been, for a long time now, nothing revolutionary for a couple with a sexual- or gender-minority member to seek out a therapist known to be part of the LGBT community, or known to be an ally. But the trajectories that bring these couples to me—to us—are every bit as complex, and often painful, as ever. To put it simply: LGBT couples are just like any other couple; and, we're also different.

Psychologists have to understand the differences to be able to appreciate the similarities. LGBT psychology has helped psychology more generally appreciate in new ways that sexuality and gender are complex, substantially socially constructed, more diverse and fluid than we once imagined, and, while not devoid of mysterious elements, psychologically understandable, if we are willing to use the right conceptual lenses.

It is not unusual for a couple to come see me when a member of the couple is coming out. It seems so ordinary that I often have to take a moment to realize that these couples take as an assumption that there is no, or at least little, stigma in seeking a mental health professional's help at a challenging LGBT life juncture—that they come in with hope-verging-on-confidence that their circumstances need not, and will not, be pathologized.

And yet, my coming out patients experience pain, most often, as wrenching as coming-out pain has ever been. Part of my job is to help them see in clear focus that, while, yes, families may be rejecting, jobs may be lost, and bullying and violence may occur, self-determined freedom may be worth any cost—and, that development happens. Parents, more often than not, come around. Life has more space than might seem the case through the crack in the closet door. And love has its unmistakable power.

As readers of this column know, I'm a psychoanalyst who believes with passion in the value of psychology as a

big tent—a practitioner who loves and draws on science. And science about couples with LGBT members tells us some interesting things.

When a person comes out as trans in a loving couple, the old advice that divorce is the proper next step is, simply, wrong. The work of a social worker/family therapist colleague, Arlene Istar Lev, shows convincingly that, when therapists normalize diverse sexual and gender experiences, most loving couples remain together.

The same can be the case when a member of a couple comes out as bisexual, gay, or lesbian; if the couple's therapist takes a position of neutrality among the healthy and normal possibilities for couples' developmental trajectories, many couples decide to remain together, and grow more intimate and close. Not without bumps, kids can adjust, religious congregations can be affirming, and work colleagues can provide terrific social support.

Science also tells us that gender and sexuality are intersectional—that there are important diversities within LGBT populations, determined by issues of race, ethnicity, culture, class, religion/spirituality, and other factors, each with their specific and unique dynamics. And research about service utilization tells us, unmistakably, that, when minority communities perceive psychotherapists to be culturally and intersectionally competent, we are sought out. Paraphrasing a bit playfully—if we build a psychology, they will come.

I am likely to live to see the day when most couples in which both members are LGBT take their right to form strong, loving, lasting partnerships, and marriages if they choose, as ordinary human rights; see psychology as their wise, strong, vocal, proud ally; and have no expectation other than that their families and communities will support them actively. But it will always be the case for me that I came of age, personally and professionally, in a time and place where that was not so. I am shaped, as are we all, by experiences and memories—and by capacities, always, to develop and change.

So what does psychoanalysis have to do with all this? Time to make the indirect allusions explicit.

Unlike Freud—but not at all unlike many contemporary psychologist-psychoanalysts—I see families and couples as well as individuals in my practice. But I am guided, in all the work I do, by Freud's enduring notion that self-exploration in psychotherapy and psychoanalysis is a radical act of personal freedom. A life solution for any given person, chosen after thoughtful reflection and deep self-exploration, may be different from what most others choose, and, precisely for that reason, a radically healthy choice.

Like many of us, Freud did not always apply some of the best elements of his theory to himself. A supremely humanistic man, he was an outspoken advocate for LGBT civil rights, and was an intellectual wellspring for later LGBT psychology in positing, from participant-observer clinical experience, an inherent bisexual potential in everyone. Yet, as emerges in his correspondence, he was frightened and rejecting when he discovered homosexual desires in himself. He thought they could be eliminated through disciplined self-analysis, but, as has been groundedly speculated in current theoretical writing, he may have placed his chair behind his patient couch to avoid, rather than experience and analyze, the countertransference stimulation he felt when he looked at his patients, and saw them looking at him.

When Nazi persecution led psychoanalysis to re-center in the US, my subfield took a conservative, often homophobic and misogynistic, turn. Gayness was reframed as developmental arrest. It has been more than forty years now that LGBT analysts—there are ever-growing numbers of us—have been addressing and redressing these wrongs.

Why do we do it? How does an analytic perspective undergird our efforts? Three stories:

A few years ago, I lost a beloved analytic mentor. I had always admired and learned from her thinking, and been appreciative of her personal warmth and professional encouragement toward me. When I got married, she congratulated me and welcomed the chance to meet my partner, whom she treated with warmth and graciousness from the first encounter. I learned only after she died that, in her sincere, scientific view, gayness was problematic. But that never affected her open-mindedness, or open-heartedness—or behavior—with me as a colleague. That is the living analytic sensibility, at its best.

I wondered what it would be like to get married, and learned what it was really like only after it happened. It was both the most special and the most ordinary of days. Like all happy Jewish grooms, I reveled in smashing the glass—as my husband did, when he smashed his glass as well. My shy nephew danced with almost-abandon; aunts and uncles were warmer toward me than ever, relieved I was finally hitched. Beyond this kind of personal revelation, in the weeks following, I felt, in a palpable way, that I had somehow played a role in the increasing momentum toward social change swirling within and around me. Again, a profoundly psychoanalytic experience—that what we say and do creates transformative, and sometimes discontinuous, change.

This winter, for the first time, an LGBT patient in long-term treatment with me got married. The serious and persistent mental illness that brought her into a productive psychoanalytic psychotherapy did not disappear, but the personal growth, the deep happiness, and their marked clinical impact were there for us both to marvel at. That old psychoanalytic chestnut that patients must not make major life decisions until their treatment is over? It mostly does not linger on, in my office at any rate. Like all psychologists, I enjoy being data-driven. Ψ

Richard Ruth, Ph.D. is on the core faculty of the Psy.D. program at The George Washington University and teaches in the Child and Adolescent Psychotherapy Program at the Washington School of Psychiatry. He has been in private practice since 1988 in Wheaton. He welcomes reactions, questions, and ideas for future columns, and can be reached at rruth@gwu.edu.

MPAGS Members' Reflections on Training in Couples Therapy

LAUREN BATTAGLIA DUMONT, MS, TIFFANY DUFFING, MA, COREY MOLZON, MS

Couples Therapy: A Better, or Different, Perspective?

LAUREN BATTAGLIA DUMONT, MS

As a clinician in training, I have spent quite some time with my individual clients. By "spending time with," I mean that I spend time both in the room with my clients, and outside of the room thinking about their presentation, consulting various theoretical models, sifting through dozens of interventions in an attempt to try to find the "right ones," and engaging in a plethora of discussions with peers and supervisors about all of the above.

After spending so much time with my clients, especially those I have been seeing for almost a year, I thought that I had a reasonably clear understanding of them as individuals, and how they interact with the world around them, both through the anecdotes they relayed to me and our interactions in the therapy room. Spending countless time analyzing the transference and counter-transference, I thought that Freud had provided me with the golden tool for understanding my clients' interpersonal dynamics. I was under the assumption that the therapy room was an accurate microcosm of their social world. It wasn't until I started therapy with a couple, let's call them Joe and Susanne, that I began to learn how working with two individuals simultaneously can provide so much insight into their interpersonal worlds.

When I first met with Joe and Susanne together, we spent most of the session discussing informed consent, course of treatment, and going through paperwork. We had a brief conversation about what brought them into couples therapy (they cited "communication problems") and then our hour together was over. Over the next two weeks, I met with both Joe and Susanne separately, in order to obtain their individual histories and personal perspectives. After meeting with them separately, I thought that I had a good understanding of what their relationship was like. They reported to me the content of their typical conversations and fights, and alluded to what their fight cycle might look like. They also each reported how they saw themselves as individuals, and what they believed their respective roles in their marriage to be.

One week later, I was ready to go ahead and start seeing Joe and Susanne together. I walked into the room, sat down, and watched as the "facts" they provided me with morphed into a fog. These facts were in some ways accurate, but in other ways clouding what lay beneath them. By watching their relationship unfold before my eyes, I was able to see beyond the content of what they each had shared with me, and I realized how much I really did not, and could not, know about Joe and Susanne until I saw them with each other.

I began to see that the "sadness" Susanne discussed with me expressed itself as criticism toward Joe when she was with him. I saw that the "anger" that Joe discussed with me expressed itself as indifference toward Susanne when he was with her. So, Susanne was feeling sad, but acting critical, and Joe was feeling angry, but acting indifferent. No wonder they cited such communication difficulties! They are communicating to each other via words and behaviors that don't match what they are actually feeling inside.

This experience generated constant wonder in my mind…I wondered how my perception of my individual clients would change if suddenly one of their friends, family members, romantic partners, or bosses suddenly appeared in the room next to them, and I was able to witness the process of their interpersonal relationships. Would there be any inconsistencies, or incongruences between what they told me, and what I saw? If so, how would those incongruences change my conceptualization or treatment of my clients? Was I under some illusion, some spell, with my individual clients that allowed me to see their "foggy" persona, and not their actual self as seen by significant others in their lives?

Through much consultation and discernment, I began to realize that although one gains so much insight into clients' interpersonal dynamics through couples therapy, all is not lost with individual therapy! In individual therapy we deal with what the client perceives as reality, which is a real and valid experience for him or her. However, I am realizing that awareness of the possible discrepancies between the therapy room "microcosm" and real life is important to consider and discuss with all clients. Couples therapy can serve as a constant reminder of the very real lives that our clients lead outside of session, and remind us to constantly generate multiple hypotheses about how clients may be interacting with the world.

This journey, as a clinician in training, is an exciting one. These frequent "aha!" moments are exciting, and can broaden our horizons and perspectives. I look forward to my continued work with clients, and all that they will teach me along the way.

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MPA Highlights

Healthy Kids Day

Thanks to the efforts of a number of several fantastic volunteers, MPA was able to participate in **two** outreach/ public education events for Y Healthy Kids Day (at Silver Spring Y and New Hampshire Estates Elementary) on April 26th. Both booths had bean bag toss games and prizes, which, along with out friendly volunteers, attracted lots of kids and their families! Between the two locations, we had about 400 kids/800 families come by! We talked about resilience and gave out brochures promoting psychological health and the mind-body connection.

A HUGE thanks to those who came out for Healthy Kids Day: Ana Aguirre-Deandreis, Mary Alvord, Lise Becker, Jessica Floyd, Roseanne Middleton, Jessica Samson (who also kindly put in hours in advance of the event to decorate the bean bag toss game), Angela Priester, Bethany Wetherill, Judith DeVito and Dick DeVito who braved all day at the SS Y, and Judith Glasser who was out of town, but contacted all the Ys set up MPA participation!

We hope you'll consider volunteering next year at the Y Healthy Kids Day (typically 3rd or 4th Saturday in April) or at the 50+ Health Fair this coming October 17th in Columbia. Mark your calendars! More details to come.

OCI 2014

The MPA's annual Ocean City Institute provides a unique opportunity for professional development, socialization, and relaxation time in Maryland's favorite retreat. This May 9-11, members and non-members joined us at the beach to enjoy social events with fellow psychologists, learn some new skills for their practices, and relax with a getaway at the beach.

Be sure to check the CE schedule on the back cover of this issue, or visit the website, to check out other great continuing education and networking opportunities!

MPAG Reflections *continued from page 29*

Fostering Self-Awareness Through Couples Therapy

TIFFANY DUFFING, MA

As a graduate student and clinician-in-training, I have certainly experienced times of self-doubt about whether I am the skillful therapist that all clients deserve. Often referred to as the *Imposter Syndrome*, these feelings of inadequacy led to times when I questioned my abilities as a clinician; I doubted if I possessed, or even had the aptitude for, what seems to be a naturally occurring talent witnessed in the most skilled psychotherapists. In many instances, I have been able to see past my self-doubt and recall prior demonstrations of my competencies. Part of re-convincing myself included reminders that becoming the therapist that I desire to be is a continual process, and that while I possessed core elements at the foundation, the true talent develops through years—perhaps decades—of experience, supervision, and on-going self-reflection.

Despite this general awareness that becoming a skilled clinician takes time and patience, I indeed have had instances where my confidence was overshadowed by situational doubt. The most common theme of this self-doubt involved working with clients whose concerns were centered on unhealthy or dysfunctional relationships. More specifically, when providing couples therapy I have found myself both aware of my capabilities and passion, yet perplexed with questions regarding my qualifications. I have wondered how I, a woman married less than a decade, could possibly help couples who have been married longer than I have been alive. More generally, I have questioned how a graduate *student* such as myself could actually be the therapist clients are seeking.

What I have learned through providing couples therapy (with the help of great supervisors) is that neither I, my life, nor my own marriage needs to be perfect in order to help couples successfully navigate through their struggles. I do not need to know what it feels like to be married for decades. I do not need to have an emotional wall separating myself from my spouse in order to hear and empathize with my client's experiences. As a couples therapist, what I must be able to do is assist the couple in identifying their strengths and areas of distress; I am responsible for helping them establish a roadmap for positive change while also encouraging acceptance and empathy. Offering couples therapy has challenged me to remain aware of the dynamics occurring in the session and their relationship, and know how that knowledge fits into their identified problems.

Perhaps most importantly, I have learned that the first step in facilitating effective couples therapy is to remain hopeful, both in my own abilities and the couples' abilities. For me, treating couples is exciting, challenging, rewarding, and exhausting all at the same time. It allows me to extend my services past the individual and directly into a client's broader world, their relationships. There are moments when I think I am doing my job well and other times when I ask myself if I have what it takes. At the end of the day, I must remind myself that my skills and abilities are a work in progress. Just as I encourage my clients to be patient while identifying their own strengths and areas of growth, I also have to be willing to extend this same understanding and compassion to myself.

Thoughts from a Novice Therapist

COREY MOLZON, MS

Shortly after being assigned my first couples therapy case, I was asked by a friend to describe the kinds of experiences that I was getting in graduate school. I quickly ran through my generic list, highlighting assessment, individual therapy, and couple's therapy, when my friend gasped. Before I had time to ask my friend if she was okay, I found myself being told about how little I knew about couples, marriage, and relationships. As my friend reminded me, I am "only a twenty-something-year-old girl," so how could I possibly have anything to offer the couple that I am treating.

In my next couples session, I felt hesitant in the room, and frustrated by my inability to help my clients. I remember feeling uncertain and completely useless as I sat in the room with them. I spoke to my supervisor and sought out interventions that I could bring into the therapy room as a safety net to protect myself from failure and my clients from harm.

Throughout this time, I felt that I could not possibly relate to, understand, or help the couple that I was working with because I simply did not have enough life experience to provide effective couples therapy without the use of standardized techniques and guidelines. Contrary to my work with individuals, I did not trust my clinical instincts or the therapeutic relationship to be able to help this couple. Finally, I disclosed to my supervisor my fears of not having the life experience and skills to help this couple make progress toward their treatment goals. After voicing my internal fears to my supervisor, I realized that I had started to put a great deal of pressure on myself to "fix" the couple. In order to do this, I believed that I needed to bring in elaborate techniques and interventions to help this couple "get better." By focusing on the use of standardized techniques and interventions to help the couple, I lost sight of possibly the most helpful aspect of psychotherapeutic treatment: the relationship.

My supervisor encouraged me to reflect on my experiences with the couple. Through this process, I began to recognize how important the relationship is to my therapeutic style. Thus, without having developed a solid therapeutic relationship with the couple, I found myself struggling to feel grounded in the room and confident in my developing ability as a couple's therapist. This experience taught me how valuable the relationship is to all therapeutic treatment, regardless of the type of client or clients with whom I am working. As this realization sank in, I began to give myself permission to focus on the relationship, and with that, I found renewed belief in myself as a clinician. From this experience, I have not only grown as a therapist, but I have also learned the importance of being open and reflective in the face of challenges. Ψ

Classified Ads

Positions Available

CLINICAL PSYCHOLOGIST—Springfield Hospital Center: Springfield Hospital Center, a State of Maryland Psychiatric Hospital located in Carroll County Maryland has an immediate full time (40 hours per week) opening for a Staff Psychologist in its Recovery Program. Duties to include treatment plan development as part of a multidisciplinary treatment team, completion of annual assessments, and group and individual therapy. Selected candidate will be performing clinical services as part of our Treatment Mall, a patient program in which patients leave their assigned units to participate on a daily basis in treatment programming. Psychological testing skills using currently validated instruments a plus for highest consideration, but not required. Interested candidates should send their CV, proof of Maryland Licensure and 2 de-identified psychological test reports to Robert Levin, Ph.D., Director of Psychological Services, Springfield Hospital Center, 6655 Sykesville Road, Sykesville, MD 21784. Springfield is an Equal Opportunity Employer.

CLINICAL PSYCHOLOGIST—Springfield Hospital Center: Springfield Hospital Center, a State of Maryland Psychiatric Hospital located in Carroll County Maryland has an immediate opening for a half-time (20 hours per week) Maryland Licensed Psychologist. Duties to include treatment plan development as part of a multidisciplinary treatment team, completion of initial assessments, and group and individual therapy. Psychological testing skills using current instruments a plus but not required. For strongest consideration, send CV proof of Maryland Licensure, and 2 de-identified psychological test reports to Robert Levin, Ph.D., Director of Psychological Services, Springfield Hospital Center, 6655 Sykesville Road, Sykesville, MD 21784. Springfield is an Equal Opportunity Employer.

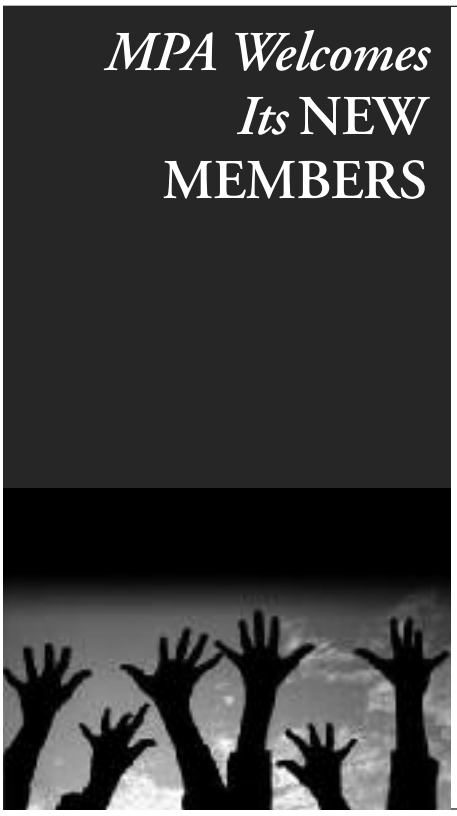
Office Space Available

BETHESDA: Office Condominium for Sale: Decorated, Furnished Office Condominium (Waiting Room, Bathroom, Two Large Therapist's Offices with Windows). Located on Old Georgetown Road and comes with a "Deeded" Parking Space. Metro within easy walking distance, street and garage parking is also convenient. Unit is 698 Sq. Ft. with two entrances (front is 5 steps up from sidewalk. Comes with/without independent sublets. Serious Inquiries Only—301-503-9476! NO REALATORS!

COLUMBIA: Very large, sound-proof, furnished office with fireplace and a wall of windows on wooded lot in townhouse professional park. Child-friendly waiting room and shared bathroom. Excellent location with easy access from nearby counties—close to rte. 29 and 32. Post office, stores, and restaurants in walking distance. Full or part-time availability. Contact Julie Morrison, Psy.D. (410-952-9574) jmorrison7@comcast.net

ELLICOTT CITY: Sound proofed furnished and unfurnished offices available. Full time and shared daily offices in a very congenial, multi-disciplinary Mental Health professional environment. Includes workroom (Photocopier & Fax available) and a full kitchen. Handicapped access, ample parking, private staff bathrooms. Convenient to Routes 40, 70, 29 and 695. Contact Mike Boyle: 410-465-2500.

ROCKVILLE/NORTH BETHESDA: Large, unfurnished office (12 x 17) with wall to wall windows (overlooking parkland) in suite of three offices with shared waiting room, file room and kitchen/admin area. Share suite with psychologist and clinical social worker. Located on third floor of well-maintained, four story professional building on Tower Oaks Boulevard, just off Montrose Road near 270. Free parking. Beautiful office, great location. Available June 1, 2014. Contact Andrea Goldensohn at 301-468-7711 or drg@andreagoldensohn.com.



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SAVE THE DATES

SEPTEMBER 12, 2014

ICD Diagnosis and DSM Changes: A New Horizon

Carol D. Goodheart, Ed.D.

9:00 AM – 4:30 PM
(LUNCH IS INCLUDED)

6 CE Credits

The Conference Center
at the Maritime Institute
692 Maritime Boulevard
Linthicum Heights, MD

OCTOBER 10, 2014

MPA Annual Convention

Up to 7 CE Credits

MPA Annual Convention will be a full day of CE which will include multicultural and ethics workshops in addition to a variety of other topics to enrich and expand your treatment repertoire. *(Brochure will be mailed this summer.)*

2014 SLATE OF CANDIDATES FOR MPA OFFICES

President-Elect – **Joann Altiero, Ph.D.**

Representative At Large – **Gregory S. Chasson, Ph.D.**

Treasurer – **Richard G. Wirtz, Psy.D.**

More information about candidates, including their biographical information and position statement, is available in the Members section of the MPA website at **www.marylandpsychology.org/directory/2014offices.cfm** (login required, but accessible from the homepage, QR code below, or directly from the URL.

Later this month you will receive the MPA ballot in the mail. Please participate by taking a few moments to vote on the 2014 slate of candidates for MPA offices.

10025 Governor Warfield Parkway, Suite 102
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MPAF Continuing Education 2014 Spring/Summer

	Presenter	CE Credit	Price	Time & Location
Continuous				
Boundary Issues and Multiple Relationships: An Online Ethics Course for Psychologists Meets the MD license renewal req. for ethics/laws/risk management	Michael Heitt, Psy.D., Moderator	4 CE's	$95 MEMBERS $145 NONMEMBERS	www.marylandpsychology.org
Continuous				
Medicare's PQRS: What is it? How do I do it?	Paul Berman, Ph.D.	2 CE's	$15 MEMBERS $30 NONMEMBERS	www.marylandpsychology.org
7/17/14				
"Lunch and Learn Series" Advocacy in the Schools: Turning Clinical Data into Results for Your Patients	Rebecca Resnik, Psy.D.	1.5 CE's	$25	12:00-2:00 PM MPA Office 10025 Gov. Warfield Pkwy, Suite 102, Columbia, MD
9/12/14				
ICD Diagnosis and DSM Changes: A New Horizon	Carol Goodheart, Ed.D.	6 CE's	$165 MEMBERS $250 NONMEMBERS LUNCH INCLUDED	9 AM–4:30 PM Conference Center at Maritime Institute Linthicum Heights, MD
10/10/14				
MPA Annual Convention (Morning sessions meet the MD license renewal req. for Cultural Diversity and the afternoon session meets the requirement for Ethics/laws/risk management)	Various	Up to 7 CE's	Refer to Upcoming Brochure	Sheraton Hotel Annapolis, MD

Please continue to check the MPA website – we will be adding additional workshops as they are planned throughout the year. If there is a topic or presenter you would like see presented please indicate that on your evaluation sheets.