WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

N E W S L E T T E R

SUMMER 2013

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From the Desk of the President

Greetings, Membership!

By Karen Hansen

Summer is almost here, a time many of us local people look forward to all year long. Although summer is amazingly short and the weather usually continues to be unpredictable until July 4th, we still base our love of the Northwest largely upon Northwest summers. Those "lazy, hazy, crazy, days of summer" can include mountain hikes, lingering sunsets, sun-ripened tomatoes, outdoor concerts, patio dining, relaxing with friends, baseball games, and boating on Puget Sound… need I go on? We all probably live for these days, even though they seem to fly by faster each year. My personal favorite is grilling on the deck because no matter how stressful the work day has been, it always gives me a sense of being on vacation. Life is good, there is enough time for what is important and enough beauty to counter some of life's ugliness, so hope for the future makes sense.

Laura Groshong, our honored Legislative Advocate

The WSSCSW has had a busy spring and we are winding up the end of our fiscal year activities. We had a wonderful planning retreat in May around the theme of "A Year of Integration and Growth." Your Board met for an extended session to discuss dreams and visions for the year to come. We focused upon ways to further integrate our organization with the membership, the clinical community, the broader Seattle population, and the National CSWA organization. Integrating complex systems creates increased stability and flexibility, according to Daniel Siegel, the father of interpersonal neurobiology. Our hope for our organization is to further its outreach and influence as well as to better address the needs of the membership. In the coming months we will be communicating more specifics about educational programming, the membership renewal cycle, services to support Associate Members, and Diversity-enhancing programs. We have a full Board of relatively new members who are talented and fired up to address the organization's mission.

Of course life, especially for volunteer Board members, is often impacted by change.

One of the larger changes for our Board this year is the partial retirement of Laura Groshong. Laura has been an integral part of our Society for many years and has been active on the Board for over 16 years. She has served as our Legislative Advocate and lobbyist in Olympia and has represented our interests at the national level. She was instrumental in authoring our licensure law and the Approved Supervisor Law, and worked on countless other legal and legislative actions that affect our clinical work and our clients. Most of you

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WSSCSW

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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 professions to mid-range, seasoned, and retired citizens.

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 Message

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know there is rarely a question on our listserv that Laura does not weigh in on, and many have marveled that there is rarely more than a 20 second delay in her helpful, informed responses. Laura knows about nearly everything related to clinical work in the State of Washington. It has been reassuring to know that somehow, she is "always there."

But even Laura has a personal life. Changes in her family will soon lead to Laura becoming a Grandparent, so she is scaling back the relentless work she has been doing for us over these many years. We will certainly miss her presence and wisdom, and we will have to take up much of the slack amongst ourselves. She will be working with several individuals to train them to follow in her footsteps. I know she has put much thought into who to select for this important work and I will allow her to introduce them and the roles they will play in the future. In the meantime, I'd like to take this opportunity to say, "Thank You Laura, for Sixteen Sweet Years" of substantial, effective work. You have made Washington a model for the country in terms of organizational excellence and legislative potency. You will be a hard act to follow, but we will do our best to carry on your legacy at WSSCSW!

Many of you attended our end of the year Gala on June 6th, where we honored Laura and Lonnie Johns Brown, who has also worked as our lobbyist in Olympia. Laura and Lonnie have been a terrific team. We were sorry Lonnie was not able to attend the party, due to her commitment to a budget approval vote taking place in Olympia that day. It was an evening of celebration with the membership and recognition for all our volunteers. Over fifty members gathered at the Blue Ridge Clubhouse to socialize, connect, dine on delicious food prepared by Ravishing Radish Catering, and hear testimony about the value and contributions of our volunteers. I will not mention every volunteer's name in this letter but suffice it to say that all were acknowledged and each was offered a bouquet of beautiful seasonal flowers from the farm stalls at Pike Place Market. Please look for photos from the party online. I felt proud and lucky to be among such a terrific group of clinical social workers!

There are more changes to note on the Board. Carolyn Sharp, a past president and treasurer with over seven years of Board service, will be stepping down this June. She has been my model and trainer for the role of president these past two years. She has been committed to Board accountability, to furthering our diversity initiative, and to clinical excellence, throughout her years of service. She has a loyal following of members who value her intelligence and leadership talent and she has been a hard act to follow. In addi-

WSSCSW newsletter is mailed quarterly to members of **WSSCSW**.

Classified ads are $10 for every 25 words, $20 for 50 words, etc. Articles and ads should be emailed to Lynn Wohlers at wohlers13@gmail.com.
Newsletter design: Stephanie Schriger, stephanie@designandgraphics.biz

Articles expressing the personal views of members on issues affecting the social work profession are welcome and will be published at the discretion of the editors and **WSSCSW** board. Articles reflect the views of authors and Society endorsement is not intended.

tion to Carolyn's departure, Jay Laughlin will be leaving the role of treasurer, and Marian Harris will be our new Board Treasurer beginning July 1st. Jay has not only been an excellent treasurer for over a year, he has also shepherded the Here @ Home program for outreach to veterans. Although the status of that program is now uncertain, Jay's countless hours as a program designer and organizer have been a terrific help. Thanks to his expertise and commitment to watching the bottom line, our finances have never been in better shape. Thank you Carolyn and Jay, for your service to the organization.

Additionally, we are saying goodbye to Sara Slater as Professional Development Chair, a role she held for over 4 years. She has been replaced by Tanya Ranchigoda and Diane Stewart (Broderick), an able team who will bring fresh energy and ideas to this role. Thanks so much Sara, for your service, and thanks to Tanya and Diane for stepping up to lead one of our most visible programs. We also have new blood on the Newsletter team: Brook Damour and Sara Slater are joining Lynn Wohlers to edit our quarterly newsletters. Thanks to both (double thanks to Sara for continuing to contribute her talents to the organization!).

I hope this newsletter finds you as excited as I am about summer in the Northwest. May you rest and be refreshed in the lengthening days of beauty ahead. I look forward to deepening our integration and growth as an organization in the year to come, along with each of you as current members, and with all the new members who will join us in our Fall Membership Drive.

In Peace,

Karen Hansen

WSSCSW Board President

Welcome to our New President Elect

By Sara Slater

Last week I had the pleasure of interviewing **Ann DeMaris Davids**, our new President Elect.

Ann has been our Ethics chair over the past year and a fellow board member, and I so enjoyed her calm, can-do manner when we worked together on Laura Groshong's first "I Googled You" conference a year ago. Yet our opportunities for prolonged conversation have been slim. So when the chance for this coffee date came up, I jumped on it. Who is this person who will be our future Prez? And what motivates her to step up to such a role?

Here's the spoiler: Ann is a true hybrid of the best of our membership. She'll represent us well.

Ann is a Seattle native, daughter of a psychiatrist, graduate of our own Nathan Hale High School, wife of a Presbyterian pastor turned employment consultant for developmentally delayed adults, mother of three mostly grown children, and soon-to-be empty nester. She has lived in the middle of the country, all the way across the country and back to the NW. So she has formed a few impressions of how things get done in various places, which can only be an asset for the WSSCSW.

Professionally, Ann is an MSW graduate of the University of Michigan at Ann Arbor, with a strong interest in dance and early childhood education; she's also a certified movement analyst, and like many of us, these various areas of study are linked by Ann's own evolution in life. You'll have to ask her for more details about how she got from a to b to c, but I can tell you that recognizing the emotional content being released through movement and dance sparked her desire to pursue clinical social work at the graduate level.

But even that clarity of direction did not follow a straight line. Ann had one child while IN graduate school, followed by two more. She spent a number of years raising her family while keeping her hand in volunteer leadership roles at church or in schools, and when she came back to the Northwest, it was basically as a New Professional (aka Associates, as we now refer to those newer to practice).

"I did my degree, didn't practice, then returned to the field years later to work on my hours," says Ann. "And I completely lucked out with a postgraduate

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Ethics Committee Transitions

Ann DeMaris Davids

I'm stepping down as Ethics Committee Chair beginning July 1st as I begin my time as President-Elect. This has meant a few changes within the Ethics Committee. While waiting for the selection of a new Ethics Chair, Melissa Wood Brewster has stepped up to take on the task of Interim Chair, backed up by Ellen Wood. Heidi Nelson and Albert Casale have joined the committee during the year, as John Walenta has stepped off. At our June meeting we began to talk about what I coined "Everyday Ethics." This has been and may continue to be a working theme for the Ethics Committee. I have appreciated working with others interested in how clinical social workers interact with our Code of Ethics and will enjoy seeing what they develop in the future.

You can contact Melissa Wood Brewster with any ethical questions at woodbrewster@gmail.com.

Paying Attention to the Road: Ethics

By Ann DeMaris Davids, MSW, LICSW

With current events, I've been thinking a lot about how important paying attention can be in our day to day use of roads. That perhaps our reliance on others to think for us might make the road conditions more dangerous. This may or may not have been the situation recently when an "oversize load" was being hauled across the Skagit River Bridge on Interstate 5 and hit the bridge, causing a catastrophic collapse. The driver was following a pilot car, whose purpose is to keep the load safe from clearance difficulties. The pilot car, according to news reports, has a flag on a pole that the truck driver can see. If the flag makes it through, then the driver believes it is safe to follow. So what happened? How could the system fail so spectacularly? I've been wondering if the system that is designed to keep this from happening was actually instrumental in its own failure.

I started thinking like this after I attended a conference called "The Dilemma of Ethics" sponsored by the Seattle Psychoanalytic Society and Institute. One of the speakers, Rion Hart, suggested a book called Traffic: Why We Drive the Way We Do (and What it Says About Us) by Tom Vanderbilt (2009). The book really is about traffic but Hart connected a few of the book's examples to the importance of developing the art of ethical thinking, so that we might bring ethics into our day-to-day clinical practices. As I began to read Vanderbilt's book myself, I began to understand the importance of being able to pay attention to what I'm doing with clients and not just using the code of ethics like traffic signals or pilot cars in my work. The author wrote about an intersection with a traffic light which was a site of many accidents. To test a theory, the traffic light was removed and a roundabout was installed. Months of study proved that having no traffic light was safer than keeping the traffic light. The very thing which had been installed for safety turned out to be the cause of unsafe behavior. The inescapable conclusion was that when people stopped thinking and gave up responsibility for their own behavior by giving authority to the traffic light, tragedy ensued. When people were put in the position of having to make decisions on their own because of the roundabout, they were safer.

As the investigation continues, time will tell what actually happened at the Skagit River Bridge. But the incident got me thinking about what can happen if we stop thinking for ourselves and treat the code of ethics as a pilot car or traffic light. I am not suggesting that we get rid of our code of ethics (or traffic lights), which serves a vital function, but rather that by staying alert and paying attention to the environment that we navigate, we might be able to slow down and avoid a catastrophe. In clinical practice, as I have been noticing more and more, there are many different kinds of "traffic moments" which need many different responses. We just need to keep thinking for ourselves as we pay attention to whatever road conditions we may face.

WELCOME

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internship through the Northwest Alliance for Psychoanalytic Studies at their Alliance Community Psychotherapy Clinic that provided me with some outstanding supervision and didactic training."

It was through the Alliance that Ann met WSSCSW members Tom Saunders and Jacqui Metzger, relationships that sparked interest in our organization. Which eventually led her to Karen Hansen and Shirley Bonney's "Starting Your Private Practice" class and ultimately, an invitation to step into volunteering.

Ann says she chooses to volunteer because "you get a sense of belonging when you make a commitment and put down roots." It was her experience when first joining the WSSCSW that solidified that desire to commit: "when I first applied, I had no idea what category I belonged in. I was long out of graduate school, yet I was practicing as a postgraduate intern and was still without licensure—so what was I, as far as membership was concerned? What I received was a creative solution and a warm welcome."

Today, Ann juggles a part-time job at Valley Cities as a mental health outreach specialist with her private practice, "two settings both experiencing immense change." She's comfortable with home visits, coffee shop chats, connecting on park benches, or meeting in her quiet office. Philosophically speaking, she's influenced by her psychoanalytic work, DBT, AEDP, cognitive processing therapy, and child and family systems.

Our delightful conversation included many questions from Ann about the Society, which caused me to reflect on my own ten-year association. The two biggest areas of growth I've witnessed--the focus on attracting and supporting newer members of our profession, and the effort to become more relevant to clinical social workers in all practice settings--seem to mirror Ann's own professional evolution beautifully. As perhaps our first President elect "to not be solely in private practice," but to have equal footing in community practice, the experience of developing her professional self later in life, and the integration of various geographic and philosophic points of view, well, yes—I do believe Ann is an ideal hybrid of our membership!

As to her vision, Ann is quite comfortable in her "training year" to develop this as she observes and learns. "I believe it's an important role of the Board to hold and contain the concerns of our membership during all the change before us as a profession," she says. "Working things through together makes us heads that can think, not just heads above water."

See what I mean about "calm and can-do?" A warm welcome to Ann in her new role!

CLINICAL SOCIAL WORK ASSOCIATION MEMBERSHIP

WSSCSW is an affiliated group of the Clinical Social Work Association (CSWA). CSWA advocates for our practice at the national level, providing analysis of macro social work issues which affect us all every day. CSWA membership also confers other valuable benefits, such as free consultative service for legal and ethical questions and discounted comprehensive professional liability insurance. Please consider complimenting your WSSCSW membership with a CSWA membership. CSWA member dues are $35 for students, $60 for emeritus members, $85 for new professionals, and $100 for general members. More information is available at: www.clinicalsocialworkassociation.org.

Different Strokes for Different Folks:

Defining the Relevant Dimensions of Effective Psychotherapy (Evidenced Based Practice)

By Karen Hansen, LICSW

I would like to share some research and discussion from the work of John C. Norcross, which considers treatment variables such as the person of the patient, their pre-morbid history, unresolved losses or traumas, social support systems, culture, and especially their attachment style. These are all examples of variables that influence the length of treatment and the cost outcome.

John presented his research and work at the UCLA Conference I attended this spring. His book, Psychotherapy Relationships that Work (Oxford University Press, 2011) is exciting and relevant. It summarizes research that supports the elements of effective therapeutic relationships across treatment styles and diagnoses, providing a truly empirical counterpoint to the Milliman model, explained below.

Evidenced Based Practice (EBP) as a concept is viewed by many of us in the profession with suspicion. The reason for this is understandable; much EBP research has been funded or otherwise supported by insurance companies, drug companies, and other entities that serve to benefit from reducing mental health treatment length and costs. A well-known current example of this is the guidelines for mental health treatment which were developed by the Milliman Actuarial Company, an actuarial firm in Seattle. The Milliman guidelines are used by most insurers in Washington State and around the country. These guidelines, based on selective research, attempt to dictate the number of sessions that insurance companies should approve and cover for various diagnoses. Of course, limiting the length of treatment by diagnosis alone leaves out many key variables that influence treatment.

Clinical Social Workers are known for placing the person in context, so much of what I have to say will not surprise you. We start our clinical training with a strong emphasis on starting where the client is. This may include the client's level of trust, their level of emotional upset, their self-awareness and psychological mindedness, the strength of their social supports, their economic situation, their culture, and many other characteristics. With the development of interpersonal neurobiology, we now can include brain functioning and development along with the previously mentioned variables.

All of these variables contribute to the treatment relationship, where the healing takes place. Not all mental health providers consider these various dimensions as carefully as we clinical social workers do. We have never been a "one size fits all" profession in our thinking about clinical work. I think this carves out our niche value as a profession amongst other disciplines, and it is one of my important sources of pride in being a Clinical Social Worker. Now we can read about and rely on truly Evidenced Based Practice research that supports these elements as the essence of what works in psychotherapy, in contrast to the Milliman model. This is what Norcross et al. provide in the Journal of Clinical Psychology: In Session, Vol. 76 (2) (2011), which I will review in this article.

To identify ways to effectively adapt treatment to the individual person, the APA convened a Task Force which conducted meta-analyses of research studies that link what works in psychotherapy to eight selected patient characteristics. For the study, the patient characteristics that were chosen were reactance/resistance level, stages of change, therapeutic preference, culture, coping style, expectations, attachment style, and religion/spirituality. The overall conclusion of the task force was that adapting or tailoring the therapy relationship to specific patient characteristics, in addition to the diagnosis, enhances the effectiveness of treatment. The benefit of using these criteria, in my understanding, is to strengthen and improve the quality of the relationship, from which spring the results of good treatment. Being skilled at developing the relationship is the essence of all good clinical training. It is my hope that detailing some of the elements that contribute to this across patient characteristics will strengthen your understanding of clinical effectiveness, as well as provide a relevant critique of the Milliman model.

I have chosen to limit my coverage of the material to the following two areas: attachment style and culture. I refer the reader who wishes more detail about the other patient characteristics to the full set of journal articles, which will be acces-

sible by a link on the WSSCSW website under the "Members Only" section; premium content; research publications.

Many of us have studied attachment style is an area and applied it to treatment. Developing a secure attachment with the patient is the goal of much of our work, and knowing our own attachment style and growing it to become more secure is another important part of being an effective therapist.

For most, if not all clinical social workers, investing in one's own therapy allows for security to develop and/or deepen. We cannot be a secure base for our clients if we are not secure within ourselves, and if we have not developed a secure attachment style, we are much more likely to be induced into playing out insecure attachment patterns in the treatment.

One result established by three meta-analyses of research on the relationship between attachment style and therapy outcome (Levy, et al., pg.194) is that securely attached clients tend to benefit more from psychotherapy than insecurely attached clients. It makes sense that being able to trust and use the therapist as a secure base allows treatment to progress more smoothly. Psychotherapy treatment for a person with a secure attachment style might even fit into the Milliman Guidelines in a realistic way. However, in my experience, the bulk of the client situations that we see are people with dismissing, enmeshed/preoccupied, or unresolved attachment patterns (relating to the anxious-resistant, ambivalent, or avoidant infant attachment patterns as established in the Ainsworth Strange Situation Study of 1978). Establishing a secure relationship in the treatment is a more productive way to resolve emotional distress than simply attempting to resolve the symptoms that determine the DSM-5 diagnosis.

"We cannot be a secure base for our clients if we are not secure within ourselves."

This is difficult to document in the treatment reports some of us write to obtain insurance authorization for our work. Symptoms often do not tell the whole story of what is going on and how long treatment may take to complete, especially with hidden trauma cases. I'd like to expand on this with descriptions of how attachment styles can affect treatment.

A **Secure Attachment patient** tends to be "open, collaborative, compliant, committed, and proactive in treatment, trusting of therapists, and most important, able to integrate their therapist's comments" (Levy et al., pg. 195) These folks get better fast and are often easier to work with.

A **Preoccupied Attachment patient** may "initially appear to be easier to treat, eager to discuss their worries" in effect being over disclosing and cooperative/adaptive (Ibid). We tend to feel we understand them more quickly, but they actually may be much more difficult to treat because they are internally much less open and compliant, thus, they show less improvement. Unless we have picked up on this issue early on we may be surprised when they miss sessions, do not benefit from interventions, or even leave treatment early.

A **Dismissive Attachment patient** is often resistant to treatment, has difficulty asking for help and retreats from help when it is offered. We may feel excluded from their lives, as if we are not important in any way to them. They may not disclose essential information about their lives. They do not allow us to participate in their emotional regulation, and in general they keep us at a distance. It is hard to feel valued and engaged with these patients and we may wonder why they keep coming to see us.

An **Unresolved for Trauma or Loss Attachment patient**, a category which can be added to the above categories, is especially difficult to treat, as their issues make developing a secure relationship challenging. This may include patients who would also be diagnosed with Borderline Personality Disorder and these are the complex cases that most of us rely on consultation or supervision to negotiate. The treatment alliance is especially difficult to establish and treatment may be long term or long term/episodic.

The article includes the following practice implications:

1. Assess the patient's attachment style, formally or informally, as part of your initial assessment, since it has a strong influence on the treatment process and outcome. The following link is an example of the Adult Attachment Style Assessment Interview: http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf)
2. Expect longer and more difficult treatment with preoccupied attachment patients and unresolved for trauma or loss patients. Use this expectation in your treatment reports if you need to authorize sessions.
3. If the patient shows a dismissive attachment style, calibrate a more engaging therapy style. If the patient shows

a preoccupied style, be more containing and structured, to allow for their tendency to become overwhelmed. Titrate these to allow for the patient's degree of dismissiveness or preoccupation.

4. Modify your style as the treatment progresses and as more trust is achieved and the attachment is more secure, allowing the patient to be the initiator or relaxing the containing function as the patient shows increased ability to self-regulate.

As we progress towards insisting that insurance organizations honor mental health parity, attachment styles will no doubt become an important element in documenting the need for adequate treatment time. This may also help support the real issue of chronic vs. acute mental health treatment. We will need to become strong advocates for our clients who need ongoing care. This may become the single most important issue in the mental health parity challenge with insurance companies.

Lastly, I would like to comment on the article by Smith, Rodriguez, et al. on Culture as a patient variable. It echoes much of what WSSCSW has been concerned with over the past several years in our organizational goals. Diversity is an important subject to consider as clinical social workers, not only within our organization, but in our ability to treat diverse populations. For example, we know that engagement in mental health services for most ethnic minorities has been low, yet poverty and trauma, factors which can seriously exacerbate mental illness, can be especially high for many of these populations.

The vast majority of treatment professionals are white/European American and primarily English speaking. That largely describes the WSSCSW as we currently exist. Yet 20% of the US population speaks a language other than English in the home and ethnic minorities represent roughly 25% of the population, which will grow to 50% by the year 2040 and beyond (Smith et al., pg. 167). If we are going to move forward in an ethical way, we have to continue to develop diversity within the organization and increase our cultural competence as clinicians.

The definition of culturally adapted treatment is: "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Ibid, pg. 167). Some recommended themes to achieve this are:

1. Practice flexibility and do not hold on to dogma or treatment protocols that interfere with the cultural familiarity of the client.
2. Deliver services in a meaningful cultural context when possible.
3. Be open to what clients bring to therapy, and do not dismiss material that maybe culturally relevant, even when it is different from the cultural background of the therapist.
4. Incorporate traditional, culturally appropriate treatments with existing resources and treatment approaches, if possible.
5. Communicate empathy in a culturally appropriate manner.
6. Do not interpret cultural differences as deficits (Ibid, pg. 167).

Ways to implement the above suggestions may include language and appropriate services (interpreters), matching clients to ethnically similar therapists when possible, infusing cultural metaphors and symbols into your practice, recognizing overarching cultural concepts, recognizing cultural content in the client's worldview, paying attention to the social and economic realities of the client's cultural group, etc.

A clinical example (not included in the research) is an Asian client who suffered sexual abuse and needed to consider how/if she would confront her perpetrator, who was part of her own cultural and familial group. The "betrayal" of loyalty went beyond that of the typical Caucasian family. The therapist needed flexibility to understand what a confrontation meant within the client's cultural context, along with the psychological dimensions of her trauma history. In general, family loyalty for adults in many Asian families often supersedes what we as members of the dominant Euro-American culture assume to be healthy separation-individuation.

In another clinical example (not included in the research), a therapist utilized the client's cultural resources to assist with implementing a mindfulness-based practice for anxiety. Because of the client's trauma history, she dreaded approaching the process of interviewing for new jobs. Helping her begin to connect with the tension and stress in her body, guiding and deepening her breathing, and suggesting a daily practice of the same was a useful intervention. After inquiring about her personal resources it was learned that she enjoyed relaxing to the soothing Chinese Christian music that was

a familiar part of her cultural heritage. The therapist suggested she use the music along with the breathing and body-based awareness work to facilitate her progress. In general, research supports that culturally adapted therapy produces better results in well-being, health, and recovery from substance dependence, with changes maintained over time.

This is one of the stronger patient variables in determining Evidence Based Treatment success, according to Smith et al. As a professional organization we must continue to underscore diversity training, cultural understanding, recruitment, and organizational dynamics if we are to help prepare clinical social workers for 21st century America. I believe we must go about this change mindfully and intentionally. The WSSCSW Board is laying out steps for the year(s) to come while building upon the foundation for a culturally diverse organization laid down by our past two presidents, Carolyn Sharp and Rob Odell.

I anticipate the day when WSSCSW represents a culturally integrated membership, Board, and level of clinical competence. We can then assert that we are practicing in ways that are consistent with Evidenced Based Practice.

I hope this brief summary whets your appetite for thinking about what works for whom in your practice. There is always more to learn in our profession and always further progress to make in ourselves, and in the organizations we belong to. I look forward to continuing to learn with you as we move forward into the new year with WSSCSW.

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3. Smith T.B., Domenech Rodriguez, M., & Bernal, G. Culture. pg. 176-175.

Advertisement

Part-time Therapist Position

Shepherd's Counseling Service, located on Capitol Hill in Seattle, currently has an opening for a part-time therapist. Shepherd's Counseling Services (shepherdstherapy.org) provides individual and group therapy to adult survivors of childhood sexual abuse. Applicants must be licensed (LICSW or LMHC), have experience treating abuse and developmental trauma, and have significant individual therapy experience. Group experience preferred. Please send cover letter and current resume to: brook@shepherdstherapy.org.

WSSCSW STUDENT PAPER AWARDS

Part of the WSSCSW mission is to support and promote high standards of practice for those entering the profession. To this end, we offer an Outstanding Student Paper Award to masters level social work students in Washington State in their graduating year. This year we awarded 1 Grand Prize of $350 plus a 1 year membership to the WSSCSW to the strongest paper submitted, and a runner up prize of $150 plus 1 year membership to the WSSCSW. The winners were honored at graduation and at the WSSCSW annual party.

Entries must be clinical practice papers that contain both clinical case material and discussion of theory that applies to the understanding and treatment of the case presented. The paper must be presented in an integrated, cogent way that shows the practical application of theoretical ideas. The entries must contain a 1-page cover page detailing "Why I Want to Be a Clinical Social Worker." We are pleased to present this year's first place paper, by Sarah Jen.

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Caring for an Aging Father

By Sara Jen

For the purposes of this paper, we will consider the case of an aging father who resides in a small farming town in Washington State. His family of adult children is attempting to deal with the recent death of their elderly mother as well as arranging for the care and well-being of their father. The family of interest includes six children whose ages are between 45 and 65 years old. Each is married and they have children of their own who range in age from eleven to thirty-six years old. Their mother passed away four months ago from a massive stroke. Her health had been slowly declining and while her stroke was unexpected, her children were relatively prepared for her passing. Each child was present during her hospitalization and attended her funeral nearby their childhood home. However, only four of the children now live within an hour's drive of their father's country home. The other two daughters live out of state.

Since before their mother's death, the health of their father, Bert, was in decline. Within the past five years, Bert has had both knees replaced and has limited his daily activities due to physical pain and weakness in addition to some forgetfulness. Having owned and maintained his own farm for all of his adult life, Bert was a fit and independent man, but recently he has neglected his troubling finances and his home which is in a state of disrepair and rarely well-cleaned. His children encouraged him to refrain from maintaining the farm, but he continues to raise dairy calves. This creates physically demanding work for him on a daily basis including hauling of hay, cleaning and repair of stalls, and feeding twice a day. For a few months, his daughter had arranged for a maid service to clean Bert's home on a monthly basis, however, he requested that this service be discontinued, citing his lack of privacy and lack of need.

Bert's children urged him to limit his driving as he has become less reliable when operating both his vehicle and farm equipment. Since the death of his wife, Bert has appeared "quiet", "lost", and "lonely" to his children. They have become concerned by the rapid decline in his cognitive skills, noting his delayed response rate and apparent "checking out" from time to time. He is also physically slowing and shows a lack of motivation in continuing the daily tasks he has carried out for many years. Bert and his wife had a long and loving marriage, but his relationship with his children is more complex. Having struggled financially, Bert put pressure on his children to contribute to the family's income. Bert is described as a strict disciplinarian and generally emotionally unexpressive, similar to his own father's parenting style. While his children recognize great strength and resilience in Bert, they bear both resentment and gratitude toward their father to varying degrees. They were close to their mother and feel as though they lost their link in communication with their father when she passed. They are at a loss as to how to communicate with their father and deal with his decline in health, which was seemingly accelerated by the recent death of his spouse.

As the older adult population grows, academic research has taken an interest in the aging process and how families respond to these transitions. The narrative of adult children taking on the majority of their aging parents' care is common enough to be termed a "normative family stress" (Mancini, 1989). While research has mistakenly focused solely on family dyads, systems theory broadens what is known about parent-child and sibling-sibling relationships and expands to encompass the entire family (Mancini, 1989). According to Family Systems Theory, transitions such as the decline of a parent, can lead to a shift in balance or a disruption to the family's established equilibrium. When one family member experiences a change in health, all other members respond in order to maintain the delicate balance they have created (Richards, 2009). Equity theory also suggests that a perceived imbalance or shift in need in the family will produce distress in all relationships. However, it is possible that this theoretical approach may be overly simplistic when applied to the parent-child relationship, in which there is an inherent reverse in direction of unbalanced care throughout the lifespan (Mancini, 1989). While very little research has expanded to truly test these theories in the common narrative of parental aging, there have been many studies limited to dyadic relationships and emotional responses which suggest the many complex circumstances this family might be experiencing.

These adult children may suffer from many tensions and challenges due to their current situation. Their wish to be helpful and establish more open communication may only be deflected by their father who has proven to be stubborn and determined

to remain as independent as possible. They are likely to feel conflicted over their involvement in his daily activities. The work of Spitze and Gallant states that when children step in to care for their aging parents, there is an inherent ambivalence in this contradiction in roles, which challenges solidarity and forces new emotional responses (2004). "The Bitter with the Sweet", identifies various feelings that older adults may have that carry potential for conflict, such as feeling they have no need for care, wanting to put off care, feeling their children are being overprotective or too demanding, or feeling forced to lie about their condition in order to maintain autonomy (2004). These are all possible emotional responses for Bert to manifest. Additional research suggests that, "unreciprocated receipt of benefits from another is psychologically costly and damaging to self-esteem," meaning that it may be difficult for Bert to receive unreturned aid from his children as from any other source (Mancini, 1989, pg. 118). However, it should be mentioned that this result has been questioned in application to the parent-child relationship, which assumes an imbalance of aid.

It is also likely that there will be tension between siblings based on various structural characteristics of this family. As each have families of their own, they are likely to feel torn between caring for their aging father and attending to their own children and households. However, they may also feel pressured by each other to be of aid in particular ways. As an extension of systems theory, Richards (2009) suggests that the changing of familial roles disrupts their long-maintained balance. The principle of divergence states that siblings often become more differentiated as they age, each seeking to minimize adverse comparisons by claiming their own niche within the family structure (Sulloway, 1996). These divergences can funnel siblings into specified roles when their parents age such as the bill payer, legal or medical advisor, transporter, communicator or absentee (Richards, 2009). It is not uncommon for daughters to be expected to carry the burden of direct and instrumental care while sons may feel more inclined to provide financial assistance (Kaufman & Uhlenberg, 1998). These tensions are visible in Bert's family, considering that the oldest son and current "family leader" is also the most financially stable. Indeed, his greatest contribution has been buying Bert's farm so that he can manage financial matters more directly, while expecting his sister, who lives just over an hour away, to maintain care and transportation. Her placement in this role is widely accepted, as she is also currently unemployed and therefore expected to have expendable time that other children do not.

Due to geographical distance, it is also possible that feelings of guilt may arise in distanced siblings for not being more available, but also alarm when they do visit and find how their father has declined (Lustbader & Hooyman, 1994). It is not uncommon for children who visit only occasionally to feel a strong sense of urgency during their visits in order to do as much as they can for their aging parent before they depart. This urgency and alarm can produce feelings of defensiveness and promote blaming among siblings who live in closer proximity to their parent (Lustbader, 2012).

To assist these adult children in handling their father's care, we will briefly examine possible interventions and community resources available to them based on the more general issue of caring for a declining parent before examining more unique aspects of this case. Many negative outcomes have been associated with care giving, including depression, stress, denial, isolation, poor physical health and mortality. Huyng-Hohnbaum et al. (2008) utilized a pretest/posttest format over an eight-week period in order to consider the effectiveness of a multi-component intervention strategy in the lives of caregivers. Weekly sessions were led by an interdisciplinary team and emphasized cognitive-behavioral skill building in order to cope with common stressors with the aim of improving health outcomes. Unfortunately, this study lacked a control group for comparison, and while the posttest showed increased positive affect and less depressive symptoms in caregivers, there was no significant change in felt burden.

This study's strength is that the 199 individuals included cared for elders with a wide variety of cognitive and physical impairments, while most intervention studies tend to be limited to one disease. For instance, the effectiveness of Adult Day Services has been tested against a control group and found to enhance caregiver well-being, increase service use and decrease nursing home placement of older adult care recipients. However, this study was limited to caregivers of older adults suffering from dementia (Gitlin et al., 2006). Similarly, Computerlink is a computer support service meant for caregivers for individuals with Alzheimer's disease. A pretest/posttest randomized trial showed that adult children caregivers who

used this service over a 12-month period benefitted from both solitary (illness education, skills training) and communicative (bulletin board, private mail) components of the program showed decreased stress in four forms: physical, emotional, relational and activity restriction based on self-report measures. Risk factors were also found such as living alone with the care recipient, being a spouse (rather than adult child), and having little to no support network (Bass et al.,1998).

This computerized technique is beneficial for individuals who are generally reserved in group settings or wish to remain anonymous. They also may benefit from the ease of involvement since they can connect to the program at any time and from any location. Smith and Toseland (2006) also aimed to limit transportation cost and inconvenience by utilizing a telephone support program led by a licensed social worker over 12 weeks for 90 minutes. These teleconference sessions aimed to provide education, social support and emotion- and problem-focused coping strategies to caregivers for frail elders. This was found to be effective when compared to a control group in lowering self-reported feelings of burden, depressive symptoms and strain for adult children, but not for spouses. Gant, Steffen and Lauderdale (2007) also found both a basic education (educational booklet and biweekly phone check-ins) and video (10 videos with accompanying booklet and weekly phone coaching sessions) programs to significantly improve the mental health of adult male children giving care to aging parents with dementia when compared to a control group.

"It may take a crisis before these children feel the need to be directly involved in his care..."

These interventions offer both in-person and long-distance support for adult children caring for their aging parents. As mentioned earlier, however, studies considering interventions for a variety of aging issues and impairments are difficult to find. A more general approach may be more beneficial to Bert's children, as he has no diagnosable ailments, but is showing a more general decline in health and motivation. Assessing interventions for appropriateness to this situation is also difficult because many studies incorporate multiple strategies at once (video/booklet/phone instruction/social support), which makes it difficult to know which component is most effective. There is also the challenge of finding an intervention strategy that is clearly defined enough to be replicated. The interventions discussed also pose the problem of reliance on self-reported changes and potential for participants to give expected or hoped for results following a treatment or intervention. The results also do not rule out the placebo effect or the fact that just making an effort at managing one's emotional responses often can have a positive effect regardless of the specific type of intervention.

In this case, identifying local community resources may present a challenge both for the children and for Bert. As Bert lives alone in a small town, both availability and transportation pose a problem. Two of his sons live within a ten-minute drive, but both work full-time as do their wives and the next nearest siblings are forty minutes and over an hour's drive away. Similar to some of the intervention studies here, there are also support groups for aging elders by phone and internet which may be available to Bert, but the most likely form of support for him would be through his church. Having been a member of the same church his whole life, Bert has built a strong support network through his religious connections and is already receiving aid from church members in the form of house visits and precooked meals.

Two possible options for more formal care might include a local long-term care agency, which also offers short-term stays or respite placement, caregiver burnout classes and caregiver support groups for family members of frail older adults. He could also utilize an in-home care agency that offers flexible services including errand transportation, two-hour visits (morning and evening to help with getting up and going to bed), as well as cleaning, assistance with activities of daily living, and even 24-hour care if needed.

According to Hansson et al., it is not uncommon for adult children to take a conservative approach to intervening in the lives of aging parents, with 26 percent of their participants stating that they would not get involved until asked (1990). As Bert is not seen as being in immediate danger, it may take a crisis before these children feel the need to be directly involved in his care, in which case it may also take time before they feel the need for additional support.

Now that we have established the general circumstance and possible interventions and resources aimed toward helping adult children care for elderly parents, it may be beneficial to adjust discussion to more specific aspects of this case: the recent death of Bert's spouse and his lack of emotional closeness to his children. While our focus will become more specific, these situations are not unique to this family alone and the issues they face have been topics of recent research feeding into a more general narrative.

First of all, the recent death of a spouse and mother complicates the aging process by inserting the grief process into an existing complex transition. As a local practitioner who works closely with older adults, Helen Sikov would suggest that the loss of a spouse can challenge family members to reroute their mode of communication which has most likely been in place for many years (2012). Since all of the children were close to their mother and emotionally distanced from their father, they may feel less able to communicate directly with their father. As Rossi and Rossi (1990) have found, it is likely that mothers often mediate relationships and communication between daughters and fathers, in which case these daughters may feel challenged to build their own rapport with their father.

Richards also suggests that a holistic approach to health is most beneficial in the mutual process of "caresharing" (2009). When a spouse and mother is lost, all family members lose a sense of emotional support and feel challenged to repress their grief in the face of the continued need to care for the left behind parent. Both for the remaining spouse and the children, it will be crucial that they learn to share their feelings of guilt, fear, failure or loss as they simultaneously change existing roles in the family. When considering their father's evolving needs, it will also be important for the children to consider how his day-to-day experiences will change due to the loss of his wife and sole companion in his household, particularly the loss of companionship and emotional support (Richards, 2009). There also may be positive changes that occur as a result of the spouse's death. The living spouse may have been hard pressed to keep up with the demands of caring for their ailing companion and might see resulting improvements in health and ability when no longer encumbered by the physical stress of care giving.

In terms of emotional closeness, there can be additional challenges in a caregiving situation when the parent in need was emotionally distant while parenting his young children. Attachment Theory states that a child's attachment style to their parents is established very early on in life. This attachment is typically stronger between children and their mothers rather than fathers, translating into emotional closeness and protective behaviors. Chances are that children who grew up with a distant father are less securely attached to him as a parent figure. This lack of inherent emotional closeness may present issues of questioned motivation when adult children are faced with the task of caring for their parent. The line between acting out of attachment and obligation can be a highly difficult tension and emotional ambiguity for children to deal with when asking how much they owe their aging parents (Grollman & Grollman, 1978).

While an emotionally distant parent who is consistent may be managed with some emotional ambiguity and questioning, it is possible that the situation may become only more complex after the death of a spouse. Grieving has the power to bring out strong emotional responses in a father whose children have never had to see him as an emotional being. They may lack the necessary scripts for comforting a grieving father or anticipating the needs of a newly emotional man. Richards suggests that children take care to recognize and address their own emotional responses to the grieving process in order to be more fully and effectively responsive when comforting or caring for their grief-stricken parent (2009). It may also be beneficial to children to become familiar with their emotional responses to giving care in a family environment that may hold negative emotional memories for them. Children often do not fully recover psychologically from traumas of their childhood as early events tend to stretch out in memory, similar to a child's perception of time (Lustbader, 2012). If children carry emotional burdens of their past, they may revert back to the emotional responses they learned in their family of origin and become helpless in the face of adverse circumstances. It will be important that children are able to rely on their secondary attachment to their siblings in order to gain needed support. Emotional responses may also be heightened by the resurfacing of family secrets or intense shame, depending on the family's unique history (Richards, 2009).

This paper has provided a brief summary of a complex case as well as theoretical background on possible interventions available to a family of adult children as they face carrying for their aging father. This work was further developed by incorporating more in-depth discussion of specific aspects of the case. While it is apparent that a good deal of recent research has focused on the complexity of aging and intergenerational relationships, we hope that future work will be devoted to the family as a more complex system than combined dyadic relationships. Elaboration on specific aspects of this case, allowed for the incorporation of a more varied literature review and synthesis when it comes to providing care to an elderly parent following the death of a spouse and while feeling emotionally distanced from that parent.

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NEW MEMBERS EVENT

By Priya Raghav

We showed up, we did it, we talked about it. Then we did it some more. I'm talking about networking, the theme of our recent new member meeting. How often do we have a chance to think about the role that networking has played in our professional lives? How often have you heard other folks talk about it? Thanks to Membership Committee Chairs Sukanya Pani and Molly Davenport, I had the pleasure of hearing three veteran clinical social workers, Marian Harris, Norma Timbang and Lynn Wohlers, talk about the importance of networking in their career lives.

Critical examples of networking were shared, whether it was a long term mentorship relationship that shaped clinical learning or a two minute acquaintance at an event that landed a job. The role that networking has played in the growth of WSSCSW also provided an important discussion. Everyone at the meeting was introduced by a friend, colleague or mentor, leading me to reflect on the significance of networking as a tool for strengthening our society's membership. Imagine: if each of us could invite just one social worker to join the society in the next year, we would double our current membership by June 2014. It's a simple idea that could impact our mission in a profound way.

The evening's discussion deepened with a collective expression of interest in networking to further WSSCSW's commitment to racial diversity within the organization. And to carry this commitment forward, critical action items emerged, including connecting with potential and current members of color with the goal of mutual professional support and development. As a person of color, I see tremendous value in creating such a space for clinicians of color to network and dialogue within WSSCSW. A stronger representation of clinicians of color in WSSCSW would be consistent with our profession's value of promoting social justice and reaching out to populations for contributions otherwise missed. With more clinicians of color on board, our organization would more accurately reflect the diversity of the population we collective serve. We would also render a more powerful legislative voice on issues concerning mental health and people of color, providers and consumers alike. Finally, it is my long term hope that our conscious recruitment of members of color, coupled with our advocacy efforts, would favorably impact how mental health is perceived by many communities of color, where stigma around mental health can be a huge barrier to receiving services. It is exciting that all of this can be achieved through the power of networking.

While analysis at the macro level is important, our vision cannot materialize without working on our micro skills. Our evening wouldn't have been complete without addressing what networking really boils down to. Through the collective experiences of people in the room, I gathered that for each of us, networking may be a natural or an acquired skill. It may be comfortable at certain times and in certain situations, or intimidating. Regardless, it is important to remind ourselves that the time we take to seek and form these human relationships is an investment in our own growth and our profession's growth. And making the first move is a risk well worth taking. After all, isn't our work all about the human connection?

MEMBER PROFILES

Edited by Molly Davenport

Anne Duroe recently returned to her native Seattle after having lived away - in Michigan, New York, and Massachusetts - for many years. Anne earned her MSW from the University of Michigan in 2004, and completed a postgraduate fellowship in psychodynamic psychotherapy at the University of Michigan's Psychological Clinic. Anne practiced in Ann Arbor for 8 years, both in a psychodynamically-focused private practice and as a therapist in the PTSD clinic at the VA medical center. At the VA, she specialized in trauma-focused therapies with veterans and led an outreach program to help newly returned veterans connect to mental health services. Before becoming a social worker, Anne earned a master's degree in art history and taught art history to college students. Anne currently has a private practice in Seattle, where she draws on her diverse training and experience in her work with clients. When not working, Anne enjoys caring for, playing with, and learning from her two young children.

Norma Timbang has a private practice in north and central Seattle and teaches at the University of Washington School of Social Work. She partners with clients to address the traumatic impacts of sexual and intimate partner violence, hate crimes, harassment, workplace discrimination, and social identity development (e.g., people of color, LGBTQ, women, older women). She incorporates CBT, MCBT, IPT, RCT, motivational interviewing, psychoeducation, empowerment, mind/body/spirit, and other therapeutic practices. Norma also facilitates support groups for various groups, including adult survivors of sexual assault or incest, survivors of intimate partner violence, women of color community organizers, people of color struggling with internalized oppression, and significant others of loved ones struggling with addiction. Norma also facilitates workshops on communications skills building, responses to conflict and microaggressions, organizational healing, InterGroup Dialogue, and Transformative Justice practices.

Kirsten Sandgren is a recent graduate of the University of Washington School of Social Work, where she received her MSW. She has experience working with military personnel and criminal justice system-involved clients who have co-occurring disorders. She hopes to build her career around the treatment of trauma and is excited to begin the process of earning an LICSW.

Melissa Laws obtained her MSW from University of Washington School of Social Work in 2009 and is working towards her LICSW. She is also a Chemical Dependency Professional with over 20 years' experience, working primarily with residential and intensive inpatient clients. Melissa and her husband own and operate Prosperity Counseling & Treatment Services Inc. and Prosperity Wellness Center in Pierce County. She is also a Certified Tobacco Treatment Specialist and has experience working with gender-specific women's issues such as eating disorders, domestic violence, borderline personality disorder, relational and sex addiction, and co-occurring disorders.

NEW MEMBERS

The Membership Committee welcomes these new and returning members and the new members whose profiles appear above: (since early June)

Jon Conte
Courtney Francis

We look forward to meeting and getting to know each one of you!

Your WSSCSW membership expires soon!

You can renew online any time after July 1. Renew by September 1 to continue receiving all the benefits of membership and avoid late fees. Manual forms are available upon request.

Contact Molly Davenport (molyush@hotmail.com) or Sukanya Pani (sukanya.pani@gmail.com) with any questions about renewal.

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SAVE THE DATE

SHARON STANLEY, PhD
will be presenting a day-long training called

Beyond Abstract Language

the Truth of Face-Heart-Brain Communication and the Five Practices of Somatic Transformation.

Saturday, October 19th, 2013, from 9 – 4

at the University of Washington, School of Social Work Room 305 A & B

Sharon has practiced as a psychotherapist and educator of psychotherapists for over thirty years. Her quest for healing complex trauma has been personal, cultural and professional. For the past fifteen years, Sharon has developed and taught courses to mental health professionals in body-centered principles and practices for the healing of complex trauma.

A brochure for this program will be mailed in the early fall. For more information please contact Robin Westby at 206/467-2611 or robinwestby@gmail.com.