HELPING FAMILIES OVERCOME
OPIOID ADDICTION

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Opioids and the Family
The opioid epidemic that is currently plaguing the U.S. has again brought to the fore the importance of providing substance use disorder treatment within the familial context.
Catherine Devaney McKay, MC
William F. Northey, Jr., PhD

Addiction and the Elderly
An overview of the factors that may leave members of the elderly population vulnerable to addiction and opioid misuse, and some useful therapeutic interventions.
Sarah Bauer, MS

Systemic Research: Mothers with Substance Use Disorder and their Children
Rates of substance use among women are increasing, with a large percentage of these women providing primary caregiving to minor children. Engagement of children in family systems treatment with their mother is an opportunity to prevent substance use, social and emotional problems, as well as improve mother’s recovery.
Natasha Slesnick, PhD

Chronic Pain, Opioid Use, and MFTs
Despite the increase in opioid prescriptions for pain, the amount of pain in the U.S. has actually increased. Clearly, opioids are not having their intended effect. In fact, evidence supports that most people taking opioids have more pain and a reduced quality of life.
Don Teater, MD
Martha Teater, MA

“Because of the number of people taking opioids and the changes opioids cause, prescribers need the help of MFTs as they treat pain and care for people who take opioids.”
Neonatal Abstinence Syndrome: A Review for Marriage and Family Therapists

Neonatal abstinence syndrome is developing in a high percentage of infants with prenatal exposure to opioids and is characterized by a wide range of symptoms. MFTs should be aware of protective factors, screening considerations, and interventions. Jerrod Brown, PhD Cheryl Arndt, PhD Matthew D. Krasowski, MD, PhD

“When unidentified and untreated, NAS contributes to both short- and long-term consequences, such as cognitive functioning deficits and substance abuse across the lifespan. This emphasizes the importance of early identification through improved screening procedures.”
Systemically trained family therapists are needed!

The insidious effects of the opioid epidemic are well documented. Considering that it is estimated 115 people die every day in the USA from opioid addiction, it is no surprise that individuals, couples, families and entire communities are being adversely impacted. The President's Commission on Combating Drug Addiction and the Opioid Crisis reported that one of the five necessary elements in treating opioid addiction includes, “Simultaneous access to adjunctive psychosocial treatment that may include: group therapy, individual counseling, family therapy, relapse prevention, other psychosocial treatment.” Systemically trained family therapists are needed!

While our governmental agencies struggle with developing effective policies that reduce the pervasiveness of opioid addiction, family therapists will continue to be necessary and valued providers in treating opioid use and addiction. In this issue, you will find a range of topics and information that can be helpful when you encounter opioid use and addiction—because it is very likely you will encounter opioid addiction.

One contributing factor to the current crisis involves the historical use of pain patient advocacy. The pain patient model was well intended to include patients in care and ensure they had a place in the communications loop. However, the unintended consequence was that patients were becoming addicted and creating a demand—within the feedback loop—for more opioids.

Systemically trained family therapists have a longstanding history of understanding complexities of individuals in treatment being the sole informant about treatment issues. Further, within the clinical challenges of opioid addiction are multiple ethical issues that need consideration such as informed consent, collaboration, multiple relationships, referrals and clarity regarding who is being treated. For those who are not systemically trained, ignorance of these situations, as exhibited by the pain patient advocacy model, has a high potential to create harm. Systemically trained family therapists are needed!

Even if not directly treating opioid addiction, MFTs may be working with the high-risk population of chronic pain clients. Teater and Teater (p. 18) report it is estimated that nearly one-third of the population lives with chronic pain. Chronic pain can wreak havoc on any system and, too often, opioids are an ill-fated intervention. MFTs are particularly suited to deal with the systemic impact and work toward prevention strategies, as well as treating chronic pain. Systemically trained family therapists are needed!
AAMFT’s core purpose/mission statement: “Recognizing that relationships are fundamental to the health and well-being of individuals, couples, families, and communities, AAMFT exists to advance the profession and the practice of marriage and family therapy.”

Alarming, is the increased prevalence of substance use among women. McKay and Northey (p. 6) discuss that between 1999 and 2014, the rate of substance abuse and overdose deaths among women increased by more than 400% compared to 265% for men; and babies born exposed to opioids quadrupled. Further, he reports that marriage is a protective factor against relapse for men, but for women, marriage is actually a risk factor. Systemically trained family therapists are needed!

The President’s Commission recommends that interventions and strategies focus on keeping families together—when it can be done safely—and approaches should include utilizing comprehensive family-centered treatment. Systemic family therapists are uniquely trained to deal with the multitude of variables presented by opioid addiction and chronic pain. We all know that working with individuals, couples, families and communities from a systemic perspective involves much more than techniques…much, much, more. Yet, there are others among the behavioral healthcare professions who advocate that the use of relational interventions is all that’s needed to work with complex systems and treatment issues such as opioid addiction. More distressing, many believe that systemically trained family therapists should simply be a subset of another behavioral healthcare profession.

In order for our profession to have a seat at the treatment table, all of us must remain diligent regarding these subversive beliefs and corresponding tactics to minimize our profession. Treating something as pervasive as opioid use and addiction requires our unique skills, knowledge and experience, and we must remain viable treatment providers along the treatment continuum.

Systemically trained family therapists are needed!

Sincerely,

TRACY TODD, PHD
AAMFT Members Attend United Nations Meeting on Evidence-based Family Therapies

Dr. Fred Piercy, along with other AAMFT members, attended a United Nations meeting in Vienna in early June on the application of evidence-based family therapies for substance abuse disorders in low-income countries. The meeting was sponsored by the UN’s Office of Drugs and Crime (UNODC).

AAMFT members included Fred Piercy, Laurie Charles, and Manjushree Palit. Dr. Piercy remarked, “it was gratifying to be part of such a potentially pivotal UN-sponsored event and to see a range of family therapy professionals working together on a goal with such far reaching implications for so many people across the world.”

Giovanna Campello of the United Nations Office of Drugs and Crime stated that it was indeed “high time” for the UN to acknowledge that evidence-based family therapies for adolescents with drug disorders has entered the world stage and was delighted that the UN would have a role in disseminating elements of these therapies to low-income countries.

Participants came from a number of countries, including: the Philippines, Turkey, Viet Nam, Uzbekistan, India, the Netherlands, Spain, the UK, US, Germany, and Austria.

DATA NOTE

Facts & Faces of Opioid Addiction

4.3 million
Americans are using opioids for non-medical purposes.

115 people
die each day from prescription painkiller overdose.

21.2 years
is the average age for first-time use of prescription painkillers in the past year.

SOURCE: NATIONAL SURVEY ON DRUG USE AND HEALTH AND CENTERS FOR DISEASE CONTROL.
Congress and the Opioid Epidemic

AAMFT has been involved in lobbying Congress to help address the opioid epidemic by allowing MFTs to treat Medicare beneficiaries and other individuals and families impacted by the opioid epidemic.

Congress has introduced a flurry of bills to address the opioid crisis. One significant bill introduced in April was the Opioid Emergency Response Act (HR 5531). Sponsored by Congressman Vern Buchanan (R-FL), this important legislation includes a provision that adds MFTs and mental health counselors (MHCs) as Medicare providers. In addition to adding MFTs as Medicare providers, HR 5531 includes provisions from other healthcare bills that would reduce opioid use among Medicare patients in emergency rooms, continue existing grants to states to improve access to treatment, provide additional funding for the National Institutes of Health to research non-opioid treatments, and require the VA to study the link between opioids and the high rate of suicides among veterans. By including a section adding MFTs and MHCs as Medicare providers, this legislation recognizes that increasing access to behavioral health providers is a key part of the response to the opioid crisis.

AAMFT endorsed HR 5531, along with the American College of Emergency Physicians, the National Board for Certified Counselors, and Centerstone, a major provider of community-based behavioral healthcare. After the bill was introduced, AAMFT and its allies lobbied members of Congress to cosponsor this new legislation. On April 18, AAMFT sent out a grassroots email blast to all U.S. members urging their representatives to cosponsor HR 5531. As a result, over 1,800 messages were sent to members of Congress urging them to support this legislation. In addition to grassroots messages, in April, several AAMFT Family TEAM members traveled to Washington to lobby their members of Congress to support including MFTs as Medicare providers.

Both the House and Senate are moving legislation to address the opioid crisis. On June 26, the House passed HR 6, a comprehensive bill to address the opioid crisis. Among other things, this legislation would require Medicare to cover opioid use disorder treatment services provided by some professionals, create a federal panel to coordinate the federal response to the opioid crisis, and create a loan repayment program for behavioral health providers who provide services in substance use disorder treatment programs. Unfortunately, many opioid-related bills, including HR 5531, were not included in HR 6. Although HR 6 passed the House by a vote of 396 to 14, some members of Congress who voted for the bill stated that the bill will not do enough to deal with the opioid crisis and that more federal funding is needed to treat impacted persons.

The Senate, Finance, Judiciary and Health, Education, Labor and Pensions (HELP) Committees have all passed opioid-related legislation. The entire Senate is expected to take up these bills, along with HR 6, later this year. AAMFT will continue to advocate for Congress to address the vast shortage of behavioral health providers treating the Medicare population by urging Congress to include MFTs as Medicare providers.
Catherine Devaney McKay, MC  
William F. Northey, Jr., PhD
Despite the long history and evidence-based couple and family interventions for substance use disorders (SUD; Stanton, 1997; Stanton & Shadish, 1997) consistent integration of family therapy with programs that provide SUD treatment is rare, despite efforts by national and international organizations to bridge the gap between family therapy and SUD treatment (Rowe, 2012). The opioid epidemic that is currently plaguing the United States has again brought to the fore the importance of providing SUD treatment within the familial context.

The Centers for Disease Control and Prevention (CDC, 2016) has called the current opioid epidemic the worst addiction epidemic in U.S. history with opioid deaths, sales of opioids, admissions to treatment, and babies born exposed to opioids all quadrupling between 1999 and 2014. The rate of substance abuse and overdose deaths among women has increased by more than 400% compared to 265% for men (CDC, 2017).
Women experience more rapid onset of tolerance and addiction and have higher levels of co-occurring disorders than do men, and many women with substance use disorders report sexual abuse in childhood and violence in adult intimate relationships. The link between a woman’s substance use disorder and her partner’s is a factor as well—for example, marriage is a protective factor against relapse for men, but for women it is a risk factor. Many women who are pregnant or who have young children do not seek treatment or drop out of treatment because they are overwhelmed and concerned that authorities will remove their children (National Institute on Drug Abuse, 2016).

Methadone has been widely used to treat opioid dependence since the 1960s and, along with buprenorphine, a newer drug, is considered the gold standard for treating opioid use disorder (Ayanga, Shorter, & Kosten, 2016). Methadone stops heroin cravings, the leading cause of relapse, and blocks the painful effects of heroin withdrawal. Whereas heroin destabilizes the brain, methadone actually helps to stabilize it. A 1997 National Institutes of Health (NIH) panel concluded that the safety and efficacy of methadone maintenance treatment (MMT) has been unequivocally established, adding that methadone itself is an opioid and it is not uncommon for some people to remain in treatment indefinitely. Although it is true that methadone is a narcotic, it does not produce the satisfactory feeling of a high or the euphoria in people who are opioid dependent. That said, it is all too common that family members are not common that family members are talking with their partners utilizing MMT to get off the very medication that allows them to engage in their recovery. While people are generally okay with the use of insulin for diabetes, some individuals are fundamentally opposed to the use of MMT to address SUD. Likely the stigma associated with SUD is partially to blame for such reactions, but there is also a belief that because methadone is a narcotic, there is no difference between it and other opioids, both legal and illicit.

For pregnant women, methadone continues to be the best treatment option because it also prevents premature births and spontaneous abortions that can occur during withdrawal from heroin and other short-acting opioids.

**Engagement in treatment**

While people with opioid use disorders (OUD) enter treatment for a number of reasons, it is common for women to first come to treatment when they learn or suspect that they are pregnant, often bringing their partners with them. One such woman was Lisa, who came to an MMT program after she found out she was pregnant and she was joined by her husband, Thomas. Engagement in MMT can be challenging initially, but one of the benefits of using methadone is that it prevents people from going into withdrawal, which is often a significant motivation to return to using illicit opioids. Opioid withdrawal is quite agonizing and initially includes agitation, restlessness, fever, and flu-like symptoms (up to five days). In that middle phase, which can last up to two weeks, there is depression, cravings, chills, and cramps. The final phase, which can last up to two months, includes mood swings, anxiety, insomnia, and cravings. The risks for relapse and overdose are the most severe when people are going through withdrawal. Because MMT mitigates many of the withdrawal symptoms, engagement in treatment increases when people are utilizing MMT.

Once established in MMT, it is the ideal time to engage clients in systemic therapy. In the case of Thomas and Lisa, Thomas began his use of opioids with his mother, who continues to use methadone for treatment of heroin addiction. April is a 47-year-old mother who was living with her husband, Thomas. Engagement in treatment increases when people are utilizing MMT.

**CASE STUDY: THE FOCUS OF SYSTEMIC THERAPY**

Lisa and Thomas presented as many couples do who are struggling with OUD. Lisa and Thomas represent a relatively new population of young men and women who present as couples in rural areas where both members of the couple are opioid dependent and are in their child-bearing and parenting years. Their babies are subject to social, medical, and psychological services has the highest probability of being the most effective of all available treatments for opioid addiction.

Despite the evidence of its effectiveness for treating moderate to severe opioid use disorder, controversy over the use of MMT remains because methadone is itself an opioid and it is not uncommon for some people to remain in treatment indefinitely. Although it is true that methadone is a narcotic, it does not produce the satisfactory feeling of a high or the euphoria in people who are opioid dependent. That said, it is all too common that family members are talking with their partners utilizing MMT to get off the very medication that allows them to engage in their recovery. While people are generally okay with the use of insulin for diabetes, some individuals are fundamentally opposed to the use of MMT to address SUD. Likely the stigma associated with SUD is partially to blame for such reactions, but there is also a belief that because methadone is a narcotic, there is no difference between it and other opioids, both legal and illicit.

For pregnant women, methadone continues to be the best treatment option because it also prevents premature births and spontaneous abortions that can occur during withdrawal from heroin and other short-acting opioids.
heroin and shares a home with Lisa, Thomas, and their children. In 2016, the American Academy of Pediatrics (AAP) published a clinical report which recommended that its members screen and help families where substance use is a problem. The AAP highlighted the impact of parental substance abuse on healthy family functioning, routines, and relationships, raising the need for family-based approaches to treatment. With couples in which OUD is an issue for both members, family-centered treatment is imperative to not only improve the outcomes for the couple, but both the long- and short-term outcomes for their children as well. When OUD is a multigenerational problem, involvement of grandparents and extended family is necessary to leverage family resources to mitigate the impact of OUD on the family.

**Multisystem influences**

Systemic family therapists are uniquely suited to provide services to family when OUD is operating. As noted previously, the use of substances disrupts family routines, responsibilities, and activities. These impacts are exacerbated when there are multiple family members using substances. Unfortunately, SUDs are usually comorbid with other biopsychosocial consequences, including medical issues (such as Hepatitis C), poverty, homelessness, unemployment, marginalization, stigmatization, and lack of access to care. The intersection of these problems presents challenges for family therapists and other helpers, particularly in rural communities, where there may be a shortage of qualified providers.

Lisa and Thomas lived in a rural area where services were limited. Despite Lisa beginning MMT with Thomas before the birth of her first daughter, Crystal, there were several complications with the birth. These were due to prenatal exposure to substances and neonatal abstinence syndrome, resulting in an extended stay in a neonatal intensive care unit in another part of the state. Their local hospital was unable to provide the necessary care to Crystal. The stress related to the problematic birth and extended separation from Crystal led to increased conflict between Lisa and Thomas, leading their counselor to make a referral for family therapy.

As the case study suggests, the issues facing families in which there is OUD are complicated and exacerbated when multiple family members are engaging in problematic substances. For family therapists, balancing the needs of all the family members presents additional challenges. The risk of relapse and the ability to effectively parent are often inextricably interwoven with contextual issues, such as stigma, poverty, homelessness, marginalization, discrimination, trauma, and abuse. Despite these challenges, there are often strengths that families can call upon when striving for recovery from SUD. It has long been established that family and significant other involvement in treatment increases both engagement and retention, both critical to increasing the chances that treatment will be effective. Thus, capitalizing on familial strengths is imperative to successful OUD treatment (Stanton, 1997).

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**THE RISK OF RELAPSE AND THE ABILITY TO EFFECTIVELY PARENT ARE OFTEN INEXTRICABLY INTERWOVEN WITH CONTEXTUAL ISSUES, SUCH AS STIGMA, POVERTY, HOMELESSNESS, MARGINALIZATION, DISCRIMINATION, TRAUMA, AND ABUSE**

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**References**


Addiction and the Elderly
When we think of people in active addiction, the common perception is people who are young and may not have come from the “best” home environment. This perception has some truth to it, as many individuals struggling from addiction are between the ages of 18-25, but this perception does not account for the population that exists in the shadows—one that needs personalized help and treatment—the elderly. The elderly population, as per the National Council on Alcoholism and Drug Dependence, accounts for about 2.5 million people struggling with addiction, and continues to grow at an alarming rate as the baby boomer generation ages (Wilcox, 2018). This population, for the purpose of this article, is defined as individuals over the age of 55 years of age and the terms elderly and baby boomer population (deemed to be 55-75) are used interchangeably.

Sarah Bauer, MS
While the reasons for an individual experiencing addiction can be individualistic and stem from the biopsychosocial model, specialized issues emerge when working with the elderly and addiction in therapy. Characterized commonly by a work-family imbalance, high value and importance on recognition and respect for authority, the baby boomer population thrives on interpersonal and face-to-face relationships with others (Ryback, 2016; West Midland Family Center, 2018). Addiction concerns aside, consider the population at hand, living in a changing world. As the millennial population, vastly different than the baby boomers, grows into adults and emerges into the workplace, challenges are created for baby boomers who did not grow up with current technology and other advances.

The stereotypes of individuals dealing with addiction can target young adults and provide specialized services for individuals to seek treatment, such as medicated-assisted treatments, including methadone maintenance and detoxification rehabilitation services. While these specialized services are beneficial to some, they may not resonate with the elderly population, who may not perceive that they have an issue; they may not feel that these services pertain to them.

The reasons why
Why does addiction occur, especially in the elderly population? To understand the reasons, one must investigate the culture of the generation. Members of the baby boomer generation were teenagers and young adults during the Vietnam War, spanning the 1960s-70s. This time frame is often remembered as a period of free love, drug use, and anger about the war (West Midland Family Center, 2018). Some individuals coming home from war may have returned with trauma and mental illness, which, during that time, went largely untreated (Skooig, 2011). This culture may create the acceptance of use of illicit substances and/or alcohol in an increased fashion.

As many baby boomers reach retirement age, value in the workplace and the recognition of their work may no longer provide reasons to thrive. The elderly, when retired, may feel a loss of self, with thoughts such as, “I am not wanted/needed” and “I don’t feel that I have a place in the world anymore.” This, coupled with boredom, may increase illicit substance and alcohol use to cope with feelings of boredom and decreased motivation.

Relationships are a major component of the lives of the elderly, and the loss of these relationships due to death, divorce, children moving out, or otherwise can be traumatizing. The launching of adult children may feel like a loss to the elderly, as their once full nest becomes empty. Or, consider a divorce between two people who have been married for 30 years. The trauma of the divorce, coupled with the recognition of the loss of that spouse, may leave individuals seeking other means of coping, including illicit substances and/or alcohol.

As the baby boomers age, their bodies also begin to face limitations, and modifications are necessary for individuals to continue to participate in everyday activities. As per the World Health Organization (WHO), while individuals are living longer (well into their 60s and beyond) the quality of life is compromised due to health conditions (2015). The elderly may suffer from a variety of conditions, including chronic pain, diabetes, and others in which doctors may prescribe Oxycontin and benzodiazepines, such as Xanax or Klonopin, to assist with alleviating these conditions. With the opioid epidemic becoming nationally recognized, policies and laws (such as New Jersey’s implementation of the reduction of the number of opiates that can be prescribed per year) decrease the number of opiates that can be dispensed (New Jersey Consumers Law, 2017). When the prescriptions decrease, the elderly may seek other means to obtain opiates or other narcotics. These characteristics are not the sole reasons why addiction occurs, but can shed light on understanding why addiction has occurred within the elderly at such a rapid rate.

Life after detox
When an individual recognizes that they are suffering from addiction, detox and/or rehab may be assistive to help an individual experience sobriety and move into recovery. Detox and rehab are viewed by some of my clients as “a positive vacuum in time until I get home.” In other words, an individual who is in detox and rehab receives
specialized attention for their addiction through education and may receive medication for their withdrawal symptoms, but once they return home, they return to the same environment where their addiction began. One of the main challenges behind returning home from detox is that the same issues that may have caused their addiction still exist. Addiction does not end when an individual goes to an inpatient facility. The same people, the same places, the same behaviors remain, and for an individual who is in early recovery, this can negatively affect them, and relapse may occur.

Continued treatment outside of detox/rehab is necessary for an individual to remain sober. The National Institute on Drug Abuse reports relapse rates ranging between 40-60% (National Institute on Drug Abuse, 2014). The stigma surrounding treatment for illicit substances has decreased, but remains high among the elderly population, where many have a “don’t ask, don’t tell” mindset. The stigma about mental health treatment among the elderly remains, as the prevalence of individuals who suffer from diagnosed mental health disorders accounts for 20% of the population, with far more individuals suffering in silence without treatment (Gum, King-Kallimanis, & Kohn, 2009). Further, studies have shown that between 21-66% of elderly individuals who are experiencing addiction also suffer from a mental health disorder, which complicates treatment and life after detox (Centers for Disease Control and Prevention, 2017).

Lifestyle and diet changes are often highly recommended to stay sober and in recovery, though these suggestions may not be useful or practical for the elderly population due to medical conditions and/or limitations. These changes may also require an elderly individual to leave home due to others in the household who are in active addiction. This type of change can be traumatic, as recovery houses are geared towards young adults and may have steps that are not accessible to an elderly individual with limitations such as using a wheelchair.

**Therapeutic interventions**

Some of the best interventions I have found in working with the elderly population after rehab and detox are:

1. **Remember the struggles that the elderly population face (they are people, too)**

   While young adults may experience issues with parents and friends, elderly populations experience issues around their friends and family passing away and may have no other support systems after this point. One client said to me recently, “everybody is dying… I have no idea how to cope,” after several family members and friends passed away in a few short months. We, as therapists, can assist these clients by serving as their support systems and providing a listening ear and a kind voice. They are people, too, and we must refrain from entering any bias that we may have. Some of the biases, such as, “they should know better given their age,” are not appropriate and can affect our care of this population. It is important to be mindful of these biases.

2. **Education, education, education**

   Many people may not understand addiction or what it entails. Those in addiction, especially those who are abusing alcohol, many not understand what alcohol addiction is due to its legality in the United States. Others may have grown up in a culture where higher use of alcohol was acceptable. Therefore, education about what addiction is and assisting the individual and family to determine the reasons behind addiction is beneficial in sobriety/recovery.

3. **Increase coping mechanisms/accountability**

   Many individuals use illicit substances or alcohol due to low coping mechanisms to stressful situations. The elderly population may be resistant to treatment and cite reasons such as, “I’m already old and set in my ways… why should I change?” or “I’m not hurting anyone but myself.” At the core of these thoughts may be a fear that change is negative or that they may never change or be “fixed.” To help the client recognize that their actions are impacting others, as well as themselves, it is beneficial to begin working towards a stable state, which is what many of us are seeking in our lives, regardless of age.

**References**


Sarah Bauer, MFT, MS, is a staff marriage and family therapist at Council for Relationships in Philadelphia. Her interests include working with couples, families, and individuals surrounding addiction, domestic violence, and trauma. She is an AAMFT Pre-Clinical Fellow.
Mothers with Substance Use Disorder and their Children

Rates of substance use among women are increasing, with 7.3% of U.S. women reporting a drug use problem (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Among these women, 70% have primary responsibility for minor children, and research indicates that these children are at risk for poorer developmental outcomes than their peers (Hussong et al., 2008)—substance use is a family disorder. In fact, approximately 11% of U.S. children live in a family with one or more parents with a substance use disorder (SUD). Half of these children will have an SUD themselves by young adulthood. Research studies note that the connection between parental substance use and child substance use is linked to parent-child relationship quality. Therefore, family systems therapy has great promise to improve outcomes for both mother and child, but surprisingly, little such intervention research has been conducted. Engagement of children in family systems treatment with their mother is an opportunity to prevent substance use, social and emotional problems from developing in the children, as well as improving mother’s recovery.

Natasha Slesnick, PhD
Differences in family interaction as a function of drug of choice are not well-known. Research concludes that the parenting of mothers with an opioid use disorder differs from that of mothers without a substance use disorder; however, most of this research has focused on interactions of mothers with their infant or very young children. An exception, Slesnick, Feng, Brakenhoff, and Brigham (2014) observed that parenting and parent-child (8-16 years) interaction may be less negative for mothers with an opioid use disorder (OUD) compared to mothers with an alcohol use disorder. In particular, in a mother-child observational task, mothers with an OUD were observed to show less undermining behaviors. In addition, both mother and child self-reported higher maternal acceptance than other mothers and children. The clinical effects of opioid use include anxiety reduction, euphoria and a profound sense of well-being, which may have resulted in these observed positive effects. However, all mothers, regardless of drug of choice, struggled with parenting as self-reported parenting scores fell into the range observed for clinical samples. Another study (Guo & Slesnick, 2018) showed that in comparison to other drugs of choice, opioid use in mothers is more influenced by their children. In particular, children's externalizing behaviors predicted higher opioid use in mothers nine months later. In contrast, among women with a primary alcohol use disorder, child driven effects were not observed. Guo and Slesnick's findings (2018) suggest that including children in substance use treatment with their mothers may be especially important for enhancing mothers’ opioid use outcomes.

Even though many in the field acknowledge the bidirectional effects among parents and children, very few studies have examined the impact of parental substance use treatment on their children's psychosocial functioning. Kelley, Bravo and Braitman (2016) and Kelley and Fals-Stewart (2002) documented the indirect positive effects of couple's treatment for parents with an SUD on the children. In these studies, the children did not receive treatment. Kelley and Fals-Stewart (2002) reported that parents' ratings of children's psychosocial functioning were higher for children whose substance using father participated in Behavioral Couples Therapy (BCT) compared to individual therapy or attention control, regardless of primary alcohol or drug use. A small number of studies have tested parenting interventions for substance using women with children under the age of five years in their care (Suchman, Decoste, McMahon, Rounsville, & Mayes, 2011). These studies range in focus from behavioral skills training to advocacy and education, and have reported little change in parent-child interaction or in child adjustment, even though parenting behaviors change (Suchman et al., 2011). Suchman and colleagues (2011) conclude that women with substance use disorders often have poor attachment histories and exposure to childhood and recent trauma. Interventions fostering behavior management skills will do little to strengthen the parent-child relationship without improving their capacity to recognize and respond to the emotional cues of their children. In conclusion, relational intervention may be essential.

To our knowledge, our work is the first to examine engaging 8-16-year-old children in their mother’s substance use treatment through providing family systems therapy (Slesnick & Zhang, 2016). In a five-year randomized clinical trial, we tested a family systems therapy, ecologically-based family therapy (EBFT), compared to an individual therapy condition (Women’s Health Education, WHE) among primarily single mothers seeking substance use treatment through a community treatment program. The majority of mothers reported opioids as their drug of choice (48%), followed by marijuana, alcohol and cocaine. All women received treatment through the substance use treatment facility in addition to either EBFT or WHE. EBFT is a manualized family systems therapy and is guided by the Theory of Social Ecology (Bronfenbrenner, 1979), which is based on the recognition that substance use and related individual and family problems derive from many sources of influence and occur in the context of multiple systems. EBFT has been rated as a promising evidence-based practice by the California Evidence-Based Clearinghouse and as a supported evidence-based practice by the National Institute of Justice. EBFT and WHE were offered in 12, 50-minute sessions, and mothers and children were assessed using self-report and observational measures at baseline, 3, 6, 12 and 18 months post-baseline.

In regard to opioid use, data revealed some evidence that not including children in their mother’s treatment can harm opioid use outcomes. That is, as mother’s communication with her child improved with therapy, higher opioid use occurred over time, but only for those in the non-family therapy condition. In line with a family systems theoretical framework, children who were not involved in family therapy might not have reinforced and responded to the positive changes by their mothers, resulting in poorer maternal substance use outcomes (Slesnick & Zhang, 2016). In regard to alcohol and other drugs, declines were observed in both groups of women, but findings showed that women receiving family systems therapy reported a
faster decline of alcohol, marijuana and cocaine use compared to women receiving individual therapy (Slesnick & Zhang, 2016). Additional analyses of data showed that family therapy offered preventive benefits to the children, in particular, reduced and delayed alcohol and drug use (Bartle-Haring, Slesnick, & Murnan, in press), and improved children’s problem behaviors (Zhang & Slesnick, in press). The intervention also showed efficacy for prostituting mothers and their children (n = 68). Substance use and depressive symptoms improved among prostituting mothers, as well as observed mother-child interaction (Murnan, Wu & Slesnick, in press). And finally, the bidirectional effects of mother’s substance use and children’s adjustment was examined. Children with mothers who showed decreased substance use and psychological control exhibited lower problem behaviors compared to children with mothers showing increased substance use and psychological control (Zhang, Slesnick, & Feng, 2018). Importantly, mothers in the family therapy condition were more likely to show reduced substance use and psychological control compared to mothers in the control condition, further highlighting the benefits of family systems therapy.

Couple and family therapy with substance users is usually recommended as an "add-on" intervention to the treatment plan of the substance use treatment facility. Of interest in this study is that at three months, only 34% of women reported receiving substance use treatment through the substance use treatment facility and by six months, only 20% of women reported still receiving substance use treatment at the facility. For most women, the intervention received through our project was the only intervention that they received, supporting consideration of family systems therapy as a stand-alone substance use treatment intervention. Anecdotally, we observed that when women lapsed into substance use, they avoided the treatment facility. In EBFT, an emphasis is made on the importance of meeting with the therapist regardless of lapses. Also, a non-judgmental stance of unconditional positive regard is maintained, which likely enhanced our ability to engage women. Taken together, the findings support the effectiveness of family systems therapy for mothers with an SUD and their children and highlight the importance of family interaction in explaining children’s problem behaviors. Findings contribute to mounting evidence that drug of choice influences family interaction, substance use and child outcomes. Opioid use showed a different pattern of change compared to other drugs, and influenced mother-child interaction differently. This suggests that a focus on the unique effects of opioids on family interaction should be considered. And finally, the findings presented here support the recommendation that treatment programs engage children of substance using mothers in family systems treatment.

Mothers in the family therapy condition were more likely to show reduced substance use and psychological control compared to mothers in the control condition, further highlighting the benefits of family systems therapy.

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Chronic Pain, Opioid Use, and MFTs

Over the past 20 years, use and abuse of prescription opioids has greatly increased in the United States (Centers for Disease Control and Prevention [CDC], 2016). In 1996, prescribers wrote prescriptions for enough opioids for every man, woman, and child to have the equivalent of 96 mg of morphine per person per year (Pain and Policy Studies Group, 2011). By 2015, that had increased to 640 mg per person per year. That’s the equivalent of 128 Vicodin tablets for every person, including children. Despite this increase in prescribing, the amount of pain in the U.S. has actually increased. Clearly, opioids are not having their intended effect. In fact, there is science to support the fact that most people on opioids have more pain and a reduced quality of life.  

Don Teater, MD        Martha Teater, MA
There are many reasons why this is happening, but the two main reasons may be:

- Aggressive marketing by the pharmaceutical industry
- Prescribers receive very little education on the treatment of pain

MFTs are well positioned to help individuals and families who are impacted by chronic pain, as well as those who are using opioids. With about one-third of our population living with chronic pain, any MFT can do a quick calculation of their community’s population to see how many people are hurting in their own area.

**Scope of the problem**

Increased prescribing has resulted in many Americans taking opioids on a regular basis. It is estimated that up to 4% of the adult population (12 million people) take opioids on a regular basis for pain (Boudreau et al., 2009). Historically, there was no maximum daily dose for opioids, so many of these people will now be on doses higher than the maximum daily dose (90 MME) recommended by the CDC in 2016 (Dowell, Haegerich, & Chou, 2016). Up to 30% of those on chronic opioid therapy are also on benzodiazepines, which the CDC also recommends against.

A national survey in 2016 estimated that 2.1 million Americans have opioid use disorder (OUD) and 11 million had abused opioids (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Opioids cause brain changes, sometimes leading people to present exaggerated symptoms in an effort to be prescribed opioids. Considering those on chronic opioid therapy for pain, those with OUD, and those who take opioids non-medically, around 10% of the adult population is taking opioids on a regular basis.
Brain changes
Regularly taking opioids causes changes to the brain that makes normal medical interactions with physicians more problematic and difficult. Opioids have several remarkable effects (that decrease over time) ultimately resulting in the opposite (negative) effect. These negative effects become even worse when medications are decreased or stopped, making discontinuation very difficult.

Depression: Opioids initially are very powerful antidepressants—better than any of the current medications used for depression. In fact, for most people with even the most severe depression, one dose of opioid will completely relieve their negative mood, at least temporarily. For those with depression, that is a very powerful positive impact. Unfortunately, with ongoing doses that effect decreases, and as their mood continues to decline, opioids ultimately cause depression or make previous depression worse.

Anxiety: Opioids are also initially very powerful anxiolytic medications. Again, as with depression, that effect fades over time and ultimately results in worse anxiety. The anxiety gets much more problematic with reduction or discontinuation of the opioid and results in a tremendous, irrational fear. In our experience, this is one of the most significant reasons why people don't want to reduce or stop their opioids.

Pain: Obviously, opioids are used to treat pain. As with depression and anxiety, this effect decreases over time and commonly results in more pain—called opioid hyperalgesia. This may contribute to increased opioid prescribing, while more people are suffering from pain than ever (Murray, 2013).

Studies have shown that those on opioids for chronic pain have a worse quality of life than those with pain who are not on opioids.

MFTs are at the core of pain treatment
Because of the number of people taking opioids and the changes opioids cause, prescribers need the help of MFTs as they treat pain and care for people who take opioids. There are three types of situations in which an integrated approach to care improves outcomes and helps medical professionals: 1) those with chronic pain on ongoing opioid therapy, 2) those with chronic pain who are not on long-term opioid therapy, 3) those who take opioids nonmedically and/or are suffering from the disease of opioid use disorder.

For those with chronic pain who are not taking opioids, it is important to work with them to treat their pain, improve their lives, and help them avoid starting on opioids for pain. Epidemiologic studies have shown that those on opioids for chronic pain have a worse quality of life than those with pain who are not on opioids (Eriksen, Sjøgren, Bruera, Ekholm, & Rasmussen, 2006).

Evidence-based treatment
Behavioral therapy techniques focusing on cognitive-behavioral (CBT) and mindfulness approaches have some of the most robust evidence of any kind of pain treatment, demonstrating reduced pain and improved quality of life (Fiellin et al., 2013; Shpaner et al., 2014; Sturgeon, 2014). In fact, these therapies can actually reverse the brain changes that have been caused by chronic pain (Shou et al., 2017). There are no medications or medical procedures that can do that.

CBT is an evidence-based approach to treating people with chronic pain. The goal is to help people modify their thoughts about pain, which can dramatically change the amount of pain they feel. The most commonly used CBT tools for treating pain are the ABC worksheet (rooted in the work of Ellis, 1957), thought distortions, decatastrophizing, and working on automatic negative thoughts. Many MFTs are already familiar with these interventions, so it’s easy to adapt them for this purpose.

Mindfulness is the other evidence-supported approach to helping people with chronic pain. Using these techniques can boost people’s ability to tolerate difficult physical sensations and emotional distress. This leads to a reduction in pain. There are many mindful practices that can help with pain—breathing, movement, body scan, meditation, visualization, imagery, yoga, and others.

For those with chronic pain on opioids, MFTs are a critical part of an integrated solution to helping people reduce their opioid use and improve their pain. Studies have shown that reducing the dose of opioids will result in less pain (Eriksen et al., 2006). However, as described earlier, the process of reducing the dose is often accompanied by increased depression, anxiety, and pain. It is only after the reduction that the pain improves. To help with the opioid reduction process, MFTs can use CBT and mindfulness techniques for chronic pain while also educating the client about the expected increase in depression, anxiety, and pain during this transition. Primary care physicians may find these patients to be some of their most challenging, and will welcome help from MFTs.

MFTs have much to offer as they accept referrals from medical providers to treat pain. This includes completing a thorough assessment, collaborating with the medical team, developing goals, and using CBT and mindfulness. MFTs can also work on increasing the person's activity level, enhancing social connections, and building in pleasurable activities.

People with OUD are challenging for clinicians (medical or MFTs) who may have no training in substance
Mindfulness is the other evidence-supported approach to helping people with chronic pain. Using these techniques can boost people’s ability to tolerate difficult physical sensations and emotional distress. There are many mindful practices that can help with pain—breathing, movement, body scan, meditation, visualization, imagery, yoga, and others.

use disorders. All addictions cause damage to the brain’s connections to the frontal cortex, resulting in difficulty making rational decisions. This means that people with OUD do not always make wise decisions and may continue their use of opioids despite interventions by family, friends, and professionals. MFTs can work with families who are devastated by these behaviors.

MFTs should be ready to refer clients to a medication-assisted treatment provider for treatment of OUD. It is important to remember that medication treatment of OUD with methadone or buprenorphine is by far the most successful treatment. Abstinence-based treatment has a very high failure rate (90%), and when people relapse they commonly overdose (Cherkis, 2015). For this reason, great caution should be used before recommending this treatment. Canada has recently released guidelines that recommend buprenorphine or methadone, but guide against abstinence-based treatment (Canadian Research Initiative in Substance Misuse [CRISM], 2018).

As an MFT, you can seek out training in the behavioral treatment of chronic pain. This will equip you to serve the many individuals and families in your community who are hurting. It also will benefit those who have trouble with opioid use. You’ll benefit from connecting with referral sources, and you’ll find, as we have, that there are tremendous rewards in helping people move from hurt to hope.

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References


Neonatal Abstinence Syndrome

A Review for Marriage and Family Therapists

Jerrod Brown, PhD
Cheryl Arndt, PhD
Matthew D. Krasowski, MD
Neonatal abstinence syndrome (NAS), also referred to as neonatal opioid withdrawal syndrome, is the phenomenon of opioid withdrawal in infants (Hudak & Tan, 2012). This syndrome typically occurs within 48 to 72 hours of birth, but can take as long as four weeks until onset (Jones, Finnegan, & Kaltenbach, 2012). NAS typically occurs when mothers use opioids for an extended period during pregnancy. The syndrome is much less common when opioids are used only briefly during pregnancy, such as for the management of pain during labor.

To raise awareness of these issues among marriage and family therapists, this article introduces NAS, identifies protective factors, reviews screening considerations, and discusses treatment-related issues.
According to the Centers for Disease Control, between 2000 and 2012, the incidence of NAS increased 400%, from a rate of 1.7 per 1,000 delivery admissions to a rate of 3.9 (Ko et al., 2017). Research has also found that opioids are prescribed in approximately 25-30% of pregnancies in the United States (Ailes et al., 2015). Common opioids include hydrocodone (Vicodin®, Lortab®), oxycodone (OxyContin®, Percocet®), morphine, codeine, hydromorphone (Dilaudid®), and heroin. With the exception of heroin, the commonly abused opioids are prescription medications. Thus, prenatal exposure to opioids can occur from both medical and non-medical use of opioids. Opioid exposure can have devastating consequences on newborns, with the vast majority of exposed newborns showing at least some clinically significant signs and symptoms (Patrick et al., 2012). In fact, between 55% and 94% of infants with prenatal exposure to opioids go on to develop neonatal abstinence syndrome (Jansson, Velez, & Harrow, 2009).

The condition is characterized by a wide range of signs and symptoms (Hudak & Tan, 2012). After birth, NAS can resemble an illness, such as viral or bacterial infection, with fever, vomiting, diarrhea, sweating, respiratory and sinus issues, dehydration, and mottling (Whitten, 2012). Further, irritability often emerges and may include excessive crying and sleep issues. Poor maternal attachment and feeding difficulties may emerge (Kraft, Stover, & Davis, 2016; Salo et al., 2010). In later childhood, children who had NAS often exhibit impairments in cognitive function, such as deficits in verbal and math performance (Hans, 1989; Wilson, McCreary, Kean, & Baxter, 1979).

Additionally, individuals with NAS are predisposed to sensory impairments, learning disorders, behavioral disorders (such as attention deficit/hyperactivity disorder and conduct disorder), substance use problems, and parental abuse and neglect (Ornoy, 2003; Ornoy, Michailevskaya, Lukshov, Bar-Hamburger, & Harel, 1996; Sirnes et al., 2017).

Symptoms of NAS vary, largely as a function of the opioid exposure itself. The type of opioid, dose of opioid, and timing in pregnancy of exposure to opioid all influence the constellation of symptoms in a given case. Similarly, the genetic predispositions and other environmental exposures of the individual influence the ultimate presentation of NAS (Jones & Fielder, 2015; Wachman et al., 2013). In utero exposure to parental tobacco products or certain psychiatric medications (such as selective serotonin reuptake inhibitors like fluoxetine/Prozac®) may alter or exacerbate certain symptoms (Jones, Chisolm, Jansson, & Terplan, 2013; Patrick, Davis, Lehmann, & Cooper, 2015; Seligman et al., 2008).

As a result of this complicated and ever-changing diagnostic picture, the identification and treatment of NAS can be challenging. Despite the dangerous repercussions of prenatal opioid exposure outlined, there have been increases in the consumption of opioids by pregnant women in recent years, a trend that reflects the broader crisis in U.S. opioid abuse. As a result, NAS has developed into a public health crisis in the U.S. Marriage and family therapists can benefit from being informed about ways to mitigate the impact of this crisis.

Protective factors

There are a number of protective factors that can limit the range of symptoms and consequences of NAS. Foremost among the ways to alleviate the symptoms of NAS is a strong relationship with the primary caregiver (Knopf, 2017). This relationship should be nurturing and characterized by stability. The primary caregiver can use swaddling, soft clothing, frequent feedings, and realistic expectations to ensure that the infant is well nurtured. The home environment should be calm and quiet, as well as devoid of substance abuse and violence to maximize outcomes for the child. To ensure this, substance abuse treatment for the parent may
The primary caregiver can use swaddling, soft clothing, frequent feedings, and realistic expectations to ensure that the infant is well nurtured.

be necessary in some cases. As the child grows, a combination of special education and social services can help ensure that the individual becomes a self-sufficient adult (Nygaard, Slinning, Moe, & Walhovd, 2016).

Screening
The early identification of NAS is of paramount importance in intervening on behalf of these infants. A first step is better understanding the type, severity, and timing of opioid exposure. Neonatal abstinence scoring systems can assist professionals in both understanding and diagnosing the severity of opioid withdrawal symptoms, which can inform the selection and planning of treatment (Jansson, Velez, & Harrow, 2009). Examples of these scoring systems include the Lipsitz Neonatal Drug-Withdrawal Scoring System and the Finnegan Neonatal Abstinence Scoring System. During this process, the mother should be screened for mental health issues, substance use problems, access to healthcare and services, and level of social support. MFTs have the potential to play an integral role in this process. For example, these professionals could assist in the identification of infants with NAS, refer these infants to the appropriate care providers, and assist and educate clients and families who are dealing with the challenges of NAS.

Treatment considerations
In the best of circumstances, the treatment of NAS begins prior to birth and involves both pharmacological and non-pharmacological approaches. Prior to birth, medication-assisted treatment is preferable to sudden abstinence due to potential symptoms of withdrawal in the mother (Jones, O’Grady, Malfi, & Tuten, 2008). In particular, stopping the consumption of opioids increases the risk of miscarriage and premature birth. Instead, physician-supervised opioid-substitution programs (using medications such as methadone and buprenorphine) have demonstrated better pregnancy outcomes by limiting the symptoms of withdrawal and other problematic behaviors (Kaltenbach, Berghella, & Finnegan, 1998). Nonetheless, medication-assisted treatment will not reverse the effects of prenatal opioid exposure and prevent NAS.

At birth, the medical team should be prepared to treat severe withdrawal symptoms. Pharmacological treatment (such as neonatal morphine solution) should be explored as an option to help stabilize the infant (Hudak & Tan, 2012). In the drug selection process, doctors should carefully consider the type of drug that the infant was exposed to during gestation, along with the timing and severity of the exposure. Once the withdrawal symptoms subside, the doctors must systematically wean the infant off of the substance.

Beyond medication-based treatment, a top priority of professionals must be the development of a strong attachment between the infant and the primary caregiver. This may be a struggle due to the symptoms of NAS, which commonly include irritability. The attachment between mother and child can be further challenged by...
MFTs have the opportunity to assist in this endeavor and can help by identifying both expectant mothers with opioid use and children with the symptoms of NAS. Despite NAS being entirely preventable, a study encompassing 20% of all neonatal intensive care units in the U.S. found that the rate of children born with NAS was 27 cases per 1,000 in 2015 (Plumridge, 2015). When unidentified and untreated, NAS contributes to both short- and long-term consequences, such as cognitive functioning deficits and substance abuse across the lifespan. This emphasizes the importance of early identification through improved screening procedures. MFTs have the opportunity to assist in this endeavor and can help by identifying both expectant mothers with opioid use and children with the symptoms of NAS. Once identified, MFTs can help parents implement protective factors and ensure adequate treatment to limit the impacts of NAS. Such an approach holds promise in improving proximate and distal outcomes for individuals with NAS.

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Substance Use Disorder and Confidentiality

Working with families in which there is an opioid or substance use disorder can add a layer of complexity not only clinically, but legally and ethically. Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Federal Register, 2017), commonly referred to as just “42 CFR” or “Part 2,” was first promulgated in the 1970s to mitigate the potential adverse consequences in any civil, criminal, administrative, or legislative proceeding due to the release of information obtained when a person is receiving treatment for a substance use disorder (SUD).
Parental substance use and misuse is the reason that more than one-third of children in the U.S. are removed from their homes, up from less than 20% in 2000.

Consequently, Part 2 raises the threshold by which programs or clinicians can release information related to SUD treatment. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2018):

**Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent.** Part 2 specifies a set of requirements for consent forms, including but not limited to the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure.

In February of 2018, Part 2 was updated to better align with the changes made in the U.S. healthcare delivery system, including Health Insurance Portability and Accountability (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Acts. This update, known as “final rule,” addresses the circumstances under which lawful holders and their legal representatives, contractors, and subcontractors may use and disclose patient identifying information for purposes of payment, healthcare operations, and audits and evaluations.

While the final rule has considered the impact of HIPAA and HITECH, it is noteworthy that Part 2 still holds SUD treatment providers to a higher standard relative to what HIPAA allows. The putative goal of SAMHSA was to seek a balance between protecting the confidentiality of SUD client records and ensuring that those protections do not create additional barriers to seeking and benefiting from new healthcare models designed to integrate care and increase client safety. Violations of confidentiality for clients with SUD can often have dire consequences, including the loss of employment, housing, child custody, arrest and criminal prosecution, and discrimination by medical professions and insurers. While Part 2 does generally require more explicit consents to release information, it also provides for the exchanges of information with entities in which payment for services or healthcare operations are involved. So, activities such as billing, claims management, audits, training, accreditation and licensure, business planning, customer services, and similar activities do not require a person- or entity-specific consent to exchange information. That is, a standard consent will suffice to exchange information for the aforementioned activities.

The second major change in the final rule was the inclusion of an abbreviated notice for prohibition of redisclosure, which means that entities that disclose information can include a statement on the disclosed information that prohibits redisclosure. The Part 2 notice generally reads:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.

As MFTs, it is important to recognize where we fit in the overall healthcare delivery system and ensure that our practices are consistent with federal and state rules and regulations. In the last decade, HIPAA has become ubiquitous in the U.S. healthcare landscape, but for clients with an SUD, the information we can exchange would be consistent with HIPAA might not be sufficient to satisfy Part 2, particularly when it comes to the redisclosure of information. It is also important to be aware of state regulations as well, for both HIPAA and Part 2 might not apply if state regulations are more stringent.

In reviewing AAMFT’s Code of Ethics (2015), Standard II, 2.1 directly addresses disclosing to clients at the outset of services the possible limitations of the clients’ right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Further, 2.2 addresses that MFTs do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual.
competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual’s confidences to others in the client unit without the prior written permission of that individual.

The opioid epidemic has presented further challenges for family and behavioral health organizations. Parental substance use and misuse is the reason that more than one-third of children in the U.S. are removed from their homes, up from less than 20% in 2000 (Child Welfare Information Gateway, 2014). An additional consequence of parental OUD is Neonatal Abstinence Syndrome (NAS), which not only results in significant issues for newborns (such as difficulty sleeping and eating, irritability, and slow weight gain), but also results in extended hospital stays that have psychosocial and financial implications.

In response to the increase in NAS and other postpartum risks for children and mothers, a number of states have enacted legislation specifically designed to mitigate the impact of newborns exposed to substances and potentially reduce risks to children when they return home. Generally, the legislation is focused on hospitals that are required to assess and report to child protective services when a newborn tests positive for substance exposure in utero. Additionally, some jurisdictions require that Plans of Safe Care be put in place prior to a substance exposed infant being sent home.

The implications for both mandating and reporting of substance exposed newborns and Plans of Safe Care present unique challenges for MFTs who work with families struggling with SUD and are involved with child protective services. The risks and potential consequences for children and families and the involvement of multiple clinicians, agencies, and organizations creates an intricate system of care that necessitate forethought and coordination to effectively assist families to navigate the complexity of healthcare and family services providers who will be involved.

Working with families where SUD is an issue brings to the fore several ethical challenges, including informed consent, confidentiality and disclosure of information, collaboration and multiple relationships, autonomy, beneficence, referrals, and clarity around “who is the client.” MFTs must be diligent in clarifying their roles, explaining with whom we are contracting to provide services, and providing clear explanations to clients relative to our legal and ethical responsibilities.

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References


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POSTTRAUMATIC STRESS DISORDER
In 2016, an American died by suicide every 12.3 minutes, and there are an estimated 1.1 million suicide attempts annually in the United States. (American Foundation for Suicide Prevention [AFSP], 2016). Ninety percent of individuals who died by suicide had a psychiatric diagnosis at the time of death (AFSP, 2016). Suicide is the tenth leading cause of death in the U.S., and the second leading cause of death for adolescents (AFSP, 2016). The suicide rate among Native American and Alaskan Native ages 15-24 is 1.5 times the national average, and military veterans comprise 22.2% of all suicides (AFSP, 2016). Suicide costs $44 billion annually in the U.S. and causes a tremendous amount of pain and grief for loved ones (AFSP, 2016).
Suicidal and homicidal threats are the most important issues we face as clinicians. We have a duty to protect individuals from harm; however, we receive little training and education in evidenced-based methods to do so. There has been tremendous progress in the field of clinical suicidology, with increases in funding and knowledge (the American Foundation for Suicide Prevention has sponsored millions of dollars toward prevention and research). In addition, the military spends a tremendous amount of money on suicide prevention research. There is an increased focus in suicide prevention research to understand the lived experiences of individuals who have made attempts, and the “Zero Suicide” task force was created to raise standards of care (see zerosuicide.sprc.org). Yet, with all of these areas of progress, we do not have mandated training for MFTs in the field of clinical suicidology.

Unfortunately, not much has changed with clinical interventions despite advances with evidenced-based modalities. EBTs are not widely implemented. In fact, a third of clinicians still use “no suicide contracts,” which provides a false sense of safety, and actually increases liability (Jobes, 2016). There is an over-reliance on inpatient hospitalizations and medications, rather than supporting outpatient, evidenced-based interventions (including dialectical behavior therapy [DBT], cognitive behavioral therapy for suicidal patients [CBT-SP], collaborative assessment and management of suicidality [CAMS], and safety planning interventions [SPI]).

There are three primary factors contributing to this dilemma. First, MFTs are not required to complete any type of formal education or training in clinical suicidology. Second, there are only two diagnoses in the DSM-5 (American Psychiatric Association [APA], 2013) that have suicide as a symptom (major depressive disorder and borderline personality disorder). This is problematic for diagnosis and treatment planning. MDD and BPD are not the only two diagnoses that correlate with suicide risk, but clinicians are forced to use these in the absence of a separate suicidal behavior diagnosis, even though they may not be appropriate. This leads to misdiagnosis and inappropriate treatment planning. Third, there is a misnomer among clinicians that if you treat mental illness it will eliminate suicide risk—which is not always the case.

We need more research and training in EBTs within suicidology, however, there are confounding issues with countertransference, fear of malpractice, and a lack of awareness and education in the field (Bongar & Sullivan, 2013). Clinicians have historically focused on treating mental health problems, such as depression and anxiety, with the assumption that a client’s suicidal thoughts and behaviors will cease once the depression or anxiety disorder is resolved; but this is not true for every client. Research strongly supports targeting and treating suicidal ideation and behaviors specifically, and directly (Brown & Jager-Hyman, 2014).

Suicidal and homicidal threats are the most important issues we face as clinicians. We have a duty to protect individuals from harm; however, we receive little training and education in evidenced-based methods to do so.

There is an over-reliance on inpatient hospitalizations and medications, rather than supporting outpatient, evidenced-based interventions.

It is time that MFTs have mandatory training in the assessment, intervention and prevention of suicidal behavior, as we are likely to encounter suicidal clients at some point in our career. There is a national push toward “suicide safer” care in behavioral health (Pisani, Murrie, & Silverman, 2015). Suicidal behavior is an intra-psychic phenomenon and an interpersonal issue, and both need to be addressed in education, training, and interventions (Jobes, 2016). Suicide has devastating effects on families and our society, and we have an integral role in helping those in need.

The field of suicidology gets less attention than other foundational skills that must be taught to clinicians in graduate school and during clinical training, yet it is one of the most important issues that may present during the course of therapy (Bongar & Sullivan, 2013). Very few MFTs have been adequately trained in the assessment and management of suicidal behavior. Recently, Assembly Bill No. 89 was passed that will require California psychologists as of January 1, 2020, to obtain a one-time six-hour training, or applied supervised experience, in suicide risk assessment and intervention. However, MFTs do not have this same requirement.

As marriage and family therapists, we should all move forward with educating ourselves in suicide prevention, as it is one of the most important issues that we face during the course of therapy.
Competencies and State Requirements

MFTs need to develop core competencies related to working with individuals struggling with suicidal behavior. The American Association of Suicidology’s (AAS, 2016) competency guidelines include:

• To understand your own attitudes, morals, values, and approaches with suicidal clients. This includes reconciling the difference and potential conflict between a clinician’s goal to prevent suicide and the client’s goal to eliminate psychological pain through suicide.

• To understand the demographic and clinical risk and protective factors that correlate with suicidal behavior.

• To understand the dominant theories in the field of clinical suicidology.

• To understand what to ask as part of a comprehensive suicide assessment (SAFE-T Guidelines), which includes suicide risk screenings, and evidenced based suicide assessments, in order to determine risk.

• To understand the psychiatric diagnoses most often correlated with suicide risk.

• To obtain training in evidenced-based interventions (CAMs, CBT-SP, DBT, and SPI).

• To understand the various levels of care and resources available to support high-risk clients.

• To implement individualized safety planning, and not use contracts that promote a false sense of safety.

• To understand HIPAA laws and regulations about breeches of confidentiality to help a suicidal patient.

Currently, there are only nine states that require training in suicide assessment, treatment, and management for health professionals.

• California’s AB89 will require psychologists to complete six hours of coursework or experience under supervision in suicide risk assessment and intervention.

• Indiana’s HB 1430 requires certified or licensed emergency medical personnel to complete an evidenced-based training in suicide.

• Kentucky’s KRS Section 210.366 requires three to six hours of training every six years for certified and licensed mental health professionals.

• Nevada’s AB93 requires mental health professionals to receive instruction on suicide prevention and awareness.

• New Hampshire’s SB33 requires three hours of CEUs for licensed professionals in the area of suicide prevention and intervention.

• Pennsylvania’s HB 64 requires licensed mental health professionals to complete one hour of CEU in suicide assessment and treatment.

• Tennessee’s SB 489 requires certified or licensed mental health professionals to complete two hours of training once every five years in suicide prevention, assessment, and treatment.

• Utah’s HB209 requires two hours of training for licensure of mental health professionals.

• Washington’s RCW 43.70.442 requires three to six hours of training at least once every six years for certified or licensed mental health professionals.

References


Professional Resources

Suicide Prevention Resource Center
www.sprc.org/training-institute/amsr

American Association of Suicidology
www.suicidology.org
Becoming Adult: The Role of Education in Couples Therapy

What would happen if everybody were taught about relationships? What would happen if everybody learned about the importance of safe connection, how wounds impact a person’s ability to be present, and his or her emotional reactivity? What if couples were taught that healthy relationships are a state of psychological development and that they are attainable? What if couples were able to do more of their own self-education and work? How would relationships change?
Society does not educate people in relating
When couples put time and energy into exploring who they are, and focus on becoming who they wish to be, they have enormous power to change their relationships and manifest their dreams. It is from this vantage point that incorporating a relationship educational process as an adjunct to couples therapy will be explored.

Relationships are meaningful, complex and omnipresent. Humans are embedded in relationships. They live and breathe them. From the very beginning, floating in the amniotic fluid of the womb, a fetus is in a deep connection with its mother. And its mother is in deep connection with him or her, as well as in relationship with others, with her culture, and even with her thoughts and feelings about herself.

Our society does not yet fully recognize the importance of acquiring relationship skills and abilities. Schools do not teach about relationships along with the required reading, writing, and arithmetic. Relationships are left to “just happen.” The ability to relate comes by osmosis through the functioning of one’s families of origin. Resultantly, adults do not understand the ingredients needed to be able to relate successfully. Virginia Satir encouraged marriage and family therapists to shift their focus to relationship education. According to Eisenberg (2011), in Satir’s 1984 presentation to PAIRS Professional Training, Satir stated, “. . .what people bring to me in the guise of problems are their ways of living that keep them hampered and pathologically oriented. What we’re doing now is seeing how education allows us to move toward more joy, more reality, more connectedness, more accomplishment and more opportunities for people to grow” (para. 40).

Maps and training for therapists
Therapists need maps if they are working with couples. They most likely have taken advanced couples training which enables the therapist to have cognitive maps. These maps allow therapists to have knowledge that their clients do not have and put therapists in the driver’s seat. Unfortunately, because therapists hold the maps and their clients do not, the therapist becomes responsible for giving their clients all of the new understandings and skills they need. This creates a dependency, which, while productive initially, is also problematic.

The role of the couples therapist
Couples therapists have a role that is complex and broad. They help their couples tackle new understandings, new emotions, gain new skills and develop a new experience of both self and each other. Therapists hold; they model; they teach; they guide; they re-parent; they facilitate. They step into the relationship with the couple.

As highly trained professionals in the arena of relationships, couples therapists are uniquely positioned to guide people into understanding the role self-education plays in healing and growth. Couples therapists can help their clients take responsibility for their relationship health. Bowen (1978) instructed therapists to move out of a position of healing or helping where families passively wait for a cure to “getting the family into position to accept responsibility for its own change” (p. 246).

Relationships are meaningful, complex and omnipresent. Humans are embedded in relationships. They live and breathe them.

The myth of the therapist as the fixer
How many therapists have had a couple arrive for their first appointment with the expectation that after a few sessions the therapist would help them shift their entire relational world? It is as if they are saying, “fix us.” The couple has not taken the time, energy or initiative to educate themselves regarding their relationship. They have not realized that it is their responsibility to do what is required to evolve and be their best selves. They only know that they are in pain and feel powerless.

Couples therapists can be overwhelmed by their clients’ lack of knowledge, by their lack of self-skills, such as awareness of deep feelings or beliefs that negatively impact connection. To compensate for the sense of overwhelm or ineffectualness, a therapist may unwittingly step into the role of “fixer.” If the therapist gets stuck in that role, burnout is likely.

Couples rely on their therapist to help them sort through massive amounts of material and to develop new skills. It is as if they are babies and the therapist is feeding them, bite by bite. Therapy opens entirely new perceptual worlds, vulnerable feelings, and ways of communicating. It is appropriate and necessary that the therapist holds the couple and provides safety. Yet, the differentiation process demands that eventually, each client will hold his or her own spoon and learn to feed themselves and each other.

A rite of initiation through the gate of relationship
The elephant in the room is that working on relationships is a rite of initiation. Until the couples in therapy take responsibility for their healing and lives, the real work does not begin. It cannot. It is only when each partner takes hold of the reins of their lives that they move from being undifferentiated and childlike to fully responsive co-creators of their future together.
The questions are, will couples will take responsibility for the learning required to take ownership of their relationships, and will their therapists encourage them to do so?

Couples learning and growth
Couples can teach themselves when provided with the educational material they need sequentially—so that they can accomplish each task necessary before moving on to the next one.

Couples learning and growth involves a number of factors, including effective educational materials, stories, experiential exercises, and an open attitude and the belief that change is possible. It requires recognizing the journey of self-discovery as an important part of change, and like any other journey, there will be times of joy and times of difficulty. Most people are not born with trust funds. People have to work to support themselves. Similarly, most of couples have to work to create the wealth of connection.

Couples therapists can orient their clients to self-growth, differentiation, and sophisticated psychological understanding. Given effective education and practice, most people can “rewire” themselves and improve their relationships.

The process of educating couples
Imagine a new couple coming into therapy for their first session. What do they already know? How sophisticated are they in self and relationship awareness?

Imagine that in addition to working with their therapist, a couple takes on the task of holding their own spoon. The couple decides to begin an educational relationship learning process as an adjunct to their therapy. They begin to understand their negative relationship cycle and how their deep underlying attachment needs and fears fuel it. They learn how they perceive and feel and what tendencies and patterns they bring forward from their early history.

Imagine that they read stories about other couples, and their feelings of shame and isolation begin to fall away. They realize they are not alone. Psychological processes are illuminated. They better understand and gain new ways of dealing with what had previously seemed unsolvable. Imagine that they learn to reduce their negative interactions.

What if the couple understood the concept of “reaching” before their therapist helped them with a connecting enactment? According to Johnson (2009), reaching is a tangible sign of a couple’s desire for connection. Johnson also states (2008) “Key moments of bonding, when one person reaches for another and the other responds, take courage, but they are magical and transforming” (p. 258). What if this understanding allowed them to reach more successfully? What if they understood that when their partner blocked their reach, it was because they were afraid of contact, or missed it because they weren’t tuned in, or dropped it because they were triggered? What if they understood they could use their cognitive mind to help self-regulate when their reach wasn’t responded to in the way they wished?

Imagine that they learn about trauma and wounds and boundaries; that they practice how to communicate with vulnerability.

When couples are exposed to cognitive learning, and example processes and stories, they have the opportunity to build new cognitive structure, to become more aware, have more choice interactions, and behave in ways that are more supportive and less reactive.

As the couple takes responsibility for their relational learning and growth process, and as they engage in this new learning—both inside and outside of the therapy room—they transition to a more grounded and adult relationship.

Couples education serves both the couple and their therapist. The world is changing. There are many ways a couple can enhance their therapy and gain additional relational knowledge and skills. There are many resources available. A couple may gain more skills and knowledge while doing the work of therapy, and by assuming increased self-responsibility, engage more fully in the differentiation process.

By having a more self and relationally aware client, the therapist avoids the role of the “fixer,” and has the satisfaction of assisting the client in greater growth and differentiation.

People have enormous power to change themselves, their relationships and their world. Relational education allows new perceptions to open, attitudes to shift, and greater progress to be made. It leads to improved and more joyful relationships and a healthier planet.

Jennifer Lehr, MA, LMFT, is a Clinical Fellow of AAMFT and author and creator of WeConcile®, an online educational and experiential process for couples to improve their relationships, as well as the WeConcile Coach Program, which allows therapists and other relationship helping professionals to use WeConcile for free to guide their clients. Lehr has authored numerous articles promoting an understanding of both individual psychological healing and couples healing. She also runs creativity-based healing groups.

References
Assessing the Need for Increased Self-Care in Therapists

“Caroline,” in her last year of graduate school in a marriage and family therapy program, has a placement at a busy Child Guidance Center where she has a fairly large caseload each week. In the weekly meeting with her supervisor, “Lourdes,” Caroline breaks down, describing how she feels emotionally triggered by many of her clients lately. Lourdes inquires immediately about how her sessions have been going, and if Caroline feels that this triggering is impacting her ability to be fully available in therapy sessions. Caroline claims she is sometimes distracted in sessions, has been poor with time management, and has cried with a client during one session. She insists however, that the stress and emotions are not impacting her ability to be an effective therapist, but rather, doing therapy gives her purpose and helps her escape her own difficult life.
Lourdes then asks if there is anything going on in her life, and Caroline shares that her adult daughter and two granddaughters have moved back in with her, and this has caused a lot of stress on her marriage. Child Protective Services is involved and investigating their household after Caroline’s ex-son-in-law lodged complaints of abuse against all of them. On top of all this, Caroline’s husband has been diagnosed with clinical depression after losing his job a few months earlier, and they are struggling financially. Lourdes suggests that they schedule more frequent supervision meetings, that Caroline consider seeking out a therapist for herself, and that she will be calling the clinical director at Caroline’s college in order to touch base and coordinate a strong liaison for supporting and monitoring her work. Caroline tries hard to convince Lourdes that she’s fine and begs her not to limit her clinical work, and reports, “It’s all I have right now; it’s what I love and it’s what keeps me sane and gets me through each day.”

The above scenario is a familiar one for many graduate school and agency supervisors. In fact, many therapists, even seasoned ones, can likely recall a personally challenging time in their career where they felt they really needed to hone in on whether stress was impacting their clinical work.

About eight years ago, my father had a massive heart attack and subsequent stroke that left him in a coma after emergency brain surgery; he was not supposed to make it through that first night. Yet he did make it through that night, and each one after it. It was a very long, two-month recovery in an intensive care unit nearly two hours away from my home. As the only one local to assist my mother, I spent those weeks running back and forth on very little sleep to give her a break, taking care of her home and dog, meeting with doctors and elder law attorneys, all while taking care of my own children and private practice.

I had arranged for coverage in client emergencies, and notified each one that due to a family emergency, I would need to take two weeks off. I remember what a strange feeling it was to have the “tables turned;” when my clients began reaching out to me, letting me know they were fine, and to focus on myself and my family, offering thoughts and prayers for my father. It felt uncomfortable and unnatural, but at the same time, gave me the opportunity to reflect on whether I was strong enough to return to doing therapy when those two weeks were up.

I did some soul searching and decided to amp up my self-care, asking neighbors for rides for my kids, accepting offers to take the girls to school in the morning so I could sleep in, ordering pizza for dinner instead of cooking, even an offer of a friend driving a nearly four-hour round trip to bring a change of clothing and some documents to my mom for me. These were all things I was not accustomed to doing; I wasn’t really one to ask for help, but I knew I needed to do so in order to stay strong enough to return to work.

As I did during my time of personal challenge and stress, Caroline should be focusing on and evaluating whether she is strong and healthy enough to do clinical work. Doing therapy is clearly not like many other jobs. It requires mental energy, clear thinking, patience, and the ability to temporarily exit one’s own life. Times of personal stress can challenge these skills. So, in the case with Caroline, how did Lourdes do as a supervisor? Did she do enough to address her concerns for Caroline? Did she adequately assess the well-being and best interests of the clients in Caroline’s care?

In the AAMFT Code of Ethics Preamble (2015), the first tenet is “Honoring Public Trust.” As with any professional, licensable field, when the public reaches out to a provider of a service, they should be confident that there are measures in place to ensure professional, ethical standards of treatment. One such method of “checks and balances” for the therapy field is supervision. Adhering to this important preamble, Caroline made an excellent choice in using the third tenet, “Seeking Consultation.” The Code of Ethics is clear that, “Marriage and Family Therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.” Our field can be isolating if one does not utilize colleagues, trainings, or supervision to check in with others about the stressors and nuances of our work.

In their meeting, Lourdes considered the tenet in the preamble of “Ethical Decision Making.” As a supervisor, one of Lourdes’ responsibilities is to make sure therapists are practicing in accordance with the ethical code in the field. “Marriage and Family Therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations.” She did this by asking a series of questions aimed at assessing whether Caroline’s personal issues were impeding her ability to provide ethical treatment to her clients.

**Standard 1, Responsibility to Clients.**

1.9 Relationship Beneficial to Client

Marriage and Family Therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefitting from the relationship.

In the scenario described, how do we know if Caroline’s clients are benefitting from therapy? Caroline’s report is the only information her supervisor has. Perhaps Lourdes could suggest sitting in on, or recording a few of her sessions. Or Lourdes could have Caroline present some cases in the agency’s weekly group supervision so that she
could get her colleagues’ support and feedback on them. All of these efforts help Lourdes assess whether Caroline’s therapy is still benefiting clients. If Lourdes is really lucky, her agency has already implemented some sort of an assessment measure to gauge client outcomes, and these could be used as yet another layer of confirmation that Caroline’s work is effective. Client-directed, outcome-informed therapy (CDOI) approaches, such as Partners for Change Outcome Management System (PCOMS), are a useful to have in place for challenges like this.

Standard III, Professional Competence. 3.1 Maintenance of Competency
Marriage and Family Therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience. Once outside of graduate school, MFTs may become “rusty” on the literature and research on burnout, compassion fatigue, and the importance of self-care for therapists. It is important, if therapists are not already doing so, and especially if they are experiencing personal crises like Caroline, to keep current with this vital information.

Maintaining competency encompasses many things, perhaps most importantly though, is monitoring the “self of the therapist” throughout one’s career. Researchers Rosenberg and Pace (2006) advise “adopting self-care measures and collegial support to prevent further deleterious effects. These may include but are not limited to increasing awareness of the signs and symptoms of burnout through education, self-awareness, and supervision” (p. 97).

3.3 Seek Assistance
Marriage and Family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment. Aside from seeking out supervision, therapists who are struggling with “(over)full plates” in their personal lives should consider seeking out their own therapy. Some graduate programs mandate a certain number of required therapy sessions for all clinicians, yet others suggest or require it on an as-needed basis. In any case, a therapist obtaining his or her own therapist is the responsible and ethical thing to do when there are many warning sighs of personal struggle. It would be prudent for Caroline to be engaging in therapy to help her navigate the many layers of stress and expectation in her life.

Standard IV, Responsibility to Students and Supervisees. 4.5 Oversight of Supervisee Professionalism
Marriage and Family Therapists take reasonable measures to ensure that services provided by supervisees are professional.

In addition to all the other ideas for monitoring Caroline’s work, her supervisor is expected to use anything she has at her disposal to assure professional services are being offered. Additional ways of oversight might include Lourdes’ suggestion of contacting the clinical director at Caroline’s college, or the director of the graduate program, to share any concerns. It is a good standard of clinical practice to include getting releases from clients to coordinate care with other involved parties, like therapists or doctors. Likewise, connections between various program directors, supervisors, and academic instructors might yield a richer picture of the therapist’s functioning. Is the therapist paying attention in class, adequately absorbing important model and technique information, performing well academically, utilizing supervision fully, or experiencing any trouble with clients, or have there been any concerns or complaints? Indeed, a socially-constructed reality, based on the voices of many, is the best way to help “see” the most complete picture of a therapist’s performance.

Overall, it appears that Lourdes did a thorough job in assessing, offering suggestion and support, and most importantly, developing a “safety plan” to uphold both the tenets of doing ethical family therapy, as well as monitoring whether Caroline is able to keep the clients’ needs and best interests in the forefront of her work.

A collaborative approach is ideal in situations such as Caroline’s. It is key to be on top of monitoring the clinical work of any therapist who is experiencing personal difficulties that appear overwhelming. Norris, Gutheil, and Strasburger (2003) write about the possible detriments that can occur from the stressed out therapist, namely, boundary crossings and violations. The authors stress the therapist risk factors for such violations, including the therapist’s own life crises. Even the most seasoned therapists can find their skills tested by personal stress or trauma, therefore, best to think of this as preventative, proactive steps, rather than something punitive. As a wise man once wrote:

A principle is the expression of perfection, and as imperfect beings like us cannot practice perfection, we devise every moment limits of its compromise in practice. —Mahatma Gandhi

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Suggestions for Clients: Questions to Ask Your Therapist

How does a person select a therapist? How lucky or unlucky are you likely to be with your choice?

Obviously you are likely to be in better shape if you get a referral from a trustworthy source and don’t simply pick up a phone and call a random name in the yellow pages or on the internet. But even that’s far from a sure thing. In my own life, we had two situations where we were referred by responsible therapists to other therapists who proved totally inappropriate. One was a well-known female therapist for my wife, about whom my respected supervisor at the hospital where I worked said, “I wouldn’t refer my dog to her.” In the other instance, we were referred to a child therapist and only belatedly, when we realized nothing good was happening, did we learn that this therapist had studied psychology while in jail for spying for another country.
He really knew nothing about therapy other than to sit and shut up—not really great for a 10-year-old kid—let alone the concept of the family therapy we needed so much, which was entirely foreign to him.

I have often fantasized that it should be standard professional practice for each of us therapists to summarize outstanding characteristics of our clinical practice. I propose that such a summary be limited to a single page, the kind that could even be turned into an identity card that one wears, as well as posts outside of one’s office. Caveat emptor! (Let the buyer beware.) Give the client a break and let them know something more about the person to whom they are entrusting their lives. See my calling card, as an example.

In A Democratic Mind: Psychology and Psychiatry with Fewer Meds and More Soul (2017), I address a series of questions that the client needs to ask.

First question: If you go to a therapist, most often something is bothering you and you want relief and help. But do you also want anything more—say a wholesome critical review of your life and your style of living? Are you happy if the therapist asks broad questions about your health, work, marriage, children, sexuality, friendships, finances, leisure time activity, philosophy of life, or what have you, and then proposes that you make changes that are not only related to your immediate problem and pain? Do you appreciate the intention to give you the broader counsel of a long range view of your possible psychological growth and greater maturity, or do you want to stick concretely to your initial request for pain relief?

Second question: Therapy is obviously about helping people with their pain and suffering, very much including the various harms that they are doing to themselves in their way of life, but should it also address the injustices and harm that people are doing to other human beings?

Sample “Calling Card”

PROF. ISRAEL W. CHARNY, PHD

AGE. I am quite old, but very experienced, and notwithstanding age, very active—including either swimming or gym every morning.

PERSPECTIVE. I love therapy. I attribute so much of my good life to my own psychoanalysis, and believe in the power of therapy to help or cure many emotional conditions and relationship problems—but regretfully, like in all medicine, not always.

ORIENTATION. Existential, psychoanalytic, systemic (family therapy), cognitive-behavioral—where what is most important is choosing a way of therapy that is most likely to provide real help.

Further Translation: Therapy needs to be geared to the truths and realities of a given person’s and family’s life situation. It combines getting better at fighting back to change bad situations and learning to go and yield to what cannot be changed.

ACCEPTANCE VERSUS CONFRONTATION. I work with a mixture of both—caring for people and empathizing deeply with their pain and worries, talking straight and holding up a truthful mirror.

CASES. Individual, marriage, family, and combinations; also supervision of therapists emphasizing the therapist’s use of self and their own inner experiences while doing therapy with their clients.

LENGTH OF THERAPY. Varies—though I am prejudiced for depth therapy if possible. I call a halt to therapy if we are not making progress.

LANGUAGES. English and Hebrew.

FEES. Similar to outpatient consultation with a doctor in a hospital, but for a 45-minute session, with a significant reduction possible by agreement.

I welcome difficult cases where a person or a family want to fight for health.


Fourth question: What does family therapy really mean and offer? Does family therapy mean making peace as much as possible between related persons, or does it also refer to fairness, justice and integrity and fighting back against evil in intimate relationships?

I suggest that many, if not all, forms of therapeutic work, as well as many integrations of tools from several types of therapy, are entirely kosher and wise, so long as the therapy addresses not only symptom reduction and control, but also lifestyle selection—especially a clear look at whether and how a person is doing harm to their own life and whether and how a person is doing harm to the lives of other people.

Israel W. Charny, PhD, is an Israeli-American clinical psychologist in Jerusalem. He was the founder and first president of the Israeli Family Therapy Association and later president of the International Family Therapy Association. In 1985, he presented a Master’s Couple Therapy Session at the AAMFT annual conference and was honored with the status of Fellow. Routledge will be issuing an e-book of his well-reviewed Existential/Dialectical Marital Therapy: Breaking the Secret Code of Marriage. Charny also recently authored A Democratic Mind: Psychology and Psychiatry with Fewer Meds and More Soul and Psychotherapy for a Democratic Mind: Treatment of Intimacy, Tragedy, Violence and Evil. He is a Clinical Fellow of AAMFT.

Reference

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