WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

Spring 2014

In this issue:

From the Desk of the President

Greetings and Happy Spring 2014

By Karen Hansen

Another Spring is in the air and Seattleites are feeling it - smiling more, shedding layers, getting outside to walk, bike, run, and stroll, digging into the wet earth and planting primroses, veggie starts, and color spots. We are trying to shake off our sleepy, inward winter ways and come out to join the world of new life. As your president, I am beginning to think about the transitions ahead in the Society — the exciting events being planned, and the communications that need to start happening to get everyone on board as an organization. As the picture above depicts, I am preparing to step down as your president, taking the back seat of past president and turning over the new leadership to Ann Demaris Davids, who has been in training for this over the past year.

This issue of the newsletter is dedicated to getting to know your Board. We have interviews with key figures in key roles, because it is good to know who these folks are, to demystify the Board and to offer a more inclusive perspective to our members. Board work is a satisfying way to participate and benefit from the organization, as it allows folks to get to see the inner workings and to shape what is evolving. We strive to show that we are inclusive of many types of clinical social workers in our month-to-month operations. Over the past two years I have been working to find and recruit talented Board Members, and I am very pleased with the developing sense of passion and clinical wisdom that has come together. In May, we will be holding our annual Board Retreat to further our teamwork and to get to know each other better. We are beginning an ongoing process of diversity training and awareness. In an effort to sensitize the leadership and the organization to a more diverse perspective, we want to more fully represent what clinical social workers are and do.

In June we will be honoring our volunteers, and in particular, we will nominate several individuals who have embodied over-and-beyond commitment and service to WSSCSW. Please contribute your ideas about who we might honor this year, for service in general and in the area of diversity. We are excited to be holding this catered event at the College Club Boating Center on Lake Union, so Save the Date of June 5th from 6:30-9:00 and plan to join us for this festive and memorable event!!!

Another set of events are being organized for next fall, and spring, 2015. Pat Ogden will be presenting on Sensorimotor Therapy on November 1st, and her lead trainer Janine Fischer will present a follow-up in March, 2015 on using the sensorimotor approach with suicidal crisis and other behavioral acting out issues in treatment. The sensorimotor approach developed following from clinicians wanting more direct and body-based ways of addressing trauma. It follows on

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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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our past year's conference presented by Sharon Stanley on Somatic Transformation work. These presenters and topics continue our "Year of Integration and Growth" theme; this theme will extend into next year as well. CEM events are being planned to coordinate with these two exciting conferences, sure to be highlights in the clinical community of Seattle.

The Board continues to work hard to address your needs and to support the programs that make up our organization. We are currently in need of a secretary and a treasurer. Both are key positions, and quite manageable ones, with the structures and supports that are in place. We now have a paid accountant/bookkeeper along with our Executive Assistant, Aimee Roos, making volunteer Board positions easier and more streamlined. The positive feelings and satisfying work that gets done make working on our Board rewarding. If you have any interest in either position, please let me know and we can discuss the details of what's involved. These are both excellent ways to enter the Board as a relative newcomer, and then be able to contribute as well as learn from the experience and wisdom represented by our more tenured members.

This will be my last newsletter President's message, as Ann Demaris Davids will be writing for the summer newsletter (which may be offered online rather than in a printed version). I have enjoyed the challenge of thinking outside the box with you (and sometimes very much inside the box), as I convey my thoughts and experience regarding important issues ahead, both in the organization and in the newsletter. I will continue to contribute to the newsletter and I encourage each one of you to do so as well. We have a rich and wonderful membership and every voice needs to be heard!

At your Service,
Karen Hansen, LICSW
WSSCSW Board President

Awaiting Your Letters to the Editor!

Please write to:
Newsletter@WSSCSW.org

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

CULTURAL HUMILITY: The Interpersonal Piece of Cultural Competency

By Melissa Wood Brewster, LICSW

One of my earliest experiences with cultural competency, as a young, clinical social worker, was learning about county-designated cultural specialists while working in a community mental health setting. While some clinicians were designated "Asian Specialists," or "African-American Specialists," to name a couple, I had the opportunity to become a "Deaf Specialist." At the time, I worked in a program that served the deaf and hard of hearing population. Apparently, I had gained enough expertise in understanding the culture of the Deaf community (the capitol 'D' implies the cultural meaning of being deaf) to become a specialist.

Certainly, there was pride that came with receiving the "Deaf Specialist" designation but I recall it also came with some confusion. How could I be a Deaf Specialist when I wasn't even deaf, myself? In addition, how could a clinician who was born and raised in a Latino community not qualify as a Latino specialist just because he or she hadn't yet put in the required number of hours working with others from that population? Thus the question arises, which some professionals have started to address, of whether we actually can claim to be competent in culture, and even receive a certificate or special title for our competency. Some might even question whether it's ethical.

Striving to be a more culturally sensitive clinician is critical in healthcare. However, the current interpretation of cultural competency comes with its' limitations. The current model leads us to believe that knowledge about culture is static and measurable. It also assumes all too often that understanding culture is only about understanding people who are non-white, ethnic minorities, as seen historically. In her "Medical Margins Blog" on "Health Policy and Nursing" (August 2011), Josephine Ensign shares that this model of cultural perspective stems from American-European colonialism when white, English-speaking males were meeting, studying, and reporting back to their home towns about non-white, non-English-speaking natives. And as much as we like to think the world has progressed since then, we still experience the dominant culture expressing curiosity and intrigue with the minority culture. This implies a differentiation in power as well as a one-way interaction and can lead members of the minority culture to feel like the "other," who don't necessarily belong.

Rather than claiming to be a specialist in a certain culture and interpreting our knowledge as an end product, we need to be humble. Cultural humility, as it is referred, "emphasizes a lifelong commitment to self-reflection, and to paying attention to power inequities inherent in the healthcare encounter" (Ensign, 2011). This is a continuous process that involves a more active level of engagement. In their article titled "Reflections on Cultural Humility" (August 2013), Waters and Asbill describe three factors that can help us work towards cultural humility; "a life-long commitment to self-evaluation and self-critique," "a desire to fix power imbalances where none ought to exist" and "developing partnerships with people and groups who advocate for others."

Cultural humility encourages a more level playing field in clinical and social interactions. For example, the acknowledgement of cultural differences is reciprocated, by not just asking about the other but also by sharing about oneself. This indicates a willingness toward mutual vulnerability and a denial of the "right to know" about those outside the dominant culture. As a result, members of the minority culture may not feel as much like objects under a microscope but more in equitable human relationships with others providing an opportunity to build connection. As a University of Washington graduate student in social work puts it, "it [cultural humility] forces us to come from a place of equality rather than superiority of knowledge or privilege."

As a member of the board for The Washington State Society for Clinical Social Workers, I am honored to be working with a group of people who are committed to strengthening diversity and cultural humility within the organization and in support of our individual practices. The Board is currently identifying ways to be more actively and consistently engaged with each other to increase cultural understanding among all the members. This is not as easy as taking a CEU training or earning hours to be a cultural specialist. It requires us to maintain an open and curious, but humble stance with each other, with a willingness to admit we do not know about the other as well our courage to reveal ourselves.

Ensign, J. (2011, August 16). Cultural competence, meet cultural humility. Medical Margins Blog. Retrieved March 23, 2014 from http://josephineensign.wordpress.com/

Waters, A. & Asbill, L. (2013, August). Reflections on cultural humility. American Psychological Association CYF News. Retrieved March 23, 2014 from http://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx

DETACH OR DIRECT

By Lara Okoloko, LICSW

Addiction — are family members part of the problem or part of the solution?

Recently I sat in the audience as a renowned author and speaker spoke about addiction. I recognized a few people in the vast auditorium as family members of people with substance use problems, including one woman who lost her son to an overdose a couple of years ago. After the author's presentation the audience was invited to ask questions. Many who took the microphone were concerned family members asking how to help their loved ones. The author responded simply, "Don't spend more than one minute trying to change anyone else." When pressed by another audience member he said, "Decide if you can have them in your life or not. Go to Al-anon." After hearing the author speak passionately and provocatively on addiction for the last hour, I expected more on the subject of family involvement in change.

I was reminded of a question posed by a new client a few months back. She sat across from me, answering my question about her best hope for how I would be able to help her with her problem. Her partner was having severe problems with alcohol and she was not sure what to do. "Should I detach from him or should I direct him?" she asked me.

That question has stayed with me because it captures the conflicted advice that we give people who love someone with substance use problems so well. We tell them they can't change anyone else, treatment doesn't work if you don't want it, you have to wait until the addict hits bottom, and you have to stop being co-dependent and enabling. But we also tell them that they should do an intervention, send their loved one to rehab, or kick them out of the house.

"Should I detach or should I direct?" the client was asking. What a great question. As a counselor who works with family members concerned about their loved one's substance use, I find that nearly everyone who comes to my practice has two goals: to help their loved one get better and to stay in relationship with them while they do it. So then the answer is neither. Detaching from the relationship won't help either of those goals. Directing is probably something that they have already tried. The answer to the question of whether it is best to detach or to direct is neither one. The answer is to lead.

To lead is not to control or to rule with authority. To lead is to influence. Much like in dancing, we can't control where someone places their feet, but our steps influence our partner's rhythm and direction. "A leader," says author John Maxwell, "is one who knows the way, goes the way, and shows the way." No one can "fix" anyone else but there is much territory to cover in the realm of what the concerned family member can change. They can change their communication tactics, they can change their boundaries, they can change the behaviors that they reward, they can change their reactions to the drinking and using behavior, they can change their response to every problem and crisis caused by the drinking and drugs. Dancing together, when the family begins to make these changes they change the steps of their loved one. Change begets change. As one father told me about his relationship with his addicted daughter, "I reached out and bumped the rudder." A small change in direction can put you miles into new territory if you stay on course.

To lead is to inspire change. Most family members whom I meet in my practice are successful in engaging their loved one to get help – the same loved one they described as "in denial" or "refusing" help. How do they do it? They deepen their understanding of their loved one's perspective, they use respectful communication, they establish common goals, and they look for opportunities when their suggestions will be accepted. They steer the family towards help.

Ambivalence about change is not a complication in treating addiction, it is a hallmark of it. As professional helpers, we have to stop telling people to wait until their loved ones get worse – "hits rock bottom" – before they can get help. There are methods that work for treatment ambivalence that can be helpful for family members ready to lead the change in their family. Dr. Robert J. Meyers, of the University of New Mexico, outlines his evidence-based protocol for helping family members engage their reluctant loved one into treatment in the book "Get Your Loved One Sober." Dr. Xavier Amador offers congruent strategies in his book for family members of people with severe mental illness and low insight, called "I am not sick, I don't need help." For both concerned family members and we professionals who make referrals, Anne Fletcher's book "Inside Rehab" helps make the treatment industry understandable and navigable.

Reading Recommendations:

Meyers, R. J., & Wolfe, B. L. (2004). Get your loved one sober: Alternatives to nagging, pleading, and threatening. Center City, Minn.: Hazelden.

Amador, X. (2007). I am not sick I don't need help: How to help someone with a mental illness accept treatment. Peconic, New York: Vida Press.

Fletcher, A. M. (2013). Inside rehab: the surprising truth about addiction treatment: and how to get help that works. New York: Viking.

Interviews With Our Board

MOLLY DAVENPORT

Molly works on the WSCCSW board as the Membership and Diversity Committee co-chair, supporting inclusion in the Society's membership and work. She has a background as a case manager and psychotherapist, helping clients through collaboration and integration of the past.

1. How/why did you become a member?
I became a member through a mentoring group in 2003. I had a couple friends who said hey, why don't you come to a meeting? It was great. I didn't have a lot of connections in Seattle and it was nice as a way to get more connected to the community, to network, and to meet people.

2. And then a board member?
Several years ago Bridget Aldaraca led a group to help newer clinicians prepare for licensure. She then asked me to join the Professional Development Committee and I started there. Karen Hansen invited me to join the board a few years ago to focus on membership and diversity issues.

3. What have you gained from being a WSSCSW member?
I think it's easy to feel isolated in the kind of work we do. It's very dyadic. You may work in a place on a team but you don't really work [in session] with your co-workers. It's nice to meet people, connect, feel part of a bigger something, and not be out there on your own. I've gotten supervision and continuing ed that's been really helpful. Knowing what other people are doing and being more familiar with bigger issues like legislation, insurance, CPT codes.

4. What sort of clinical social work do you do?
I work at Wellspring Family Services providing individual therapy to adults and a few adolescents and kids along the way.

5. Any leisure hobbies/activities that you'd like to share with the membership?
I'm a huge baseball and basketball fan. I'm looking forward to the start of the Mariners season.

6. Tell us a little about the way you practice clinical social work. What theories/beliefs/values matter the most to you in your work?
I really believe in trying to connect the past and present; to understand the present in the context of the past. I operate from a collaborative perspective because I'm not the expert and I'm not you [the client). We [as therapist and client] work together to understand what's going on because I'm not the expert on people's lives the way that they are.

STACEY DEFRIES

Stacey Defries has been a member of WSSCW for the past three years and has been a Board member for much of that time, serving as chair of the Associates committee.

1. How and why did you become a member of WSSCSW?
Stacey joined WSSCSW because she believed she could gain from the additional support and networking opportunities, and she wanted to be connected with clinical social workers throughout the region. She also found the organization's emphasis on professional development and ethical thinking to be a strong draw.

2. And then a board member?
Stacey decided to become a board member because she felt motivated to do what she could to cultivate the relationship and the communication between UW and the WSSCW.

3. What have you gained from being a WSSCSW member?
She is passionate about being part of the next generation of social workers, and believes that knowing all she can to help them transition from their education to the field is critical. "Social work students are my thing--mentoring their education and career, seeing students from day one through graduation, and then staying connected after they leave UW." She sees WSSCW as an important resource, and is focused on encouraging students in their networking. "My role is to help guide them and to help them know what their options are, especially if there is a volunteer opportunity or a training that would be beneficial."

4. What sort of clinical social work do you do?
Stacey has called the University of Washington her own practice site for a number of years now, originally combining her work in social work education with a small private practice. She has also worked at the macro level in public health. She received her MSW from Hunter College in New York, and cites attachment theory, object relations and psychodynamic theory as her influences. Stacey relocated to the Northwest in 2002, and is now full time at UW, as a lecturer and as an advisor and instructor in the office of field placement.

5. Any leisure hobbies/activities that you'd like to share with the membership?
Stacey notes "the social work creep" in her professional and volunteer roles, so she is

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glad that her passion flows easily from one to the other. This appears to be true in her personal interests as well, which she says include a love of trail running, and a commitment to social justice.

6. Tell us a little about the way you practice clinical social work. What theories/beliefs/values matter the most to you in your work?
"My work is a lot of fun--I love placing students and following their education." She enjoys becoming familiar with placement sites and working with placement supervisors to ensure the best possible matches for her students. It allows her to become familiar with a broad range of practice sites and to be part of the wider social work community.

This perspective makes Stacey about as perfect a fit as we could hope for in her position as chair of the Associates committee, as it has been the vision of the WSSCSW for a number of years now to cultivate a clinical home with us for new practitioners. Developing ties with both individuals as well as educational institutions is a major part of this, so we are lucky indeed to have someone with Stacey's vision and dedication.

DAWN DICKSON

Dawn is one of our newest board members, serving enthusiastically in the role of professional development co-chair alongside Tanya Ranchigoda.

1. How/why did you become a member, and then a board member?
As is typical with many who choose to volunteer in this capacity, Dawn learned much about it from former professional development committee member Robin Adler, who, Dawn says, had many good things to say about it. "I just really wanted to get involved," she says. And so she has, jumping right into the development and running of the current year's clinical evening meetings.

2. What have you gained from being a WSSCSW member?
"I'm in the middle of this shift, so I am especially appreciative of all that WSSCW has to offer. It's such a vibrant community, and I am learning so much from everybody, particularly through the list serv--what a great resource!" Dawn has also been working on her own professional development, collaborating with two consultants - one focused on developing a vision and identity to allow her to go deeper in her new work with individuals and couples, and the other through the NW Alliance, where she provides analysis to clients through the clinic, further cultivating her Jungian training.

3. Tell us a little about the way you practice clinical social work. What theories/beliefs/values matter the most to you in your work?
For most of her many years of practice, Dawn has been dedicated to medical and community based work, with the past nine in outpatient oncology; last year, she followed her heart into making a significant professional change, launching her own practice in May. As an oncology social worker frequently focused on end of life care, Dawn describes the challenge of working with physical illness, and being fully present to our clients and ourselves at the bedside. She feels that her mindfulness-based approach, cultivated through intensive studies at the Institute Metta in California, has helped not only in her career, but in her life as well. She describes her current transition to private practice as a huge shift in her professional identity, one that allows her to put all of her spiritual beliefs and principles to work. The desire for change and growth, she says, was sparked in part by her experience as witness to her own mother's illness, and she considers it a gift from her mother.

Dawn adds that she not only loves being a social worker, she loves being a business owner who, after years of long commutes, now works about five minutes from home. She loves being around other therapists, which makes her current location in the Fremont Professional Building a plus; ultimately, she says, "I envision working on a collective of some sort."

4. Any leisure hobbies/activities that you'd like to share with the membership?
"I love to travel, particularly international travel. My vow to myself is to leave the country once a year." She has spent many years studying indigenous healing methods and is intensely curious about what happens in the process. This integrates Dawn's personal and professional passions.

DENISE M. GALLEGOS-LEAVELL

Denise is the new co-leader of the Membership and Diversity Committee. She currently is a student, bringing a unique perspective to the board.

1. How and why did you become a member of WSSCSW?
I was in an advanced clinical practice class, and my instructor Jon Conte suggested joining this organization to network with other clinical social workers and to participate in mentoring groups. I thought it would be beneficial to me as a student to learn

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from professionals in the field and that I could better define who I am as a clinician through the activities/classes put on by WSSCSW.

2. And then a board member?
I joined the board at the encouragement of my one of my instructors who is also a board member, Tanya. I felt I could bring a unique voice to the membership and diversity committee.

3. What have you gained from being a WSSCSW member?
In the time I have been active in WSSCSW I have met clinicians who inspire me as I move into the profession. I have also learned much about supporting the organization and other clinical social workers from my fellow board members, particularly my co-chair in the membership and diversity committee, Molly.

4. What sort of clinical social work do you do?
My work is focused on survivors of trauma. I have worked in the past with victims of violent crime in a variety of positions and am currently in advanced practicum at Harborview Center for Sexual Assault and Traumatic Stress. I am also interested in cultural issues in the clinical setting and I am assisting in a class addressing this at the UW SSW.

5. Any leisure hobbies/activities that you'd like to share with the membership?
As a student in practicum, a teaching assistant, and supporting co-ordination of a human trafficking program evaluation I am kept extremely busy. I still take time to enjoy trying new restaurants and activities with my daughters attending school in Portland, and I enjoy reading across a wide variety of genres including history, literature, and philosophy.

6. Tell us a little about the way you practice clinical social work. What theories/beliefs/values matter the most to you in your work?
The most important aspect of practice to me is the client in their context. To me this means consideration of both the institution they are encountering for service and their cultural life within the greater world and the service setting. I also believe the evocative space between client and therapist is the catalyst for successful treatment.

TANYA RANCHIGODA

Tanya supports WSCCSW as co-leader of our professional development programs, which provide those enriching clinical evening programs that support learning and connection throughout membership. She is a psychotherapist in private practice with particular expertise in mindfulness.

1. How/why did you become a member?
I became a member because I saw that the society was offering a course on how to start your own private practice. I went ahead and joined, and that course is why I have a private practice. Karen Hansen and Bonnie Bhatti gave it and I loved it. They made it all seem possible.

2. And then a board member?
Karen Hansen bought me lunch a year and a half ago, and I was hesitant because of time commitments, but she was willing to have a co-leader position and it seemed possible. Professional development is something I'm interested in. I also wanted to support diversity on the board. I was born in Canada and both my parents are from Sri Lanka.

3. What have you gained from being a WSSCSW member?
A lot of learning as a board member. I feel like I have a voice at the table and people are respectful of your voice. My clinical skills have really been accentuated by having access to so many clinically strong members and the programs and resources. The listserv...I never hesitate to drop something and I get a ton of completely spot on answers. Constant learning and the society encourages and supports this.

4. What sort of clinical social work do you do?
I have a small private practice where I see individuals and on occasion, a couple with a shared experience, such as loss of a child. I do a lot of grief and loss work and adjustment to illness work. I also have 10 years' experience in medical social work. I also teach at the UW in the graduate school of social work.

5. Any leisure hobbies/activities that you'd like to share with the membership?
My husband and I love to travel and we recently went on Safari to Africa, which was amazing. I'm a new mom second time around, which is proving to be exhausting. I love to eat and love to experience new adventures. I like almost every kind of food but generally spicy things.

6. Tell us a little about the way you practice clinical social work. What theories/beliefs/values matter the most to you in your work?

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What's come through for me in private practice and is in line with my personal beliefs, is mindfulness. That's huge for me. Mindfulness, presence, non-judgment. Compassion to self and to others. Start with non-judgment with yourself and then onto others. I feel like you can easily weave it into other types of practice like CBT, psycho-dynamic, etc. It's a great way to hold trauma and stories we hear every single day. I think it's good for clinical practice as well as self-care. It's a way of being in the world, not just a clinical practice.

KARYN MACKENZIE

Karyn provides an invaluable, though low profile, service to our society as our listserv moderator. She has been a member of WSSCSW for four years and works at Virginia Mason Cancer Center.

1. How and why did you become a member of WSSCSW?

I first heard about WSSCSW while I was completing my MSW at the UW School of Social Work. They offered mentoring to the Day Cohort, but unfortunately, I was in the Weekend Cohort. It was a couple of years after graduation that I heard something about WSSCSW again, and looked to see if I could join. It turned out that Associates (LSWAICs) could join, so I did, in March 2010. Three months later the opportunity arose to become the listserv moderator.

2. What have you gained from your membership?

A wonderful connection to so many other professionals, their knowledge, resources, and experience. It is amazing every day to read the questions and answers that go across the listserv, not to mention the many events and learning opportunities that are offered. It truly is a diverse, talented group of people. I feel very fortunate to be a part of this organization.

3. How did you come to moderate the listserv?

A posting went out asking if anyone was interested in moderating, which includes, among other things, reading every email, "policing" the postings, helping people who are having technical difficulties accessing their accounts, and adding/deleting people to/from the group. As I was pretty much reading all the postings anyway, and had worked as a web tech in the past, Rob and Bruce trained me up, and here we are 4 years later.

4. What's it like to be the moderator?

I try and read the emails first thing in the morning, at lunch, again on the bus home, and then at bedtime. If people need help, I try to answer them from work if I can, because people do need to have access to their accounts. I enjoy helping people get their accounts all squared away, and it used to be that Yahoo didn't require you to have an ID, but now, they do. Otherwise, Yahoo is less complicated, which is a good thing.

Mainly I worry about two things: hacking, and inappropriate emails. The second one doesn't happen very often, and can be taken care of pretty quickly. Hacking, now that just is a headache. If someone clicks on the link, their computer or phone may very well get infected. It's very hard to get rid of a Trojan Horse, or something like that. So, I work with the person who was hacked, and send out an email as soon as we know it was spam to NOT open the email and to delete it. But, I also rely on members to use good common sense.

Being the moderator is a great way to be connected to everyone. I have met only a small percentage of the members in person over the years, but I've talked to so many of you....

5. What kinds of things have you seen over the years on the listserv?

Pretty much the usual requests for referrals, questions about Medicare, private insurance, billing, books on specific topics, coaching, support groups, grief and loss, sobriety programs, and licensure and CEUs seem to be the hottest topics. The most interesting conversations are the "hot" topics where people answer each other back in the group. I'm nosy, and enjoy those - and now you know....

6. What's the most unique/strangest posting you can remember?

I plead the 5th on this one. One person's strange is another person's serious request.

7. What function does the listserv play for the WSSCSW community?

It links us all together, creates an interconnectedness that otherwise we wouldn't have. How would we communicate so effectively, so quickly without it? I don't think the WSSCSW would be what it is without the Listserv.

8. Do you have any thoughts about how we might better use this tool?

We could probably have subgroups, if people wanted to have their own conversation going

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Expanding Gender

By Jamie Katz, MSW, LMHC

When I was growing up in the 70s, the messages I received about gender were clear. The aisles of every toy store were clearly delineated: trucks and superheroes were for the boys, and the pink aisles with the Barbies and Rub-a-Dub Dollies were for the girls. I remember watching M*A*S*H, a popular TV show set during the Korean War. Jamie Farr's character, Corporal Klinger, dressed in women's dresses in the hopes of looking "insane" enough to receive a medical army discharge. The audience take away was that anyone behaving in a gender nonconforming way was either a.) faking it, b.) crazy, or c.) both. The 70s were a long time ago, but some attitudes are slow to change.

Many trans* individuals are unable to express themselves safely or live authentically due to the intense pressure to stay within the strict male/female world (citation below). Many children receive clinical diagnosis such as Gender Identity Disorder of Childhood, now Gender Dysphoria, according to the DSM V. The view of gender variance as pathological stems from a cultural understanding that to be "normal," biological sex must align with the corresponding psychological sense of being male or female.

Research suggests that children who are not supported in their gender expression are at higher risk for depression, homelessness, and substance abuse later in life. Youth who have the support of their families, however, have better outcomes. For more information on transgender youth read Doctor Johanna Olson's research.

We have reason to be hopeful. Recent media stories of transgender children have increased awareness of the complexity of gender identity. Some businesses are starting to incorporate gender nonconforming terms and individuals into their marketing campaigns.

Facebook is now allowing its users to choose a gender option for their profile pages beyond just male or female. There are 51 options to choose from.

Some people feel that Facebook has not gone far enough. "There is still no option to identify my relationship with my queer/genderqueer child without selecting Son or Daughter, even after they changed their profile to neutral pronouns," one user noted on the Facebook Diversity announcement.

Barneys New York has included a diverse group of 17 transgender models in their Spring 2014 campaign: Brothers, Sisters, Sons & Daughters. This campaign is heartening and beautiful, and provides each model an opportunity to speak out and tell their stories.

Supporting a child for who they are is a protective factor against low self-esteem, bullying, poor academic performance, and depression. For gender nonconforming children, the risks are greater. Family support is important. Perhaps even more important is the push for a broader conception of gender and greater tolerance of the range of gender expression that exists.

I advocate for an Informed Consent model to support gender affirming care for transgender, intersex and gender non-conforming people. For more information about Informed Consent for Access to Trans Health (ICATH), please see this link: http://www.icath.org/

Citation: The word trans* (trans WITH the asterisk) represents all of the gender identities within the gender spectrum that do not conform to our cultural norm-- these would include gender fluid, gender queer, two spirit, gender binary, etc.

BOARD

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on about something. An example might be if you and I and Denise wanted to talk about something and one of us posted an invite on the Listserv, and the other two answered, and then we formed our own little email conversation off that. People probably already do that.

9. What do you do when you're not managing the listserv?
I'm an outpatient Oncology Social Worker at the Virginia Mason Cancer Institute in Seattle. I graduated from UW Seattle SSW (go Huskies!), and have been here in Seattle since 2003. I love quilting, and have just started a new Hunter's Square quilt. The last quilt I made took me three years so a bit of a recovery period was needed. I also love gardening, playing the hammer dulcimer, and hanging out with my cats and ancient Pug Zeus. He's about 225 now (he will be 15 in human years this summer). The rest of my family lives mostly in Maine and New Hampshire.

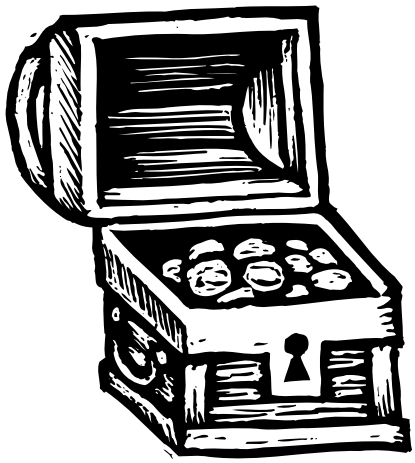
Illness As A Transformative Experience

By Dawn Dickson, MSW, LICSW

Prior to opening my private practice, I worked for many years as an Oncology Social Worker. For a year I provided weekly therapy through an interpreter to an Iraqi woman, a refugee with an aggressive breast cancer. She was terrified, given language and cultural barriers. She initially hid her diagnosis from her six children by never removing the hijab from her bald head in their presence. In her view she was permanently damaged with a death sentence. Most of our therapy involved acknowledging feelings, dispelling myths, and helping her navigate the confusing and often impersonal healthcare system.

After many months I felt a bit stuck in our work together. At a loss, I turned to Joseph Campbell's model of dealing with adversity which he referred to as the hero's (heroine's) journey. In *A Hero with a Thousand Faces* (1949), Campbell outlines commonalities found in stories cross-culturally and historically in which the protagonist must venture out on an arduous journey of challenge and discovery. The hero receives a call and wishes he hadn't. He tries to refuse the call but realizes he has little choice. The hero always leaves home (comfort, safety, familiarity) and heads out alone (even with a large support system the cancer patient is, in a sense, on their own). As Campbell puts it, the hero receives The Call to Adventure. Stories, myths, and movies show us that the adventure could be anything: wandering the maze to kill the Minotaur, entering the belly of the whale, obtaining the ring from the underworld, or entering the Hunger Games arena. I like the motif of the dark forest. When we enter the forest we cannot see. We do not know where we are going and we are disoriented. While the goal is to find the Holy Grail, exit the forest and return home, the hero must first face many tests, obstacles, challenges and dangers. This resonates for anyone dealing with illness.

While making his way the hero is given a task: He must find the hidden treasure. The treasure may be easy or difficult to find. It may be large or small. There may be one treasure or many. I have heard cancer patients say that they have discovered a renewed sense of compassion for self and others. I remember



a perpetually busy man deciding to take his whole family on a long cruise. One woman came into support group and announced, "I did it! I bought a piano!" She had frugally denied herself something she had always wanted and was now taking piano lessons.

Not everyone finds the treasure, and some don't even look. Nor is finding the treasure necessarily contingent upon survival. I have known people to be cured from cancer who never allowed themselves to be introspective enough to dig for it, while others cherish the treasures they find before they leave this world. The idea is to locate the treasure, exit the forest and return home to share it with the village. It is the community's job to welcome the heroine home. We might also say that she returns home to herself, changed, with an inner treasure, hard won and life-altering.

So what is it that makes one person look for the treasure while others barrel through without contemplation? I have often wondered why it is that one person cannot emerge from the maze of despair while another is able to transcend adversity, make meaning, and move on. Lawrence LeShan wrote about this idea in (1990), which has sparked workshops and conferences around the country. He encourages patients to question the meaning of their illness, and asks what might be emerging as a new life purpose, given their circumstances. The literature on post traumatic growth (PTG) may also give us some ideas. It is suggested that with PTG, one moves beyond simple recovery, in which we see an enhancement of the psychological state. It involves "a process of revision and reconstruction of shattered beliefs that results in the development of new beliefs and assumptions that can accommodate the traumatic experience" (Gerrish, Dyck, and Marsh. Post-Traumatic Growth and Bereavement; Mortality, Vol. 14, No. 3, August 2009). The assumptions that correlate with PTG include a belief that the world is benevolent, the world is meaningful, and the self is worthy. In other words, resiliency is linked to a sense of trust, purpose, and self-worth. Perhaps this is why someone with a history of significant trauma may have more difficulty adjusting to illness. Their trauma experience may contribute to a sense that the world is not safe, there is no meaning to events, and their suffering is their fault.

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NEW CMS 1500 FORM Required on April 1, 2014

By Laura Groshong, LICSW, Legislative Consultant

The CMS 1500 Form (02/12) used to submit medical claims has been updated and most health plans will start requiring use of the new form for any third party reimbursement. The revised CMS-1500 form accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3. Basically, the form updates appear to help align with implementation of ICD-10, which will take effect in October 2014. Below you'll find line specific changes to make on the form, courtesy of Laura Groshong, LICSW, Clinical Social Work Association Director, Government Relations:

Items 1-7: Fill out the same as the previous CMS-1500.

Item 8: Leave blank.

Item 9: For Medigap insurance. 9a and 9b leave blank. If Medigap used, fill out 9c OR 9d.

Item 10a-d: Fill out the same as previous CMS-1500.

Item 11a-d: Fill out the same as previous CMS-1500, but note that the location of 11b on the form has changed.

Item 12-20: Fill out the same as previous CMS-1500 unless there is a supervising physician.

Item 21: Diagnostic Codes: There are now 12 lines for diagnostic codes instead of six as in the previous CMS-1500. Be sure to use ICD-9 Codes until October 1, 2014. On October 1, 2014, begin using ICD-10 codes. Put "9" next to "ICD Ind." for ICD-9 Codes and "0" next to "ICD Ind." for ICD-10 Codes.

Item 22-24d: Fill out the same as previous CMS-1500.

Item 24e: Must be filled out with the letter (not number) next to the diagnostic code referred to.

Item 24f-33b: Fill out the same as in previous CMS-1500 EXCEPT when plan requires 33b.

The changes appear to be limited and the basic function of the form remains very similar to the previous form. For more information go to:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2842CP.pdf.

ILLNESS

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Cancer patients often ask, "Why me?" This question may be rooted in grief-related anger, or it may simply be an attempt to make sense of what seems so senseless. Perhaps the question our clients need to ponder is not so much why, but how, what and where? How has this illness changed me? What is my disease trying to tell me? Where in my life have I abandoned myself? These questions are less accusatory than the question "Why?" They are softer and include inquiry, curiosity, and multiple possible answers. They allow for compassion. At some point in every social worker's career, she will encounter at least one client grappling with a life threatening or chronic illness. These ideas may be good to keep in mind as we work with people suffering with illness.

As I told my Iraqi patient the Heroine's Journey story, she looked at me with wide eyes. Through tears, she said, "I know what the treasure is. The treasure is my life, and when I get through all of this I am going to learn English. Maybe I will have American friends." Touched, I reflected, "Now wouldn't that be a great gift to the community?" She eventually felt ready to leave therapy. Occasionally I would get calls from other refugee patients who were sent to me by her. I was happy to know she had come out of isolation to help others.

One day, many years later, while filling bottles of fresh water at a community spring, I looked across the well and saw her. Wearing her beautiful abaya and hijab she walked over and hugged me. I am still deeply moved by the vision of two women from very different worlds, surrounded by onlookers, embracing at the well. I smiled when she spoke to me in English. I thanked her for finding the treasure and bringing it back to the village.

Gerrish, N., Dyck, M. J. & Marsh, A. (2009). Post-traumatic growth and bereavement.

Mortality, 14(3), 226-244.

LeShan, L. (1994). Cancer as a turning point: A handbook for people with cancer, their families, and health professionals. (Plume).

NEW MEMBER PROFILES

BONNIE BURG, LICSW, BCD

Bonnie graduated from the University of Chicago, SSA and recently moved to Orcas Island, where she has opened a private practice in Eastsound.

She has practiced psychotherapy with individuals and couples for 40 years, was on the faculty of the University of Illinois for 18 years and has worked in teaching hospitals, mental health clinics, and community organizations doing clinical practice, supervision and consultation. She is trained as an analytically-oriented psychodynamic therapist, and in the context of the therapeutic relationship she believes client and therapist develop a shared understanding of life experiences, current issues, feelings and reactions that have become a painful "new normal." Together they find fresh ways to tackle old problems, manage ongoing life burdens, and create new opportunities for growth.

She also offers financial therapy as a specialized approach to issues related to money stress. She notes that money brings up one's deepest feelings around safety, security, self-esteem, power and control, and financial therapy can help individuals and couples find greater calm and control in the turbulent waters of their financial situation.

ANDREW GALBREATH, MSW, LICSW

Andrew Galbreath graduated from the University of Washington's Clinical Social Work graduate program in 2010, focusing on clinical practice with children, youth, and

families. In 2012, he received his Chemical Dependency Certification and is currently working with youth and young adults who experience co-occurring disorders at both Youth Eastside Services and in his private practice in Bellevue. Andrew aims to continue expanding his practice and eventually pursue his PhD.

JAMIE KATZ, MSW, LMHC

Jamie Katz specializes in the treatment of PTSD and anxiety and provides one on one therapy to adults, adolescents, and children. She has expertise working with gender nonconforming youth and their families and provides supportive therapy to members of the trans* community. Jamie conducts trainings on gender identity development to educators and service providers working with trans* youth. Before starting her private practice, she worked as a Bilingual (Spanish) therapist at the King County Sexual Assault Resource Center (KCSARC) providing prolonged exposure therapy, cognitive processing therapy, and TF CBT to survivors of sexual abuse. Jamie received her MSW from the University of Washington in 1997.

KIM MILES, MSW, LMHC

Kim earned her MSW from the University of Washington in 2001. She is a Licensed Mental Health Counselor (LMHC), and has obtained her Chemical Dependency Professional License and an endorsement as an Infant Mental Health Specialist, Level III. She currently works for Group Health's Behavioral Health Services as a Masters Level Therapist. She has a particular interest in working with people with PTSD, substance use disorders, and depression & anxiety disorders. She enjoys working with people of all ages, and has practiced in a wide variety of social work settings.

MONICA MILLER, MSW, LSWAIC

Monica graduated from the University of Washington School of Social Work with an MSW in 2011. She currently works for the University of Washington Neighborhood Clinics in a program that integrates behavioral health into the primary care setting. Prior to this, Monica worked at the Harborview Medical Center Emergency Department and the Downtown Emergency Service Center. She loves to spend her free time reading, enjoying the outdoors, and playing fetch with her puppy.

SUE MORELAND, MSW, LICSW

Sue has a private practice in Kirkland, near Evergreen Hospital. She graduated from the

UW School of Social Work in 1984 and has been in private practice since 1989. She notes that her office is run as an LLC, but not as a group practice, which she thinks works great!

She has worked in community mental health settings, and with college students, adolescents and families in public schools. Her post graduate training has been three pronged, with significant informal training as a psychodynamic psychotherapist (past 14 years), as a relational couple's and family therapist, and training in the use of CBT/ACT to treat anxiety and mood disorders.

She works with relational issues (couple or otherwise), grief related to loss or illness, mood disorders, anxiety disorders, family conflict, peer or school performance issues, parenting challenges, and with adolescents. She focuses on helping clients develop the capacity for personal and relational success and satisfaction as efficiently as possible, beginning with a comprehensive assessment and clear recommendations for a specific path forward. Currently she is also involved in HIPAA-proofing the tech side of her practice.

She adds that she has been married to the best guy ever for 29 years, has two young adult daughters, and enjoys reading, swimming, biking, cooking and gardening.

MELISSA PETERSON, MSW, ADP STUDENT

Melissa Peterson is returning back to Seattle after completing her Masters in Social Work at Arizona State University. Melissa recently interned at Phoenix Children's Hospital, where she primarily worked in the emergency department, but also assisted in inpatient medical social work. Prior to interning at the pediatric hospital, Melissa interned at a local Phoenix inpatient behavioral hospital, where she performed psychosocial assessments during intake, facilitated group process and psycho-education groups, and assisted with discharge planning.

Melissa has a strong interest in pediatric care and the process of attachment through relationships and development. She has not started working yet and is interested in medical social work, so she has been applying to positions at Seattle hospitals.

When work gives her a break, her love for the outdoors takes her hiking with her labradoodle, cycling, or running.

ROBIN ROUSSELLE, MSW, LICSW

Robin earned her MSW at the University of Washington in 1995. She recently returned to Washington after working on Maui for 15 years as a medical social worker / therapeutic yoga teacher. She is a Certified Viniyoga Therapist and uses the tools of yoga to support her clients' healing, well-being and self-reflection.

She has a private practice in North Seattle. She is a member of IAYT (International Association of Yoga Therapists) and NASW, and holds clinical SW licenses in Washington, Hawaii, and Oregon.

NINA SHILLING, MSW, LICSW

Nina has been a psychotherapist for more than 35 years. Prior to moving to Seattle in 2009, she had a long-time private practice in Larchmont, New York, with expertise in all of the modalities ranging from individual to couple, family, and group psychotherapies.

In addition to specializing in relationship issues, she has long-standing experience using body-mind techniques to enhance immune function in general, and for people with life-threatening illness in particular.

As a Lecturer in Social Work in the Department of Psychiatry, Weill-Cornell Medical College since 1989, she has had many wonderful years as a clinical teacher and supervisor of psychiatry residents and fellows, psychology post-doctoral interns, social work doctoral candidates, and staff members.

She now has a young and growing practice in downtown Seattle, and is a new member of WSSCSW.

NEW MEMBERS

The Membership Committee wants to welcome these new and returning members, as well as the new members whose profiles appear above.

SHELLY BALLMER
LYNNE HAKIM
DARYLLYN HARRIS

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

Certificate Program in Clinical Theory and Practice

October 2014 – May 2015

Wellspring 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's content is practical and applied through the use of teaching cases. The major influences on clinical practice and an understanding of human development are integrated to provide a comprehensive learning experience. 100 hours of continuing education credits are available which also apply to Associates' CE mandates (approximately 20 of which count towards supervision requirements). For more information: www.wellspringfs.org or Roberta Myers (LICSW, BCD), Program Chair, 425 452-9605

Have an ethical dilemma or question?

Contact the WSSCSW Ethics Committee:

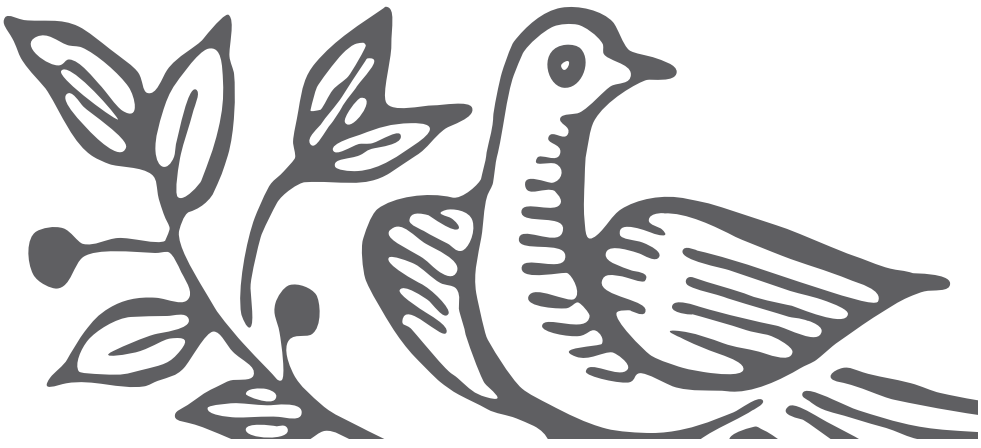
Melissa Wood Brewster (Interim Chair): woodbrewster@gmail.com

Albert Casale: albert.casale@gmail.com

Audrey Allred: audreyallred@gmail.com

Ellen Wood: ellenbwood1@yahoo.com

Heidi Nelson: hjn1@comcast.net



Calendar of events, 2014:

WSSCSW BOARD MEETINGS:
Regular meeting: April 12th from 9 to11 AM

EXTENDED BOARD RETREAT AND MEETING:
May 17th at Atlantic Street Center Conference Room from 9 to 2

Regular meeting: June 14th from 9 to11.

ANNUAL VOLUNTEER RECOGNITION CELEBRATION & MEMBERS' PARTY
at College Club Boating Center: June 5th from 6:30 to 9:00 PM.

HIPAA CONFERENCE:
April 5th at UW SSW, from 9 AM to 4 PM.

WATCH THE LIST SERV FOR A NEW MEMBERS EVENT: DATE, TBA

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 http://www.clinicalsocialworkassociation.org.

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