WASHINGTON STATE SOCIETY FOR
CLINICAL SOCIAL WORK
NEWSLETTER

SPRING 2008

In this issue:

PRESIDENT'S MESSAGE

Words from the heart

BY MARIANNE PETTERSEN

This is my last newsletter column, and in the previous ones over the past three years, I have tried to speak from my heart about the vitality of the Society striving for worthy goals and about my own direct experiences as president. I am looking back on a lot of years of involvement.

When I first joined the Society in 1992, it would have been unimaginable to me (actually, laughable!) to think that some years later I would be in this position writing this farewell. A leadership role is not a comfortable one for me and in many ways still isn't. Maybe that sounds surprising since "here I am." But I hope my disclosure helps you to think about and explore your own possibilities within the Society—involving yourself in ways that may be surprising to you.

> *Teamwork is the quintessential contradiction of a society grounded in individual achievement.*
>
> — Marvin R. Weisbord

During my tenure as president, the Society membership has grown in number (about 20 percent in the last four years), and our organization appeals to a broader range of clinical orientations and practice settings among our community of clinical social workers. That the membership of the Society reflects the breadth of clinical social work practice in our community was one of my goals as president, and I think we have quite a ways to go before we represent the full racial and cultural breadth of our clinical community. We do not yet represent the full cultural and racial breadth of our clinical community but WSSCSW is dedicating itself to the exploration and achievement of this goal. To be successful, we will need to reach out more actively and develop relationships.

I have most enjoyed the relationships.

We have also come so far in creating a home for our new professionals and are committed to doing more. I would like to see us expand our educational offerings, including our ethics trainings, inviting the best trainers in the field from both the local and national scenes. Our educational offerings and our legislative

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WSSCSW

The Washington State Society for Clinical Social Work was established in 1973 and incorporated in 1988 as a 501(c)(6) to promote and advance specialization of clinical practice within the social work profession. It is an organization of clinical social workers practicing in a variety of settings including mental health clinics, family service agencies, hospitals and medical clinics, and private practice in the state of Washington. Its members span the professional life cycle from students and new professionals to mid-range, seasoned, and retired clinicians.

WSSCSW offers its members continuing educational opportunities, legislative advocacy including lobbying, network and professional growth opportunities and special programs for new professionals.

WSSCSW is a nonprofit tax-exempt professional organization with a board of directors composed of officers elected by the membership and chairpersons of the various committees. It is affiliated with the Clinical Social Work Association, which represents clinical social workers on the national level and actively works with them to represent local as well as national concerns.

PRESIDENT'S LETTER

continued from front page

program are the lifeblood of the organization. We continue to have such a strong legislative program. I have many times imagined what it would be like if we did not have a means to "watch our backs" and grow our profession in the ways that we have. Our financial footing is solid, thanks in great part to our treasurers, and I am proud of our newsletter—as it has been an expressive vehicle for the Society. The listserv provides us with another means to connect, communicate, and express ourselves. These are such important resources for all of us.

After having shared what I believe we have accomplished in the last four years, I could share my "wish list" with you but will invite you instead to contribute to the vision of the Society's future by speaking up and involving yourself. Our work is such that we are often solitary and must urge ourselves out into our professional community to collaborate and be creative. For me, I have most enjoyed the relationships I have had the opportunity to experience as president. Having worked with such an exceptional group of people throughout the past few years, I want to especially thank our hard-working committee members and others who really keep the organization ticking.

My best experiences in our various endeavors together have been when I made use of my clinical skills. The most difficult moments were when I didn't. I have had the great fortune of collaborating with and being supported by gifted, wise, organized, and forgiving people. We have made good use of containing, imagining, reflecting, catching projections, discretion, gentle interpretations, diplomacy, editing, joking, repression, sublimation, denial … you get my drift. In our successes and in the occasional painful mess ups, we have stayed a team. I wouldn't have enjoyed the last four years nearly as much without all of you. ♦

> *Good leaders make people feel that they're at the very heart of things, not at the periphery. Everyone feels that he or she makes a difference to the success of the organization. When that happens people feel centered and that gives their work meaning.*
>
> — Warren Bennis

DINNER MEETING REVIEW

"I became what was done to me" — WSSCSW dinner meeting on working with adult survivors of childhood sexual abuse

BY BRIDGET ALDARACA

On January 15, the Clinical Society was privileged to share its space in Room 305 at the University of Washington School of Social Work with speakers from two important community resources for adults who have experienced the trauma of childhood sexual abuse: Shepherd's Counseling Services, represented by Director Janice Palm, LMHC, and the Therapy Network for Sexual Abuse survivors, with steering committee members Marc Gilmartin, LMHC, and Randy Maríñez, LMHC.

Marc Gilmartin opened the meeting with a discussion of four of the transference and countertransference themes that surface in working with adult survivors of sexual abuse: seducer–seduced, rescuer–needy child, abuser–victim, and ineffective parent–neglected child. Throughout his presentation, Marc repeatedly returned to his own theme or mantra, that transference and countertransference are co-constructed through the dynamics of the therapeutic process, and that the primary need of the client is relational. He discussed eloquently the "torture of fear" that is often defended against by an identification with the abuser and underlined the client's need to learn transparency without experiencing a fear of succumbing to the will of the other.

Janice Palm's discussed the effect of sexual trauma on the development of the self. Trauma "interrupts development of the self" to the point that a "sense of self" can be lost. People who have suffered the trauma of sexual abuse become unable to trust their own perceptions. They may cope with their sense of humiliation and fear by identifying with the idealized power and perceived omnipotence of their abuser. "I became what was done to me." Janice emphasized that healing does not take place in an orderly sequence and that the therapist must be careful to respect the client's need to keep up a protective façade until they feel safe enough to reveal the newly emerging self.

Therapy work with trauma victims has a significant place in the literature about trauma. We talk about compassion fatigue and vicarious traumatization. In this context, Janice talked to us about her own experience when she felt that "I came to the end of myself." And she reminded us of an important axiom which we may often need to relearn in the therapy session, "when you don't know what to do, do nothing." Perhaps learning to stop and to be comfortable with being rather than doing is what allows us to develop not only as therapists but also, in Janice's words, "as human beings."

The final segment of the discussion was a lively and dynamic question-and-answer session led by Randy Maríñez in which many of the painful and difficult aspects of facilitating healing from sexual abuse were addressed. The Therapy Network for Sexual Abuse Survivors is a volunteer network of experienced therapists in collaboration with the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS). The list of volunteer therapists already includes many members of the WSSCSW who share the network's goal of providing affordable, long-term therapy for adults traumatized as children by sexual abuse. Those interested in finding out more about this volunteer opportunity may call the HCSTATS office at 206-521-1800. Shepherd's Counseling Services accepts sliding-fee scale clients and also accepts many insurance plans. For more information about their services, contact their website at *www.shepherdstherapy.org* or call 206-323-7131.

The Professional Development Committee hopes to plan at least one meeting a year in which we further our society's goal of reaching out to different agencies in the community in order to enable their members to learn about our professional goals and meet with our membership, as well as to afford an opportunity for WSSCSW members to learn about the many different community resources while making new friends. ♦

calendar

APRIL 2008

Friday, April 18, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

Thursday, April 24
- Volunteer appreciation dinner

Wednesday, April 30
- Dinner meeting: "Perspectives on Varied Approaches to Treating Anxiety"
- Michele Pomarico, LICSW; Caron Harrang, LICSW
- UW School of Social Work

Wednesday, April 30
- Deadline for the Outstanding Student Paper Award

MAY 2008

Friday, May 16, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

JUNE 2008

Thursday, June 19
- Annual party of the membership

Friday, June 20, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

JULY 2008

Friday, July 18, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

AUGUST 2008

Early August
- Membership renewal

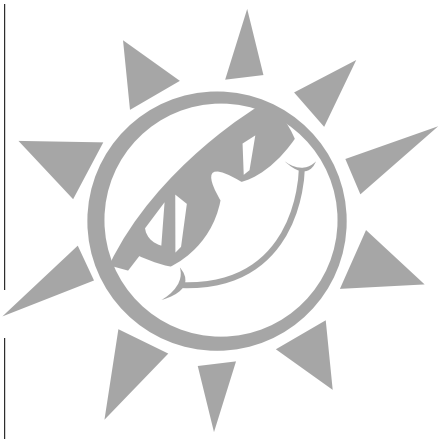
Friday, August 15, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

SEPTEMBER 2008

Monday, September 15
- Membership renewal deadline

Friday, September 19, 12 – 2 pm
- WSSCSW board meeting
- Hawthorne Hills Professional Center

Be sure to check our website at wsscsw.org for up-to-date details of events.



stay tuned!

WSSCSW annual party
- Our annual fête is fast approaching. We hope you will join us in celebrating the accomplishments of the Society over the last year and in honoring one of our own.
- Watch for details coming soon!

Have you moved?

Please let us know your new addess. Email your name and address to: aimeeroos@yahoo.com

Benefits available to WSSCSW's new professionals

- Mentorship groups for all second-year MSW students at the UWA School of Social Work and to new professional members. Mentoring in the group setting, involves support, information, access to professionals, and an arena in which you can explore your identities as clinical social workers.
- Individual mentoring for all new professional members. We have a list of members who have volunteered to provide individual mentoring to the new professional member. The focus is to help with questions about job search, licensure, supervision, further training, WSSCSW benefits and involvement, and other questions the new member may have.
- Referrals to members who offer clinical supervision to the new professional member. The clinical supervision is provided by Washington State approved supervisors, in either individual or group settings, and on a sliding fee scale basis.
- A confidential referral list of individual members offering sliding fee scale individual psychotherapy to the new professional member.

To obtain information on any of these new professional member benefits, please contact Karen Hansen, LICSW, New Professional Committee chair, 206-789-3878, *karenhansenmsw@gmail.com*, or Carrie Smith, LICSW, New Professional Committee member, 206-329-4763, *csv3@mindspring.com*.

VETERANS OUTREACH PROGRAM

Thank-yous, introductions, and updates

BY FRANK KOKOROWSKI

I would like to begin by thanking Robert Odell for his unparalleled contribution to and guidance of the WSSCSW Veteran Outreach Program. I am pleased and honored to assume responsibility for the VOP on behalf of the Society as Rob prepares for his new challenges as president.

VOP is a profound statement of the Society's concern and support for our service men and women who have been deployed to the Iraq/Afghan theaters. The Society's efforts began in 2005 and (I believe) were the first efforts by a professional society to reach out to these veterans and their families. Since then, with the growing impact of the war here at home, professionals have been organizing nationally to provide clinical services to returning veterans and their families. Groups such as the Soldiers Project and Give an Hour are both national efforts encouraging private clinicians to give clinical time to returning veterans.

Part of my efforts in this position will be to explore ways VOP can collaborate with these other groups to strengthen our and their efforts. As this evolves, I will keep the Society informed.

The clinical society's decision and effort in creating VOP was sensitive and visionary. As the numbers of returning veterans grows and continues, the initial reluctance on the part of veterans to seek care is turning into waiting lists for services. Of particular concern are the consequences the veteran's war experience is having on family and children. Science and history teach us we can not afford to neglect their needs.

My efforts in the coming year will focus on exploring collaboration with similar professional groups, strengthening VOP, providing meaningful training and encouraging more society members to participate. Efforts are currently underway for two trainings that will deepen our awareness of psychological trauma and our understanding of the veteran. I ask you to please consider participating in VOP as a clinician and becoming more active in the committee. ♦

WSSCSW Newsletter is mailed quarterly to members of WSSCSW. Deadline for the next newsletter is **June 15, 2008**. Classified ads are $10 for 25 words, $20 for 50 words, etc. Articles and ads should be emailed to Mary Ashworth at **mary.ashworth@att.net**. Newsletter design: Dennis Martin Design, 206-363-4500.

MEMBERSHIP

Occam's razor the Society's roster

BY ERIC G. HUFFMAN

Occam's razor is a philosophical or scientific principle which states that the best explanation of an event is the one that is the simplest, using the fewest assumptions or hypotheses. Using this principle, I have concluded that without a doubt gremlins have been at work. No other explanation for the few but peculiar errors in this year's membership roster is possible.

While we have been unable to eliminate the gremlins, I am going to publish here some urgent corrections that can't wait for the roster update in June. No gremlin is going to mess up crucial practice information while I'm Membership Committee chair!

Please note the following corrections or additions:

- New member, Bruce Gimplin, LICSW, has a private practice at 3216 NE 45th Place, Seattle, WA 98105, 206-919-9070. He is located in north Seattle (NS). He serves clients: AD, EL, CP, FA, CC, GR, BC.
- Longtime member David Parnes, LICSW, should also be listed in the downtown (DO) section for location if you are seeking referrals there.
- The correct address for Alma Rolf, LICSW, is 720 N 35th St, Suite 201, Seattle, WA 98103.
- The correct address for our treasurer, Carolyn Sharp, LICSW, is 3876 Bridge Way N, Suite 200, Seattle, WA 98103.
- Ilene Schwartz, LICSW, another longtime member is actually in the directory but due to a typo her name is not separated from the entry above hers. I want to be sure her name is circled in your roster on page 12 so she too can be easily located as a resource.

Next year should be much better as our new database will be up and running. I may contact McAfee and Norton for anti-gremlin downloads.

Welcome to new members

Tina R. Gilbert
Tina is a new professional who earned her MSW at the University of Washington in 2006. She is currently a social worker at the VA Puget Sound Medical Center. Tina found out about the Washington State Society for Clinical Social Work through her participation in a Society mentorship group. Tina is also a member of the NASW.

Bruce Gimplin
Bruce earned his MSW at the University of Washington in 2001. He maintains a private practice in Seattle and is also the bereavement coordinator at Group Health Cooperative. Bruce has worked in other medical settings and is a member of the Association of Oncology Social Workers. (He also has a history in comedy improvisation.) Bruce holds the LICSW in Washington State.

Susan Goedde
Susan earned her MSW at the University of Washington in 1972. She maintains a private practice in Seattle. Her past experience includes medical social work, as well as oncology social work. She is a member of the NASW and the Seattle Counselors Association. Susan holds the LICSW in Washington State.

Carol E. Hall
Carol earned her MSW at SUNY Albany in 1990. She maintains a private practice in Seattle. Carol is a returning member to the Society and is interested in networking with colleagues, expanding her referral base, and breaking the isolation of private practice. She is a member of NASW and holds the LICSW in Washington State.

Marian S. Harris
Marian earned her MSW from Florida State University in 1977, and her PhD from Smith College School of Social Work in 1997. She is a professor of social work at the UW Tacoma campus. Marian is the author of over twenty journal articles, book chapters, and book reviews. In addition to being a guest lecturer and workshop leader, Marian has won numerous honors and awards including Social Work Educator of the Year 2004, presented by the NASW Washington Chapter. She is a member of NASW, Society for Social Work and Research,

and the American Association of University Women. Marian holds the LICSW in Washington State.

Trip Quillman
Trip is a returning member to the Society. He maintains private practices in Everett and Seattle. Trip was the recent presenter at a Society dinner meeting on the topic of "Therapy with the Borderline Client: Projective Identification and Right Brain to Right Brain Communication." He holds the LICSW in Washington State.

Laura Schiltz
Laura earned her MSW from Fordham University in 1995. Since her graduation, she has been working in medical social work. Laura is interested in doing more clinical work and beginning a private practice. She is joining WSSCSW in order to network, have access to educational opportunities, and stay apprised of current issues. Laura is currently taking the "Starting Your Own Private Practice" course offered through the Society. She is currently completing her supervision hours toward the LICSW.

Richard T. Sirota
Richard earned his MSW at the University of Washington in 1995. He maintains a private practice in Bellevue and is the executive director of Rational Treatment Services. Richard is a member of NASW and the Seattle Counselors Association.

Larry Venditto
Larry earned his MSW at the University of Washington in 1985. He maintains a private practice in Seattle and also works at Pacific Medical and Treatment Services in Bothell. Larry is fluent in German. He is joining the Society to become part of a larger community. Larry has found that he often doesn't know other social workers in his area: what they practice or even where they are. In addition to this professional networking, Larry is interested in educational and social events as well as mutual referrals. Larry is licensed as a marriage and family therapist and as a chemical dependency professional and holds the LICSW in Washington State. ♦

BOARD SPOTLIGHT

A note from WSSCSW president-elect

BY ROB ODELL

Thank you again for the many kind words I have received about accepting the president-elect position. I am very fortunate that Marianne Pettersen has done such a remarkable job as president. She has been very attentive to helping me get up to speed. The entire board has been supportive and kind. In April, the board has its annual retreat and that's a time when it tries to take stock of our status as an organization, and develop a plan for the future.

For this brief note I mainly want to encourage you to communicate directly with me (via e-mail or U.S. mail) any thoughts you may have about WSSCSW as a professional organization. How should WSSCSW develop, improve, or just "change?" In your note, add how long you have been a member (that will save me time having to look it up), the prime reason(s) you became a member, and how well WSSCSW is fulfilling those goals.

I believe "fresh eyes" and "wisdom of the ages" are of equal value in this effort. I will try to respond substantively to each message—please understand that if my response is brief, it probably took me a long time to get there, and that I will hold your guidance close as I work.

One other request: don't stop with just one message. I am always interested in your "bird's eye view" of WSSCSW—your "big picture" of where our organization should be headed. If you have a more detailed or specific observation about one or more areas, I may refer your message to one or more of our capable committee chairs, or our staff person. We are all activists by the nature of our work; I look forward to guiding our superb and valuable energy as wisely as I can. ♦

kudos

Bravo!

COMPILED BY MARY ASHWORTH, NEWSLETTER EDITOR

Diane Grisé-Crismani

Many people sent recognitions of members for our spring newsletter, but first of all the board would like to recognize our Public Relations Committee Chair Diane Grisé-Crismani. Recently Diane traveled to the east coast where she was a discussant of one of the scientific papers presented at The American Psychoanalytic Association's annual winter meeting in New York City. The paper she was discussing was authored by Leon Hoffman and Ruth Karush and involved an eight-year study of child and adolescent analysts in New York City. Bravo, Diane!

Rob Odell

Dana Blue sends his thanks to Rob Odell for ten years of service as our listserv moderator.

Bruce Gimplin, Sarah Peterson, and Nancy Code

Eric Huffman sends his kudos to Bruce Gimplin, Sarah Peterson, and Nancy Code for their help in mailing out the 2008 WSSCSW roster.

Bruce Gimplin, Cristina Mullen, and Sara Slater

Rob Odell writes: " I want to express my gratitude to Bruce Gimplin and Cristina Mullen, who have graciously agreed to team up and moderate our WSSCSW e-mail group. They are also sharing the responsibility for moderating our Veterans Outreach Program (VOP) e-mail group, so thank you both again! Thanks also to our Communications Committee chair, Sara Slater, who has stepped in with a great effort and commitment."

Nathaniel Shara

Lastly the board wishes to congratulate Nathaniel Shara, a graduate student of social work at the University of Washington on winning our $1000 scholarship award for his paper. The selection committee found his paper to be very well written and thorough in its discussion of the therapeutic relationship and how it is affected—and not separate from—social justice issues. We have included Nathaniel's essay in this newsletter on page 11. ♦

Check us out online:
wssccsw.org

PROFESSIONAL DEVELOPMENT

Review of our winter short courses

BY SHIRLEY BONNEY

Three short courses were offered this winter on a variety of subjects. Below are some brief overviews.

Two models of supervision

The first course, beginning in January and covering the supervision of clinical work for the beginning supervisor, was taught by Bill Etnyre, Ph.D. Bill discussed two models of supervision: positivist and constructivist. He addressed the influence of agency dynamics in supervision and dual roles supervisors in agencies can hold who are responsible for both clinical and administrative supervision.

Attending to enactments and countertransference in supervision was another topic considered. This course provided hours towards licensure for master's level clinicians.

Somatic transformation

Sharon Stanley, Ph.D., offered a course entitled "Somatic Transformation: A Life-span Approach to Chronic Stress and Trauma" in February. The course described a new paradigm in mental health that Allan Schore, a leading neuropsychologist, calls regulation theory. The shift from theory-driven mental health treatment to an integration of emerging research creates an exciting challenge for clinicians. This challenge was met enthusistically by the fourteen course participants as they engaged in the research findings and clinical principles for treating trauma, addiction and personality disorders.

Four treatment principles were presented as clinical practices to integrate emerging neurological research. These principles included: 1) the development of awareness of sensations and subtle body movements to enhance intersubjective knowing and empathy; 2) recognition and response to subtle physiological cues that indicate shifts in autonomic nervous system states; 3) phenomenological methodology to inquire into present moment experience where neural change occurs; and 4) an interactive reflective process to synthesize and integrate right brain therapeutic processes into left brain explicit knowing.

The course offered a variety of learning experiences including lecture, demonstrations, dialogue, discussion, and practice.

Beginning a private practice

Karen Hansen, LICSW, and Shirley Bonney, LICSW, team-taught a class in February and March on beginning a private practice. The twelve participants were involved in addressing a number of aspects necessary to build a private practice. Each participant gained a clearer understanding of the type of practice they wished to build.

Topics covered included what kind of clients each person was most interested in seeing, the kind of marketing activities that best suited each of their personalities, their preferred type of practice, the nuts and bolts of billing/record keeping, and the forms needed to begin private practice. Lively discussions ensued regarding the tension between valuing oneself as a helping person and the integration of the helper role with that of an entrepreneur.

At the end of the course, each participant developed a six-month business plan to implement as they continue to move toward building their practices.

Any ideas that members have for short courses are welcome. Please contact Shirley Bonney, chair, Professional Development Committee, at *shirleybonney@hotmail.com*. ♦

interfaces

Agency spotlight

BY MARIANNE PETTERSEN AND LAURA GROSHONG

As has been mentioned in previous newsletters, WSSCSW began an agency "meet and greet" last year. The board has invited agency directors to board meetings in order for us to learn about their programs and essential issues of their agencies. In hearing from Graydon Andrus, director of the Downtown Emergency Service Center, we learned of his agency's need for approved supervisors as well as the challenges posed by the new supervision rule for MSWs. This winter, we were able to provide DESC with three volunteer supervisors from the WSSCSW membership to provide group supervision for agency clinicians. In addition, our legislative chair, Laura Groshong, helped spearhead a change in the supervision regulations reducing the five-year postgraduate experience requirement for approved supervisors to two years.

… helped spearhead a change in the supervision regulations reducing the five-year postgraduate experience to two.

In March of this year, the WSSCSW board welcomed Joan Clement of Harborview Hospital. Joan spent an hour with the board in an informal discussion about her experiences in a variety of agencies and the perception of clinical social workers in those agencies. She now heads up Madison Clinic, a clinic connected to Harborview which serves clients who are HIV-positive with about half of them having a mental health diagnosis. She said the change to the supervision rule will help her immensely in recruiting and retaining staff.

Joan reported her belief that stereotypes exist and amplify the divide between agency clinicians and private practitioners. She noted that the difference between hospital standards (social work degrees required) and state standards (no social work degree required) are problematic. Joan expressed she would like to see clinical knowledge applied to settings which are not providing direct services like grand rounds, medical social work and in clinics which are not focused on mental health as their priority. Joan considered it unfortunate that the jobs that used to be done by social workers with clinical knowledge in the Harborview/University system were taken by ARNPs four to five years ago.

There was a general discussion about the effect of the military veterans on the mental health system. From what Joan has seen, there is a bias against acknowledging and addressing mental health problems in the military but not in the Veterans Administration. The mental health problems of the bulk of veterans however she believes, are not being addressed in the VA. Joan expressed her concern about the mental health problems many in the military have prior to being deployed, including some sex offenders. Rob explained our outreach program (VOP) to the families of the National Guard and how underserved they are. Joan agreed.

Rob Odell expressed the Society's interest in building better ties to agencies and Joan welcomed this effort which she believed would benefit the whole social work community. The Society offered to provide members to present to Harborview staff on topics identified by Joan and her staff as a way of enhancing both services and our relationships. ♦

STUDENT AWARD

Scholarship awarded to UW graduate student

BY LYLA ROSS

Every year the Society offers a scholarship to a graduate student at the University of Washington School of Social Work. The scholarship of $1000 is to be applied to the student's tuition. This year's selection committee included Carrie Smith, Karen Hansen, Bonnie Bhatti, and Lyla Ross. Applicants were asked to respond to the question: "Why I want to be a clinical social worker." The committee received five papers addressing the question from multiple professional and personal points of view.

It was clear the students thought about the question and integrated what they have learned in the educational setting with their own personal experiences. The fields of clinical social work represented in the papers varied, and it was a pleasure to read the hopes and dreams of the next group of graduates from University of Washington as they are full of life, motivation, determination, and skill.

The committee made the final selection based on several different factors including paper content and layout. We struggled to decide and in the end chose a paper written by Nathaniel Shara. Nathaniel not only impressed us with his commitment to the field of clinical social work but also with his understanding that clinical social work does not exclude the importance of examining how social injustices play a part in our work with clients. It is clear that Nathaniel has the empathy and understanding of our complicated world to offer insight and hope to his future clients.

Nathaniel will be receiving recognition at the awards ceremony held in May at the University of Washington School of Social Work. As a part of the award, Nathaniel will be getting a membership to the Society, and we hope to see him at the various WSSCSW activities during the coming year.

Congratulations, Nathaniel! ♦

STUDENT PAPER

"Why I want to be a clinical social worker"

BY NATHANIEL SHARA, UW GRADUATE STUDENT IN SOCIAL WORK

I have chosen clinical social work because I believe that the experience of authentic connection with another person — and of feeling accepted by that person — offers the most profound healing available to humankind. Furthermore, I think that the therapeutic relationship creates a frame within which it is possible for many people to experience this kind of connection and healing for the first time in their lives. When I reflect on the struggles I experienced growing up as the gay, only-child of immigrant parents, I vividly recall the individuals who supported me in my process. As I struggled to reconcile my identities as a young gay man and as a first-generation desi, these teachers and counselors offered me the warmth and care that I needed in order to survive until I could leave high school and my hometown in search of my own communities. Since then I have located myself and my practice at the intersections of multiple communities.

I chose to go into social work because of the emphasis on context and person-in-environment. During my time in the MSW program however, it seems as though students are expected to choose either to develop their clinical skills, or to deepen their analysis of policy and oppression. Having been involved in work with GLBTQ people of color in both my practicum placements, I have come to believe that it is not possible to separate these skill sets. It is not enough for a therapist to create a safe and accepting environment if the therapy is divorced from the realities of racism, homophobia, and other systems of oppression.

Washington State has far too few clinicians of color, never mind those with knowledge and skill in working with sexual and gender minorities. I maintain that clinical work informed by social justice values can offer profound healing to people who routinely experience injustice. I feel that my strengths: strong insight and self-awareness, as well as a sense of curiosity and empathy make me well-suited to this task. I dream of being a part of a network of clinicians who share these values and who believe that the ultimate goal of therapy is not just greater self-awareness for our clients, but self-acceptance as well. ♦

conversations

The gifts of spring

BY DEBORAH WOOLLEY, ETHICS COMMITTEE CHAIR

I am writing in the season of daffodils and late evening light, but the seed for this article was planted sometime during the gift-giving season of December. Like most therapists, I suppose, I occasionally receive gifts from clients; and the part of my brain that is attuned to ethical issues is always vaguely unsettled by these events. It's the same part of my brain that is alert to the power dynamics in relationships, the power that we hold as therapists based on such things as our authority, presumed expertise, limited availability, and the potential for harm that comes along with this power.

Clients give us gifts for many reasons, of course, conscious and unconscious; and their gift-giving may carry many levels of meaning—a communication about themselves, an expression of feelings about us or about the therapy relationship, an effort to introduce more reciprocity into the relationship, and so on—all of which have clinical relevance and are important to talk about in the session. That much is clear. But what I have been pondering is the ethical, as opposed to the clinical, dimension of receiving a gift.

The extreme examples pose no ethical dilemmas. If, say, my client who is a travel agent offered me a free ticket to Hawaii or my Microsoft client gave me a new laptop, I would no more consider accepting the gift than I would consider asking a client for a loan. These gifts would be clear violations of both the CSWA and the NASW codes of ethics which state that social workers should not "take advantage of … to further their own interests" (NASW) or "exploit for personal advantage" (CSWA) our relationships with clients.

Neither code of ethics says anything about gifts specifically. They do address "bartering" with clients for our services. While prohibiting the acceptance of "services" from clients in exchange for our professional services (i.e., we can't trade travel advice or legal advice for therapy sessions), both codes state that accepting "goods" is acceptable, as long as it "will not be detrimental to the client or the professional relationship." But this latter phrase begs the very question I'm posing here: Is there something about accepting a gift from a client that is inherently detrimental to the professional relationship, and therefore unethical? For even with gifts where there is no personal "advantage" or personal "interests" involved, I still feel as if we're entering territory where something or other is at risk, and I'm not sure what or how.

I once heard a sociology professor make the statement: "A gift creates an obligation, a debt." The receiver becomes obligated to, indebted to, the giver. Thus the clear prohibition in most professions' ethical codes against accepting gifts of a certain monetary value or favors or services from clients: if we are personally indebted to the client, our professional roles are constrained by the personal obligation.

Most of the gifts I've received from clients are of little or no monetary value—garden produce, holiday cookies, a photograph the client had taken or a watercolor they had painted, or good-luck figurine for the new office. Some had monetary value—hand-knit scarves, a set of teacups—but I accepted them, in part because the client was so pleased to be giving them to me, in part because the gift was a communication of something about the client's self and to refuse it seemed to be a rejection of that aspect of self, in part because it was a social gesture, and I am socialized to gratefully accept what is given. In none of these cases did I feel I was "taking advantage of" my relationship with the client. None resulted in a feeling of indebtedness to the client, perhaps since the benefit I received was negligible. But they

did create a feeling of obligation, a sense that in accepting the gift I had accepted a new obligation to my client. What is the nature of that obligation?

As a therapist I have a clinical obligation to my client. With the giving of the gift, subtexts enter the clinical dialogue, their nature depending upon what the gesture means to the client. Questions may surface about self-worth, acceptability, or love for example, "Did you like it?", "Did I please you?", "Is my gift/am I worthy? Has your respect for me increased?", "Am I good enough?". Or statements about identity may come into focus such as, "See, I spend a lot of time in the kitchen just like women do.", "See, although I look and act like an ordinary American, I identify as Japanese.". Statements and questions about the relationship may be surfacing in the gift giving such as "See, I deserve your respect.", "Now we each have given something to the other." These subtexts are fruitful material, of course, for the clinical work, and the gift (whether accepted or not) creates an obligation to explore them.

Gift giving and accepting also creates a social obligation. Whatever the clinical meaning of the gift, the client has chosen to make a social gesture. In accepting it, we temporarily enter social terrain, and the rules of social obligation apply. And just as when a friend gives me a gift of something she made, I feel obligated to use it or wear it or display it at a time when she will notice, so that when she sees me she will know I value her gift, so also after receiving one of these gifts from a client, I found myself wondering about whether I had used that garden produce in my cooking during the past week and what I could say about its taste, or whether I had worn the hand-knit scarf to work recently. This sense of obligation was a distraction, needless to say, from my professional and clinical obligation to the client, namely to provide psychotherapy.

What would be merely awkward in a social relationship becomes, in the professional relationship, a betrayal of trust.

And I sense yet another level to the obligation, one which arises from the intersection of the clinical and the social obligations; and it's this level which raises the more subtle ethical question for me. Whatever its value to me, however negligible, it has value to the client; that's why she's giving it. In offering me this thing of value to her, the client is entrusting me with some part of herself. And therefore, because I am in the helping professions, it seems to me that I become obligated to uphold her trust by demonstrating that I value the gift—by using it, wearing it, displaying it—and value it sufficiently, whatever that is. If I fail to do so, the client feels devalued, i.e., hurt. And because I am in the helping professions, the most basic ethical principle of which is to "Do no harm," I've violated a professional ethic. What would be merely awkward in a social relationship becomes, in the professional relationship, a betrayal of trust.

Which seems a rather far-fetched position to take when dealing with holiday cookies and garden tomatoes! So my hope is that others reading this newsletter will send in your thoughts on this issue for the summer and fall issues of this newsletter. ♦

Please send responses in the form of a Word document to Mary Ashworth, editor, mary.ashworth@att.net.

Summary of 2008 legislative work

BY LAURA GROSHONG

The 2008 legislative session ended on schedule Thursday, March 13. This "short" session, i.e., two months long instead of four months, was one of the most intense I have experienced, though there were a number of important health care issues which were put off until next session. Here is the outcome of the issues I consider to be most important for clinical social workers this year. Action on the bills is in italics.

Supervision change for LICSWs

HB 2474 was heard on January 14. This bill will change the requirement for LICSW approved supervisors from five years post-licensure clinical experience to two years clinical experience post licensure. *Final action: Passed the House unanimously on February 13 and the Senate unanimously on March 10. Currently waiting for the Governor's signature and should be signed by April 5. It will then go into effect 90 days following her signature.*

Registered counselors

The governor has made the reorganization of the registered counselors "request legislation," meaning it has more clout than bills that are sponsored by legislators. As you know, there has been substantial discussion and conflict about the future of the independent registered counselors, which have no educational or supervisory requirements. The Department of Health Audit this past summer was as critical of this category as the newspaper articles which started the reorganization almost two years ago. The bills, HB 2674 and SB 6456, are a summary of the recommendations of the Registered Counselor Work Group, of which I was a member, which met for more than fifty hours the past summer. About 14,000 of the current 18,000 registered counselors will be put in new supervised categories, e.g., agency-affiliated counselors and those who are working toward licensure. Both bills have passed Health Committees and are likely to be passed by their House of origin. These bills will need to be reconciled in conference committee. *Final action: These bills went through a total of twelve drafts, primarily to rework the requirements and scope of practice for the new independent registered counselor categories, to be called certified counselor and certified adviser. The final bill which passed was 2SHB 2674. See the Summary of the reorganization in 2SHB 2674, the bill which passed the Legislature, below. The Governor is expected to sign this bill by April 5. The bill will then go into effect on July 1, 2009.*

Mandatory reporting

The Department of Health is proposing a rule which would require all licensed health care professionals to report any malpractice or unethical behavior on the part of other licensed professionals which they become aware of. The original language was extremely broad, requiring reporting on second hand information, reporting by all associations, and the use of psychological or physical testing, and drug screens, at the discretion of DOH. The rule has been modified as followed: eliminated professional associations and societies as mandatory reporting entities; strengthened language to assure impaired practitioners can be reported and referred directly to the substance abuse monitoring programs, except when there has already been patient harm; requires reporting of only final determinations and findings; tightened language to assure license holders have to report based on actual knowledge of malpractice, not merely information. *Current status: The rule has been significantly cut back from the broad range it had initially. The final version has not been released. I will keep you posted on the development of this rule.*

Minor age of consent bill

This bill, HB 2552, sponsored by Rep. Mary Lou Dickerson, would allow parents to require minor children to go into outpatient or inpatient treatment and allow parents to read their minor child's mental health records. Current law says that any minor thirteen or over can refuse treatment and keep their records confidential if they choose. This bill is an attempt to solve the problem of adolescents with behavior problems who do not meet the involuntary treatment standard of harm to self or others, but have behavior which is out of control and/or drug use. Some parents feel they need more say about whether children should have treatment or not. The approach being developed puts parents in an adversarial posi-

tion with their children, which has developmental complications for a dolescents, as well as overlooking the possible family conflicts which may need treatment. Currently many parents send children out of state to residential programs in Utah or Idaho where the laws allow parents to make decisions about the mental health treatment of minors until eighteen. The current form of HB 2552 requires court approval and an evaluation by a licensed clinician with extensive experience working with adolescents if minor does not wish to go into treatment. Adolescents can only be forced into outpatient treatment for three months at a time, inpatient treatment for sixty days at a time. HB 2552 has passed the Early Education Committee and is in Appropriations. *Possible action: Please let me know if your group would like to weigh in on this issue. Final action: This bill died in Appropriations and the issue will be considered further.*

Data-mining

This bill, HB 2664, is part of the work of the Healthy Washington Coalition. This bill would prevent information from being sold by physicians or pharmacists to drug companies which is a violation of privacy. In spite of HIPAA restrictions on marketing and buying and selling patient information, this practice has been rampant. Recently an article in the *New York Times Magazine*, "Dr. Drug Rep," described the practice. *Final action: After passing the Senate, this bill failed to pass in the House after a bitter fight between a coalition of health care advocates/union lobbyists and drug lobbyists. This issue will no doubt be back next year.*

As for national issues, you may have noticed I have not been sending much information lately. Congress and the president are in lame duck mode and the issues which looked so promising in the fall, i.e., the SCHIP bill for health care for children (including mental health parity) and the mental health parity bills have stalled. I am fairly confident that there will be action on these bills in 2009, but it is very unlikely either will pass prior to then.

Update

In a move that surprised many lobbyists, including me, the House passed their version of the mental health parity bill on March 8. In an earlier post I sent a summary of the differences between the House and Senate bills and with Washington's mental health parity law. There is some question about whether the federal bills can be reconciled at this time. ♦

Laura Groshong, WSSCSW legislative chair; Pam Crone, NASW lobbyist; Karen Burgess, DOH deputy administrator, Graydon Andrus, Downtown Emergency Service Center clinical director; and Rep. Eileen Cody, prime sponsor of HB 2474.

Scott Edwards, past-president of WAMFT; Arian Magnuson-Whyte, executive director of WMHCA; and Laura Groshong, WSSCSW legislative chair – the leaders of the master's groups who worked on the RC bill.

Summary of 2SHB 2674: Registered counselor reorganization

LAURA GROSHONG, WSSCSW LEGISLATIVE CHAIR

The author wishes to thank Scott Edwards, LMFT, and Adrian Magnuson-Whyte, LMHC, for their help in preparing this document.

Introduction

2SHB 2674, modifying credentialing standards for counselors, passed the legislature on March 8, 2008. The governor signed this bill on March 25. This bill will reorganize the registered counselor category, creating eight new regulatory titles and categories for the 18,500 individuals who were previously in the registered counselor category. The reorganization of the registered counselor category represents a huge step forward in the protection of the members of the public who use mental health and counseling services in Washington, a group that were never fully informed about the differences between the various state sanctioned counseling and mental health titles. This bill represents thousands of hours of work on the part of licensed mental health clinicians, psychologists, chemical dependency professionals, registered counselors, the Department of Health, the governor, the Legislature, the press, and consumers.

Background on registered counselors

The reorganization of the registered counselor category has been an active work in progress for the past two years. Many mental health clinicians and others concerned about protecting the public have been appalled by the twenty-year existence of this category, which allowed anyone to pay $40 and take a four-hour HIV/AIDS course to become a "registered counselor." The registered counselor category was created in 1988, paradoxically the year clinical social workers, mental health counselors, and marriage and family therapists became certified with standards for education, experience, supervision, and examination (psychologists, psychiatrists, and advanced practice registered nurses were already licensed.) The registered counselor category was created because of complaints from a vocal group of alternative counselors, including wiccans, spiritual counselors, voice dialoguers, flower essence counselors, laughing yoga therapists, and other counselors using dozens of other alternative methods. These alternative counselors insisted that they should be given a state sanctioned category without any educational, experiential, supervisory, or examination requirements. Hypnotherapists also were assigned a title, registered hypnotherapists, without any specific requirements beyond stating they were "employing hypnosis as a modality" (RCW 18.19.090). Though it was not clear at the time, in creating the registered counselor category, Washington became the only state to give potentially untrained and uneducated mental health counselors a state sanctioned title. (Maine has since added a registered counselor category of about 200.)

It is worth considering why so few states have chosen to regulate the alternative forms of counseling. The huge variety of alternative counseling which exists cannot be adequately investigated by the state, which relies on the standards generated by national educational entities for licensed groups, e.g., Council on Social Work Education and Council for Accreditation of Counseling and Related Educational Programs. The majority of states prohibit the practice of mental health treatment or counseling without being licensed in a mental health field, specifically denying any unlicensed individual the right to "practice psychotherapy" or "diagnose mental health disorders." Washington did not have any restrictions on the practice of registered counselors, including these areas.

The certified mental health groups became licensed in 2001, meaning there were then six licensed mental health groups in Washington requiring a master's degree, clinical experience, and supervision that were providing mental health services. The titles of these groups were advanced practice registered nurses, psychologists, psychiatrists, independent clinical social workers (and advanced social workers), mental health counselors, and marriage and family therapists, which today

total about 8000 licensed mental health practitioners in Washington. Licensed mental health practitioners have at least a master's degree in a mental health field, at least two years of approved supervised experience post-master's degree, and have passed a national examination. All licensed clinicians are qualified to diagnose mental health disorders and conduct psychotherapy or counseling. Psychiatrists and advanced practice registered nurses are also qualified to prescribe psychotropic medication.

In April, 2006, the *Seattle Times* ran a series on the registered counselors, "Licensed to Harm," which was nominated for a Pulitzer Prize and brought wide attention to the problems of a regulatory category which allowed anyone to use a title which implied that they were qualified to provide counseling services. By 2006, the number of registered counselors had grown to approximately 17,000. The current number of registered counselors is about 18,500.

One of the disputed areas with regard to registered counselors has been the number of actionable complaints filed against registered counselors, particularly in comparison with the licensed mental health groups. The data has been interpreted in different ways, with the *Seattle Times* articles showing a 9 percent rate of actionable complaint for registered counselors, the same as the rate for psychologists. The data for the 2001–03 biennium, however, showed a much higher rate of actionable complaint for registered counselors than other licensed groups, almost double (LICSWs, 2 percent; LMHCs, 4 percent; LMFTs, 5 percent; registered counselors, 8 percent; 2001–03 DOH statistics.) The DOH data for 2005–07 shows the rate of actionable complaint has become roughly similar on a per capita basis at about 4 to 5 percent for registered counselors and licensed mental health groups.

Finally, the state auditor issued an independent audit of the Department of Health in August of 2007 and strongly recommended closing the registered counselor category for the public harm reasons listed in the *Seattle Times* articles.

The *Seattle Times* ran a series on registered counselors which was nominated for a Pulitzer Prize.

Registered Counselor Task Force and Registered Counselor Work Group

There have been two attempts to identify who the registered counselors are and what they do in the summers of 2006 and 2007. The intent was to develop standards for reorganizing this category and the variety of work being conducted by registered counselors. The first effort, the Registered Counselor Task Force, did not include any registered counselors, and was aggressively criticized by registered counselors in the 2007 legislative session as being unfair to registered counselors by not allowing them a voice in the discussions. This led to another attempt to define the category, the Registered Counselor Work Group, which had a legislative budget proviso of $147,000 to conduct a survey and have more extensive meetings and support services from DOH. This work group included three registered counselors and twelve other stakeholders and had six eight-hour meetings in Olympia from July to September of 2007.

The survey of eight hundred registered counselors was conducted by Gilmore Research Group, using a sixteen-question telephone survey which took about fifteen minutes per person. The extrapolated results to all 17,000 registered counselors showed that approximately 6300 registered counselors (35 percent) were working toward a license in a mental health category; about 5400 registered counselors (30 percent) were working in agencies; and about 5040 registered counselors (28 percent) were working independently. Of the independent group, about 2500 (49 percent) had a master's degree in a mental health field, but had not become licensed. Also in the independent group, about 500 (10 percent) did not have a high school degree. The remaining 2040 (41 percent) in the independent group had either a high school or bachelor's degree in mental health or another field. Seven percent of the registered counselors surveyed worked in "other" types of practice.

The wide range of work being conducted in the registered category was not surprising given the lack of requirements necessary to become a registered counselor and the use of the title as a "catch all" for groups which did not have another regulatory "home." The three registered counselors in the work group had recently (January 2007) formed an organization called the Washing-

ton Professional Counselor Association — not be confused with the Washington Mental Health Counselor Association, which represents licensed mental health counselors — and frequently referred to this group as the basis for their authority. During the 2008 legislative session the leaders of this group (representing 100 to 150 registered counselors) claimed to represent the approximately 5000 independent registered counselors. They also regarded registered counseling as a profession, in spite of the lack of clarity in the scope of practice, educational, and training requirements.

Changes to registered counselor practice

2SHB 2674, modifying credentialing standards for counselors, passed the legislature on March 8, 2008. The governor signed this bill on March 25. The changes this bill will implement are as follows:

1. Registered counselor category — the registered counselor category will end on July 1, 2010.
2. New categories — eight new categories for anyone who was previously a registered counselor will begin on July 1, 2009. All registered counselors must be in one of the new categories by July 1, 2010 to have a state sanctioned title as a non-licensed counselor.
3. Associate/trainee categories — five of the new categories are for candidates working toward a mental health license or a substance abuse certification. The new categories will become part of the RCWs which are the homes for the license being sought. The new titles are: licensed social work associate – advanced; licensed social work associate – clinical; licensed mental health counselor associate; licensed marriage and family therapist associate; and certified chemical dependency trainee. The only new requirement which may be put in place for these categories beyond the education, experience, and supervision requirements necessary for licensure as an advanced social worker, independent clinical social worker, mental health counselor, marriage and family therapist, or certification as a chemical dependency professional, will be continuing education. The continuing education requirement will be determined in rule by the Department of Health.
4. Agency-affiliated counselor — one new category will be created for any registered counselor working in an agency licensed or certified by the state, including all agencies with DSHS oversight. The new title for this category will be agency-affiliated counselor. The only new requirement which may be necessary besides the current supervisory and educational requirements in place for these positions could be Continuing Education. This requirement will be determined in rule by the Department of Health.
5. Certified counselor and certified adviser — two new categories will be created for registered counselors currently working independently who meet the new criteria for independent practice. The new titles for these categories will be certified counselor and certified adviser. There are several new requirements for these categories (below, #6–9).
6. Certified counselor requirements — anyone wishing to become a certified counselor must 1) have completed at least a bachelor degree in a counseling related field; 2) have five years of experience as a registered counselor with no actionable complaints; 3) have completed coursework in core competencies, ethics, Washington law, and risk assessment to be determined in rule by the Department of Health; 4) pass an examination on core competencies, ethics, Washington law, and risk assessment to be developed by the Department of Health; 5) have the following language in their disclosure statement: "Any individual certified under this chapter is not credentialed to diagnose mental health disorders or to conduct psychotherapy." and "The certification of an individual under this chapter does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment"; and 6) have a written agreement with a licensed mental health clinician, or other individual qualified to be a consultant to be determined by the Department of Health, who will be a consultant responsible for determining whether a potential client is within the certified counselor scope of practice. Certified counselors must disclose the fact that they have a consultant in their disclosure statement.

7. Certified adviser requirements — anyone wishing to become a certified adviser must 1) have completed at least an associate degree in a counseling related field and a mental health internship; 2) have five years of experience as a registered counselor with no actionable complaints; 3) have completed coursework in core competencies, ethics, Washington law, and risk assessment to be determined in Rule by the Department of Health; 4) pass an examination on core competencies, ethics, Washington law, and risk assessment to be developed by the Department of Health; 5) have the following language in their disclosure statement: "Any individual certified under this chapter is not credentialed to diagnose mental health disorders or to conduct psychotherapy." and "The certification of an individual under this chapter does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment"; and 6) have a written agreement with a licensed mental health clinician, or other individual qualified to be a supervisor determined by the Department of Health, who will be a supervisor responsible for determining whether a potential client is within the certified adviser scope of practice. Certified advisers must disclose the fact that they have a supervisor in their disclosure statement.
8. Certified counselor scope of practice — certified counselors may counsel and guide a client in adjusting to life situations, developing new skills, and making desired changes, in accordance with the theories and techniques of a specific counseling method and established practice standards, if the client has a global assessment of functioning (GAF) score greater than sixty, as determined by the certified counselor and consultant to the certified counselor. Certified counselors must be trained in determining GAF scores as defined in DSM-TR-IV in ways to be determined by the Department of Health. Certified counselors may counsel clients with a GAF score of less than 60 if a client is referred to them by a licensed mental health professional or physician, but are prohibited from counseling any individual with a GAF score of less than 50.
9. Certified adviser scope of practice — certified advisers may counsel and guide a client in adjusting to life situations, developing new skills, and making desired changes, in accordance with the theories and techniques of a specific counseling method and established practice standards, if the client has a global assessment of functioning (GAF) score greater than sixty, as determined by the certified adviser and the supervisor to the certified adviser. Certified advisers must be trained in determining GAF scores as defined in DSM-TR-IV in ways to be determined by the Department of Health.
10. Theory base and orientation — all applications for agency affiliated counselor, certified counselor, or certified adviser must include a description of the applicant's orientation, discipline, theory, or technique.
11. Advisory committee — a new advisory committee will be created which will advise the Department of Health on the certified counselor, certified adviser, and registered hypnotherapist regulatory categories.

Summary

2SHB 2674 creates eight new regulatory categories. There will now be eight new scopes of practice; new titles; educational requirements; supervisory/consultation requirements; and coursework requirements and an examination for registered counselors who wish to work independently. No one who has less than an associate degree in a counseling field will be allowed to join any of the new categories. There are four new associate categories for licensure candidates in mental health fields who have completed their master's degree and one new category for certification candidates in chemical dependency who have completed their bachelor degree. There is also a new category for all registered counselors working in state licensed or certified agencies. Much of the implementation of 2SHB 2674 will be determined in rule by the Department of Health. Applications for the new categories will begin on July 1, 2009. The registered counselor category will be closed on July 1, 2010. ♦

conversations

Race, class health, and mental health

BY ERIC G. HUFFMAN

The Washington State Society for Clinical Social Work has been focusing on issues of race in clinical practice and how race affects our membership. I would like to elaborate on this discussion and expand it. I also want to touch on the new findings of how the environment affects our emotions and the mechanisms of emotion affecting health and mental health.

We tend to speak less about class in this country than race, but this does not mean classes do not exist. We also may think less of class than race in our clinical settings as class is not a topic in the literature and is not given to convenient language in our everyday speech. Nevertheless class seems to play an interesting role in health and mental health; perhaps in novel ways.

Richard G. Wilkinson has argued that the relation between socioeconomic status (SES) and health is mediated through perceptions of place in the social hierarchy, called the "Hierarchy-Health Relationship." One's perceptions may produce negative emotions that translate in poorer health through neuro-endocrine mechanisms, the link between the inside and the outside world. While it is not clear that primate studies are sufficient comparisons, we know that among monkeys low social status is in itself a risk factor for poor health with hypersecreted cortisol (a damaging hormone), hypertension, and suppressed immune systems. We also know that plasma fibrinogen is an excellent predictor of and likely cause of coronary heart disease as well as being related to body mass index (BMI). There is also a well documented relationship between plasma fibrinogen and SES with lower socioeconomic status having higher plasma fibrinogen and higher mortality. Studies have also shown that stress increases plasma fibrinogen and lower SES populations have chronic increased stress. Class status may kill simply by virtue of status, regardless of access to healthcare or better nutrition.

The idea that social standing itself affects health is further supported by the observation that national mortality rates tend to be lowest in countries that have smaller income differences. This holds true even after absolute poverty and other factors are accounted for. It has been suggested that greater income equality facilitates better health in that social cohesion is promoted and relative poverty leads less to social exclusion. It is also known that low sense of control over various aspects of one's life, insecurity and loss of self-esteem mediate between health and SES. Another study finds that people's perceptions of their own SES is a better predictor of their health than "objective" measures of SES. (SES is hard to quantify. Is it only income? Is it also education? Is it the type of job one has? Etc.) This idea lends support to the hypothesis that how one sees oneself in the social hierarchy affects one's health. The effect of SES is a lifelong factor in health and one study suggests that childhood socioeconomic status predicts physical functioning fifty years later.

Although this is immeasurably complex and disputes are many, it is helpful for us as clinicians to take these factors in to account. If income inequality and health are indeed related aside from the extreme deprivation of poverty, we have a special obligation to be aware in our society as the income gap widens. On average in 2004, a CEO made 431 times what a production worker earned, up from a ratio of 107:1 in 1990 and 42:1 in 1982. The U.S. has perhaps the highest income disparity of the industrialized countries. This disparity is significant since income inequality has been roughly stable over the past decade in countries like Canada, the UK, Germany, and France.

For people of color, and African Americans in particular, the situation is often compounded by the effects of racism. But racism is its own stress factor regardless of SES for Blacks in America. In a major contribution, Robert T. Carter argues that clinicians should be assessing for race-based traumatic stress. Stress reactions occur whether or not the stressor is objective such as a death or subjective such as the perception of discrimination.

The stressful effects of racism need not be overt acts such as racial epithets aggression or violence. The small daily hassles around race and racial perceptions, called microaggressions, take a deep toll. Microaggressions have been defined as "subtle, stunning, often automatic, and nonverbal exchanges which are put-downs." Microaggressions include being perceived as a threat or perhaps not existing at all. They include being overlooked, underrespected, and devalued because of one's color.

A recent example that I witnessed occurred at a Martin Luther King Day celebration in my workplace. Various staff went to the podium to describe aspects of Dr. King's life and experiences. The staff included leaders and supervisors in the work place. One white male presenter referred to "Mr." King throughout his presentation. He meant no harm but clearly did not know how diminishing his words were. Even under daily circumstances people who have earned the title of doctor don't like to be called mister (or Ms. for that matter) and for a black man with an advanced degree and a man who won the Nobel Peace Prize, this slip has a jarring effect.

Other examples would be asking a coworker of color, "How did you get your job?" implying a possible lack of qualification. Or, complimenting a native-born Asian American on how well they speak English. Or a Latino couple is given poor service in a restaurant and when sharing the experience with white friends, they are told, "don't be so sensitive," invalidating their experience and diminishing its importance. An African American woman I know was approached aggressively in a bar as if she were a prostitute because she was there with a white male friend. When she described her anger and humiliation to another white friend, the response was a dismissive, "There are a lot of ignorant people."

The response to a microaggerssion is itself stressful. Does the victim ignore it and hold the hurt inside (again)? Does the victim respond with indignation and risk being seen as overly sensitive? Imagine the effect of daily microaggressions coupled with occasions of overt racism or violence. Consider this combination with low SES. Consider adding in the difficulties of low SES such as poor housing, inadequate diet, and lack of health care. These forms of stress are experienced as assaults on one's sense of self. Racial stressors have been linked to high blood pressure, risk for heart disease, and giving birth to underweight babies.

Micro-aggressions take a deep toll.

Carter makes the point that mental health standards are often applied in a color-blind fashion not considering race. Many studies have shown that people of color experience a range of signs and symptoms associated with acute stress and mood and anxiety disorders. Carter suggests it may be more accurate to assess the effects of racism as a psychological and emotional injury rather than a mental health disorder. That is, the effects of racism are from the environment and are situational and not simply intrapsychic. Racism creates emotional damage in the way psychological torture or being a hostage might. Color-blind psychotherapy tends to focus on how the individual must adjust to their environment but does not address the idea that their symptoms are a natural human response to trauma.

Implications for clinical practice.

It is natural for us as clinicians to focus on the intrapsychic problems of our clients as this is how we are trained and how we conceptualize the client and the world. We strive to make our clients more functional in their environments. However, we may fail to understand the environments they live in. Class is a taboo subject but may have deep effects on our clients. We need to find ways of and words for discussing and describing the experiences of class. It is easy for us to openly ask a client of a different race how the difference effects how they feel in therapy or what their worries might be. What words might we use to discuss class? "You're poor and I'm well off. How does that make you feel?" Class is more forbidden than race. We need to break the taboo and discover what schemas our clients have developed based on class issues. Is a client's ill health a clue to other life experi-

ences? What narrative do they have to explain their social standing? Is their self-perception our perception too?

The more we understand about our species and our neurobiology, the more we learn about what social animals we are and the effect of society and the environment on us down to the cellular level. We may not bring this wisdom in to our practice. We may tend to pathologize the client instead of pathologizing the society they inhabit. This is itself a microaggression in therapy. As clinical social workers, we are well aware of and are trained well in cultural sensitivity. But this may be reduced to understanding the role religion or family or childrearing practices in families of color. It may not carry over in to understanding their experiences of racism and trauma.

Carter recommends less reliance on the strict models of assessment of DSM and giving more weight to the client's reports of stress and trauma. D. W. Sue notes that therapist bias may be a reason for low use of mental health services and premature termination by African Americans. He points out that statements by therapists meant to be supportive or affirming, such as, "We are all unique," We are all individuals," "We are the same under the skin," can be felt by the client as invalidating especially to clients for whom racial identity is important. It is curious to me that licensure does not require more in-depth training in race and class issues as these are prime and perhaps primal elements of our current social existence. Of all professions, clinical social work is the best equipped to address these problems and shortcomings.

Further readings:

Carter, R. T. (2007). "Racism and Psychological and Emotional Injury: Recognizing and Assessing race Based Traumatic Stress." *The Counseling Psychologist* (35) 1, 13–105.

Guralnik, J. M, et. al. (2006). "Childhood Socioeconomic Status Predicts Physical Functioning a Half Century Later." *Journal of Gerontology Series A: Biological Sciences and Medical Sciences*, July 2006, Vol 61A Issue 7.

Singh-Manoux, S. et. al. (2005). "Does Subjective Social Status Predict Health and Change in Health Status Better than Objective Status?" *Psychosomatic Medicine*, 67:855-861.

Steptoe, A., et. al. (2003). "Influences of Socioeconomic Status and Job Control on Plasma Fibrinogen Responses to Acute Mental Stress." *Psychosomatic Medicine*, 65:137–144.

Sue, D. W., et. al. (2007). "Racial Microaggressions in Everyday Life: Implications for clinical practice." *American Psychologist*, May–June, 271-286.

Wilkinson, R. G. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge.

Wilkinson, R. G. (1997). "Socioeconomic Determinants of Health: Health inequalities: relative or absolute material standards," *BMJ*, 1997, 314:591.

Check us out online:
wsscsw.org

Join the WSSCSW email group!

Now in its tenth year of operation, with 187 WSSCSW members currently on the roster, WSSCSW's email group is one of your membership's prime benefits. It is a valuable, prolific source for making and receiving referrals, consultation on practice and clinical issues, professional education programs, available office space, and other information of interest to clinical social workers.

It's easy for current members to join. You can email Bruce Gimplin *bgimplin@msn.com* or Cristina Mullen at *cristinamullen@comcast.net*. Once your membership status is confirmed, you'll be quickly added to the roster so that you can send and receive messages. (If you change your email address, contact Bruce or Cristina with the new address. Otherwise, the new address will not receive or send messages successfully!)

Are you a WSSCSW member? Are you a member of the Clinical Social Work Association? Are you a member of both?

BY MARIANNE PETTERSEN, WSSCSW PRESIDENT

Licensed independent clinical social workers are well-respected mental health professionals in Washington and nationally. However, the interests of LICSWs, as well as those of our patients, need different representation at both levels. Neither WSSCSW nor CSWA alone can protect fully your practice. The Society strongly encourages all its members to also join the Clinical Social Work Association. You should know that there are several members of the Washington State Society for Clinical Social Work who are working on behalf of CSWA as well: Kevin Host, CSWA president; Laura Groshong, CSWA director of Government Relations; Susan Childers, CSWA newsletter editor; and Keith Myers, CSWA chair, Ethics Committee.

Here's a summary of what each group provides that directly helps you as a clinician:

WSSCSW

- Develops and protects Washington state clinical social work licensure laws and rules.
- Promotes public funding for access to clinical social work services, e.g., GA-U mental health coverage.
- Promotes private funding for access to clinical social work services, e.g., state mental health parity.
- Promotes adequate standards of training for mental health clinicians in Washington, e.g., as member of Registered Counselor Task Force.
- Has lobbyists develop a legislative agenda and discuss clinical social work concerns with state legislators.
- Promotes inclusion of clinical social work training in state schools of social work, working with schools.
- Provides new MSW graduates with access to mentoring, supervision, practical knowledge, etc.

CSWA

- Develops and protects clinical social work licensure laws and rules in all states and develop national licensure standards.
- Promotes public funding of mental health benefits, e.g., Medicaid, Medicare.
- Promotes private funding of mental health services, e.g., national mental health parity.
- Gives clinical social work a voice in the development of national mental health policy, e.g., as member of the Mental Health Liaison Group.
- Has lobbyist develop a legislative agenda and discuss clinical social work concerns with Congress.
- Promotes inclusion of clinical social work training in all schools of social work, working with CSWE.
- Provides legal consultation on handling complaints, subpoenas, forensic social work, etc.

The Society can't provide the support and representation for all of our professional needs alone. Please join the Clinical Social Work Association and have the protection and representation we need as responsible clinicians! Applications are available online at *www.clinicalsocialworkassociation.org*. Let's see Society members support the work Kevin, Laura, Susan, and Keith are doing on our behalf. ♦

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MARKETPLACE

Save the date. The first annual Dorpat Lecture in Psychoanalysis and Society, "Fundamentalism, Terrorism, and Road Maps to Peace," with Lord John Alderdice, psychoanalyst, member of the UK House of Lords for Ireland and leader of the Alliance Party, president of Liberal International. Lord Alderdice was a key negotiator of the Belfast Agreement in Northern Ireland. He has devoted himself to applying psychoanalytic understanding to resolve violent conflict in his country and guide him in dealing with the current complex challenges in international conflict resolution work. He writes: "Armed only with non-analytic explanations of violence, our world community will not make sense of terrorist attacks like those of September 11, 2001." Friday, June 20, 2008, 7:30 pm. Town Hall, 1119 8th Avenue, Seattle 98101. A community event, free to the public. Sponsored by the Northwest Alliance for Psychoanalytic Study. For more info, Jacqui Metzger, 206-522-8553 ext-108.

The Certificate Program in Clinical Theory and Practice. Family Services has offered the "Certificate Program in Clinical Theory and Practice," a 100-hour program in adult psychodynamic theory and practice, since 1991. The program follows the natural sequence that characterizes treatment, addressing common issues in the opening, middle, and termination phases of treatment. The course defines and clarifies the choices often needed at each of these stages. Course instruction includes the use of teaching cases. One hundred hours of CEUs are available. The brochure is available at familyservices.org. To register or for more information, please call Roberta Myers at 425-452-9605.

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