AMCAP NETWORKER

PRESIDENT'S MESSAGE

Dear AMCAP Members,

This has been an exciting time for me to be involved with AMCAP. I have been impressed by the dedicated volunteers who work so hard to put ideas into action. AMCAP continues to expand, grow, and improve the ability to further its mission. This is because so many people give freely of their time, skills, and knowledge.

As members of AMCAP, we share a common desire to strengthen each other in our efforts to understand how to improve mental, social, and emotional health in ways that are compatible with the teachings of Jesus Christ. It is a united effort that is making wonderful things happen. The AMCAP website and email linkage have expanded quick dissemination of information worldwide. Public relations work has expanded press coverage and public awareness of our efforts. We continue to be able to provide continuing education credits for professionals and our outreach efforts extend internationally. We now have 663 members who live in 40 states and 15 countries. These and other developments, too numerous to list, are helping AMCAP to grow and to be more effective in raising our ability to care for others. I am personally very grateful to all who contribute to this effort in any way. I also value the friendships I have made through AMCAP.

We have made wonderful gains but there is still so much that can be done. The church is growing rapidly and spreading its influence worldwide.

The need for mental health services is also increasing at a sometimes startling rate. There are still many myths and misconceptions about mental illness. The values and standards of much of the world are becoming more divergent from our beliefs. Our voice needs to be heard. That voice can be heard in many ways—through providing competent and caring mental health services to those in need, accurately educating others about mental health and religion, conducting well-designed research on topics related to our mission and beliefs, enlisting new members for AMCAP, presenting at conferences, starting a new chapter or group in your area, volunteering to help at conventions, or just sharing your friendship and support. All members have some gift to share. Each individual can strengthen the group.

I have greatly benefited from my association with AMCAP and thank all members for being part of this good cause.

Marleen S. Williams, Ph.D.
President, 2003-2005
Association of Mormon Counselors
and Psychotherapists

AMCAP NETWORKER

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Submissions are welcomed. Send submissions, together with information on contacting the author, via e-mail, on a 3½ -inch diskette, or by written copy to:

Rebecca Pack Jorgensen, PhD
Counseling Center
BYU-Idaho, KIM 270E
Rexburg, ID 83460-1685
W: 208-496-1100 Fax: 208-496-1238
E-mail: jorgensenr@byui.edu

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2003—2004 AMCAP Leadership

Executive Committee

Marleen S. Williams, Ph.D.
President / Publications
H: 801-221-0874 W: 801-422-3599
FAX: 801-422-5920
E-mail: marleen_williams@byu.edu

Noel C. Gill, Ph.D.
Vice President / Bylaws
H: 435-245-4835
FAX: 435-245-2888
E-mail: ncgill@cache.net

Dean Bender, MBA, MA
Treasurer
H: 916-300-4543 W: 916-677-5779
FAX: 916-784-7850
E-mail: dbender@bbr.net

Executive Secretary

B.J. Fullmer
H: 801-583-4497 W: 801-583-6227
FAX: 801-583-1305
E-mail: mail@amcap.net

Board Members

Doug Craig, Ph.D.
Spring 2004 Convention / Bulletin
H: 208-656-9273
W: 208-496-1106
Email: craigd@byui.edu

Rick Hawks, Ph.D.
Website Coordinator
W: 800-723-1760
H: 801-825-3100
E:mail: hti@webpipe.net

Russ Seigenberg, Ph.D.
Membership / Outreach
H : 435-752-0226
W : 435-752-0750
Fax : 435-752-7433
Email : pensio7@comcast.net

Wendy L. Watson, Ph.D.
Volunteer Coordinator / Elections
H: 733-0405 W: 801-422-2349
E-mail: wendy_ watson@byu.edu

John P. Livingstone, Ed.D.
Continuing Education / Ethics
H: 801-224-9908 W: 801-422-3692
E-mail: jplivingstone@byu.edu

Board Members (cont.)

Douglas E. Brinley, Ph.D.
Area Coordinator Supervisor
H: 801-374-1975
W: 801-422-3367
E-mail: deb4@email.byu.edu

Advisors to the Board

Kristine Plummer, LCSW
Sprint 2004 Convention
H : 801-295-5566
W : 801-447-6000 & 801-336-6363
Fax : 801-295-8765
E–mail : kris59@msn.com

Rachel E. Crook Lyon, Ph.D.
Student Recruitment
H : 801-230-3158
W : 801-422-4375
E-mail : rec2@email.byu.edu
rachel_crook@byu.edu

Wesley Spencer, Ph.D.
Area Coordinator Assistant Supervisor– Western U.S., Pacific & Asia
H: 801-750-6118
W: 435-752-0750
E:mail: wesmarnie8@juno.com

Dana Templeman, MSW,
LDSFS Representative
H: 801-295-4022 W: 801-240-3629
FAX: 801-240-4632
E-mail: templemand@ldschurch.org
DanaMT1554@aol.com

Burton C. Kelly, Ph.D.
Historian
H: 801-225-2046
Currently serving as missionary in Nauvoo

Jonathan Chamberlain, Ph.D.
Assistant Historian
H: 801-225-2598
Email: epoch2@burgoyne.com

Janet Vincent, LCSW
Convention Hostessing
H: 801-278-5278
E-mail: garr.vincent@hci.utah.edu

Jan Scharman, Ph.D.
General Authority Representative
H: 801-277-4021
W: 801-378-2387
Email: jan_scharman@byu.edu

Advisors (cont.)

Vera Ivie
Convention Photographer
H: 801-476-1959

Dennis Ashton, LMSW
Convention AV rep
W: 801-240-3634
Fax: 801-240-4632
E-Mail: ashtondd@ldschurch.org

Liz B. Sharp, M.Ed, LPC
Media consultant
H: 843-856-6505
W: 843-856-0225
Fax: 843-884-3104
Email: lizbsharp@comcast.net

Editorial Board

Richard G. Ellsworth, Ph.D.
Journal Editor S2000- S2004
W: 661-945-9892
E-mail: rge2@email.byu.edu

Garison Jeppesen, LCSW
Journal Associate Editor
Fax : 801-585-1211
Email : garison.jeppesen@hsc.utah.edu

Rebecca Jorgensen, Ph.D.
Networker Editor F2003- F2005
H: 208-656-0853
W: 208-496-1100
Fax: 208-496-1238
Email: jorgensenr@byui.edu

Aaron Jackson, Ph.D.
Monograph Editor F2000-F2003
H: 801-423-1576 W: 801-422-8031
FAX: 801-378-5921
E-mail: aaron_jackson@byu.edu

Area Coordinator Asst Supervisor

Eastern U.S., British Isles & Europe
Position open

Student Rep.

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News from AMCAP headquarters

B. J. (Betty Jo) Fullmer
Executive Secretary

2004 started off with a bang! My AMCAP hard drive crashed but luckily the AMCAP membership files were saved. The email address book disappeared, but I am managing to update it with the records from the AMCAP database. If you have not received an email about the upcoming convention, please let me know your email address and I will put you on the list. We do not sell or give your email address to those who send SPAM.

If you have lost your user id and password to the members section on the website, please let me know. Each time you renew your membership you will be given another password (unless you are a lifetime member; your password will not change). You can contact me at; mail@amcap.net

Welcome, welcome the 87 new members who joined AMCAP in 2003! The list includes 39 Professionals, 37 Students, 7 International members, 2 Retired members, 1 Associate member and 1 Institutional member.

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Margy Andersen, M.Ed.
Launi Anderson
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Donald Beste, Student
Bruce Boettcher, MFT
Vicki Booth, RN
Rod Brock, Student
Laura Brotherson
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Rayelyne Byrne, SSW
Brian Campbell, LMFT
Karen Child MA, Student
Brandon Christensen, LCSW
Cindi Christiansen, MFTIAmanda Cole, Student
Rebecca Compton, MC
Brian Crandall, Ph.D.
Fabien Jean-Claude Decodts
Valerie Dimick, MSW
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Michael Dunn, Student
Norman East,MFC
Brenda Eccles, Student
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Dawna Foucht, Student
S. Josh Frazier, MFT
Christopher Frazier, LSW
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Sandra Godfrey, LMFT, LPC
Christina Gonzalez, LMHCStacy Gooding, LCSW
Marsha Gustafson
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Jeff Johnson, M.Ed.
Jamille Johnson, Student-
Gerald Jones, Chaplain
Elizabeth Jones, Student
Denny Kartchner, MSW
Maureen Keeler, LCSW
Melissa Kigin, MFT
Elzabeth Kirkaldie, MA
Kreg Kirkham, Ph.D.
Karen Kline, LMFT
Linda Kuick, M.Ed.
Ladora Langford, Student
Angeline Lloyd, Student
Rand Martel, LCPC, LMFT
Edgar McAvoy, MA
Eric Milne, LMFT
Cheryl Mlcoch, Student
Robynne Neves, LCSW
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Gregory Prince, Ph.D.
Dalin Pulsipher, Student
Dune Rabe, LMSW-ACP
The Renaissance Ranch
Allen Sackett, MSW
Kathie Schofield, MSW
Virginia Sennett, LMSW-ACP
Thomas Sennett, MD, Ph.D.
Marilyn Snell, Ph.D.
Puawai Solo
Kenneth Stewart, LCSW
Kris Stoddard, Student
Paul Stratton, MS
David Swarthout, LICSW
Michael VanDam, CSW
Eric Walker
Carlos Watkins, LCSW
Stephanie Wilkey, Student
Linda Williamson, LPC
Thomas Wilson
Marni Yarrington, MS

Our Lifetime members are: Cheryl Bailey, Owen Clark, Jean Coe, Stephen Covey, Peter Emerson, Becky Gray, Walter Hoffman, Rod Jeppsen, Duane Laws, Cheri McDonald, Timothy Smith, Wendy Ulrich and Christine Whitaker.

AMCAP on the WEB

www.amcap.net

- **locate your area representative**
- **read journal articles**
- **check out upcoming conventions**
- **order tapes**
- **renew your membership**
- **locate members**
- **network on the discussion board**

AND SOMETHING NEW!!!!

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THROUGH AMCAP!

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PREMIER SHOWING AT 2004 SPRING CONVENTION

The AMCAP office receives many requests for lists of LDS therapists who currently provide therapy. Many want to check their insurance list, but are frustrated because they want to see a member of the LDS church too. Not all of our AMCAP members provide therapy, or are looking for new clients. If you would like to be placed in the additional directory (www.ldscounselors.net), please register on our website or send this form to the AMCAP office (by mail or fax). Only members of AMCAP can be on this list. We are not endorsing or recommending any therapist listed in the directory. Your information will be listed in both directories (including the one in the members only section of the website). The cost is $10.00 per year.

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Exp Date ____ ____Name on credit card: ____

POSITION ANNOUNCEMENT

BRIGHAM YOUNG UNIVERSITY—IDAHO

COUNSELING CENTER

TITLE: Counselor

POSITION DESCRIPTION: Counsel students with a wide range of personal problems, from adjusting to college life to serious emotional problems.

QUALIFICATIONS: Doctorate preferred, master's degree required in a counseling-related field. Experience in individual, group, and marriage counseling with young adults preferred. Church member who is eligible for a temple recommend.

BEGINNING DATE: August 16, 2004

SALARY: Dependent on experience and degree.

APPLICATION: Send resume, three letters of recommendation, official college transcripts, and a BYU-Idaho application form to:

Philip A. Packer
Assistant Academic Vice President for Instruction
290 Kimball
Brigham Young University-Idaho
Rexburg, ID 83460-1690

DATES: Applications will be accepted until April 1, 2004.

BYU-IDAHO: Brigham Young University-Idaho is a private institution affiliated with The Church of Jesus Christ of Latter-day Saints. BYU-Idaho is in the process of transitioning to a baccalaureate degree institution with a current enrollment of 11,000 students and an anticipated enrollment within the next two or three years of 11,600. Located in the community of Rexburg, Idaho, a town of approximately 17,257, BYU-Idaho is situated within a 90-minute drive of both Yellowstone National Park and Grand Teton National Park.

FALL 2003 CONVENTION PRESENTATION OVERVIEWS

AN INTRODUCTION TO DBT

GINNY SENNETT, LSCW-ACP

Dialectical Behavior Therapy was developed over a 20 year period by Marsha Linehan, PhD. Department of Psychology at the University of Washington in Seattle. Her intent was to develop a program that could successfully and efficiently meet the needs of individuals presenting with histories of multiple attempts to injure, mutilate or kill themselves. These clients, usually diagnosed with Borderline Personality Disorder, have historically been viewed as treatment resistant, manipulative in the worst sense of the word, and in general the bane of a clinician's life.

Teams of graduate students observed treatment efforts, rating interventions and strategies for maximum effectiveness and compiled the results. This generated general treatment principles, a hierarchy of primary treatment targets and a variety of therapy interventions.

The developed treatment modality was intended to be an intensive, team driven, long term (2 year) program involving case management, individual therapy, skills training group, process group, and medication management. Outcome studies are ongoing and continue to document the effectiveness of the approach.

Unfortunately, in the current economic climate few clients outside a grant funded university setting can afford the time and financial commitments necessary to complete this type of intensive program. Certainly, managed care limitations dictate the types of services most mental health facilities can provide to maintain economic viability.

The challenge then, to the managed care clinician and the private practitioner, is to adapt the ideal to the reality, and pray that after all we can do, Heavenly Father will pick up the slack.

The emphasis Dialectical Behavior Therapy places on biosocial learning theory and the integration of cognitive behavior therapy with acceptance based treatment strategies is central in successful adaptation.

Biosocial Learning Theory stipulates that some people are biologically "hardwired" so their autonomic nervous system reacts like a rocket to distressing internal and external events and that it can take days or weeks for these individuals to return to baseline if they lack self nurturance, emotion regulation, interpersonal effectiveness and distress tolerance skills.

In families where parents and other caretakers are able to teach children how to self validate their experiences and feelings, manage their emotions, and pro-actively problem solve based on a lovingly applied and consistent set of behavioral and spiritual values and expectations, this biological hardwiring can become an asset in developing creativity, compassion and empathy. These children are very likely to develop healthy self esteem as they are taught that they are cherished sons and daughters of Heavenly Father and are provided with opportunities to exercise their agency on levels appropriate with their age and experience.

However, in families where these expectations and values are absent or, worse, unpredictably or inconsistently applied and where the child's emotions, experiences, thoughts and attempts at problem solving are **consistently** invalidated, this biological hardwiring becomes devastating to child and family alike. In general, these family members tend to ignore problems because the parents themselves have been badly wounded growing up and are unskilled in problem solving, communicating and in empathic relating. Thus, the child learns to repress feelings that subsequently explode (or implode) spectacularly

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and unpredictably.

Unfortunately, these pyrotechnics generate a great deal of attention for children who are starving for trustworthy guidance and nurturing. The family, generally lacking in coping skills, is forced to engage in heroic efforts to clean up the resultant mess. As the unremitting crises continue, the family becomes exhausted and the child even more alienated. This negative reinforcement actually increases the intensity and frequency of explosions as the child desperately attempts to ward off rejection and regain attention. Thus the oscillation of repression and explosion are environmentally and socially very reinforcing and will be repeated within the therapeutic relationship as the client works to make the therapist fit the clients' view of himself and world.

Essentially, the child learns that in order to be taken seriously, a crisis must be involved. The child also learns that his or her experiences, thoughts and feelings are untrustworthy and that something indefinable causes him to be unlovable. The child learns to ignore feelings, and that quietly asking for what he or she needs will not work. The child is also very much aware of the exhausting impact their behavior has on the family. This is translated into a general sense of worthlessness, shame and despair. As one client described to me, "I'm all black inside like a slimy lake that if anyone touches they will die. I should die and then I can't hurt anyone else".

The mind-set of the therapist is as crucial to successful treatment as theoretical knowledge. One can not enter the treatment relationship with the stereotypic prejudices generally attached to the Borderline diagnosis and expect to be successful.

General Treatment Principals (the DBT Mindset) have been defined to promote allegiance, limit opportunities for blame, increase responsibility and self sufficiency and to counteract both therapist and client tendencies to make assumptions about one another. Eight treatment principles are:

1. Patients want to change and, in spite of appearances, are trying their best at any given time.

2. Patients' behavior patterns are understandable given their backgrounds and present circumstances. For example, cutting and self mutilation are complex behavior patterns with multiple reinforcer's that help clients cope with feelings so frightening and intense that death is preferable to the client if there is no other hope of release or relief.

3. Client's lives ***may not*** be worth living in their eyes. However the therapist will never agree that suicide is the appropriate solution. Rather, the solution is to ***make life worth living.***

4. Patients are trying hard and need to try harder if quality of life is to improve. Clients are not to blame for the way things are ***and it is their personal responsibility to make things different.***

5. **Clients cannot fail in DBT.** If things are not improving, it is the treatment that needs to be modified in some way.

6. **CLIENTS ARE NOT MANIPULATIVE!** This implies that they are skilled communicators, proactive problem solvers, and can gently influence people to get their needs met, while maintaining emotionally intimate long term relationships without sacrificing their self respect and values. While exactly the opposite is usually true this mindset helps to promote constructive relational interactions.

Prayer is a powerful source of comfort and support for the therapist who feels heavy laden and heart sore. Scriptures prayerfully read provide guidance and reassurance. Repentance and redemption mean that even if mistakes are made, as long as one admits them, accepts the consequences, and repairs what is reparable and tries to do better, Heavenly Father, through Jesus' act of atonement, will make up the difference. The concept of therapist as a tool and conduit for the healing power of Heavenly Father is infinitely reassuring. As a therapist, it means you never have to be alone or unsupported. This knowledge brings a calmness and a rock steady foundation to the healing process that is invaluable in staying the course with clients experiencing incredible levels of pain and distress.

7. Therapists must strive to hold the tension inherent in adopting the following therapeutic

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characteristics (or dialectics)

change oriented *and* **acceptance oriented**

nurturing/validating *and* **benevolently demanding**

unwavering centeredness on therapy goals
and
compassionate flexibility

When working with clients whose lives present an unremitting pattern of crises, a hierarchy of primary treatment targets must exist to protect the therapist from becoming overwhelmed and repeating the pattern of rejection the client has experienced. The treatment hierarchy also prevents the therapist from attempting to address trauma issues before the client has the requisite coping skills to succeed in this endeavor.

The presentation also addressed the Three Stages of the Hierarchy of Primary Treatment Targets in DBT and concluded with this encouragement:

One of the primary tenants of Dialectical Behavioral Therapy is that therapists must have a consistent source of guidance, support and encouragement to be able to work effectively with this high risk population.

What better source than Heavenly Father, Jesus Christ and the steady guidance of the Holy Ghost. The complexity of the clients histories and needs, the emotional intensity and energy required to remain present as clients tell their stories and the split second decisions required to choose the right interventions at the right time come at some level from training, at some level from experience, but most of all from the promptings of the spirit and Heavenly Father's nurturing of a gift for service and compassion.

Therapeutic Forgiveness: Developing a Model for Empowering Victims of Sexual Abuse

Elaine Walton, Ph.D.

As counselors we spend a lot of time helping our clients deal with losses. Grieving losses is complicated for victims of sexual abuse. We understand the grief process goes through stages of denial, anger, guilt/bargaining, depression, and acceptance/resolution. We can compare the loss stages to two situations, one the grief of a widow and two, the grief of an abuse victim.

1. Friends and family are usually close at hand to help a widow face the reality of a death. (Denial - √)
2. They forgive the woman for being angry. (Anger √)
3. She gains reassurance that the death was not her fault. (Guilt/Bargaining √)
4. Friends/family support her through her depression. (Depression √)
5. She is Introduced to a new kind of life without a husband—all of which helps her progress toward acceptance and resolution. (Acceptance and Resolution √).

Contrast the experience above with the grieving of an abuse victim. Abuse typically has a very different reaction from family and friends (if they are even aware of the abuse) and there's little to no validation given the victim.

1. The victim is encouraged to stay in denial.
2. Usually suppresses anger.
3. Without support, typically turns anger inward
4. In response to depression, becomes a scapegoat for more guilt, or is blamed for her/his negative attitude.
5. Instead of acceptance and resolution, becomes an aggressive complainer or a helpless dependent. Instead of validation, she/he gets more stuck.

Sexual abuse is ugly and damaging in so many ways. The literature is full of evidence of mental

(continued from page 9)
health issues created as a result of abuse. Through years of working with sexual abuse survivors, I discovered that clients who forgive their abusers get through the healing process faster.

The literature is showing an increased amount of research on forgiveness interventions to strengthen relationships. While Forgiveness is a more popular topic in the psychotherapy literature, it is not popular in the literature related to treating sexual abuse. For example, in a literature search of "Sexual abuse" combined with "treatment" (using Psych INFO) – there were 3,393 references. Add "forgiveness" – there were only 13 references. Therapists typically focus on symptoms reduction for depression, eating disorders, sexual dysfunction, interpersonal problems, dissociative disorders and self-esteem issues.

Forgiveness is typically not a treatment goal and is usually advised against. For example, in The Courage to Heal (Bass & Davis), this warning about forgiveness is given: "Trying to forgive is a futile short-circuit of the healing process. . . . Healing depends a lot on being able to forgive yourself, not on being able to forgive your molester. I don't think any TIME spent trying to forgive your molester is worthwhile time spent….." Perhaps opposition stems from a misunderstanding in defining and conceptualizing forgiveness. Forgiveness does not equate to reconciliation.

Cloe´ Madanes developed a model of forgiveness linked to repentance through the process it involves. Madanes' model is used for healing abuse in a family therapy context. She has each member of the family give an account of the offense. They describe what was seen, heard, and who did what to whom. They are to focus on factual, detailed accounts and give everyone an opportunity to talk. The offender is then asked to explain in specific ways why it was wrong, how it injured the victim and how the victim is different because of the offense. Additionally, spiritual pain is explored across the family. Exploration includes the spiritual pain of the offender, how the offender was hurt because of the offense, how he/she is different and how he/she might be suffering and hiding his/her own pain. Spiritual pain is also explored with each family member with special focus on the pain of the mother and father and why this offense might be particularly painful to them.

After these discussions, the next step is to ask for a kneeling apology from the offender. The apology must be sincere, detailed, and specific. If the offender refuses to apologize other family members are asked to respond, or the meeting can be terminated and rescheduled. An apology is sought from each member of the family—an apology for not protecting the victim or for not noticing the pain of the victim. The family determines what the consequences will be if the abuse happens again. The consequences should be feasible and severe enough to provide a deterrent. The family also designates a special protector for the victim, someone other than the mother who has power and authority. The family is instructed to talk about the ways in which the victim needs protection. They then decides on a method of reparation. Reparation should be appropriate (e.g., the offender paying for therapy or contributing to a college fund). It should not be confused with payment for sexual favors.

Treatment then moves into talking about healthy sex. The offender needs to understand what is right about sex. This might be a separate session without the entire family present. Normal family life is also explored. What was life like before and after the family crisis? This might be a time to plan a family activity such as a picnic or a vacation. During this stage, the family begins the process of restoring love for the offender by showing expressions of forgiveness and affection. This helps to find a place in the family for the offender again. It's important to talk about the role of the offender in the family, including the specific family needs that can be addressed by the offender. As the family does this, they help the offender forgive him/herself. Discussion includes ways to construct a guilt-free future—how the offender will be different, what the offender might want to do with his life. A strategy is designed for dealing with guilt (e.g., when temptations or guilty thoughts arise, do a good deed; then self-esteem replaces guilt.)

Most families of sexual abuse victims do not get this type of family intervention. Additionally, what if the offender doesn't repent? I struggled in my treatment of sexual abuse survivors to help them deal with the unfairness of offenders not apologizing or repenting. I desired for them to be

(continued from page 10)
able to accomplish for themselves the tasks and benefits they would have received had their perpetrator repented, as in Madanes treatment model.

I began to ask, "How can I help clients accomplish for themselves the tasks and benefits of a repentant offender?" As a result of this question, I've developed the model of repenting "on behalf of" the offender.

The first part of the process is an adaptation of The Miracle Question (Insoo Kim Berg). Client's are asked to "Imagine your offender kneeling at your feet" and address questions such as "what would you do?" Exploring the responses to this question will reveal the clients' barriers to imagining the offender's repentance.

In order to repent "on behalf of" the offender, we first review the five steps of repentance. Then, we go over the five steps again but from the perspective of the victim. The five steps of repentance are: recognition, remorse – or sorrow for the sin, confession, forsaking and making restitution. Working through the five steps of repentance "on behalf of" the offender from the perspective of the victim deals with resolving these issues and questions:

1. Recognition of the sin.
   - A. Name the offense and claiming the injury.
   - B. What were the moral rules that were broken, and how did the betraying event break those rules?
   - C. What is the meaning of the injury, and what are its consequences?
   - D. How am I more vulnerable?
   - E. How has my belief system changed?
   - F. What specific losses have I sustained?
   - G. What gifts have I received because of the injury, how am I stronger or different?
2. Sorrow for the sin.
   - A. Hasn't the victim experienced enough pain by being injured?
   - B. Grieving is part of the healing process.
   - C. Sorrow has been averted or camouflaged by anger, and in giving up the anger, one has to be willing to feel the sadness which gave rise to that anger.
   - D. Sorrow is a natural response to loss and will come naturally as the victim is able to name the offense and claim the injury—identifying and grieving all the losses.
3. Confession
   - A. Disclosing the offense
   - B. Breaks the silence and shares with someone
   - C. Place the blame where it belongs. If there is no blame, there is no need to for give. In order to forgive, the client has to recognize that something was wrong and someone was at fault. Once that is clearly established, then the process of forgiving and healing can proceed.
4. Forsaking the sin.
   - A. Victims can take responsibility for pro tecting themselves and others from further abuse.
   - B. Develop appropriate guidelines for determining a person's trustworthiness and the abuse survivor can establish common-sense rules of conduct to stay safe.
5. Making restitution.
   - A. Restoring order and wholeness
   - B. Balancing the scales
   - C. Therapy, support group, education /training, rejuvenating social life, starting a new hobby.

The benefits of repenting "on behalf of" the offender include:

Empowering the client to address debilitating symptoms such as eating disorders, long-term depression, sexual problems, poor self-esteem and difficult interpersonal relations.

Creating experiences of self-enhancement and personal growth through identifying the injury, claiming the offense, grieving the losses, placing blame appropriately, learning new ways to protect self and restoring resources to depleted reserves.

Enabling action to be taken from a position of strength through brining the offender to justice, or restoring a healthy relationship, or becoming free of the unhealthy connection and moving on.

Helping our clients to forgive the perpetrator brings great benefits to them. Through the process outlined above clients are able to view the offender through a different lens, a lens that allows them to experience God's miracle of forgiveness and the miracle of healing given through utilizing Christ's atonement.

CLINICIAN'S CORNER

In the following articles, members of AMCAP share ideas that they have found helpful in their own clinical practice. These ideas are suggestions only and should only be used by trained clinicians using professional judgment. AMCAP members are invited to submit clinical ideas for inclusion in future issues of the Networker. *See www.amcap.net for additional ideas from past AMCAP publications.*

Anger Management

Russ Seigenberg, PhD
Board Member

Anger is a normal human response to frustration. At its best it is a tool for change. At worst it is an imposing force of destruction. The place to begin in changing our patterns of anger is to consider our attitudes about expressing anger. We develop our attitudes by accepting input from others and by making inner decisions in reaction to life experiences. Even when we just view others' behaviors we are always making some sort of evaluation, consciously or otherwise. What we have decided is right or acceptable will later dictate our behavior when we are frustrated. We will only change when we decide to take full responsibility for our behavior and make a deep and lasting commitment to be in control of our emotions. Ultimately, we should choose to walk as Jesus walked.

> He that is slow to anger is better than the mighty; and he that ruleth his spirit than he that taketh a city.
> (Proverbs 16:32)

The Miracle Advice

There is one key idea that can help us to extinguish the flames of anger before they become a forest fire. It is God's miracle advice. This involves recognizing that the real cause of anger is judging others' behavior. **It is almost impossible to get angry without judging others.** We become frustrated when someone does not live up to our expectations of how we think they should act! We decide that their behavior was immoral, unethical, or socially substandard. We use the universal link words to anger "should" or "should not". We fail to recognize that it is only in our imaginations that others care to follow our "rules" for their conduct.

Most of us cannot even get ourselves to act the way we should. In short, getting angry is often the result of a vain wish to control our environment. It is a waste of time and energy to focus on the fact that someone did something wrong. It is much more helpful to accept that people act the way they really are. Our only choice is how we choose to respond to others' behavior.

We can diminish our anger by gaining insight into the life situation of those who offend us. We can strive to look at others with eyes of compassion. Acceptance and empathy can free us from anger. We need to feel sorry for those who wrong us and accept their limitations. We cannot control others. The only things we can really control are our own thoughts and behavior. As we take control of our own passions, we will invariably come up with an adequate solution to manage each frustration. Sometimes there is an intervention we can use to teach a life principle and sometimes we must accept that there is little we can do. Whichever it may be, when our hearts are right toward others we can enjoy the wonderful gift of inner peace.

> Judge not, that ye be not judged.
>
> For with what judgment ye judge, ye shall be judged: and with what measure ye mete, it shall be measured to you again. (Matthew 7:1-2)
>
> Love your enemies, bless them that curse you, do good to them which hate you, and pray for them which despitefully use you, and persecute you.
> (Matthew 5:44)

(continued from page 12)

Cool Thoughts

It is not situations that make us angry, but our perceptions and internal beliefs. It is our view of each problem that can trigger an angry outburst. Even a loaded gun cannot go off until the trigger strikes and sets off the charge of gunpowder in the bullet.

In the realm of human emotions, our first line of defense against angry outbursts is to stop, control our response, and take a time-out. A time-out means removing oneself from the situation and creating an opportunity to think rationally about things. Time-outs provide necessary boundaries and can stop anger from growing out of control.

***The greatest remedy for anger is delay*.**

The inner motives behind impulses to act out are generally fantasy-based. For example, when John loudly insults his mate Jane during the course of an argument, his fantasy may be that Jane will recognize how foolish she has been and decide to cooperate. The reality is that Jane will likely become angry and defensive and things will get worse. By quickly detecting the fantasy behind any angry impulses and reminding ourselves of reality we can greatly weaken tendencies toward negative behaviors.

Also, we can extinguish anger with "cool thoughts" (logical and rational thoughts from the executive part of the mind). If we allow ourselves to dwell on "hot thoughts" (emotional thoughts from the inner self), it is like pouring gasoline on the fire. Reading the following card each time we are angry signals the logical side of the personality to take control and restructure our thoughts.

Anger Card

1. Why is the person acting this way - bad mood, not understanding the situation clearly, personality trait?

2. What did I do to possibly contribute to the problem?

3. What emotion lies beneath my anger - frustration, hurt, jealousy, resentment, guilt, or insecurity? Am I being totally logical?

4. What rule of mine is this person breaking? I recognize that we all have areas of development to work on. Can I accept his basic human worth despite his perceived shortcomings in this area?

5. What is my fantasy about what will happen if I act out on my impulses? What will the real consequences be if I do not control my anger?

6. Is there any solution or compromise that would resolve this situation?

7. What could I say to appropriately express my feelings?

8. Is this problem so great that I can't forgive the person or just put it aside? What would Jesus do?

When anger rises, think of the consequences.
Benjamin Franklin

People who do Make a diference

NOEL GILL, PHD
Vice President

Since my official early retirement a little over two years ago, I have had the opportunity of serving as a disaster mental health worker for the American Red Cross. My first assignment was during the Christmas season following the 9/11 disaster in New York City. Since that time I have responded to four other disasters including tornadoes, and the recent California wildfires.

It is easy to experience a feeling of being overwhelmed when you arrive on a disaster scene. There is incredible suffering being experienced on a wide scale. It is tempting to despair, sensing there is no way to relieve all the loss and grief associated with the disaster. In a matter of speaking that is true.

As I begin my duties on each disaster assignment, I am reminded of the situation Christ faced as He awaited death upon the cross in the final acts of the atonement. In pain and agony He uttered the words, “It is finished.” Skeptics may ask, “What was actually finished?” Certainly, the world was not rid of sin, pain, or suffering. Even the small beginnings of the church organization that He organized would falter and enter into apostasy. In His infinite wisdom, He understood that *His* assignment, *His* mission was completed. He did not solve all the problems of the world in which He lived, taught, and died in. Yet, what He did made all the difference for each of us.

Along the same vein is the story about the young Polynesian boy who came across a beach of starfish stranded by the receding tide. The starfish would surely perish in the tropical sun, if they could not return to the safety of the sea. The boy began picking up starfish and throwing them back to the ocean. A wise elder of the tribe, noticing this, approached the young lad and reminded him of the futility of his efforts. The elder explained that he could not possibly make a difference, that no amount of efforts could possible save all the starfish. The young boy paused for a moment, then picked up another starfish and heaved it back into the ocean. “Maybe not” he replied, “but it makes a difference to that one.”

Disaster relief is a lot like throwing individual starfish back in the ocean. Each victim is a story in and of itself and individual efforts can and do make a difference in touched lives.

Each morning while on disaster assignments before I faced the challenges of the day, I would offer up a simple prayer that went something like this: “Lord if you were here in person today, what would you do? Guide me today to sense the needs of just one person and help me to know what I can do to lighten his/her burden.” With that mind set in place, I found that, indeed, each day I would be guided to individuals in need and would be able to assist them in their healing process.

I remember flying back home from my recent assignment at the California Wildfires and taking time to thank the Lord for allowing me to be of service and for guiding and directing my efforts. I thought how I had experienced similar feelings as a greenie missionary and as a new Bishop. Suddenly, I experienced a stupor of thought and as I struggled to understand, I experienced what seemed like the voice of the Lord speaking to me. It said, “Oh foolish son. Why do you wait for such times of need to inquire as to where you can make a difference? Does not each day provide the same opportunities to do that which I would do if I were there?”

Never had a message hit more strongly to my very core. I then realized that the process of seeking to find ways to better understand and serve our fellowman ought to be an integral part of every aspect of our lives. As members of the helping professions who adhere to the principles of the restored gospel, we are in a position to do much good in the world each day. Who better than AMCAP members to help in the healing process of those whom we serve? I have learned that it does not require a “special assignment” such as a mission call, a church calling or even an assignment to respond to a disaster to be able to seek out and rescue the lost sheep.

May each of us discover the opportunities each day for us to be individuals who make a difference.

Reflections on EMDR

Brent Scharman, PhD

At the Spring 2002 AMCAP Convention I gave a presentation entitled: *Beware of False Hope*. The theme of the presentation was that it is critical for us to provide treatment that is professionally credible (documented, to the degree possible, by research) as well as being spiritually and doctrinally sound. I made reference to having attended a presentation at the American Psychological Association (APA) 2001 convention entitled: *Fringe Psychotherapies*, which listed Eye Movement Desensitization and Reprocessing (EMDR) therapy in that category.

I wanted to give an update from the 2003 APA Convention where the issue of EMDR was addressed in two separate presentations. Gerald Koocher, PhD, treasurer of APA and staff member at the Harvard Medical School, did a fascinating presentation entitled *Fads in Psychology.* Dr. Koocher's presentation did not include a formal reference on EMDR but in the question/answer session he was asked his opinion of this technique. His responses were, to the best of my ability to write it down, as follows: "There are always evolving techniques in psychology and it is challenging to know when it is appropriate and ethical to use a new technique versus when it is inappropriate and irresponsible to use that technique. I initially felt that EMDR was quack therapy (10 years ago). It now appears that there is something to it even though it is not clear that the actual movement of the eyes is related to the outcome."

The implication of his comments was that we needed to have had practitioners doing the therapy to determine if it works but it would have been critical to make certain clients were given accurate informed consent at the time of intake.

In the most important presentation given, Perkins, Smyth, Rogers, Norcross, Beutler and Francine Shapiro participated on a panel presentation entitled, *EMDR Update of Social Political, Research and Clinical Implications.* A summary of comments made are shown below:

- EMDR is different than traditional desensitition and exposure therapy.

- The research is contradictory as to whether or not the eye movements really make a difference. However, Rogers said in summary: "Eye movement is not inert. It is not a placebo. It does have impact."

- EMDR is now the most widely researched treatment for PTSD.

- Professionals have resisted EMDR because:
  1. The initial claims were exaggerated,
  2. The original restrictions on training,
  3. The use of eye movement in the title,
  4. EMDR was not initially placed with any other theory - "It didn't come out of the lab, and it was proposed by a female. It was a miracle story."

- Beutler said, "We need to understand when it doesn't work."

Shapiro, the originator of the concept, was the last to speak. She reflected on the challenges that have come to her personally and professionally since introducing EMDR. She said that in retrospect she was naive about what she was doing and would not have named the technique EMDR but rather would have referred to the behavioral aspects of the treatment. She commented that there have been no restrictions on training since 1995. She was quietly confident and non-defensive and said she feels positive results are coming from the technique and that they will be confirmed by long-term research.

"Where e're thou art, act well they part:
The importance of gospel values in various family systems."

From Fall Conference Presentation

JANET S. SCHARMAN, PHD

Many of the families we work with find themselves in difficult situations, perhaps family configurations or relationships they hadn't planned or prepared for. That can be both challenging and disappointing, but it doesn't mean that life cannot be positive and fulfilling.

In the Bible Dictionary we read this very important phrase: "Only the home can compare with the temple in sacredness."[1] It gives no qualifiers to *the home*. There is no question that the family headed by two healthy, stable, righteous parents who share the same vision and commitment offers the greatest opportunity for raising emotionally and spiritually healthy children. We should do everything within our power to create an environment that will maximize the likelihood of successful experiences for family and children. But, we must also remember that if, for whatever reason, we or those we work with, are diverted from that path, all is not lost. "Every home," President Hinckley has said, "can provide an environment of love which will be an environment of salvation."[2] Every home.

Clear values, commitment to doing those things of eternal consequence, and good parenting skills are critical regardless of the configuration of the family. We can be helpful by identifying the positives within the family system and then building on those strengths. As therapists we are going to frame what we see with our clients, in some way, based on the dynamics or motivations as we interpret them. Why not choose to frame each client situation positively? For example, most children who are exhibiting negative behaviors are trying to do something for the family. It's not working, but the motivation is likely good. This doesn't mean that we totally ignore dysfunction or damaging behaviors. But if w can capitalize on the positive piece, even if takes some creative sleuthing to detect, we have something to start building on immediately.

For LDS families, here are some additional thoughts:

Love the Lord

Help parents become solidly grounded first. Children need to see that their parent or parents truly love the Lord with all their heart, soul and mind. It can be a powerful teaching moment when children catch parents reading scriptures alone in their bedroom, saying personal prayers, or asking for divine help in dealing with difficult issues. Don't use the Church as a club. Rather than enforcing the gospel, parents would do well enforcing sound principles. Encourage parents to talk about honesty, integrity, and their desire for their children to have a good life rather than always tying things back to the Church in a way that may create negative connections.

Encourage the righteous exercise of agency.

When those we love go astray, or we make our own mistakes, our tendency is to tighten up and try to gain more control. We may have to work harder to remind ourselves, and those with who we're working, that perhaps our very first test of faith and exercise of agency was during the pre-existence when we made the decision to follow Jesus. We fought in a terrible battle along side our Savior for the opportunity for each of us to make many more choices in the future and to deal with the results of those decisions. We must encourage children as they make righteous decisions and help them to right the wrongs when they don't.

Don't give up.

As members of the Church, we all say we believe that families are forever, and yet how many parents feel like giving up on their children when they turn 16? Each phase of childhood – whatever the age – is most often a temporary one, particularly when viewed from an eternal perspective. Sometimes parents focus their attention on raising successful children rather than on being a successful parent. There is a difference. People cannot take ultimate control of their children, but they can determine what they will personally do or not do, and we all have been promised that our righteous efforts will not be in vain.

When we as professionals combine our understanding of therapeutic strategies with true gospel principles, great miracles can happen.

Notes

1. LDS Bible Dictionary s.v. "Temple," 781
2. Gordon B. Hinckley, *Ensign*, Nov. 1994, 54

CALL FOR PAPERS

AMCAP FALL CONVENTION 2004

SEPTEMBER 30 & OCTOBER 1
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BUILDING UPON A FOUNDATION OF TRUTH

The glory of God is intelligence,
or, in other words, light and truth.
(D&C 93:36.)

There is an increasing emphasis being placed on utilizing research and evidence-based practices to strengthen psychotherapy. Religious truths can be used as building blocks for models of change. It is suggested that science and religion cannot only co-exist but thrive together.

We invite you to submit your ideas in regard to this theme and help shed more light on this intriguing challenge. Possible topics include methods for integrating spiritual perspectives into theory and practice, analysis of existing psychological theories, consideration of research findings from a gospel perspective, and practical applications of specific techniques or models.

Presentation options include workshops, panel discussions and plenary addresses. Proposals should contain the following information:

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___14. T Therapeutic Implications for Working with Families with Children who have Developmental Disability *Melissa Allen, Ph.D., Susanne Olsen, Ph.D. & Barbara Mandleco, Ph.D.* __________

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__ 18. Theory and System for Integrating Religious Material During Psychotherapy: A Rational Emotive Behavior Approach *Rick Hawks Ph.D.* __________

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__ 20. Practicing the Healer's Art *Elaine Sorenson Marshall, Ph.D.* ________

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