Greater Washington Society for Clinical Social Work

Education ♦ Advocacy ♦ Community

December 2007

news&views

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GWSCSW Dinner Meeting

Information to be Announced

www.gwscsw.org

DC Confidentiality Coalition Update

DC's Outpatient Mental Health Treatment Plan Provides Safeguards for Providers and Clients

Danille Drake

Thanks to feedback via the GWSCSW listserv, our Confidentiality Coalition had a very successful meeting with insurance company representatives at the DC Insurance Commissioner's office this October. The meeting, a follow-up to the introduction of the DC Outpatient Mental Health Treatment Plan Form put into effect just over a year ago, gave the Commissioner the opportunity to hear about providers experiences with the use (or misuse) of the form.

All DC providers—in-network as well as out-of-network—are required to adhere to the DC confidentiality restrictions, and to use this form to request treatment authorizations. (To download a copy of the Outpatient Treatment Plan form, click on: http://www.disb.dc.gov/disr/frames.asp?doc=/disr/lib/disr/information/Release of Mental_Health_Info_for_Outpatient_Mental_Health_Treatment_Form.pdf.)

By most accounts, insurance companies are using the form properly and there have been few complaints from clinicians about insurers requesting information beyond the scope allowed by the DC Mental Health Act. The complaints that have been received are quickly followed up on by the Commissioner's office, to remind the insurer of the law.

DC confidentiality legislation pertains to therapy *provided* in the District, as well as for insurance contracts *written* in the District. It permits only the following

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October Meeting with Louis Maier

Joel Kanter

On October 5, the GWSCSW held its first dinner meeting of the year with Louis Maier speaking on his personal and professional experiences as both a refugee child and as a social worker assisting these children. Dr. Maier came to the United States from Germany with his sister prior to World War II and spent his adolescent years growing up in foster care in San Francisco. During the war, he returned to Europe as a soldier and learned about his parents' fate. Following his military service, he enrolled in the MSW program at Washington University

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News & Views is published four times a year: March, June, September and December. The deadline to submit articles and advertising is the 20th two months prior to publication.

Articles and letters expressing the personal views of members on issues affecting the social work profession are welcome and will be published at the discretion of the editorial board.

Signed articles reflect the views of the authors; Society endorsement is not intended.

For advertising rates see page 35
Email ads to gwscsw@gmail.com

The next issue will be published March 2008 and the deadline is February 20.

Email articles to koganblackwell@verizon.net

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President's Message

Susan Post

By the time this appears in print, it will be holiday season for many. The early primaries will be looming, competing with family and celebratory rituals for our attention. The devastation in southern California will have faded from the front pages of our papers, and images of wildfires and thousands of displaced persons will have sunk beneath our consciousness, just as images of the Katrina waters and refugees did. Congress will likely be in recess, and I'm doubtful about what it will have accomplished.

It will be time for New Years resolutions, and though some of us manage to eschew them, we do tend to find ourselves in a reflective mode. And I wonder, will we feel optimistic or pessimistic? Will we be focused on the many challenges facing us at home and abroad, or will we retreat inward out of a sense of helplessness? Will the campaigns give us energy to become more personally involved in the world around us, as citizens and as social workers, or will they make us feel divided and negative?

As I write this, it is two days after a retreat of the society's Board of Directors. We had a beautiful day at a house in the country, overlooking the Potomac River, the foliage just beginning to change around us. It was a profoundly interesting and moving day. A few among us who were active at the beginning of the century (!) described the Society's near collapse and the heroic determination of a small group of members who fought to raise it from the flames like a Phoenix. Having gone into the retreat feeling a bit overwhelmed by this new job of mine, and wondering how I would "lead" the 14 people there, I became increasingly relaxed as I realized we were a team of equals who could take turns leading. Though there may be differences of opinion among us, we are all working for the same cause, and responsibility is easier when shared and not assumed in isolation. I think we all came out of the retreat feeling optimistic, motivated, and closer as a team.

So my New Year's wish for all of us will be that we turn to each other for support, debate, and learning. Never has continued learning felt more important than it does in this flat, vulnerable, ecologically and politically challenged world. We wonder: What is our community? Do we look at immigration issues as local or national or international? Do we envision the U.S. becoming an increasingly unilateral world presence, or do we work to understand the forces at play in the Middle East, the Sudan, China and Korea? Do we talk to our "enemies" or not?

Recent discussions on our listserv have been rich in opinion and thought on a range of subjects, reflecting energy and an eagerness to debate ideas within the Society. Please join the conversation, the larger community, and let us all hear your voice. Let's do our part to make 2008 a more honorable and judicious year. ❖

Treasurer's Report

Ted Billings

Thanks to Janet Dante, Barbara Tahler and Ann McClung for agreeing to serve on the newly formed Finance Committee. We will be meeting several times over the course of the year to review procedures, discuss resource allocation and make recommendations to the Board and Executive Committee.

The Society's financial health remains strong. Membership dues, our largest source of income, are strong and support a number of popular activities, such as the newsletter, *News and Views,* advocacy efforts, and educational programming. The referral panel and prepaid legal plan are self-supporting. Administrative expenses are stable and the Board is discussing moving some of last year's modest surplus in funds to our reserve account.

Please let me know if you have any questions or comments at my new e-mail address: Ted.Billings@gmail.com. ❖

New Group for Women: On Becoming Yourself

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Grace Riddell, LICSW, LCSW

Phone: 301-942-3237 • Email: GRiddell@aol.com

GWSCSW Study Groups

Please send us information about any study groups you participate in that may be open to new members within the Society. Below are two such groups:

The Dissociative Disorders Study Group is a clinical consultation & study group which focuses on the application of various clinical approaches in the current psychotherapy of post-trauma victims. The group was started by Frank Putnam and Aaron Ament in or around 1979, originally meeting at Suburban Hospital and now meeting at Psychiatric Institute of Washington, 4228 Wisconsin Avenue on the first Friday of each month from 7:30 to 9:30 PM.

As a reference, we use Putnam's basic text on dissociative disorders, but have broadened our focus to the understanding and treatment of trauma sequalae and the importance of shame as a core issue for so many of our clients. We believe dissociative symptoms are very often not picked up by therapists because we don't have an accurate trauma history and don't know what to look for.

We are a small group of therapists, with a range of experience working with dissociative clients and this interesting range of defenses. We look forward to the return of Dr. Aaron Ament to the group, and welcome new members. Two CEUs are awarded for any sessions attended in a year.

For more information, call Sheila Cohen at 301-652-0995 or email her at Shecohen@AOL.com.

The Family Therapy Study Group is a newly formed group that focuses on a variety of approaches to family therapy (structural, strategic, communications, Bowenian, etc) with the identified patients ranging from small children to the elderly. We also discuss work with couples. The group meets once a month in Chevy Chase, DC at noon.

Our learning will encompass readings, case presentations, role plays, and videos of our work with clients. The group welcomes members who have had many years of practice and newer clinicians who want to learn more. Two CEUs are awarded for any sessions attended in a year.

For more information, contact Jen Kogan at 202-215-2790 or via email at koganblackwell@verizon.net. ❖

Maier, *continued from page 1*

where his dissertation research was a study of 30 refugee children. After receiving his MSW, he continued to work with these children in Jewish organizations. In the 1960s, Dr. Maier came to the DC area where he was Director of Group Work at Chestnut Lodge, and he received his PhD in social work from Catholic University.

In the meeting, Dr. Maier shared a number of poignant stories about his arrival in the United States. He initially expected this to be a temporary separation from his parents and corresponded with them for a year or so before the United States entered the war in December 1941. Then communication stopped and he did not learn of their deaths until he returned to Europe as a soldier. He told of his experience as an immigrant adolescent in foster care in San Francisco and his relationship with the social worker from the sponsoring agency. Problems with learning a new language and negotiating a new culture resonated with attendees who had experiences with immigration from other nations. Maier believed that the "secure base" of a relatively happy childhood in Germany helped to sustain both him and his sister in coping with this difficult adjustment.

In recent years, Maier, still in part-time private practice at age 83, has authored two books about his wartime experiences: *In Lieu of Flowers* (2005), and *From the Golden Gate to the Black Forest: The Odyssey of A New American in Search of His Parents' Fate* (Schreiber, 2007). He concluded his talk by sharing his recent experience of returning to his hometown in Germany to do a reading from his books. ❖

News from the Clinical Social Work Institute

Carolyn Gruber

We had six more graduates on June first. That brings us to a total of fourteen CSWI PhDs and we expect several more people to finish their dissertations soon. Recent students have conducted fascinating research on such diverse topics as the meaning of money to the therapist, burn out in clinical social workers, personality trait predictors of acute stress disorder, bariatric surgery, first time mothers' experience of childbirth…well you get the idea. Our research is relevant to clinical social work practice. Students also do final case presentations that represent the finest in technique, theoretical integration, and social work values.

This semester, our courses include group therapy, research seminar, brief dynamic psychotherapy, psychopharmacology, and social work education. Next semester we will continue research and also have ethics and advocacy, couple therapy, comparative psychodynamic theories and cognitive behavioral treatment. You can review the entire curriculum by visiting our website, www.wdc-cswi.org or call 202-237-1202 and ask for a catalog. ❖

Carolyn Gruber, PhD, has returned to CSWI as interim president. We are also working with the Institute for Clinical Social Work in Chicago to see if we can integrate the two institutions.

News from the AAPCSW

Joel Kanter

The American Association for Psychoanalysis in Clinical Social Work (formerly the NMCOP) is a national organization with over 800 members for clinical social workers with interest in psychoanalytic theory, psychoanalytic practice, and the interplay of psychoanalytic concepts with social work practice. The majority of members are not psychoanalysts, but clinical social workers whose practices are informed by psychoanalytic ideas.

The AAPCSW is now part of a consortium with other psychoanalytic organizations, including the American Psychoanalytic Association and Division 39 of the American Psychological Association, which works on various projects including the publication of the *Psychodynamic Diagnostic Manual* (the PDM), training standards, and the 150th year commemoration of Freud's birthday at the Austrian Embassy.

Membership is only $65/year and offers members an excellent newsletter, participation in a lively listserv, reduced registration fees for conferences, and now discounts to an assortment of social work and psychoanalytic journals. These now include subscriptions to the *Clinical Social Work Journal* for $41 (reg $82), *Psychoanalytic Social Work* for $16 (reg $60), *Smith College Studies in Social Work* for $24 (reg $40), as well as *Journal of the American Psychoanalytic Association, Psychoanalytic Quarterly* and *Contemporary Psychoanalysis*. These discounts can easily exceed the cost of membership. For more information on the AAPCSW, go to its website at www.aapcsw.org. ❖

This Little Piggy Went to Market

Carmen Vaughn

The idea of marketing our work as private practitioners is frequently an unpopular one with social workers. Whether it stems from personal modesty, ideas of ethical conflict, or unresolved beliefs about ourselves and our business practices, as a profession we are often ineffective when it comes to advertising what we do. This may be true of us as individuals, as well as collectively, through our professional organizations. As a consequence of this professional modesty, social workers are still grappling with explaining what we do to the lay public and find ourselves relegated to the bottom of the psychotherapy community totem pole when it comes to remuneration, acknowledgment and respect. Despite the fact that our profession supplies this country with the majority of its psychotherapists, a social worker is not the first person a potential client thinks of when he/she is seeking a therapist.

Although all of us are aware of these issues, we may not look to ourselves as the real source of the problem. That is, we never really question the usual self-imposed dilemma of getting referrals without doing anything proactive to get them.

A year ago a group of us in Northern Virginia who met through the GWSCSW listserv decided to start a marketing group to help each other get over our reluctance, our fears and our discomfort with marketing our practices. We have met weekly ever since and have learned a good deal in the process about ourselves, our profession and our community. We've generated many ideas and implemented some of them. Along the way we have asked basic questions about ourselves and the social work profession itself, such as: What, actually, is the difference between social workers and other psychotherapy professionals? Why should anyone go to a social worker instead of another professional? Do we have something, anything, different to offer in the way we help our clients? Why should we accept less pay for equal, if not better, service? Why isn't our contribution celebrated or even acknowledged by the public? We think that all these questions come down, one way or another, to the dearth of marketing in our field.

The group's initial focus was on contacting and networking with other professionals in our community. We decided that we would position ourselves as knowledgeable about our local neighborhoods and their concerns. We called ourselves Therapists Without Walls and designed brochures aimed first at medical, and then later, other professionals. We offered pro bono presentations, seminars and telephone consultations as well as referral services.

Then we began to think about how to access clients directly. We hit on the idea of using the already well-established resource of our local Starbucks as a venue. We began to brainstorm about which potential clients were unidentified and underserved in our community and tried to think out of the box to find solutions. For example, one of us did research by interviewing parents and nannies at the local playgrounds about their concerns. As a result, we started a drop-in mothers' group targeting professional mothers of young children who felt isolated and discounted since leaving their salaried jobs to care for their children.

One of the benefits of our working as a group is that we know each others' interests and strengths and can

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Marketing , *continued from page 5*

refer to each other. In the case of the mothers' group, the two members who started the group realized that their interests lay elsewhere and were able to pass the group to another member who took over and made it flourish.

We gave presentations to businesses in the area, met with other professional groups and individuals and researched and contacted organizations whose members seemed likely to benefit from our services.

The greatest benefit of our groups has been the support and encouragement to break out of our comfort zones and not be afraid to be creative and unorthodox with our ideas. We usually try things in pairs because it feels safer and we always run an idea by the whole group before proceeding. We are currently exploring and debating the use of the Internet and other mass media techniques.

It would be nice if we could say that our referrals have soared as a result of our efforts. The truth is that while some referrals are the direct result of our activities, the group's influence on our volume of business is hard to pin down. Its real value is probably in convincing us that private practice is a business and like it or not, we therapists have to think like business people, including creating and implementing marketing plans for our work. ❖

Carmen Vaughan, LCSW, has a private practice in McLean, Virginia. She co-founded Therapists Without Walls with Carolyn Dozier, Susan Marks and Ellen Murphy.

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2008 PROGRAMS

The Artist and His Muse:
Puccini and the Creation of Tosca
Sunday, January 13
9:30 AM – 12:30 PM
Presenter: Tom Allen, MD

Medication and Meanings: An Update on the Neurobiological Understandings of the Affective Disorders, Conflicts for Patients and Pyschotherapists
3 Sessions: February 10, March 9, March 30
9:30 AM – 12:30 PM
Presenters: Kathleen Evans, MSN, RN, CS-P &
Francis Mondimore, MD

Working with Sadomasochistic Transferences and Countertransferences in the Clinical Relationship
Sunday, April 13
9:30 AM – 12:30 PM
Presenter: Beverly Betz, MSW, MA

Silence is Not Always Golden:
Working with Children and Adolescents
Sunday, May 18
9:30 AM – 12:30 PM
Presenter: Laurie S. Orgel, MD

End of Year Social Brunch
Sunday, June 8
11:30 AM – 1:30 PM

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Bonnie Gallagher (202) 244-1821

***DC Confidentiality** , continued from page 1*

five categories of information to be disclosed to third party payors for routine claims review, providing the patient has authorized this disclosure:

1. Administrative Data
2. Patient's status re voluntary or involuntary
3. Diagnosis, according to a professionally accepted diagnostic system, such as the ICD 9 or DSM IV (with 5 axes)
4. Prognosis, limited to estimated duration of treatment.
5. Reason for admission or continuing treatment. As part of the explication of the reason for beginning or continuing treatment, the insurance companies may ask the following questions:
    - Is medication being prescribed? If so, what is the medication and who is the prescribing person?
    - Goals of treatment. While this term is not defined precisely, it is understood that the response should be limited to a brief statement indicating the goals of treatment, that help to explain the reason for the treatment, e.g. "relief of depression or anxiety," "resolution of acute crisis," "medication management," "resolution of unconscious conflict, "helping to develop more satisfactory relationships."

It is important to be aware of the limits of information you, as a clinical social worker, can legally provide a third party, even with the patient/client's consent. If the insurer requests additional information, the process goes as follows:

- The client follows the appeals procedure outlined in his/her contract.
- The appeal is reviewed at the next level, without additional information requested or provided.
- Once the appeals process is exhausted, the patient/client requests an Independent Review.

An insurance contract that has required a subscriber to sign an agreement to make all mental health records available is not adhering to the DC law and should be reported to the DC Insurance Commissioner. Such a signed contract does NOT negate the law as it is written.

A telephone review is also outside the bounds of the DC law: a written note explaining the limitations of information allowed, with the above regulations cited, should suffice for the protection of confidentiality.

Under certain circumstances, you must comply if the client/patient requests that you provide a copy of your records, because your formal record (minus any private notes) is the property of the client/patient. However, if, in your clinical judgment, turning the records over to the client/patient is not in his/her best interest, you have the legal authority to decline.

The next phase

Our next phase as a Task Force is to work with the Department of Health and the DC Insurance Commissioner. Our goal is to define the meaning of Independent Review to ensure it is truly independent, and to determine a means of selecting independent reviewers that is acceptable to all three parties.

If you encounter any problems with insurance companies requiring more information than allowed, please contact Kathy Willis (202) 442-7758 of the DC Insurance Commissioner's office. She is very interested in hearing of matters of noncompliance and will follow up with the insurer.

Also, please feel free to address any questions to me through the Society listserv or by personal email at ddrakephd@comcast.net.

For insurance reimbursement problems that appear to be clerical in nature and not related to release of information, we are advised to contact Charlitta Brown at the D.C. Department of Health.

Thank you for your continuing support and feedback in protecting that which is most vital to effective psychotherapy: confidentiality of treatment. ❖

Danille Drake, PhD, has represented GWSCSW and clinical social work on the DC Confidentiality Coalition since the DC law was challenged by managed care and insurance organizations six years ago. She is in private practice in Bethesda and McLean.

Beyond Refrigerator Moms and Identified Patients: The Role of Family Therapy in Addressing the Autism Epidemic

Jonah Green

The following is a composite of several families I have seen:

Jeanine was terrified that something was wrong with her two-year old second child, Steven. Steven seemed to have difficulty sustaining eye contact; he was making few vocalizations, and he seemed to have poor motor skills. Jeanine began taking Steven to various diagnosticians, including developmental pediatricians and neuropsychologists. A psychologist diagnosed Steven with Pervasive Developmental Disorder NOS when Steven was three. Bill, Steven's father, accused Jeanine of biasing the testers with her exaggerated descriptions of Steven's behavior. Jeanine began taking Steven to speech and occupational therapies, even as Bill accused Jeanine of ignoring his needs as well as those of their first child, Barbara. Jeanine arranged for a very costly and time consuming treatment called Applied Behavioral Analysis, wherein a number of specialists came into their home to provide Steven with intensive social stimulation. Bill complained about the time and money involved. Many arguments ensued. Although he initially made progress through the treatment, Steven's behaviors began to regress. He became very disruptive, and engaged in increasingly repetitive behaviors. Bill filed for divorce shortly after Steven turned 5. A nasty battle over finances and custody ensued; by the time Steven was 7, he was living in two separate homes. Most treatments had been stopped or severely curtailed. Steven's behavior became increasingly chaotic and disorganized.

For reasons that surely include improved detection and diagnostic techniques, but may also include social and environmental causes, the last 10-15 years have seen an explosion in the number of children diagnosed with Autism Spectrum Disorders (ASDs). Recent estimates indicate that one in 150 children born today will develop an ASD. While children who have ASDs may have a variety of diagnoses (Rhett's Disorder, Childhood Disintegrative Disorder, Autistic Disorder, Pervasive Developmental Disorder NOS, Asperger's Disorder), and vary widely in their level of functioning, they share a number of difficulties; all children on the autism spectrum lack essential social skills, especially the capacity for effective reciprocal communication, and most have a variety of difficulties expressing themselves through language. Many also engage in excessive rituals, frequently tantrum, or display overly intense and focused interests. Autistic individuals often have significant strengths, such as having one extreme talent (a "splinter skill"), and most are very good visual learners.

A number of treatments have developed in recent years that can assist autistic children in their development. These treatments include floor play, a model of intensive child-parent play which can be very effective in increasing social and emotional skills; speech and language therapy; occupational therapy, with a particular focus on sensory integration; the TEACCH program, which provides visual structure and an organization of a child's environment; Applied Behavioral Analysis, a very intensive program that works on principles of operant conditioning; social skills groups; dietary interventions; and medication management.

A number of parenting approaches have also developed that assist parents in addressing the behavioral issues that are common in children with ASDs. Some approaches, such as Functional Behavioral Analysis, operate within an operant conditioning framework, while others, such as the Collaborative Problem-Solving method, seek to address children's deficits in impulse control, cognitive flexibility, and affect regulation. Most guides for parents with children with ASDs advocate a number of general principles, such as the importance of focusing on children's strengths, maintaining consistent routines, giving children lead time before transitioning them to new activities, and assisting children in communicating their needs in constructive ways.

Specialists on autism also encourage parents to focus on ways that they can improve the lives of their children outside of the home environment. Many offer guidance on how to assist parents in advocating for appropriate educational accommodations and placements. They encourage parents to structure play dates

and find clubs and activities for children with ASDs where they can develop friendships, and advocate the use of techniques such as "social stories," as well as perspective-taking exercises, to help them develop social skills.

Many of the above interventions are effective for children with autism. Most interventions, however, are costly and time consuming. More importantly, none address the child's entire family system. Even the parenting approaches, which do address family relationships, generally speak to situations when there is one caretaker and one child. Surely none of the above interventions would effectively address Steven's needs, because his chaotic home environment would undo a great many of them. Studies show that families of children with autism have higher rates of family strife and divorce, and also that chaotic family environments in turn can exacerbate the symptoms of autism. It would seem that those who treat autism ought to be looking at the family as a primary area for intervention.

As the impact of autism on families has become increasingly evident, professionals and volunteer organizations have begun to make efforts to address the concerns of family members. Several organizations, especially the Autism Society of America, offer programs that provide education and support to parents of children with ASDs. The literature on autism has begun to stress to parents the importance of taking care of themselves and their marital relationship. Numerous mental health agencies have begun to provide individual and group treatment that attends to the emotional needs of siblings of children with ASDs, and many organizations have begun "Sibshops" that serve as social support groups for siblings of children with ASDs and other special needs.

Many of these efforts are extremely valuable; still, none of them address the complex needs of families like Steven's; those best positioned to address such a family should be mental health clinicians. But clinicians have been slow to develop interventions for children with autism from a family systems perspective. Perhaps this is because family approaches that they used prior to the present epidemic were ineffective and even damaging. From the 1950s onward, many clinicians who had read Bruno Bettelheim generated needless guilt and blame when they advised families that "refrigerator

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Autism Epidemic *, continued from page 9*

Mothers" caused autism. Other therapists, schooled in systems theory, but ignorant of the realities of autism, persisted in calling children with ASDs "identified patients" implying that ASDs were merely reflections of difficulties in the "family system." At a minimum, this approach led families to avoid effectively treating autism; at its worst, it was another way of blaming parents. As a result of these missteps, family therapists were ill equipped to address autism as its impact on children and their families began to spread.

In the late 1990s, as the impact of ASD on families became more evident, mental health clinicians began to take more constructive and realistic approaches towards assisting families. The American Psychological Association put out videos and pamphlets advising clinicians to educate families about the illness, guide them towards appropriate resources, and offer support and guidance, including advice to parents to "take care of their marriages." While these guidelines constituted an improvement over earlier approaches, they were still inadequate in addressing the complex needs of many families with autistic children. Because the autism diagnosis itself was a cause of stress for Bill and Jeanine, the educational approach might even have exacerbated matters for them.

In the last few years systemic approaches to autism have begun to develop that have avoided the pitfalls of the past and have begun to address families' multifaceted needs. Family therapist William Kantz has written about the need to guide parents and other family members through a grieving process to accept their child's disability. Jennifer Elders, a pediatric nurse, has conducted research on how to help disengaged parents, most often men, interact with their autistic children. Marion O'Brien, a family studies professor, and Julie Daggett, a clinical psychologist, offer perhaps the most comprehensive guide thus far on how to assist families that include children with autism in their book *Beyond the Autism Diagnosis: A Professional's Guide to Helping Families,* (2006). O'Brien and Daggett examine the impact that autism has on the finances of families and the time and energy of parents, as well as the effect of autism on relationships between spouses, siblings, members of the extended family, and even friendships that parents have with other adults. While not a guide specifically for mental health clinicians, they offer professionals ideas on how to intervene to assist families in addressing these challenges.

As the autism epidemic continues to spread, families will increasingly need mental health practitioners who are knowledgeable about *both* ASDs and family dynamics. Poorly structured family systems do *not* cause autism, but a vulnerable family system stressed by an autistic child can maintain autistic symptoms. Conversely, strong family systems, that include family members who are educated about autism, can generate social, emotional, and academic development in autistic children who, in turn, can strengthen their families. If practitioners work with families to address the unique challenges and opportunities that come with raising children with ASDs, they can build greater family cohesion, and more consistent and nurturing home environments. Families will be better able to teach their children skills, serve as effective advocates, and access the many valuable treatments and resources that are now available for their autistic children. ❖

Jonah Green practices therapy for children, families, and individual adults in Montgomery County. He specializes in working with families that include children with special needs.

GWSCSW Continuing Education presents…

Empowering Remarried Families: Assessment and Intervention

Sunday, January 28
10:00 AM – 1:00 PM
Presenter: Jonah Green

Increases in life expectancy and divorce have led to an explosion in the number of marriages wherein at least one partner has previously been married. Both adults and children within these complex family systems face special challenges as well as opportunities. This course will assist clinicians in assessing and working effectively with remarried families. Specific topics will include: types of remarried families; characteristics, tasks and assessment of the remarried family system; strengthening the remarried family system; supporting stepparents and birth parents; and assisting children and stepchildren.

Member: $45 / Non-Member: $75

3 CEUs

For registration information, see page 29
or call the office (202) 537-0007

Yoga Nidra: Useful Adjunct to Traditional Psychotherapy

Karen Soltes

Yoga Nidra can provide a quality of rest that deeply restores our nervous system in a way that regular sleep may not. While the therapeutic benefits of this practice are becoming more obvious, there are few among us who cannot benefit from the deep sense of rest and well-being that is produced from the practice.

This ancient meditation practice is showing great potential for reducing symptoms of insomnia, depression, and anxiety in a diverse population, as well as developing an increased sense of control over one's life. Until recently, Yoga Nidra was not taught or practiced widely in the United States.

While some of the stated benefits of Yoga Nidra described in the literature have come from anecdotal reports, well-controlled research projects on the practice have begun. A pilot study was conducted at Walter Reed Army Hospital with active duty soldiers suffering from post-traumatic stress disorder. The results from the study have shown that Yoga Nidra is effective in reducing the symptoms of PTSD, including sleep disturbance, anxiety, and a greater sense of control over one's life circumstances.

Further studies are beginning with the military as a way to treat PTSD.

Other studies have shown the practice to improve a number of physiological conditions, including decreasing hypertension, lowering levels of both cortisol and cholesterol, and improving the brain's ability to absorb information as well as its ability to later recall information, both critical factors in learning.

My own experience has been as both a psychotherapist and yoga teacher. I have been teaching weekly classes in Yoga Nidra, as well as private sessions with adults and children as young as 6 years of age. In my weekly class, students often report that the practice has improved their sleep by making it more restful, and by helping individuals who have difficulty both falling and staying asleep. Students have also reported that the practice has created an overall improved sense of well-being, and has helped them to reach a deeper acceptance of life as it is.

Given that most of us are being faced with increased levels of stress in the course of our daily lives, Yoga Nidra can be a useful practice to restore a sense of balance in the face of daily challenges. Furthermore, once the practice is learned, it can be done at home with a CD or downloaded onto an iPod, thereby giving people a practice that they can use independently. This is particularly useful in reducing insomnia.

In my yoga teaching and in my social work practice, I have found an abbreviated form of Yoga Nidra to be a successful adjunct to traditional therapy for children who present with a range of anxiety, sleep, and attention issues. The practice can be adapted to work with individuals in addressing strong emotions and long held beliefs about oneself that interfere with optimal functioning.

Yoga Nidra can be a useful body-centered therapy to help people resolve difficulties that have not improved significantly with traditional "talk" therapies. It has been a particularly effective tool for individuals with dissociative disorders, enabling them to learn to safely feel sensations in the body and be with painful emotional and physical sensations. This can help clients feel strong enough to work through difficult issues and not spend enormous energy avoiding challenging states.

Like any practice, the benefits increase over time and with regular practice. I have seen the most profound and steady changes in my students who have a regular practice that includes both weekly class and a home practice. ❖

In addition to her private practice, Karen Soltes, LCSW-C teaches a weekly class at Circle Yoga in DC. If you are interested in trying out this practice or would like more information on the potential benefits and uses, feel free to contact her at ksoltes@aol.com.

The Relationship Between Food and Life

Karen Schachter

"One cannot think well, love well, sleep well, if one has not dined well." Virginia Woolf

Virginia Woolf was on to something: food—and our relationship to it—is our sustenance, our lifeblood. It has the potential to be a source of nourishment or, as is the case for many, a source of angst and unhappiness. Food, and our relationship to it, has a strong impact on the quality of our lives. Food is often a metaphor for our relationship with other aspects of our lives.

As social workers, we are not typically trained to think about food. Rarely do we consider how our clients' food intake may be contributing to their depression, their anxiety, their bingeing, their purging, their lethargy, their attentional problems, their behavioral concerns, or their mood instabilities.

The standard American diet (SAD) consists primarily of highly processed, refined foods—foods that lack nutrients, enzymes, and essential fats, which are integral to stable and healthy brain chemistry. Instead, SAD foods are fast, "fake," and empty (not unlike how some of our clients might describe their lives). These foods contain a host of additives, sugars, dyes, pesticides, and hormones. Many of the additives found in most processed foods (like MSG, aspartame and other artificial sweeteners, and dyes) have been implicated in a host of neurological, behavioral, and mood problems.

Eating SAD foods contributes to a sad life. And living a fast, empty life contributes to perpetuating a way of eating that lacks true nourishment and sustenance. When our clients' diets are primarily made up of these "fake" foods, it is no wonder that they feel depressed, anxious, have trouble focusing, or feel stuck in a binge-diet or binge-purge cycle.

In my work combining psychotherapy and nutrition, I have found that it is most helpful to take a two-pronged approach with clients. I try to help them look at their diets (*what* they are eating) and consider how that might be impacting their mental health and well-being. I also consider their psychological and lifestyle issues, which, in turn, likely affect *how* they take care of themselves, with food and otherwise.

Although nutritionists can help educate a client about the ideal foods to eat, I have found that often, social workers can have a great impact on our clients' habits—eating or otherwise.

As therapists, we are in the perfect position to help our clients make dietary changes that will affect their mood and their well-being. We can educate them about the impact of their SAD diets and, even more important, we can explore with them what makes it hard to make healthier choices.

For example, are they overly stressed and moving too quickly through life and, thus, choosing "fast" foods? Do they feel deprived if they don't "treat" themselves with sugary sweets? How else does that deprivation get expressed in their lives, and how can they "feed" themselves some real nourishment (the kind that doesn't come out of a carton of ice cream)? Are they dependent on external sources of "sustenance" like caffeine and sugar, rather than seeking more real sources of satisfaction? Does treating themselves poorly with food parallel any other areas of their lives?

We can help our clients slow down—in life and with food. We can help them savor, enjoy, nourish, and delight—in life and with food. We can help them tune in to themselves: what is it their bodies need and what is it their souls need? We can help them bring themselves to the table—with food and with their loved ones. We can help them deeply nourish themselves, again, with food, and in their lives.

Virginia Woolf was right: dining well is critical, not just for our clients, but for each of us. Food and life go hand in hand. The way we eat not only affects how we feel and therefore how we live, but the opposite is also true: the way we live, the way we work, the way we love, profoundly impacts how we choose to feed and nourish ourselves. ❖

Karen Schachter is a licensed clinical social worker and a certified health counselor who works with adults, children, and families to help them develop positive relationships with food and their bodies from a nutritional and psychological perspective. In addition to individual and family counseling, she offers workshops and classes on a variety of topics. Interested in receiving her free monthly healthy eating/living tips? Please send an email to info@karenschachtermsw.com. Karen can be reached at (202) 237-8013 or www.karenschachtermsw.com

One Child. One Therapist. For as Long as It Takes.

Adele Natter

As social workers, we know that healthy, nurturing relationships are the basis of good mental health. We trust that the people we care about will be there for us, and this knowledge sustains us. Now consider the plight of foster children. Foster children suffer repeated and profound losses—often, abuse and neglect—and lose confidence in relationships. Traumatic loss is repeated after the child enters the foster care system. As children are moved between temporary placements, parental figures change, social workers change, schools change, and relationships are sundered. Even if these children get psychological treatment, it is often at a training clinic, where student social workers and interns leave at the end of the academic year. This experience reinforces the message that attachments are dangerous and painful, that caring won't last, and that relationships can't be relied upon.

The clinical program of A Home Within is one solution to the problems of therapist turnover and relationship instability in the lives of foster children. A Home Within is a nonprofit organization of dedicated professionals who exercise their sense of social responsibility through programs to help foster children. The clinical program provides weekly, long-term, individual psychotherapy to foster children. The therapeutic relationship may be a lifeline and the only point of stability in the life of a child whose other attachments get broken. Therapists in private practice provide treatment to a foster child on a pro bono basis "for as long as it takes." Clinicians receive free supervision from highly experienced supervisors who are also donating their time. Members of the chapter meet on an occasional basis. Meetings are supportive and educational (CEUs are given).

In September, when the school year was already underway, 14-year-old Lonnie poked his head into the doorway of my office and said, "Hi." I hadn't seen him since the previous June. He had grown a lot, and seemed so much different from when I first met him. Lonnie's mother had died three years earlier, and he and his siblings had been with their father in another state. Increasingly psychotic and paranoid, the father nailed the windows shut; trusting no one, he kept the children out of school and inside the house for a year, even after the utilities were shut off. One night he told the children to pack their belongings, and they drove through the night to an aunt's house in this area.

Once in the office, Lonnie seated himself awkwardly.

"So, what's been happening?" I inquired.

"I'm doing good, getting good grades—As—in school. I want to thank you. You helped me, and now I'm doing good."

This was totally unexpected. I hope that I composed my features and that the shock and surprise didn't register.

"Oh? What did I do that helped you?"

"You helped me talk out my problems."

He enumerated the problems he had talked about: his mother's death, being abandoned by his "crazy" father and delivered here "like so many UPS packages," fighting with his siblings and being disobedient to his aunt, and academic and behavioral problems in school. He reported that he now takes responsibility for his younger siblings after school, starts them on their homework before doing his own, is going to try out for the team, and repeated that he is getting As. He reported that he has activities and responsibilities each day after school and had come to tell me that he was "finished."

Since this was our only termination session, I reviewed our journey. In my own mind, I recalled our first sessions, in which numerous imaginary figures engaged in the most vicious fighting I'd ever seen: stabbing, beheading, raping, disemboweling. In addition, their allegiances constantly shifted, with backstabbing, corruption, double agents, and people changing sides in an instant. No one was safe, and no one could be trusted.

Out loud, I gave Lonnie credit for turning himself around.

continued on page 15

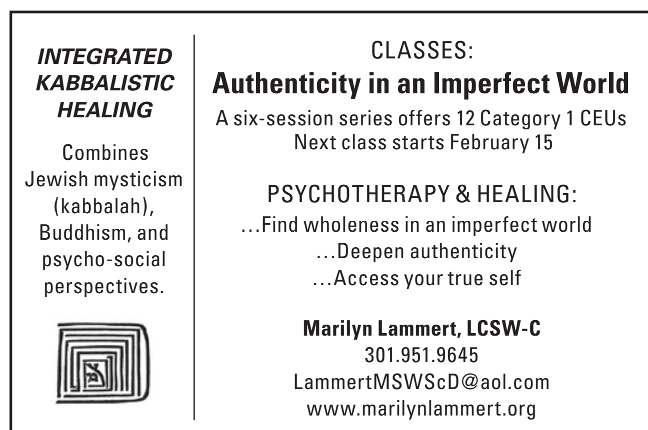
Authenticity in an Imperfect World: Integrated Kabbalistic Healing

Marilyn Lammert

After many years of practice as a psychotherapist and teacher of clinical social work, I reached a point a few years ago where I longed for something new. Training in psychodynamic and cognitive-behavioral approaches to therapy, and most intensively in Gestalt therapy, had equipped me to function effectively as a therapist. However, I wanted to explore more fully how I—and by extension, my clients—could live more authentically in an imperfect world by exploring how body, mind, and spirit were integrated.

There is an old saying, "When the student is ready, the teacher appears." Never was this more true for me than when, at the urging of an old friend, I was introduced to Jason Shulman and Integrated Kabbalistic Healing (IKH) at a 2001 Omega Institute workshop. His approach spoke to deep questions within me, mostly questions I couldn't clearly articulate. The combination of ideas from many wisdom traditions was appealing because it was so different from looking at the world through the lens of the mainstream Protestant Christianity I was raised with.

While many spiritual paths are about getting somewhere, about striving, IKH is not about attaining purification or perfection. Rather, it teaches us about the shared human condition of being imperfect, of falling down and getting up over and over again. It is also about being kind to our imperfect selves. Since I struggle with needing to present myself in a perfect way (and this is the antithesis of being authentic), these teachings are very welcome.



IKH was developed by Jason Shulman, a healer and spiritual teacher who integrates in the core of his work aspects of kabbalistic wisdom—kabbalah being the Jewish mystical tradition—with ideas from Buddhism and western psychology.

When people ask what this work has done for me, I reply that it has changed my relationship with suffering, and with life itself, including the way I experience myself and the way I am in the world. Over the last six years, through my study and practice of IKH, I have come to a deeper place, where I am more curious, and I see life as a journey. I have a sense of a larger benevolent universe; I am not so afraid or anxious. I am regularly reminded of the curiosity and awe I feel at being connected to the people, including clients, with whom I share this journey. Through this work, I have found that my gratitude, kindness, and forgiveness toward self and others have naturally increased. Quite simply, my life has become more authentic.

Psychotherapy is an integral part of this work. Self-exploration is how we know who we are, through facing our wounds and our histories. We also face that we are suffering, and we obtain a glimmer of the part of our suffering we cannot even bear to know (although, of course, we do bear even that part, as best we can). This self-exploration is a crucial step in our spiritual journey.

Healer and client sit together in IKH in much the same way they do in psychotherapy, focusing on the relational, intersubjective aspects of the experience of the client in the room. In psychotherapy, the focus is primarily on the personal. In IKH, the focus includes the personal, but extends beyond it. In psychotherapy, awareness of suffering may lead us to a place of compassionate relationship with ourselves. In IKH, there is something more, something else in the present moment. The wonder of it—this "something else"—is sometimes there in psychotherapy as well, though not named. In IKH, that "something else" evolves out of the relational, intersubjective aspects of experience of client and therapist. It becomes a doorway into an experience that isn't from the personal history of either the client or the healer. The value of contact with this larger, more impersonal experience or frame of refer-

ence is that we can learn to attend to that new level of awareness. We can work with it consciously.

Indeed, a key feature of IKH is that the healing journey and the spiritual journey are the same, inextricably linked. As we heal in the deepest sense—including but not limited to just the physical or just the emotional—we wake up spiritually. And by this I don't mean waking up in any sort of religious sense. What I mean is that our awareness changes. And as awareness transforms, our body and mind and spirit heal. As we do this work, waking up and healing happen together.

Life is the great teacher, even as it is unpredictable and hurtful. Major difficulties we encounter include our relationship with suffering and death as well as the larger thing that human beings have called by many names for thousands of years, usually with capital letters—God, the Absolute, or Reality. IKH addresses those questions.

It also teaches that the more we heal, the more we trust what life brings on a daily basis. And the more we trust, the more the mystery of life reveals itself and the more we learn. Integrated Kabbalistic Healing has helped me understand this intimate and profound process. I feel a deep gratitude for my connection to this work and the community of seekers and healers I have found. ❖

Marilyn Lammert provides therapy to adult individuals and couples at her office near downtown Bethesda. She includes IKH in her practice and offers classes and study groups presenting ideas from kabbalistic healing that inform clinical work and enhance personal growth Category 1 CEUs are available for social workers.

One Child, *continued from page 13*

"You made a decision that you wanted to get on a team, and you didn't let yourself get distracted from that." (During one of the umpteen games of basketball he played in my office, I had asked him to reflect on the fact that, by messing up in school, he was only hurting himself and further removing himself from his goals.)

I remembered with Lonnie the many times his aunt, frustrated and angry, had threatened to send him away. Only now could he admit that he had felt worried about this possibility and, for the first time, actually reported a dream about being sent away. I acknowledged that his help was needed after school at home and that he had become responsible enough to be helpful at home.

One year later, Lonnie is doing well, getting good grades in high school, and continues to be a responsible and contributing member of his family. ❖

Please contact Adele Natter, at (301) 509-4848, or the chapter president, Richard Ruth, Ph.D., at (301) 933-3072, if you are interested in A Home Within's clinical program.

GWSCSW Continuing Education presents…

The Supervisory Relationship

Friday/Saturday, February 8 & 9
8:30 AM – 3:30 PM
Presenter: Tamara Kaiser

A two-day workshop for those who supervise or who are considering supervising, with a focus on the relational dynamics between supervisor and supervisee. The underlying assumption is that this relationship is the most significant medium through which clinical social work is taught to practitioners. The primary elements of the supervisory relationship include the use of power and authority, and the development of trust and shared meaning. The process of supervision is seen as one of accountability and the goal is that of insuring competent service to clients. All of this takes place in a larger context, which includes the agency, the community, funding sources and credentialing bodies. Lunch is included both days.

Member: $230 / Non-Member: $350

12 CEUs

For registration information, see page 29
or call the office (202) 537-0007

Managing Boundaries in Psychotherapy

Joyce Smith

Defining "boundaries" in psychotherapy is complex because boundaries are inherently relational, and may vary depending on the treatment context.

We are trained as therapists to put our client's needs first and set standards for ethical treatment. It is our responsibility to set clear boundaries, consistent with the context in which we work, to ensure the safety and integrity of the treatment relationship. We are in charge of the treatment relationship and are expected to produce results, yet we are dependent on our clients for treatment outcome. We are expected to respect differing views and practices of our colleagues and yet hold them accountable for ethical practice.

Our Code of Ethics serves as an external guideline, but explicit standards cannot address the more subtle dilemmas that occur daily and call on us to create ongoing ethical frameworks in real time. It is our responsibility to manage the treatment relationship by operating not only within our explicit Codes but also within flexible ethical frameworks adapted to ensure the safety and integrity of the immediate, dynamic relationship.

Boundaries are more than a set of rules or terms of a contract in a treatment context. Designed to protect the client in the fiduciary relationship (where vulnerability resides on the side of the client and power and influence reside on the side of the therapist), and also to protect the therapist's time and privacy, boundaries vary within treatment contexts. They encompass the relational contact between the therapist and client, defining a "holding environment" of evolving safety in which the client can grow in trust and freedom to explore vulnerabilities. Therapeutic holding involves confidentiality, never using the client for one's own benefit, and containing the client's psychopathology, and one's own countertransference, for the client's benefit.

Therapists transgress boundaries when their needs, past experiences and countertransference predominate in the complex interactions between client and therapist. Boundary transgressions vary. They can be relatively minor such as being late for a client's appointment, forgetting to bill on time, mistakenly misnaming a client, or ending a session early. They can be well intentioned such as offers of rides, lending money for bus fare, offers of employment or job connections. They can be subtle such as not paying attention, directing the conversation to topics more interesting to the therapist, or withholding information about the therapist that will affect the therapy. They can be more blatant such as excessive self-disclosure, breaching confidentiality, taking advantage of a client's expertise for one's personal advantage, or asking a client to provide goods or services for the therapist or for other clients of the therapist. Anything that alters the treatment frame introduces uncertainty and ambiguity, thus threatening the safety of the treatment connection.

To best manage the treatment relationship one must maintain awareness of the numerous factors that shape any treatment dyad. Both parties bring their unique characteristics, personality structures, and unconscious biases to the relationship. Both have vulnerabilities. Each comes to the relationship at a particular life stage with all that this entails.

Some factors unique to the therapist are the therapist's past personal therapy and supervision. Unresolved boundary dilemmas and abuses in those relationships can create blind spots and possible enactment by the therapist with the client. For example, the therapist may have had a supervisor who took advantage of his or her power, including sexual or other exploitive acting out with the therapist or with the supervisor's clients. This adverse role modeling, if not recognized as such, can lead to possible re-enactment by the therapist with his/her clients and supervisees. The therapist may have experienced shaming teaching methods, sexual involvement with a faculty member, or have received insufficient training in ethics and in management of transference/countertransference. Such negative experiences or deficiencies also make the therapist vulnerable to future re-enactment.

Life as well as career stage variables affect the treatment relationship. Younger therapists who feel inadequate and inexperienced may be defensive with clients. With more experience, therapists need to avoid becoming overconfident and fail to notice unique aspects and needs of clients. Older therapists may look to younger clients for a sense of rejuvenation and vicarious adventure. Crises and stressors, such as divorce, low patient

count, and financial problems need to be managed so as not to interfere with the treatment relationship.

These are a few of the factors that affect boundary maintenance. Because we are human and fallible, and because our work often involves and evokes intense feelings, most of us have experienced boundary breaches and dilemmas of some sort in our training and professional careers. Many of us work in isolated practices in competition with each other. While it is always prudent to discuss boundary dilemmas with supervisors and/or colleagues, how can we create safe environments for discussion of our ethical conflicts and mistakes? How can we come to agreement about what constitutes "usual and customary" practice when there are many, sometimes conflicting treatment modalities? How do we hold colleagues accountable for ethical practice without ostracizing and shaming? These tensions highlight some of the challenges we face. It is important to acknowledge these challenges and facilitate nonjudgmental discussions and educational forums to learn from each other as we grapple with the complexities of setting and maintaining boundaries that protect the treatment dyad connection and make our work possible. ❖

Joyce Smith, LICSW, is in private practice in Washington DC

When We Are Called to Testify in Custody Disputes: Some Useful Guidelines

Jonah Green

Those of us who work with children and families occasionally receive requests to testify in custody disputes. When we are notified of such requests, we often feel pulled by divergent needs: to influence the court in the best interests of the child, to maintain a working alliance with both parents, to protect ourselves legally, and to get paid for the times we spend in court. Several policies can help address these needs:

1. If someone requests that you testify, ask to write a report instead. If this is not possible, ask to be deposed; request payment for time spent in the deposition, as well as preparation and travel time.
2. If one party insists on a court appearance, request a subpoena, and again ask for payment for all time related to the appearance.
3. Challenge requests to provide copies of notes, offering instead to provide a summary of the treatment. Cite confidentiality and the best interest of the child as the reasons for this approach.
4. When asked to comment on parents' capabilities, stick to observable facts. Never characterize parents' behavior, or venture into diagnosing them.
5. State what children's needs seem to be (i.e., continuity, structure, etc.) and what general custody and visitation arrangements may best meet those needs (i.e., frequent contact with both parents, minimal transitions, etc.). Refrain from recommending specific custody and visitation arrangements.
6. Except in unusual circumstances, maintain that children need to have substantial contact with both parents, as well as other adults with whom they have formed attachments.
7. If concerned that a party may take legal action against you, have an attorney present while testifying. ❖

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For more information and a schedule of our seminars, please call us at
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PLEASE RESPOND TO THIS SURVEY AND PASS IT ONTO TO SOMEONE WHO MAY BENEFIT FROM THIS INFORMATION

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PLAY THERAPY SURVEY

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Employer/Agency Address____

____

1. Do you work with children?____________________
2. If so, what age group & what capacity?____________________
3. Did you have play therapy training in your preparation as a clinician? ____________________
4. Have you had any play therapy training in the past (play, art, sandtray, etc)? ____________________
5. If yes, please elaborate (how many hours, sessions, etc.)?____________________
6. Are you currently interested in obtaining training in play therapy (play, art, sandtray, etc.)?__________
7. What areas of play therapy would you be interested in learning about?____________________
8. Does your employer provide on-going continuing education (CEUs) opportunities?__________
9. Would your employer support training in play therapy for you? ____________________
10. What about on-site training? ____________________
11. What about providing space for outsiders to attend as well?____________________
12. Is there space for training on-site at your facility?____________________
13. If so, how many does the room accommodate?____________________
14. Would your employer provide training space in exchange for a reduction in fee? __________
15. If yes, how many clinicians from your facility would attend the trainings? __________
16. If your employer is not able to pay for your training, are you willing to pay for training? __________
17. How do you obtain CEUs for licensure renewal?____________________
18. Are you interested in becoming a Registered Play Therapist? ____________________
19. If yes, would you be committed to attending training once a month for approximately 15 months? ______
20. Would you be available to attend the summer institute which is 1-2 weeks of training? __________
21. How far are you willing to travel (hours, miles)? ____________________
22. What days & times are you better able to attend trainings on, once a month? __________
23. Are you interested in teaching, providing supervision, etc.? ____________________
24. Are you in need of clinical supervision for play therapy?____________________
25. Are there any additional topics you think should be provided as trainings? __________

Thank You! We appreciate your feedback.

On Becoming Ourselves

Grace Riddell

> "Who are you?" said the Caterpillar…
>
> "I hardly know, Sir, just at present," Alice replied rather shyly, "at least I know who I was when I got up this morning, but I think I must have changed several times since then."
>
> ~ Lewis Carroll, *Alice's Adventures in Wonderland*

Like many of our clients, Alice has doubt about her identity in an ever-changing world. She experiences change as situational without understanding the inner process of transition. Even though we know that life is full of changes, our society does not allow a mechanism to prepare for moving from one phase of life to another. Nature teaches us that change is the norm—yet, to incorporate change, we need to reorient and redefine ourselves in new situations. Without the interior work of transition, change is just a rearrangement of the furniture.

In his book *Transitions: Making Sense of Life's Changes*, (2nd Ed., 2004),William Bridges says that the three phases of transition are an ending, a beginning and an important empty or fallow time in between. The first phase involves letting go of the external and internal attachments to the old way of life. Many cultures maintain rituals for clearing the mind of old memories in order to make way for a new stage of life. Our society expects us to retire or move into a new job or house without allowing time to empty ourselves so that we can be filled with dreams and new visions. We clinicians can help our clients identify their losses and grieve them appropriately. Then, we can explore the form which the client wants his or her life to take--like the potter at the wheel forming clay into a vessel without knowing how it will be filled.

Many people avoid the second phase of transition because it can be a confusing and disturbing time. Some traditions allow for this in-between zone with rituals such as sending a person off to an unfamiliar desert or forest for a time to find oneself. Moses, Buddha and Jesus spent time alone in the wilderness (Hebrew word for sanctuary) at critical times in their lives. Spending time as a non-being vessel can be more important than action. Helping clients empty themselves can allow their dreams and visions to pour in and help to shape their futures.

Some clients may choose dramatic retreats, such as one 58-year-old woman who left her job and drove to Alaska by herself after being rejected from her long-term relationship. Afterwards, she said that on the trip she had enjoyed her own company proving to herself that she was, despite her ex-partner's claims, "pretty easy to be with." On her way home, she visited her 85-year-old mother who had never approved of her lesbian lifestyle. She and her mother resolved many aspects of their differences before her mother died.

Others may elect to stay at home in solitude and quiet, taking time for meditation, journaling and reflection. Often clients present with "I don't know who I am," which could be part of the confused and disoriented state of mind during this phase. The clinician can help the client decide if a life-changing event would be more effective than a sabbatical or vacation.

The final stage of transition is a new beginning. Potters say that taking the pot off the wheel and placing it on a new surface is the most difficult part of the craft. The clay has not yet hardened so it is fragile and vulnerable. Taking small steps without succumbing to "buyer's remorse" is this stage's challenge.

In her sixties, Ellen Burstyn inspires us on how to move into the third phase of transition. In her memoir *Lessons on Becoming Myself* she says that she vowed to move into the next period of her life boldly by looking at what she was afraid of and moving toward it instead of away from it. And, as Eleanor Roosevelt said "Do one thing every day that scares you." These can be exciting times of change—let's all take the plunge. ❖

Grace Riddell, LCSW, LICSW, M.Ed. has a private practice in DC and Maryland. Currently, she is leading two women's groups: "On Becoming Myself" and "It's All About Change." The group "It's All About Change" is for lesbians and bisexual women only.

ADVOCACY & LEGISLATION

FEDERAL

Thanks to Laura Groshong, Director of Government Relations for the Clinical Social Work Association (CSWA – formerly CSWF), GWSCSW listserv members have been kept up-to-date on the struggle this fall to pass legislation expanding health insurance protection for children. Ultimately, although a bi-partisan compromise was reached when the House adopted the Senate State Children's Health Insurance Protection (SCHIP) bill, the President cast his first veto, and Congress lacked the votes for a veto override. (The shortfall was 13 votes in the House—with several of our local Virginia Representatives opposing the measure.) Presumably a bill will be passed, with further compromise, before the current legislation runs out.

Advocating for children's health *and* clinical social work

CSWA, the National Association of Social Workers (NASW), and the American Psychological Association (APA) worked together to lobby, successfully, for several provisions in the original House version of the SCHIP bill which would have been beneficial for clinical social workers: independent inclusion in Medicare Part A; rollback of the 9% cut in Medicare reimbursement to LCSWs last January; a 5% increase in Medicare reimbursement; and a change in the Medicare mental health co-pay rate from 50% to 20%. While these provisions were all removed during the negotiations in September, legislative staffers are now aware of our issues and will be inserting similar provisions in legislation as the opportunity arises. The lead article in *Psychotherapy Finances*, October 2007, described this collaborative effort of CSWA, NASW, and APA.

Health Parity bills

Over the past 6 months, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, HR 1424, and the Mental Health Parity Act of 2007, S 558 have wound their way through Congress. S. 558 passed the Senate unanimously after an amendment we supported removed a section which would have preempted stronger state parity laws. HR 1424 is, as we write, still being reviewed and changed by members of the House Ways and Means Committee, having already passed out of the House Energy and Commerce Committee. Several amendments are pending.

What may be most important is that the two bills are getting far more attention than mental health parity bills have in the past eleven years since they have been introduced.

Working with the Mental Health Liaison Group

Each month a CSWA representative meets with the Mental Health Liaison Group, a coalition of national-level mental health associations, to share information, learn, and plan advocacy strategies. As part of that effort, CSWA has signed on to some fifteen letters to Congress and/or the President in the last four months, supporting a variety of mental health issues related to children, the elderly, parity, and more. ❖

GWSCSW is an affiliate of the CSWA, the voice of clinical social work at the national level. For more information, google Clinical Social Workers Association.

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MARYLAND

Alice Neily Mutch

Annapolis been quiet since the 2007 legislative session ended in April, though there's been considerable behind-the-scenes maneuvering going on with respect to the special October 28 budgetary session called by the Governor.

Mental health programs slated for cuts

Governor O'Malley has pledged that his administration is dedicated to crafting ways to improve healthcare coverage and healthcare outcomes. Yet he has also made it clear that serious budget cuts are in store because of the deficit. Funding for mental health programs has been slated to take a major hit.

Meanwhile, as pointed out in the letter sent by the Maryland Mental Health Coalition to the Governor and members of the Assembly and signed by our Maryland clinical social work coalition, public mental health services are badly under-funded; uninsured people with severe mental illnesses are increasingly turned away from services, while others who should be in treatment are instead in jails or prisons, or are homeless; and provider workforce shortages are at crisis levels. Further, Maryland's state and local spending per capita is well below the national average, 31st among the fifty states as a percentage of income.

A task force looks at reimbursement issues

This is a time for clinical social workers to step forward to voice concerns.

As you will remember, bills SB 107 and HB 138 were passed last session to create a Task Force on Health Care Access and Physician Reimbursement. We alerted legislators to the need for an amendment to the legislation to expand the reach of the Task Force beyond "all physicians" to include "all licensed health providers." (Special thanks to Senator Kathy Klausmeier and Delegate James Hubbard for representing the concerns of the clinical social workers and getting this legislation amended.)

The newly-created Task Force has met twice since the end of the session, and will continue through next year; it will be preparing a draft report for its December 14 meeting. Our clinical social work coalition has written to John Colmers, Secretary of Health and Mental Hygiene, to express our support and to let him know that we will be providing data about relevant clinical social work experience.

Next steps for clinical social workers

GIven the acceptance of our proposal to include all licensed health providers in the Task Force mission, we can consider ourselves "invited to the table." The next step is for legislators to get to know who clinical social workers are and what you represent, not just concerning reimbursement but about the many mental health issues important to you and your clients. Your lobbyist can speak for you, but the more involved you yourselves become, the more you can count on legislators to include your issues when they consider policy change. ❖

Alice Neily Mutch of Capital Capital Consultants of Maryland represents the coalition of the Greater Washington and Maryland societies for clinical social work in Annapolis, advocating for social work issues and guiding our legislative and grassroots efforts.

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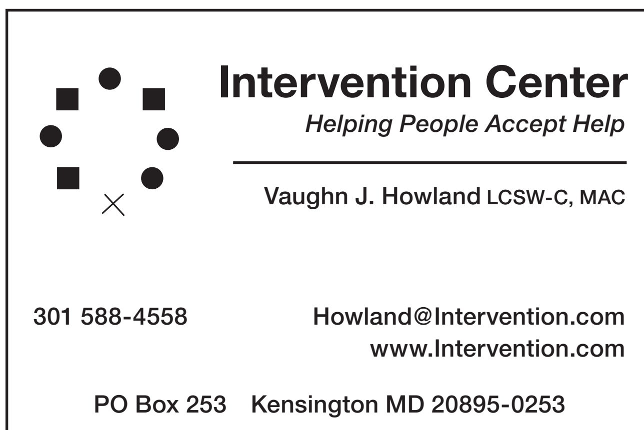
■ VIRGINIA

A notice of proposed changes to the Virginia social work licensing regulations was posted online on October 29, 2007, and will be up until December 28, 2007. Find it via the Virginia Board of Social Work website—click on Laws and Regulations on the home page, then, under Proposed Regulatory Action – Amendments to regulations proposed by the Board, click on Proposed Regulations Governing the Practice of Social Work. The public hearing was November 16, but the Board welcomes public comments in support or opposition of the changes up to December 28.

One of the significant changes is in the area of supervisory training and registration requirements. There are also changes in record-keeping and confidentiality requirements.

A highly significant change has been proposed for the time period during which a sexual relationship with a client is prohibited after the professional relationship has ended. Originally such a relationship was not permitted at all for licensed social workers, but a few years ago, when the psychologists established a minimum of two years, the social work regulation was changed to match. The current proposal is that the minimum elapsed time be five years, as it is for licensed counselors.

The proposed Virginia regulation adds: "Social workers who engage in such a relationship after five years following a termination shall have the responsibility to examine and document thoroughly that such a relationship did not have an exploitive nature, based on factors such as duration of therapy, amount of time since therapy, termination circumstances, client's personal history and mental status, adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a social worker does not change the nature of the conduct nor lift the regulatory prohibition."



The Code of Ethics for clinical social work printed in the GWSCSW Directory each year stipulates the following: "Clinical social workers do not, under any circumstances, engage in romantic or sexual contact with either current or former clients." (Clinical Social Work Association Code of Ethics II, 3, b)

GWSCSW members are encouraged to send their written comments to Evelyn Brown, executive director of the Virginia Board of Social Work, 9960 Mayland Drive, Ste 300, Richmond, Virginia 23233 or, via email, to elaine.yeatts@dhp.virginia.gov. ❖

■ DISTRICT OF COLUMBIA

Margot Aronson

Over the past year, GWSCSW has been urging the DC Board of Social Work (DC-BSW) to review the licensing law and regulations for clarity and consistency of purpose. The Board is taking a very important first step in developing a working definition for case management, and we've been invited to participate actively in that process. Bonnie Gallagher, long active in GWSCSW and a DC-BSW member, tells us more on these pages.

A brown bag lunch with Councilman Wells

In September, NASW hosted a lively brown-bag lunch meeting for Councilman Tommy Wells; some forty social workers met to discuss child welfare and other issues. The possible declassification of jobs which currently require LICSWs was a topic of particular interest. Wells told the group that Child Protection work is now governed so much by computer-generated requirements and restrictions that LICSWs find the work tedious and frustrating rather than fulfilling; turnover is very high.

Several participants countered that an agency finding it difficult to keep LICSWs would likely find it difficult to hold the interest of non-LICSWs as well, and recommended taking a new look at any approach that relies so heavily on computer-generated decision trees rather than skilled social worker judgments. Lack of worker support by management was also cited as a possible reason for turnover.

NASW and GWSCSW are working together to follow up on declassification and other issues raised at the September brown bag; members are very welcome.

Community coalition shifts gears

The CareFirst Watch Coalition is a loose association of community-minded organizations (including GWSCSW) created in response to the scandalous attempt by the CareFirst BlueCross BlueShield around five years ago to negotiate a buyout to a for-profit insurance company, with multi-million dollar bonuses promised to departing executives.

Once the buyout had been stopped, the Coalition put the spotlight on the failure of the behemoth non-profit to contribute to the community as per its charter.

The Coalition continues to keep CareFirst and its obligations in the spotlight, but is now evolving to examine other serious health care access, delivery, and insurance problems as Mary Lee Stein describes below.

Margot Aronson, LICSW, is GWSCSW vice president for legislation and advocacy. She maintains a private practice in the District.

Beyond CareFirst Watch

Mary Lee Stein

The GWSCSW Legislative Committee is working to develop the most effective way to be good advocates for the uninsured and vulnerable of our city.

As many of you know, CareFirst Blue Cross Blue Shield is no longer obligated to provide Open Enrollment health insurance in the District, and is expected to discontinue that program next year. The absence of an Open Enrollment program will increase the rolls of DC's uninsured—already a significant number.

The City Council is considering possible replacements for the CareFirst Open Enrollment program; the Commissioner of Insurance is expected to recommend some form of replacement in mid-October.

Interested parties, in particular those of us who have been involved in the CareFirst Watch Coalition, are examining the existing proposal as well as the high risk programs of other states, as we try to become as familiar with and knowledgeable as possible about this complex and very important subject.

GWSCSW involvement ensures that mental health needs are considered as the new program is developed.

Mary Lee Stein, LICSW, has been representing GWSCSW on the steering committee of the CareFirst Watch Coalition since its inception. Long active in the Society, she is in private practice in Tenleytown in the District.

DC Board of Social Work

Bonnie Gallagher

Professional boards exist to protect the public. It is our responsibility to make decisions based on the law, and, when necessary, to clarify the existing language in those laws.

Many of us can remember when the public was not adequately protected against unfair practice and unprofessional practice; indeed, many GWSCSW members were among the pioneers who lobbied for licensure to establish social work standards that the public could trust.

Over the past decade, however, our profession has expanded tremendously, and the use of para-professional practitioners for community service work has also expanded. Given the confusions and conflicts that have arisen, the Board of Social Work has decided to explore the language of the DC Health Occupations Revision Act (HORA) with regard to social work functions such as referral, advocacy, mediation, consultation, research, administration, education, and community organization, with a goal of defining where licensure is needed and where it is not necessary.

A Board committee is charged with reviewing the language and current realities, and formulating recommendations for the Board's review. The committee plans small group meetings as well as an open forum for the larger community. We welcome your suggestions on ways to make the process productive, pleasant and most of all useful. Clinical, educational, and administrative social workers are encouraged to participate, as are policy makers, teachers, and community organizers. Those of you who are retired or semi-retired can add another valuable dimension.

Please direct your comments to this writer at 202) 244-1821 or bonniegallagher@verizon.net. They will be shared with the entire board as we all work to protect the public. ❖

Bonnie Gallagher, LICSW, serves on the DC Board of Social Work and will be chairing the committee. In addition to her private practice in the District, she sees clients at the Green Door, is active with GWSCSW and president of the Association for Psychoanalytic Thought, an affiliate of the Baltimore Washington Center for Psychoanalysis.

Slowing It Down: Parenting in an Age of Anxiety

Jen Kogan

"Feelings of worth can flourish only in an atmosphere where individual differences are appreciated, mistakes are tolerated, communication is open, and rules are flexible." ~ Virginia Satir

The level of anxiety in Washington is increasing by the minute. For the parents I see in my practice, stress is high and people rarely have much down time. Too often they seem to be on the lookout for a recipe for success. This outlook often misses the mark and can leave entire families feeling unheard and alone.

What can be done to support parents who sometimes start worrying about getting their baby into a good school when he/she is just a few months old? I often listen to (mainly mother's) fears about the harm of even a few minutes of television, feeding the wrong type of cracker, the need for effective brain stimulation, and more. More than once I have heard mothers admit that they feel they have to be always "up" for their children and that they often hold themselves back from showing any sadness, anger, or fear in front of them.

In this culture of unease, it can help to slow everything down. I often ask clients to think about how they felt growing up in their own families of origin. What was the stress level on a scale from 1 to 10? How did their parents handle discipline with them and their siblings? How about affection? How was that displayed? Often, the answers to these questions can shift the viewpoint away from performance and turn instead to meeting the child where he/she is at this moment. I ask clients to wonder to themselves, "What is the need that is trying to be met here? This the best question to ask yourself first and then to pose to your child as you traverse each day's hills and valleys."

What strengthens a family is a sense of unity and purpose. I encourage parents to nourish themselves both as individuals and then together as a couple. This is because it is much easier to parent when you are feeling joyful and strong. I introduce the idea of guided imagery to parents. Trying this at home can empower both parent and child. Other techniques to foster a greater sense of connection include creating a family crest or symbol together and holding regular family meetings where everyone gets a chance to talk.

There will always be days, weeks, or months where stress can occur in a family. I believe that remaining open and playful can quiet the fears and allow clients to walk calmly beside their children into the world that awaits them.

Jen Kogan, LICSW is in private practice inTenleytown where she sees children, teens, adults, and families.

GWSCSW Continuing Education presents…

New Directions for Therapists: Couple & Family Work in the 21st Century

Thurdays, March 27 & April 3
12:30 – 2:30 PM
Presenters: Jen Kogan & Nancy Markoe

This two-session course will explore the specific needs of the 21st century family and how therapists can help couples with children navigate life's challenges. Using Couples on the Fault Line (edited by Peggy Papp) as our primary resource, we will outline new directions for therapists. Participants will be encouraged to share examples from their practice as we explore partnerships in the new millennium.

Member: $60 / Non-Member: $100

4 CEUs

For registration information, see page 29
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OUT & ABOUT

This column shares news about members' professional accomplishments—our publications, speaking engagements, seminars, workshops, graduations—as well as our volunteer projects and special interests or hobbies. Here is what some of us have been up to…

Dan Campbell was interviewed for a *Washington Post* KidsPost article that was published on Halloween. The article was titled "What Are You Afraid of?" and was about how kids can cope with their fears.

In November, Golnar Simpson, Alice Kassabian, and Dolores Paulson took a road trip to visit **Martha Cheschire** in Chapel Hill North Carolina. They found her to be healthy, vibrant, and enjoying her retirement. She takes courses and writes prolifically, as usual!

Deborah Horan was honored by the Montgomery County Business and Professional Women organization as one of nine Women of Acheivement for 2007. Deborah was recognized for her six years of service on the Montgomery County Commission for Women, two of those years as President, and for her long-standing efforts to address issues affecting women, especially in the field of sexual and domestic violence prevention.

Ruth Neubauer has just qualified to be a judge for photography shows. Her website: www.liminalspce.com is now updated with some new photographs. In addition, Ruth and Karen Van Allen spent a day in San Francisco working in a company setting with 80 men and women on their questions regarding WHAT NEXT TM as the company had two recent downsizes and will be expanding their work to include similar situations; it was very successful.

Dolores S. Paulson was inducted into the National Academy of Practice in Social Work as a Distinguished Practitioner on November 3 at a black tie dinner. This honor is a recognition of her many years of interdisciplinary practice as well as her efforts on behalf of the social work profession on the local, state, national and international levels.

Dr Paulson joins other GWSCSW members who are National Academy of Practice Distinguished Practitioners: Golnar Simpson, Audrey Walker, Joel Kanter, Alice Kassabian.

Grace Riddell gave a workshop on "Transitions or It's All About Change" to the "Over 50 Women's Group" at Whitman Walker Clinic Lesbian Services Program on September 15, 2007. The most dramatic story told was by a woman in her fifties who had suffered a breakup in her long-term relationship and decided to leave her job and take off on an automobile trip by herself to Alaska. She said that she learned that she was pretty good company and that she enjoyed being with herself despite having been recently rejected by her partner. She also drove back by way of her 85-year old mother's house to make a visit. They had been estranged for over 30 years because of her mother's disapproval of her lifestyle. Although this was a more dramatic depiction of transition than most, this woman showed how "doing something different" can change your life. There were other stories that could fill a book on how closeted lesbians have lived their lives---they are the invisible population.

Melinda Salzman collaborated with fabric artist Helema Kadir to present a workshop to staff at Omega Institute in Rhinebeck, NY. The topic was "Transforming Grief: Telling Your Story through Fabric Art." Participants made a piece of fabric art to honor either a death or another sort of loss.

Karen Soltes gave a presentation at the Maryland Association of Nonpublic Special Education Facilities (MANSEF) in November on Yoga for Children and Teens with Special.Needs. This month at Circle Yoga, Karen will be teaching a workshop on Yoga for Depression and she will also teach a workshop on Yoga Nidra at the studio. Karen says she is continuing to cultivate the intersection between the practice of yoga and psychotherapy

In 2006, the Austrian Embassy in DC hosted a Freud symposium to honor the 150 year anniversary of his birth. Many distinguished colleagues presented, including members of both the AAPCSW and the GWSCSW: **Judy Kaplan, Golnar Simpson, Katherine Brunkow, Miriam Pierce,** and **Audrey Walker**. All of the papers are available online at http://www.acfdc.org/freud- symposium- transcripts/ ❖

Send your information for Out & About to newsletter co-editors, Jen Kogan (koganblackwell@verizon.net) or Maya Godofsky (maya_beth@yahoo.com).

A One-Day Conference for Mental Health Professionals
Co-sponsored by IPI Metro and the NASW Washington Chapter of NASW

The Body in Psychoanalytic Psychotherapy

with Dr. Frances La Barre and Jacqueline Carleton, PhD

Saturday, March 8, 2008

9:00 AM – 5:00 PM at the offices of NASW Metro

Description

Freud's statement (1923) that "the ego is first and foremost a bodily ego" was somehow subsequently overlooked by both Freud and his followers. However, thanks to developmental and object relations theorists as well as neuroscientists, the primary experience of the body as conveyer of the individual's sense of self has regained attention and significance in psychoanalysis.

In this conference we will explore not only the ways in which psychoanalysis has historically approached the mind-body dichotomy, but also how the eminent place of the body and bodily-felt emotions has been reclaimed in the psychotherapeutic process. Focusing our analytic attentiveness on the process of embodiment allows us to deeply understand our own experiences and further advance the integration of mind, body and feelings.

About the Presenters

Jacqueline A. Carleton, Ph.D. is a NY State licensed psychoanalyst and has maintained a private practice in psychotherapy in New York since 1976. She is a senior faculty member of the International Core Energetic Institutes, and has been teaching extensively in Europe and Latin America (and more recently, the Middle East) for over 30 years. She is on the Board of Directors of the US Association for Body Psychotherapy, and is the founding editor of the USA Body Psychotherapy Journal. Dr. Carleton is also a consultant to ProHealth Care Associates, Department of Neurology and Integrative Pain Medicine in New York.

Frances La Barre, Ph.D. is psychoanalyst in private practice in NYC. She is the author of *On Moving and Being Moved: Nonverbal Behavior in Clinical Practice,* (Analytic Press, 2001), "The Kinetic Transference and Countertransference" *(Contemporary Psychoanalysis,* April, 2005), and other articles on the impact of movement on the psychotherapeutic process. She teaches and supervises at the Psychoanalytic Psychotherapy Study Center, The Institute for Contemporary Psychotherapy, and at The Center for Somatic Studies in New York, and at Art Therapy Italiana in Bologna, Italy.

Registration

NASW Metro
Call 202-336-8395 or visit www.naswmetro.org

Sound Investing During Market Volatility

Peter H. Cole

Peter Cole

Recent increases in the volatility of the financial markets have many clinicians thinking about their portfolios and wondering if they should make changes. Therefore, this is an excellent time to discuss the importance of maintaining a disciplined approach to diversified investing.[1]

Here are four key points to keep in mind about disciplined, diversified investing during periods of market volatility:

1. Diversification is a tool designed to reduce risk. In the financial markets, risk and reward go together. Higher reward investments tend to carry greater risk. Although all investors would like nothing better than a high reward investment that carries low risk, it is important to remember how rare that is. When one diversifies one's portfolio, it is to reduce risk. We do not diversify in order to maximize reward, rather we diversify in order to reduce risk and portfolio volatility.

2. If one's portfolio is properly diversified, then one need not carry around a great deal of anxiety about the daily ups and downs of the market. With the reduced volatility that proper diversification brings, one need not become either exultant in an up market nor dejected in a down market. Instead, one maintains a centered, approach to long term investing – not overreacting to market volatility.

3. Asset allocation and diversification is best done by calendar rather than by reactivity to market conditions. One of the biggest traps for investors is to get excited and buy when markets are rising (thereby buying high) and to get scared and sell when markets are falling (thereby selling low). The best way to avoid this is to review one's asset allocation at a regularly scheduled account review.

4. One of the best ways to build wealth is to take a longer time horizon to your investments. Sound investments, held over a long time horizon is the approach that we find works best. As Warren Buffet has said "in the short term the stock market is a voting machine, in the long term it is a weighing machine." In a short time horizon, emotions and group psychology rule the ups and downs of the markets. In the long term, the fundamental value of sound investments will rule the day.

Investors may well be in a better position to ride out the short term volatility we see in today's markets by maintaining the discipline of diversified asset allocation with a longer time horizon. ❖

Peter Cole, LCSW is a Chartered Financial Consultant, director of Insight Financial Group[1] and Clinical Professor of Psychiatry with UC Davis School of Medicine. His book, *Mastering The Financial Dimension of Your Practice: The Definitive Guide to Private Practice Development and Financial Planning* is available through Amazon.com. His new book, *True Self True Wealth* is due to be published in October. Peter can be reached at (800) 426-1399; www.trueself-truewealth.com

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[1] An asset allocation or diversification strategy does not guarantee a profit or protection from loss in a declining market.

GWSCSW BOOK CORNER

Our Book Corner celebrates the works of GWSCSW authors. Please contact us at jenniferkogan@verizon.net or at maya_beth@yahoo.com with information about your publications.

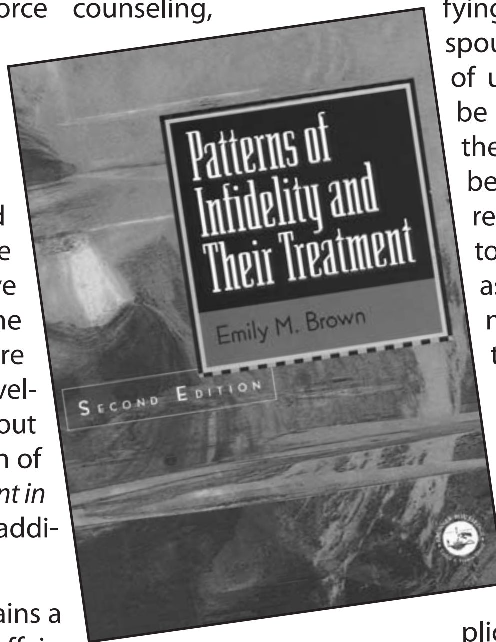
Erin Gilbert

Patterns of Infidelity and Their Treatment

Emily Brown, MSW, LCSW

Emily Brown

For Emily Brown, a difficult split with her husband roused her interest in the subject of divorce. As she researched the topic and developed a practice that included divorce counseling, her curiosity broadened to encompass the subject of affairs, particularly because she found that many people assumed divorce and infidelity were linked. She described how she did not observe this to be true in all divorces, but she did observe a lack of clinical literature about infidelity in general. Brown developed a desire to educate clinicians about affairs, which resulted in the creation of *Patterns of Infidelity and Their Treatment in* 1991, published with revisions and additions in 2001.



Brown reported that her book contains a typology of couples dealing with affairs, including categories such as conflict avoidant and intimacy avoidant, and also identifies treatment concerns and goals, and strategies for therapists. The book explores other issues such as children and affairs, violence and affairs, and the legacy of affairs in families. Brown noted that she debunks several myths surrounding infidelity throughout the book. First, she asserts that affairs are not a simple matter of identifying the good spouse and the bad spouse; rather, affairs are symptoms of underlying issues which need to be explored. Second, she states that the victim of the infidelity should be directed to speak about the pain resulting from the infidelity in order to help the individuals heal together, as opposed to railing indeterminately regarding the overall injustice of the affair. Next, Brown emphasizes that affairs do not always indicate the end of all marriages and instead can be viewed as powerful opportunities to explore and resolve underlying issues. Finally, she maintains that therapists cannot remain complicit in keeping affairs secret, a situation that often occurs when a therapist believes that disclosure would be terrible for a couple. Brown alleges that affairs should be considered catalysts of change, and *Patterns of Infidelity and Their Treatment* includes a discussion of how to facilitate such disclosures.

Brown recommended *Patterns of Infidelity and Their Treatment* for any clinician working with adults, either individually or as a couple. She noted that her companion book, *A Guide to Working through the Repercussions of Infidelity,* may be valuable for clients and other lay people struggling with affairs.

GWSCSW member Erin Gilbert is a social worker with the Linkages to Learning Program through Kensington Wheaton Youth Services.

DID YOU KNOW…

A purchase from Amazon.com made through the GWSCSW web site results in a contribution to your Society!

Go first to

www.gwscsw.org

and click the Amazon button!

GWSCSW Continuing Education Courses

Issues and Interventions in the Treatment of Grief and Loss

Because loss is a universal phenomenon, practitioners need to be equipped to address it, whether the client is talking about a recent loss or one that occurred earlier in life. This course will familiarize practitioners with the dynamics of mourning and typical patterns of grieving. With increased understanding, practitioners will be able to more skillfully help individuals and families. Qualifies for 4 hours towards ethics requirements.

Melinda Salzman
8830 Cameron Street, Ste 503
Silver Spring, MD 20910
301-588-3225

4 Fridays, January 11, 25 & Feb. 1, 8
10:00 AM – 12:00 NOON
Member: $120 / Non-Member: $200
8 Hrs.

Empowering Remarried Families: Assessment and Intervention

Increases in life expectancy and divorce have led to an explosion in the number of marriages wherein at least one partner has previously been married. Both adults and children within these complex family systems face special challenges as well as opportunities. This course will assist clinicians in assessing and working effectively with remarried families. Specific topics will include: types of remarried families; characteristics, tasks and assessment of the remarried family system; strengthening the remarried family system; supporting stepparents and birth parents; and assisting children and stepchildren.

Jonah Green
3930 Knowles Avenue, Suite 200
Kensington, MD 20895
301-466-9526

Sunday, January 28, 2008
10:00 AM – 1:00 PM
Member: $45 / Non-Member: $75
3 Hrs.

The Supervisory Relationship

A two-day workshop for those who supervise or who are considering supervising, with a focus on the relational dynamics between supervisor and supervisee. The underlying assumption is that this relationship is the most significant medium through which clinical social work is taught to practitioners. The primary elements of the supervisory relationship include the use of power and authority, and the development of trust and shared meaning. The process of supervision is seen as one of accountability and the goal is that of insuring competent service to clients. All of this takes place in a larger context, which includes the agency, the community, funding sources and credentialing bodies. Lunch is included both days.

Tamara L. Kaiser
Location TBD
612-825-8053

Friday/Saturday, February 8 & 9
8:30 AM – 3:30 PM
Member: $230 / Non-Member: $350
12 Hrs.

New Directions for Therapists: Couple & Family Work in the 21st Century

This two-session course will explore the specific needs of the 21st century family and how therapists can help couples with children navigate life's challenges. Using *Couples on the Fault Line* (edited by Peggy Papp) as our primary resource, we will outline new directions for therapists. Participants will be encouraged to share examples from their practice as we explore partnerships in the new millennium.

Jen Kogan (202-215-2790)
Nancy Markoe (202-494-6840)
Tenleytown, Washington, DC

2 Thursdays, March 27, April 3, 2008
12:30 – 2:30 PM
Member: $60 / Non-Member: $100
4 Hrs.

Emergency Coverage of Your Practice: Practical and Ethical Considerations

Just as it is important for an individual to write a will to provide for his or her dependents, it is also prudent for a clinician to prepare for an untimely or unanticipated inability to carry out their functions at work. The purpose of this course is to help clinicians anticipate the needs of their clients and their business or the organization where they work, should such an emergency arise. The goal of the course is to enable participants to identify individuals who could step in if needed, write instructions for their backup personnel, and distribute these instructions. ***Qualifies for 4 Ethics credits.***

Melinda Salzman
8830 Cameron Street, Ste 503
Silver Spring, MD 20910
301-588-3225

2 Fridays, May 2 & 9, 2008
10:00 AM –12:00 NOON
Member: $60 / Non-Member: $100
4 Hrs.

GWSCSW COURSE REGISTRATION FORM

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Address ____________________

City ____________________ State _____ Zip __________

Home Phone (_________) ____________________

Office Phone (_________) ____________________

Email ____________________

❑ GWSCSW Member

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Payment Enclosed: (make check payable to GWSCSW) $__________

Please return to:
GWSCSW, PO Box 3235, Oakton VA 22124

Questions? Call 202-537-0007

NEW MEMBER SPOTLIGHT

A series of articles profiling our new members.

Barbara Shaffer, MSW

Constance Ridgway

At the urging of our Treasurer, Ted Billings, Barbara Shaffer recently became a member of the Clinical Society. Barbara had just become Program Manager of a new organization in the DC area, the Wellness Community—Greater Washington DC, an organization dedicated to providing support, education, and social events for people living with cancer. She wanted to get to know people who could provide individual counseling to the patients at the Wellness Community, as well as become more connected to clinicians in other aspects of social work practice. She says she is honored to be part of an organization with so many people who have a depth and breadth of experience in the field.

Barbara was raised in Ithaca, New York. She says she was "always the person that people came to; being the family problem solver came naturally to me." She graduated from Cornell University with a psychology degree, but didn't see herself going into clinical psychology. She worked in law firms until a friend asked if she'd ever considered social work. She realized that going into social work "totally fit with my mindset."

By then Barbara was in the Washington DC area, married with one child. By the time she graduated from the Northern Virginia social work program of Virginia Commonwealth University in 1994, she was pregnant with her second child. She decided to take time to be a stay-at home mother until her son started Kindergarten in 1999.

Barbara's two internships in school were both in health care, the first at the Washington Hospital Center's burn unit, and the second at George Washington Hospital's outpatient cancer center. She enjoyed the health care setting and being part of a multidisciplinary team, so when she returned to work, she started at Columbia Hospital for Women's outpatient clinic. The clinic's population tended to be underserved, lower income women with a range of needs, including mental health, domestic violence and unwanted pregnancy. She also worked in the teen clinic and the oncology unit.

Barbara's former field instructor from George Washington gave her a much-desired opportunity when she announced she was leaving her position at the hospital's outpatient cancer center and asked Barbara if she wanted to apply. Barbara was the only social worker there for seven years. The center sometimes had up to 100 patients per day, a "wild and crazy ride." Barbara learned how to deal with people under very stressful circumstances. She found she "absolutely loved" working with people in crisis, helping them to find their inner strength and a way through.

Barbara learned to feel very comfortable with people facing advanced stages of illness and death, and with helping their families to cope. She learned to navigate this landscape which, although very sad at times, helped her find her niche and showed her that she is unafraid to work with people who are "looking death in the eye." This experience has helped Barbara learn about living in the moment, making choices to live life the way she wants it now, not waiting until she retires. She chooses to live by her values and not waste a lot of time with things she doesn't care about.

Toward the end of her seven years at George Washington, Barbara began to think about growing a new program, one that would reach more people by working with groups instead of one individual at a time. At GW there wasn't space or money to grow a large program. Then a new opportunity arose: she learned about the Wellness Community from a colleague through the Cancer Consortium (a group of over 60 different organizations in the DC area dedicated to reducing disparities of care in cancer treatment).

The Wellness Community is a nationwide organization with over 25 facilities across the country. Each center is fully self-supporting, garnering its own financial and social support. Dr. Harold Benjamin, whose wife had breast cancer, founded it in 1982. They found there were few places, if any, which provided pro-active

continued on page 33

OUR ONLINE SOCIETY

This column reports on questions that have been raised on the GWSCSW listserv, with some of the responses.

Topic: How do you all identify yourself on business cards, stationary, etc? I am just starting a private practice and was thinking of putting my name and degrees on one line and "clinical social worker" on the second line. I am not sure if it is necessary to put LCSW-C on the cards—would I put it right after my degrees?

… You'll definitely get conflicting advice in response to your question. One of my pet peeves is the proliferation of license abbreviations social workers append after their names, most of which the public doesn't understand. In the DC metropolitan area alone, each jurisdiction has a different way of labeling licensed clinical social workers: LCSW, LICSW, and LCSW-C. Psychologists and psychiatrists are also licensed, but they don't list anything except their highest degree. My own view is that social workers should do the same.

… I always put my degree and license info on cards and stationary after my name (MSW, LCSW-C). Unlike clinical psychologists, there is ambiguity re the legal status of an MSW and I think it is important to let people know that I'm licensed at a level for independent practice. More and more laypersons understand these letters (or sometimes they ask about their meaning which is fine with me).

… You've touched on a subject that relates to pride in our discipline, social work. While most professionals identify themselves by their academic credential (MD, PhD, JD, etc.), for some reason social workers began, some time ago, to identify themselves by their licensure (LCSW, etc.). My personal theory is that social workers felt there was no recognition of or respect for the degree "MSW." Meanwhile, we gained licensure and recognition from insurance companies, some 30 years ago, and we were very proud of that accomplishment. So we started hanging out our shingles as LCSWs, CSWs, LICSWs, LCSW-Cs, whatever the state licensure calls us. I think it's time we take pride in our fine academic training, and fall in line with other professions. It's time to put "MSW" after our names.

… I completely agree. I have my degree after my name. The next line states: Licensed Independent Clinical Social Worker (so lay people know I am licensed). And under that I have Individual, Couple and Group Psychotherapy (which describes what I do). I, too, think that social workers do not need an alphabet soup after their names.

… I always just use LCSW or LCSW, BCD after my name because that is the official designation in our profession of the highest level of clinical training/status/supervision that is required for being in private practice. By definition, you have an MSW if you are licensed at the highest level. I would much rather have people ask what an LCSW is than an MSW. This is not a "designation for insurance," it is our profession's attempt to set standards that are similar to other professions and can be communicated clearly to the public.

Ann Wroth, LCSW-C, works at NAMI, the National Alliance for the Mentally Ill. A member of the newsletter editorial board, she compiles and prepares our Online Society for each issue.

SAVE THE DATE

Washington Professionals for the Study of Psychoanalysis (WPSP), a chapter of Division 39 of the American Psychological Association

proudly presents
a very special event

Applying Western Psychological Concepts in Bhutan, a Traditional Buddhist Country

Dialogue And Multi-Media Presentation

with

Dr. Chencho Dorji
Currently a Hubert Humphrey Fellow in Psychiatry, Johns Hopkins University

Sunday, March 30, 2008
2:00 pm – 5:30 pm

National 4-H Youth Conference Center
7100 Connecticut Avenue, Chevy Chase, Maryland

3 CEUs available

INFORMATION
Ruth Neubauer, MSW
301-652-7884/ RuthNeubr@aol.com
Dr. Carolyn Cole
202-232-1031/ Cole O psyche463doc@msn.com

COMMITTEE REPORTS

Continuing Education

Ted Billings
Ted_billings@comcast.net

Our academic year is underway and I encourage everyone to review our course offering listed in the newsletter and on the website and sign up early. Tamara Kaiser will again be traveling from Minnesota to teach her popular class on supervision in February. Due to a scheduling conflict, Kathryn Basham's course on couples work with trauma survivors will be offered after the first of the year. Watch your e-mail and snail mail boxes for an update on the date.

The continuing education committee is looking for a few new members. If you have an interest in serving on the committee, please feel free to talk with me or any of the current members about what commitment is involved and what we get out of our work with the committee.

We will begin planning for the 2008-2009 academic session in January so begin to think about ideas for courses you would like to see the Society offer and what you might be interested in teaching.

Ethics

Judy Gallant
Jg708@columbia.edu

As this copy of the newsletter goes to press, the newly constituted Ethics Committee is about to hold its first meeting. The current committee members are Ellen Eule, Bonnie Gallagher and Nancy Pines. I invite any member of the Society who has an interest in serving on the committee or if you have a concern you would like us to address to contact me, Judy Gallant, chairperson, at the address above. The committee welcomes your expertise and interest.

Legislative & Advocacy

Margot Aronson
malevin@erols.com / 202-966-7749

Our busy committee has begun having legislative committee dinner meetings as a forum for sharing concerns and developing advocacy strategies. Our first dinner brought Bonnie Gallagher, Diana Seasonwein, Mimi Kavanaugh, GWSCSW President Susan Post, and me together for Thai food and a lively discussion of clinical social work concerns in DC, particularly around licensing and around social workers in child welfare work.

Meanwhile, Mary Lee Stein has been representing us on the steering committee of a coalition of community organizations focused on finding a District-wide approach to our underinsured and uninsured residents (see page 23). Advocacy efforts on this front afford our Society an opportunity to promote mental health while at the same time to increase our visibility with the Mayor and Council.

Further, we are highly appreciative of Danille Drake's ongoing work representing us on the DC Confidentiality Coalition; see page 1 for her report, which includes useful guidelines for all DC providers.

In Virginia, Alice Kassabian has been spearheading our efforts on a working group revisiting the licensing law (see page 22). She and Karen Welscher-Enlow trek down to Richmond or Charlotte for bi-monthly Virginia Society Board meetings, where they confer with the Virginia Society legislative committee and Chris Spanos, the lobbyist who represents our two societies with the Virginia assembly.

Alice also attends the VA Board of Social Work open sessions, and I attend the open sessions at the DC Board of Social Work. GWSCSW members serving on these Boards are Bonnie Gallagher (DC Board), and Dolores Paulson and Susan Horne-Quatennens (VA Board).

Our committee's work this quarter has centered on the District and Virginia; attention to Maryland issues has, regrettably, been limited by lack of Maryland member involvement. We have an excellent lobbyist in Alice Neily; Betsy Amey and others in the Maryland Society are active on our behalf in Annapolis. However, Montgomery County and Prince George's County are our GWSCSW responsibility, and the State Senators and Delegates from these counties tend to be movers and shakers. No need to drive to Annapolis: we could establish our credibility and advocate for our causes in the home districts…but it can't be done without members. This year in particular, Maryland mental health funding is slated to take a huge cut—do we want our voices to be heard?

Finding a good time for any meeting is challenging, but we're determined to try to meet monthly to stay on top of issues. We welcome

new participants from any of our three jurisdictions; come to learn and perhaps you'll get involved! Call 202-966-7749 for more information.

Mentor

Sheila Rowny
srowny@aol.com / 301-365-5823

The Mentor Committee has been receiving requests for mentors from new and recent MSW graduates. We endeavor to match people with more senior social workers in GWSCSW who have similar experience and interests as requested. Our latest plea, via the listserv, for specific specialty areas brought prompt replies from several members; thanks to all who responded. We are always looking for volunteers. Mentoring is an easy way to give something valuable back to GWSCSW and social workers new to the field or the DC Metro area. Most Mentor contacts are brief--by phone or in person, and limited in scope. You can read more about the program on the website: www.gwscsw.org. The Mentor program web page also has applications for Mentor and Mentee.

Please download an application, complete it and mail to Sheila Rowny. Call or email with any questions or requests: srowny@aol.com, 301-365-5823.

Because many beginning social workers express interest in transitioning into private practice, we will offer a reprise of the workshop "Getting Started in Private Practice." This will be a panel discussion, probably in Jan. or Feb. A notice will be mailed and posted on the listserv.

Newsletter

Jen Kogan
koganblackwell@verizon.net

Maya Godofsky
maya_beth@yahoo.com

Many thanks to all who have submitted articles over the past few issues. We experience continued amazement at the breadth of material submitted by members. It is this kind of energy that captures the spirit of our Society.

We welcome articles from all members, whether you are new to practice or an experienced clinician. Please consider writing an article for the March issue. The deadline will be in late January. Email us with your ideas regarding your clinical practice or interest(s). We anticipate receiving more pieces that offer a range of topics and interest.

We got a terrific response for editors/proofreaders which has helped tremendously. Thanks to Betsy Carmichael, Alicia George, and Kim Yamas, for their help with editing this issue. What we need now is a photo editor to take photos and/or match articles with pictures. Please contact us if you are interested. ❖

SUPPORT YOUR SOCIETY. . .

JOIN A COMMITTEE!

Welcome New Members!

Full Members:

Hannah Bergland
Gabriel Chernoff
Janet B. Connors
Susan Maguire
Karen Schachter
Karen Soltes
Randi Maines Walters

Graduate Member:

Christa Jeutter Davidson

Student Members:

Barbara Bezmenova
Hilary Hoar

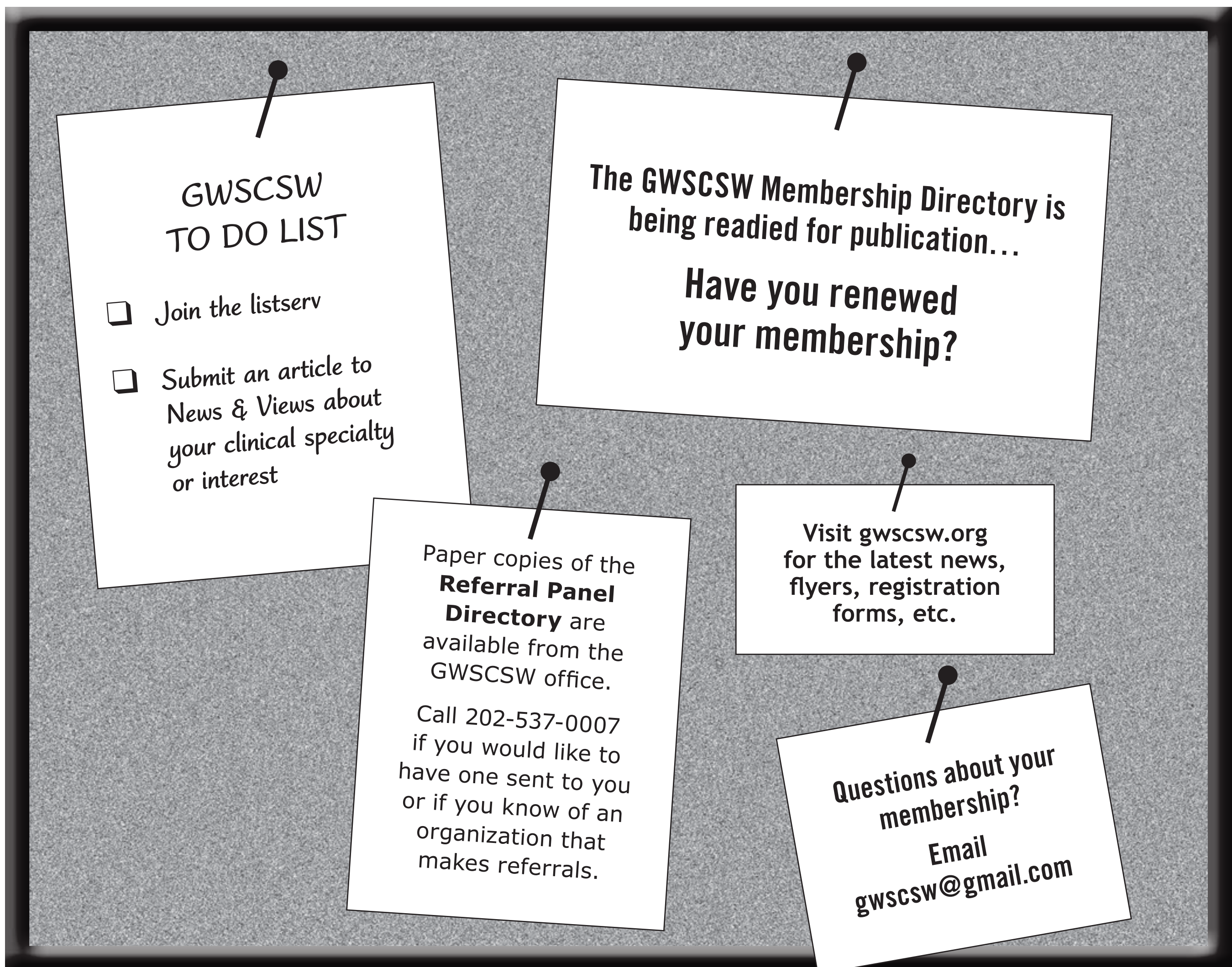
***Shaffer**, continued from page 30*

solutions to living with cancer. The program emphasizes mind-body medicine, emotional support, educational classes about cancer, and social events to help survivors stay connected and less isolated.

The Wellness Community, located on Grosvenor Lane in Bethesda, has already had over 1000 visits since March 2007 when they opened. Barbara is Program Director.

Her enthusiasm, dedication and courage came through as I interviewed Barbara. She is a welcome addition to our membership. ❖

Connie Ridgway, LCSW, LMT, is a licensed clinical social worker in Washington DC and Alexandria VA. Her practice, Full Circle Creative Healing, integrates mind and body therapies.



■ GWSCSW Directory Update / Change of Address, Office Info, Email, etc.

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ADVERTISEMENTS

Advertisements, accompanied by full payment, must be received by the GWSCSW by the first of the month preceding publication.
Material should be sent to GWSCSW, PO Box 3235, Oakton VA 22124 or gwscsw@gmail.com. For questions about advertising, call 202-537-0007.

Classified Ads: 75¢ per word
Minimum price $15 (20 words)

Display Ads:
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Quarter page 3⅜ x 4½.......... $100
Eighth page 3⅜ x 2¼ .... $ 50
Half page $175
Horizontal: 7 wide x 4½ high
Vertical: 3⅜ wide x 9¼ high

Size of display ads indicated above is width by height. These are the only sizes that will be accepted. Electronic submission (PDF) preferred.
Publication does not in any way constitute endorsement or approval by GWSCSW which reserves the right to reject advertisements for any reason at any time.

OFFICE SPACE AVAILABLE

BETHESDA: Furnished, cozy office in suite to sublet Monday and Thursday mornings, all day/eve Tues, Wed, Friday & Saturday. Minimum of four-hour blocks. Great location, walking distance to Bethesda Metro. Contact Marjorie Swett at 301-718-8075 for more information.

DUPONT CIRCLE: Great office space for rent. Large offices with high ceilings and lots of light. There's a shared waiting room with 4 offices. One office is available on Fridays after 1 pm. The other is available on Thursdays after 5 pm and all day Saturday. Please Call Phyllis Hirschkop at 202 232-2155 or e-mail hirschkop@rcn.com.

FALLS CHURCH: Office available in spacious, comfortably furnished suite with private waiting room, restroom and kitchen. Located in the heart of Falls Church with ample parking. Available Monday, Thursday, Friday and Saturday, beginning January 1st. For more information call Carol Joseph at(202) 236-3610 or email woodley01@sprynet.com.

NORTHERN VIRGINIA: Rent block of time or by the hour in our established practice in centrally located Annandale. For more information contact: Roger Rothman, LCSW 703-642-1112 or email at Rothmania@aol.com.

TYSONS: Windowed ground floor office in suite of independent psychotherapy practices. Great Tysons location. Contact Bill McLaughlin at 703-448-8450.

WEST FALLS CHURCH: Sunny townhouse office for sublease in suite of therapists' offices with shared waiting room. Near Metro between I-66 and 495. Available 8-9:30 am, evenings after 6:30 PM, Wednesday afternoon and evening, and all day Friday, Saturday and Sunday. Free parking. Contact Beverly 703-821-3055.

TRAINING

SOCIAL WORK LICENSING: Prep Courses and Home Study Materials. For sample questions, schedule, and information call Jewell Elizabeth Golden, LCSW-C, LICSW, BCD, 301-762-9090.

GROUPS

ADOLESCENT THERAPY GROUPS: Ongoing psychotherapy groups for adolescents 11–22. Offices in Bethesda and Rockville. Call Britt Rathbone, LCSW-C, 301-230-9490. www.rathbone.info.

FREE PEER SUPPORT GROUPS: For children or adolescents who have experienced significant loss (death, divorce, other separation) in Silver Spring. Call RAINBOWS MD/ DC Chapter at 301-495-0051.

EVENTS

The Baltimore Washington Center for Psychoanalysis presents:
"The Use of Female Symbolism in Psychoanalytic Treatment," Saturday, February 23, from 5:00-6:30 p.m. Presenter: Judith Huizenga, M.D.
"Manic Defenses in Adolescents," Saturday, March 8, 5:00-6:30 p.m. Presenter: Thomas Barrett, PhD.
Conveniently located off I-95 at 14900 Sweitzer Lane, Suite 102, Laurel, MD. Contact: 301-470-3635 or 410-792-8060. For more information on our events, see www.bwanalysis.org

One of the most popular benefits of GWSCSW membership…

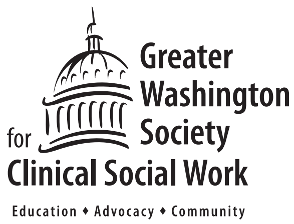
The GWSCSW Listserv!

The listserv has become our primary up-to-date method of communication about dates to remember, meetings, gatherings, continuing education seminars, deadlines for renewals of membership, legal plan, and other participatory activities.

The listserv is also a valuable resource for sharing information on issues related to ethical dilemmas, insurance, referrals, private practice issues, educational resources, and just about anything else you may want to know.

You can choose to receive the listserv emails one-by-one or as a digest which comes as one email per day and includes all postings.

To join the LISTSERV, email: GWSCSW@gmail.com



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