

The Newsletter for the Arizona Network of AAMFT

Spring/Summer 2019

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Chair's Letter



**MELISSA BAKER,
MS, LMFT**

As I sit down to write this letter, it is apparently both American Family Day and National Friendship Day. Seems appropriate to be pondering the field of systemic thought on such relationship-celebrating day!

On the national advocacy front, marriage and family therapists were again included in bills to expand allowable practitioners under Medicare. The Mental Health Access Improvement Act of 2019 was sponsored by Senator John Barrasso (R-WY) and Senator Debbie Stabenow (D-MI) as S 286 and as HR 945 by Representative Mike Thompson (D-CA) and Representative John Katko (R-NY). We will continue to advocate for this much-needed inclusion of MFTs to address provider shortages and meet the needs of our communities.

Of additional importance in federal news, the President signed an executive order in June on Improving Price and Quality Transparency in American Healthcare to Put Patients First. Specific to those providing integrated health services through Medicaid, the VA, Military Health System, Marketplace, or CHIP, the directive includes a Health Quality Roadmap that would establish and adopt quality measures. In our environment of value-based healthcare, it is important that we keep ourselves apprised of such potential changes as they are discussed.

This year has also brought with it a few significant changes to practice and licensure in Arizona. In January, BBHE rules went into effect to allow for supervised private practice by associate-level licensees. This is an allowance for practice that was previously strictly prohibited. The Board's website, azbbhe.us, includes several required and sample documents for Board approval of supervision (required before the supervisee opens their practice), supervision agreement, and verification of supervision (required every six months). If you are considering this structure, either as a supervisee or supervisor, carefully review the new rules and documentation requirements.

In April, the Governor signed HB 2569, which allows for increased ease of license "transportability" between states. The bill allows Arizona residents to be granted Arizona licensure as long as they were licensed for one year in their previous state, assuming a clean licensure history. The bill addresses multiple areas of licensure, and eases the former three-year requirement. The effective date of this bill is August 27th, and forms will be available on the Board's website soon.

Additionally, the Board is considering feedback from stakeholders regarding current supervision restrictions regarding same-discipline supervision hours as well as the limitation that AAMFT-Approved Supervisors are not considered equivalent to LMFTs for these same-discipline hours. AAMFT has provided two letters of support for the latter, requesting that AAMFT-Approved Supervisors be considered appropriate to provide the 75 hours of MFT supervision to LMFTs. We will continue to keep members informed of ongoing Board discussions and dates for public comment when scheduled.

As we transition to back-to-school calendars for both personal and professional schedules, and as we anticipate the winding-down of summer, let us find opportunities to value and support our family, friends, and fellow systemically-minded professionals!

Grief, Loss, and Infertility in Assisted Reproductive Technologies

BY ELIZABETH KRESOJEVICH-VITALE, LAMFT

Grief and loss may be identified in many different ways, depending on social location, religious beliefs, and race or ethnic background. Grief is mainly defined in western culture as the response one has in relation to the loss of someone or something they cherished. Disenfranchised grief is known as grief that goes unnoticed or unacknowledged by society; this type of grief can be especially painful, as it forces most individuals to move toward isolation during their grieving process. In western culture, it is common to experience disenfranchised grief through the journey of conceiving or acquiring a child. In the world of infertility and assisted reproduction, couples and individuals often experience this theme of unrecognized loss, leaving them confused and isolated.

Miscarriages and other types of pregnancy loss often go unrecognized in western society, whether individuals are conceiving naturally or are attempting to conceive using assisted reproductive technologies (ART). There are many hidden losses that occur for individuals as they go through the process of having a child such as involuntary childlessness, stillbirth, sudden infant death syndrome (SIDS), miscarriages, and spontaneous abortions. These hidden losses often become a burden solely for the individuals that are going through the process, and are often not shared with peers, family members, or even medical professionals. With the recent introduction of ART, an abundance of new opportunities, such as intrauterine insemination (IUI) and in vitro fertilization (IVF), for couples and individuals to conceive a child has become more readily available. Unfortunately, along with ART's low success rate, it also brings a new category of loss; couples or individuals often experience grief and loss when enduring failed IVF cycles, elective reduction, or death of a fetus in a multiple birth occurrence (McDaniel, Doherty, & Hepworth, 2014). In turn, couples and individuals begin to experience higher levels of anxiety, depression, isolation and hopelessness (Bhat, & Byatt, 2016). Posttraumatic stress is also of concern for couples and individuals, recognizing that, not only do they suffer grief and loss, but the grief may last for an extended period of time after a loss occurs making it even more difficult for couples that are participating in ongoing trials or treatments to conceive.

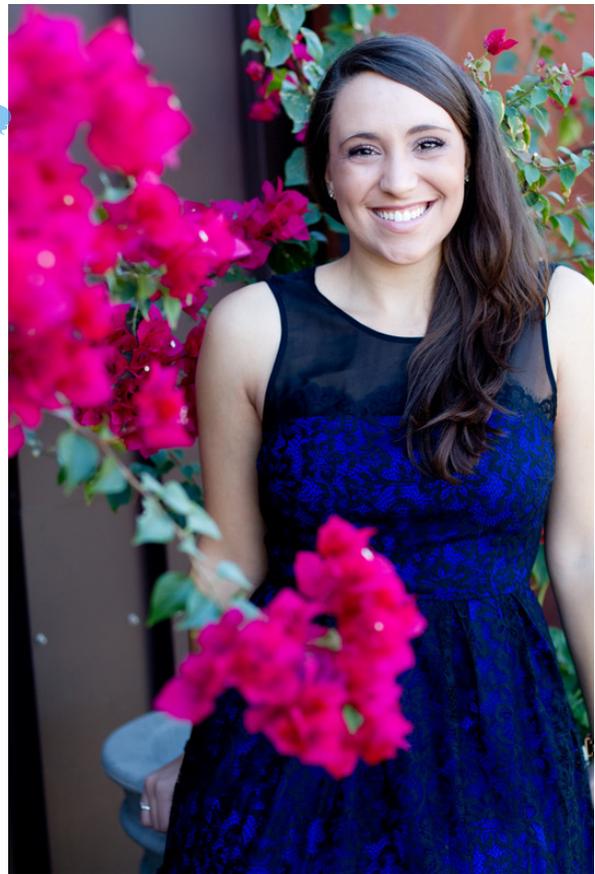
There are few research studies done in the field on the effects of grief, ambiguous loss, or posttraumatic stress (Van den Akker, & Purewal, 2015). Despite the growth of anecdotal evidence, little research is being conducted on the affects pregnancy loss through ART has on women, men, and couples, only perpetuating the societal discourses surrounding grief and infertility. The medicalization of pregnancy loss and disenfranchised grief experienced make it nearly impossible for couples and individuals to find support and healing. As for implications for practice, there are evidence-based interventions for couples and individuals that could be suffering from grief and loss during this process. For the majority of clinics and treatment facilities, it is not required for couples to be in counseling or therapy during the processes of fertility, possibly shaping the clients' views or assumptions that couples or individuals going through this process could actually benefit from receiving some sort of therapy or counseling. It is extremely important that, as therapists and medical professionals, we allow couples the space and permission to rightfully grieve, and feel the pain of their losses in a safe environment where validation can be provided.

In order for life to exist, grieving must follow close behind. In today's western society, grief is not a common practice that is done outwardly. Grief is mainly practiced as an introspective task, and when brought outward is often met with awkwardness and discomfort. Couples that face infertility suffer great pain and loss that may go unnoticed physically, yet psychologically their pain and grief is extremely real and at the forefront of their thoughts for the majority of their lives. When couples or individuals seek treatment through assisted reproductive technologies, it is often their last hope, and their last opportunity to be able to conceive a biological child.

With this, there are extreme amounts of pressure and anxiety that can be felt in result of societal discourses that surround us and our natural wants and needs as humans. Further research is necessary in many aspects of ART and grief experiences. Specifically, research regarding the psychological distress that grief produces is needed, to then discover interventions that could be used by therapists. Interventions that are able to address and recognize the grief in regards to infertility and reproductive technologies are desperately needed to serve couples and individuals the validation and support they need (McDaniel, et al., 2014). Next, fertility clinics and other medical professionals that are involved in the treatments of ART should move away from medicalization of pregnancy loss and provide more resources for couples and individuals to be able to recognize the grief that they have suffered. If a couple is seeing a mental health professional, the therapist should have a heightened sense of awareness for the woman experiencing a pregnancy loss from IVF, as they are more vulnerable to experiencing depression or an increase in anxiety (Peterson, Boivin, Norré, Smith, Thorn, & Wischmann, 2012). Mental health professionals should also take into consideration the large socio contexts that could impact the way the couple is grieving together, and how each individual is grieving.

ELIZABETH KRESOJEVICH- VITALE, LAMFT

Elizabeth is a recent Marriage, Couple and Family Therapy graduate from Lewis and Clark College in Portland, Oregon. She recently moved back to the desert and is excited to begin her journey as a professional here. She is mainly interested in working with couples and families, with a specialization in cultural integration and trauma-informed therapy. Elizabeth hopes to serve the greater Phoenix area supporting families and couples on their journey through life.



UPDATES

The Winter 2019 issue of our newsletter discussed AZBBHE rule changes regarding LAMFTs opening private practices. To clarify, this is supervised private practice with strict supervision requirements.

Refer to the **Board rules** for all pertinent information.

Visit **our new Network site** for more up-to-date info, events and to view previous editions of our newsletter.



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Medical Family Therapy

BY KELSEY FITZHUGH, LAMFT

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Medical Family Therapy is an up-and-coming model in the mental health world. The founders and influential people of Medical Family Therapy (MedFT) include Susan McDaniel, Jeri Hepworth, William Doherty, John Rolland and Thomas Campbell. Other variations of the theory include Integrated Care and the biopsychosocial approach. George Engel proposed the biopsychosocial model instead of biomedical model, as in the medical world. The basic framework of the model is defined as "the biopsychosocial treatment of individuals and families who are dealing with medical problems." MedFT is a combination of systems theory and a biopsychosocial approach to conduct therapy with patients and families who are experiencing physical health problems. The biopsychosocial model acknowledges that there are psychological and social factors that influence how someone perceives and responds to a medical emergency; therefore, how they experience the illness can be influenced by their surroundings and mental factors. Medical family therapists (MedFTs) address the systemic interactions among patients, their families, their doctors, their nurses, and other healthcare workers.

The goal of MedFT is to assist the patient and their family through the course of the physical illness and their response to the illness. Another goal is to help the patient and their family work effectively with their healthcare teams. In addition, MedFT works to promote agency by encouraging the client to make personal choices regarding dealing with the illness and the health care system. MedFT also focuses on communion by addressing the emotional bonds that can be distressed by the illness. Studies have found that the quality of social relationships is the most powerful psychosocial factor in health and illness. MedFTs must collaborate with patient's healthcare providers to provide effective integrated care.

MedFTs and physicians work in a partnership: physicians are able to educate the therapist about causes, course, and prognosis of the illness, while MedFTs can discuss the patient's experience while exploring ways to decrease the patient's and family's anxiety. MedFTs will have to sometimes utilize psychoeducation to educate the patient and their families, meaning that they need to have a working knowledge of the illness and its course.

As a best practice, it is important to examine the family's belief systems, especially when they are not complying with the medical plan. The psychosocial demands of the illness, the family's functioning, and their resources all determine how successful the family will be with coping and adapting with the illness. MedFTs may also help the family cope with multiple losses, which may include loss of independence, physical incapacity, rejection, their vision for the future, and many more. MedFTs must also support the family to set limits on the amount of control the illness has in their lives, while helping the family get more information or better care arrangements if needed. MedFTs may help the family with boundary setting on family members' helpfulness, and help the family come together in the face of the illness. Key techniques for assessment and intervention in MedFT are psychoeducation, eliciting the illness history and meaning, normalizing negative feelings, reinforcing the family non-illness identity, and finding supportive resources.



KELSEY FITZHUGH, LAMFT

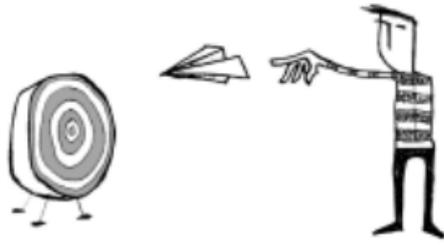
Kelsey is an LAMFT and a recent graduate from the MFT program at Arizona State University. She is interested in working in the growing field of Medical Family Therapy.

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AUGUST 29 – SEPTEMBER 1, 2019 | AUSTIN, TEXAS

Learn something interesting at the conference?
 Send it to the editors to share in the next newsletter!

cehyland@asu.edu & kaminljessica@gmail.com



Chelsea Hyland, LAMFT



Jessica Kamin, LAMFT

We hope you had a great summer! Thank you for taking the time to read our newsletter. We are always looking for articles, advertisements, feedback and suggestions to make the newsletter better. Please reach out to us via email.