

Clinical Update

California Society for Clinical Social Work



Volume XLIV Number 2, September 2012

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Acceptance and Commitment Therapy (ACT): Be Present, Open Up, and Do What Matters Most

By Bree Rhodes, MA, MFTI

Let's say that I really love my partner; I really value his support, commitment, and compassion in our relationship. And let's say that these are also values that I want to adopt for myself as a partner in this relationship. After a full day at work, I head to the grocery store to buy tonight's dinner. When I return home to my partner, laden with heavy grocery bags, the first thing I see is a sink full of dirty dishes waiting for me when I am ready to cook dinner. However, this is not the first time this has happened, so my mind quickly stew on previous experiences of the same area of contention. And whilst this is happening, I start to fuse with the frustration and annoyance that I initially felt. I react by becoming quiet and withdrawn, while my partner greets me with pleasantries and "welcome home" kisses and hugs. But I ignore these gestures because all I can think about are the dirty dishes; and "why aren't they done" quickly turns into old stories too long to dictate here. As I turn my back on him and drop everything to attend to the dirty dishes, he can see that something is wrong and asks me if I'm okay. I mumble "fine" (which Steven Tyler from Aerosmith, 1989, calls "F'd up, Insecure, Neurotic, and Emotional"). His lavish displays of love and happiness in our present moment are lost on me as I struggle with unhelpful thoughts and feelings, and become tangled with old stories, all of the past. With some small awareness that this *is* happening and that I am only making it worse by not doing anything helpful or value-driven about it, I become engulfed in secondary painful feelings of guilt and regret which only add to my initial suffering and pain. End result: I leave unfulfilled my value of being a loving, supportive, compassionate partner in a loving, supportive, compassionate relationship; I invalidate my true feelings and desires while creating more suffering for myself with the help of listening to old stories and unhelpful thoughts that color my present; and, at the end of the day, I am left doing the dishes.

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District Meetings

Greater Los Angeles District:

District Coordinator: Lynette Sim
District Coordinator Phone: 310-394-7484
District Coordinator Email: lsim1@verizon.net
Date: September 8, 2012
Time: 10:30 am to 1:00 pm
Topic: **Pets and Attachment**
Presenter: Pat Sable, PhD
Location: 3267 Corinth Ave, Los Angeles, CA

You may not have a Fido, Fluffy or Nemo at home but 77% of American households do and someone from one of those homes is going to be in your office. Many of us have heard some version of "I love my kids, spouse etc., but my pet is also a big part of my family." There is significant scientific evidence that the emotional ties people have with their pets are profoundly important on a variety of levels. During Katrina many people wouldn't leave their homes without their pets.

Companion animals give comfort and pleasure, can reduce loneliness, anxiety, depression and isolation. Please join us as Pat Sable, Ph.D, practitioner, Adjunct Professor at the University of Southern California School of Social Work and pioneer in the study of attachment presents on this very timely and important topic. Dr. Sable has published extensively on application of attachment theory in clinical practice with adults and authored the book, "Attachment and Adult Psychotherapy." Dr. Sable is very interested in the powerful and meaningful attachments people form with their pets. This promises to be a lively and informative presentation.

Members earn 1.5 CE credits at no cost. Credits for non-members are \$10.00 per unit. Non-members are welcome and may attend at no charge (no CEU certificate). MSW students are encouraged to attend as are all interested clinicians regardless of degree or license. Our meetings are open to all regardless of geography so if you see something you like please attend.

We meet at the home of Judy Messinger, 3267 Corinth Ave., LA, 90066. 2 and ½ blocks south of National, 1 block west of Sawtelle. Corinth does not intersect with National, within a mile of the junction of the 10 and 405.

Please make sure to RSVP to Judy so there is enough seating, handouts, etc. at 310-478-0560 or messingerlcsww@yahoo.com.

Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

(Continued on Next Page)

District Meetings (cont'd)

Greater Sacramento District:

Coordinator: Stephanie Brodsky
Coordinator Phone: 916-455-4778
Coordinator Email: StephanieBrodsky@msn.com
RSVP: To Coordinator
Date: September 15th, 2012
Time: 1:30 pm to 4:00 pm (1:30 – 2:00 Socializing & Networking; 2:00- 4:00 Presentation)
Presenter: Elizabeth D Bower, RN, MFT
Topic: **Jungian from the 2nd half of life: a perspective**
Location: Friends Meeting House, between H & J St, 890 57th Street, Sacramento, CA

Ms. Bower will present briefly on the first half of life and then will use fairytales that speak to the tasks for the "second half" of life. She will use this as a backdrop for weaving in the psychological tasks of this "second half" of life. This will be an interactive presentation. Ms. Bower is a certified Jungian psychoanalyst and member of the San Francisco CG Jung Institute. She has been in private practice in Sacramento since 1980, prior to that she was affiliated with the University of California Davis, Department of Psychiatry as clinical staff and clinical faculty.

CSCSW members earn 2 CE credits at no cost. Non-member LCSWs and MFTs may obtain credits for \$10.00 per unit. Non-members are welcome at no charge, no CEU certificate. Everyone is invited and we especially encourage MSW students to attend. Course meets the qualifications for 2 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

San Fernando Valley District

Coordinator: Tanya Moradians, PhD., LCSW
Coordinator Phone: 818 783-1881
Coordinator Email: TMoradia@ucla.edu
RSVP: To coordinator
Date: Sunday, September 9, 2012
Time: 10:00 am to 12:00 pm
Presenter: Elaine Leader, PhD, CGP, FACPA
Topic: **Saving Lives: Teen Suicide Prevention**
Location: Sherman Oaks Galleria Community Room (At Sepulveda and Ventura)
(First level near the Cheesecake Factory – parking will be validated)

When dealing with a suicidal crisis many people fear that they will say something that might upset the suicidal person and precipitate their suicide. This workshop examines the warning signs of teen suicidal behavior and how to intercede with the suicidal teen. Appropriate resources and referrals are explored as well as handling the aftermath of a suicide in order to prevent contagion or copycat incidents. A panel of suicide survivors share their personal experiences to increase understanding of teen depression and suicidal thinking as well as to prevent stigmatization of this issue. Dr. Leader is Co-founder and Executive Director of TEEN LINE, Cedars-Sinai Medical Center, and is a consultant to law enforcement and the media in addition to her private practice

CSCSW members earn 1.5 CE credits at no cost. Non-member LCSWs and MFTs may obtain credits for \$10.00 per unit. Non-members are welcome at no charge, no CEU certificate. Everyone is invited and we especially encourage MSW students to attend. Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

(See Page 17 for **South Bay/Torrance** September District Meeting)

THE SIXTH ANATOMY OF INTIMACY CONFERENCE

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Nine Ideas I Wish I Had Known as a Beginning Therapist

By George Rosenfeld, Ph.D.

As a baby boomer psychotherapist approaching retirement I have been thinking about the need to preserve some of the useful ideas that I fear are in danger of being lost to the next generation of therapists who are being trained to provide short-term, evidence-based treatment. If I had honored these ideas earlier in my career, I would have been a better therapist. CAUTION: Some of these ideas may be untested or untestable by research.

Become aware of your countertransference reactions.

Psychotherapy involves a struggle to notice and manage the therapist's personal feelings so they can be therapeutically helpful. Defined broadly, countertransference refers to our conscious and unconscious reactions that are awakened by the experiences and feelings of a client and our interaction with the client. All our responses in therapy are, in part, influenced by countertransference. As Anais Nin put it, "We don't see things as they are. We see things as we are." So, wherever you go, you bring yourself along; and you open your mouth and your Mother comes out. Our understandings, assumptions, and feelings during therapy are filtered through our needs, expectations, limited experiences, past dramas, life scripts, lessons taught by previous clients, and the role models living in our basement. Like Whack-a-Mole, our needs and biases keep poking up and can interfere with our attempts to be present and objective. Instead of reacting to the client and what is happening in therapy, we may be responding to other situations and less attuned to our clients than we think we are.

For example, presently, but particularly as a beginning therapist, I worried about being competent. This led to anxiety, secrecy, pushing clients too hard and fast, not pushing enough, and being too goal-oriented. This worry is fairly typical in beginning as well as experienced therapists. Now I am more comfortable sharing my doubts about appearing and being incompetent. To become competent, therapists would do well to nurture the ability to share their worries about treatment with colleagues. It is stressful enough dealing with clients in pain. Hiding ones

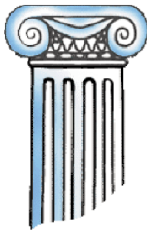
doubts compounds stress and contributes to isolation. This is a profession that requires self-care and learning from mistakes; and consultation facilitates these practices.

Have realistic expectations for change. As a beginning therapist I had unrealistic expectations for treatment: I intended to fix and to cure. Now I seek *doable* treatment goals. Today therapists are trained to expect changes after brief treatment, and they read about legendary therapists who provide treatment techniques that generate major changes in one session. However, our interventions are not as powerful as outcome studies would lead us to believe.

There are many reasons for the divide between treatment and research. A main one is that the research on therapy interventions is based on populations that are different from treatment-seeking clients. Typically research studies exclude subjects who have severe or multiple psychological problems, co-morbid physical problems, substance abuse, suicidal ideation or intention, a personality disorder, or are an ethnic minority. In other words, they exclude clients.

It is naive to feel we should be able to understand and help everyone who walks into our office irrespective of their age, intelligence, the flexibility and rationality of their thinking, sexuality and gender; their cultural, medical, neurological, genetic, ethnic, spiritual and educational backgrounds; their social class; the intensity and duration of their problems; their motivation to change; their abilities to handle anxiety; and their resources to overcome the obstacles to regularly participate in therapy.

Often I told clients not to expect magic, but it took me years to understand that this warning applied to me as well. I know how difficult it is for me to change myself, my habits, fears and expectations, even when I am highly motivated to change them. Imagine how difficult it might be to change someone else who may lack motivation, knowledge, and emotional resources, and be embedded in an environment that does not support or even frustrates change. (Cont'd on Page 13)



Inside the Institute

News from the Sanville Institute for Clinical Social Work and Psychotherapy

**A Message from Whitney van Nouhuys, PhD
Academic Dean**

School may be out for the summer, but The Sanville Institute is busy planning for several fall events in the north and the south. Please check our website for up-to-date details about these events. www.sanville.edu.

September 28th, Friday evening, Michael Wolff, popular jazz pianist, will perform again at the Jazzcafe in Berkeley, to benefit the scholarship fund in honor of his mother, Elise Blumemfeld.

The next day, Saturday, September 29th, is Sanville's Fall Convocation, also in Berkeley. Every two years we plan our fall convocation to satisfy the 6 unit CE ethics requirement and this year's topic is "When the Therapist is the One Who leaves: Ethical considerations." Members of the Sanville community along with Ruth Palmer, featured presenter, will help us all think through important issues that we may have been avoiding, such as what a professional will should cover, what happens with a clinical practice if we or a close colleague are ill or disabled, and retirement – if, when and why.

October 25th The Sanville Institute presents Valerie Sinason, British poet, writer, psychoanalyst and psychotherapist, who will speak on "Key Findings in Psychoanalytic Treatment of Children and Adults with Intellectual Disability (Mental Retardation)": 8:00 – 10:00 pm at the Institute of Contemporary Psychoanalysis (ICP). CEU's available.

Fall term starts September 5th. If you have been thinking about applying, it is not too late to talk with us, especially about the certificate program, which is a stimulating and enjoyable way to "get your feet wet" or refresh your clinical/theoretical thinking.

We are a state approved education institution with centers in Berkeley and Los Angeles offering PhD and certificate programs in clinical social work, open to social workers, MFTs, and psychiatric nurses with a master's degree in their field. For further information, please contact The Sanville Institute office at 510-848-8420 or at admin@sanville.edu.

Do You Know??

We can eblast your trainings, as well as your consultation groups, discussion groups, etc

We are planning a Law & Ethics Training for every District within the next 6 months?

If you have written a book, we can review and publish that review?

You can advertise on CSCSW's website www.clinicalsocialworksociety.org for 30 days for free?



Law and Ethics Corner

Advertising Your Practice By Myles Montgomery, JD, LCSW

Advertising of psychotherapy services has become greatly diversified in the past decade. What once was primarily provided by Yellow Page entries and the ancient word-of-mouth method, psychotherapy is now advertised through practitioner websites, social media, and professional organizations. Because of this shift, a brief discussion about the ethical and legal considerations of advertising seems timely.

One of the primary tasks of ethics is protection of the public from dangerous or harmful practices. In turning to the topic of advertising, it is fitting to consider how consumers of such services may be affected by advertising. People seeking psychotherapy services are, generally, in a place of greater vulnerability, as they are seeking help in dealing with personal and interpersonal issues. Because of the more vulnerable condition of potential clients, advertising should be directed generally, and avoid singling out individuals. The more informational the content, the less risky it becomes. Also, whenever possible, clients should be informed about the possible risks associated with psychotherapy. While this is not always possible in the context of advertising, it should be made

available at the earliest time possible.

From a legal standpoint, because advertising consists of speech, the First Amendment of the United States Constitution applies. While the First Amendment protects free speech, generally, false advertising is not a protected form of speech. So what constitutes “false advertising”? At one end, patently deceptive or false ads – which guarantee results or offer a service in which a practitioner is not competent to provide – would obviously not pass muster but from there, it becomes grey. The guiding principle here seems to be: what would a reasonable person believe is being communicated by the advertisement?

To assist clinical social workers to make ethical determinations for advertising, the key is to refrain from misleading, confusing or deceiving the public. It is important, in advertising, for psychotherapists to communicate, as clearly as possible, what type of service is being provided. It is equally important to avoid guarantees in terms of client outcomes. Further, it does not hurt to read aloud the proposed content before finalizing, to consider how it sounds to others. Having colleagues review the material as well provides another safeguard.

Myles Montgomery is a practicing social worker and attorney in Sacramento, California. Myles currently works as a civil litigator, with a focus on fraud and predatory lending suits in the mortgage industry. In addition, Myles teaches Law and Ethics at Alliant International University and holds similar classes throughout California. When not working, Myles enjoys reading across disciplines and long-distance running. He can be reached at montgomerylcsw@hotmail.com

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USC School of Social Work

2300 Michelson Drive
(Corner of Michelson & VonKarman)
Academic Center, Room C

Free Parking is located either in
USC Parking lot, or the VonKarman
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Presentation begins at 9:30

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Sciences.

California Society for Clinical Social Work Presents

Providing Mental Health Services Legally and Ethically In the Age of Cyberspace

Presenter:

Carole Bender JD, LCSW

Saturday, September 29, 2012 9:30 A.M. to 4:30

Digital technology and the World of Social Networking are entering our treatment rooms in a variety of ways e.g. e-mails and text messaging between clients and psychotherapists; Internet psychotherapy sessions; and invitations from clients to be their friend on Facebook, MySpace, LinkedIn, Twitter or other social networking sites. Since our Professional Code of Ethics were developed before the "Age of the Internet," this presentation will explore the ethical and/or legal issues of privacy, confidentiality, transparency, self-disclosure, and dual relationships in this brave new world of Social Networking. This six -hour workshop will be both informational and interactive by utilizing different scenarios and small group discussion. The workshop will also review the following areas: Scope of Practice and Competence, Professional Standard of Care, Informed Consent, Privileged Communication, Reporting Laws and Record Keeping.

Participants will be able to discuss what happens to the patient's expectation of privacy or confidentiality and to the Psychotherapist-Patient Privilege when use of the Internet enters the treatment room. Participants will be able to explain when Patient Targeted Googling (PTG) can be clinically justified and when it is not. Participants will be able to describe which questions to ask themselves when faced with a request by a patient to be their friend on Facebook. Participants will be able to describe what their Professional Code(s) of Ethics say about providing mental health services via electronic media (such as computer, telephone, radio and television). Participants will be able to differentiate between the concepts of "Confidentiality" and "Privileged Communication." Participants will be able to articulate the different mandatory reporting requirements for child abuse and elder abuse.

Carole Bender, a Licensed Clinical Social Worker and Attorney, is a former Director of the UCLA Department of Social Welfare's Center on Child Welfare and a member of the Field Faculty, and is Past President of the California Society for Clinical Social Work.

Ms. Bender has presented training on law and ethics to mental health clinicians in hospital and agency settings as well as at national and state conferences. She has held Adjunct Clinical Faculty teaching appointments at the USC School of Social Work, the UCLA School of Medicine Department of Psychiatry and the Albert Einstein College of Medicine Department of Psychiatry.

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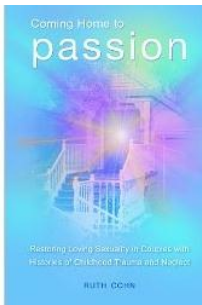
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Book Review

Coming Home to Passion: Restoring Loving Sexuality In Couples with Histories of Childhood Trauma and Neglect

By Ruth Cohn (2011).

Praeger, Santa Barbara, Ca, 2011

Reviewed by Michelle J. Frisch, Ph.D., LCSW

We psychotherapists practice in an era when neuroscience and attachment theory are dominant concepts Ruth Cohn combines these two ideas and applies them along with her expertise in sex therapy to help couples who have histories of childhood trauma and neglect. Her new book *Coming Home to Passion* is written primarily for lay people and beginning level therapists but seasoned couples therapists will enjoy a good review of attachment theory, trauma and brain research. Those not familiar with sex therapy also will learn valuable information about sex and trauma.

Although attachment theory does not provide a precise method of working with couples, it offers a conceptual base with which to view couple interactions. Helping couples understand their interaction style also assists in regulating affect within the relationship. Two of the major contributions of the book are its focus on the interaction between the members of a couple, including a great description of the cycle of escalation; and a concept that Cohn calls “staying in your own yard,” that means each member of the couple must look at his or her own part in the difficulties. Most people begin couples therapy eager to blame their partner, but they learn that if they do not get triggered and change the way they respond or act towards their partner, their partner, may change too - and the usual downward spiral may be avoided.

Cohn began her career as a therapist treating individual survivors of sexual abuse. After hearing her patients say over and over, “My partner does not understand me,” she formed a group for the partners of her patients. After 20 years, this all-male group still continues to meet. All the members, Cohn discovered, had histories of childhood neglect, a condition in which a “host of essential experiences that are supposed to happen are silently missing.” Cohn strongly believes that neglect is a form of trauma. She also makes the

good point that trauma and neglect are highly interwoven and that most survivors of trauma and neglect are victims of both.

The book is organized in four parts. The first part gives a good description of attachment theory and is a primer about relationships that cites Gottman and discusses genetic and hard-wired differences between the genders. The second part is about trauma and neglect and their effect on the brain. Cohn does a beautiful job of describing triggering, reactivity and the power of repair. Part three is “The fundamental sex education that most of us never had.” The last part describes what she calls “practice” where she offers a structure for partners to discuss their sexual relationship with each other.

Using many clear case examples from her work, Cohn describes the escalating cycles in which anger or criticism activate an old wound that causes the person to either attack or withdraw, thereby triggering the partner to attack or criticize again - and so forth into a downward spiral. Cohn also gives us a vivid example of a woman who dissociates, by first describing what she does and then naming the phenomenon.

As I was reading through *Coming Home to Passion*, I thought to myself several times, “Easier said than done.” These couples are tough. These are the kinds of sessions during which an angry spouse might walk out or couples begin the work but stop after a few meetings. In the last chapter Cohn acknowledges this fact. She states, “Although the roadmap may fit tidily and concisely into these pages, in actuality our journey can be anything but tidy and concise. It can, in fact, involve periods of arduous and intense slogging that may feel like stasis or even going backward, particularly

(Cont'd on Page 16)

Acceptance and Commitment Therapy (ACT): Be Present, Open Up, and Do What Matters Most By Bree Rhodes, MA, MFTI

Continued from Page 1

Helping the client to live more authentically and become open to the range of possibilities that are offered is akin to the aims expressed in acceptance and commitment therapy (ACT, pronounced as “act” rather than A-C-T)—a framework I often draw from when working therapeutically with clients, and have applied to my own way of life since being stuck in the sink of dirty dishes. ACT encourages individuals to *accept* the givens of life, rather than applying various control strategies to avoid both internal and external experiences, while taking *committed action* that is guided by one’s values for the purpose of living a rich and meaningful life, hence, as the name of the therapy suggests: *acceptance* and *commitment*. Having been credited as an existential humanistic cognitive behavioral therapy, ACT is described as one of the new, third wave of mindfulness-based, cognitive behavioral therapies—where dialectical behavioral therapy (DBT) is also housed—ACT encourages one to *be present, open up, and do what matters most*. These three principles wholly encompass the ACT hexiflex that is the basis for the treatment approach. It presumes that when one is able to integrate these concepts, that person is able to achieve “psychological flexibility” (as opposed to “psychological rigidity”) to help him/her handle painful thoughts and feelings effectively in such a way that they have much less impact and influence, and to help the individual clarify what is truly important and meaningful for the purpose of taking action that enriches life.

The ACT hexiflex refers to the six core processes that involve 1) being in contact with the present moment; 2) the observing self 3) cognitive defusion; 4) acceptance; 5) values; and 6) committed action.

Be Present

Being in contact with the present moment is where the practice of mindfulness is essential. Mindfulness as a skill is a major component to the ACT framework that enables the individual to be aware of the present moment, including one’s internal and external experiences. Whilst we are conditioned within a society that values multi-tasking and problem solving, it becomes easy to get caught up in our thoughts—

particularly about the past and the future—by which we lose touch with the immediate world around us. When we lose contact with the present, we run the risk of separating ourselves from experiences that may enrich our lives. On the converse, an example of mindlessness is when we find ourselves on automatic-pilot, or simply going through the motions. Slowing down and being mindful enables us to notice what information our minds and feelings are presenting in a situation, which may help influence our actions rather than propel us to react in ways that may take us further from what we actually want. ACT provides the therapist with a litany of mindfulness exercises that clients are encouraged to practice, all for the purpose of enhancing one’s awareness that is the catalyst for growth.

The second process enveloped in the principle of opening up is that of the self-as-context, or the *observing self*. This refers to the part of the self that is able to observe whatever it is that we are thinking, feeling, sensing, or doing in any moment. This therapeutic process recognizes that, while our thoughts, feelings, and sensations vary from moment to moment, the “you” that is able to observe all of those aspects never changes. This core process can be very helpful for those who are quite rigid in the way they view their self and their being-in-the-world, as it motivates the individual to be fluid given the present situation.

Open Up

Cognitive defusion and *acceptance* provide individuals with ways to help them better relate to unhelpful thoughts and uncomfortable feelings. (Please note here that when I use the word “better,” I refer to what is more helpful for the individual. ACT conceptualizes that what is more helpful or unhelpful to the client—which is wholly subjective—rather than what the therapist thinks, is best prescribed for the individual.) *Defusion* focuses on thoughts; when we are *fused* with our thoughts, we are looking *from* them, whereas, conversely, when we are *defused* from our thoughts, we are able to look *at* them, observe them, and distance ourselves from them. Defusing from our thoughts reduces the struggle that arises when we are all tangled up with them. “We see our thoughts for what they

are—nothing more or less than words or pictures” and “hold them lightly instead of clutching them tightly” (Harris, 2009, p9). For example, should one become *fused* with the old story of “I’m not good enough,” or “He’s so lazy” to the point that little else can be seen beyond that thought, experiences that may otherwise be enriching and self-fulfilling are out of perspective.

ACT proposes that much of our self-inflicted suffering is a result of our inability to accept that which is uncomfortable or unwanted, combined with our assumption that we *should* be able to fix or control what we don’t like in both our inner and outer worlds. ACT normalizes these control strategies as something we all struggle with as humans, and that when we find we can’t control, change, or fix what we perceive as being broken, we face what Dr. Russ Harris calls “the reality gap.” This is what we experience when there is a gap between what we want, and what we’ve got. We may adopt several unhelpful control strategies when we struggle with the acceptance of this natural and inevitable gap, one being avoidance of the experience that reminds us of this gap. ACT refers to this as experiential avoidance, the polar opposite of acceptance. By closing ourselves off to the possibilities of experience, we remain stagnant, for as stated by Thompson (1994): “...experience doesn’t merely change the world I inhabit, it also reveals things to me that I hadn’t known” (p236). This may put those who are largely traditional, CBT-based therapists in a tailspin, because rather than encouraging a client to thought-stop or replace negative thoughts with positive ones, ACT encourages the client to reduce the degree to which we judge our experiences as good or bad, and to make room for all feelings—both pleasant and unpleasant.

Do What Matters

When we are able to be present and open to all of our experiences from a perspective of flexibility, and relate to our thoughts and feelings in ways that are more helpful for us by reducing our struggle with them, we are freed up to be able to take committed action that is guided by what matters most to us—our values. *Values* exploration is another key focus in ACT as it serves as the basis for which the individual chooses to direct one’s life. This, too, is wholly subjective, and not what the therapist believes is best for, or should matter most to, the client. The idea is that when we are living our

lives in a direction that is guided by our values, our sense of life satisfaction will improve. Take, for example, my earlier story about the dishes. My passive-aggressive response to my partner did not bring me closer to satisfying my value of being understood, nor my value of being a loving, supportive, caring partner to my loved one. Instead, my lack of present awareness and automatic pilot responses widened the gap, and ultimately my suffering increased because I took action that was incongruent with my values. It is possible to be unsure or unaware of what one perceives his/her values to be, especially if one has been blindly following the values imposed by mom, dad, society, etc., or if the person has been living outside of his/her values for quite some time. This is often what we see with individuals struggling with long-term addiction. Part of the rich work here is deciphering what the individual really cares about most, and ACT prescribes a number of interventions and metaphors to help the individual identify these personal values.

Once the individual has clarified personal values, the next step is to take action—effective, committed action—that is guided by these values. ACT makes the distinction between values and goals, explained by Dr. Russ Harris (2009) here:

Values are like a compass. A compass gives you direction and keeps you on track when you’re traveling. And our values do the same for the journey of life. We use them to choose the direction in which we want to move and to keep us on track as we go. So when you act on a value, it’s like heading west. No matter how far west you travel, you never get there; there’s always further to go. But goals are like the things you try to achieve on your journey: they’re like the sights you want to see or the mountains you want to climb while you keep on traveling west (p 192).

Committed action marks the steps one takes leading towards a value-driven goal. The idea of committed action patterns is to gradually build the pattern from something small and possibly sporadic, to a way the individual leads a life that is ultimately rich and meaningful. “Committed action can start with limited

goals and just begin to enlarge upon the client's willingness to act. We are not so much concerned with the magnitude of these acts, as we are with the extent to which they help the client make experiential contact with value-driven, approach oriented behavior" (Hayes and Strosahl, 2004, p. 49). One may see the client-centered, strengths-based qualities within the therapist's application of ACT, in which even the smallest steps that a client makes towards valued-living is praised and positively reinforced. However, the hope is that the client finds intrinsic satisfaction by simply acting in accordance with one's values, and that this serves as the primary motivator for continued committed action.

On another day, I came home to the same scene: dirty dishes in the sink. Instantly, the same old stories and feelings of frustration and annoyance presented themselves. However, this time, I slowed down to notice what was going on in my present moment,

noticing my thoughts and feelings. Rather than struggle with them, or beat myself up for having them, I allowed them to be there. Rather than acting on impulse, I was present enough to recognize what mattered most to me in the moment—my relationship and being the loving, caring, supportive partner that I value—I was mindful to take committed action guided by this value. In this case, the committed action I took was to be assertive about my wants and needs, which opened a dialogue about what our shared wants and needs were in our relationship at that time. Since the dawn of what my partner and I can now affectionately call "The Dishes Story," we find that our abilities to be present, open up, and do what matters help us have a thriving relationship. Professionally, I have seen the application of ACT assist those struggling with depression, anxiety, eating disorders, substance abuse, and a variety of other mood-dependent behaviors reduce the struggle and lead lives driven by purpose and meaning.

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Bree Rhodes, MA, MFTI is an adult mental health therapist in California. Having received extensive formal training in ACT therapy, Bree has years of experience in the individual and group treatment of substance abuse disorders, mental health disorders, and dual diagnosis both in the United States and internationally. She can be reached at breehodes67@yahoo.com.



I know you are very busy,
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Nine Ideas I Wish I Had Known as a Beginning Therapist

By George Rosenfeld, Ph.D.

Continued from Page 5

Seek feedback about the session, course of treatment and the state of the therapeutic relationship. To improve outcome one of the most powerful things a therapist can add to what they already do is to seek feedback from the client. This is very scary to do. Bravery is required to ask clients if the session was helpful, if we covered the things they wanted to talk about, if we are going in the right direction, how they are feeling about the therapy and the therapist, and if we are making progress. Seeking feedback conveys an interest in responding to the client's dissatisfactions and prompts the client to voice them.

In business, success and failure can be objectively measured in money, while in psychotherapy we rely on subjective reactions. I can be a poor judge of how treatment is going and have been surprised by the client's feedback. For example, I had been seeing an anxious parent for Child Guidance for over six months and was quite pleased with our progress. Because of her anxiety I avoided silence and kept our conversation going by bringing up issues when the conversation stopped and she failed to initiate another topic. Probably because I expected a response that indicated her satisfaction with treatment, I asked her if there were issues that she wanted to talk about, but did not have the opportunity. She said there were. This feedback changed my treatment approach. We were able to identify our contributions to the problem (her anxiety and lack of assertiveness and my controlling the session) and concluded that we needed to share more equally the responsibility for generating topics for discussion.

When I have asked clients what has been helpful they often surprise me by saying things such as: "I loved the time we laughed about..." "You didn't get mad at me when I said..." or "I didn't realize I was depressed" or "I knew you cared when you..." Usually their responses are unrelated to the treatment techniques and interventions I have been crafting. Therapists can be unaware of their most therapeutic as well as damaging responses.

Client feedback can help to avoid the scenario in which the client leaves treatment and the therapist does not know why and did not have a chance to deal with the client's frustrations. Without feedback, it is easier for ruptures in the therapeutic relationship to go unnoticed and sabotage

treatment. Repairing ruptures can be one of the most productive events in therapy, because ruptures can provide an opportunity to directly identify and correct the client's transference distortions.

Don't beat yourself up if you miss dealing with something in a session. Now I am less upset when I notice an error, because I expect that another opportunity will come around again. I want to focus on repetitive patterns that are so robust they innervate many aspects of the client's life. If what is missed is important, then there will be other opportunities to deal with it. If the issue does not reoccur, then it may not have been important.

I am not immune to missing opportunities to provide perfectly timed interpretations. I used to think the best therapy involved fostering insight that would lead to behavioral change. But often intellectual understanding is not necessary or sufficient to create change. And it is difficult to know when the client is ready to accept interpretations. Often they are most ready when they are close to discovering it by themselves and our role may be to support this process of self-discovery. Many times clients are most able to benefit from an interpretation after they have made behavioral changes.

Capitalize on both horizontal and vertical therapy. Jay Haley divided psychotherapy into horizontal and vertical. He described vertical time as greeting the client, walking from the waiting room to the office, and getting settled prior to beginning "the therapy." Alluding to Freudian psychotherapy during which the client lies on the couch in a horizontal position, Haley characterized the part of the hour labeled, "therapy" as horizontal time. When "the therapy" stops, the client returns to vertical and pays the bill, talks further about different content, and is accompanied to the waiting room where doorknob comments are made. Haley suggested that perhaps the most powerful things get said in vertical time when the defenses are down; participants are in less formal, rigid and artificial roles; and the client might be the most revealing and receptive to the therapist's comments. I heighten my observation of the client and make interventions during the less formal, vertical time. Sometimes I end the horizontal time early and stall in the office to extend this less structured vertical time.

A corollary to this concept involves slipping information in under the defenses by placing it in subordinate clauses. For instance, saying, "Meeting people can be scary, even for an approachable person like you," can implant the thought that the client is an approachable person. The client might not challenge the thought because his or her attention is focused on how meeting people can be anxiety provoking.

Develop a menu of useful interventions to draw from and keep evaluating their effectiveness. I frequently ask the Miracle Question. To motivate clients and help them identify reasons to change I often ask them what their life would be like if they did not have the problem they are working on. I look for the client's past solutions and see if we can build upon them. I seek opportunities to normalize, reframe and externalize problems. Most therapists have their personal favorites.

Don't buy the medical model. It assumes a passive client and a beneficent therapist who provides *the* intervention of choice that causes the change. This model ignores most of what is therapeutic. It marginalizes the contribution of the two most powerful forces in psychotherapy: the therapeutic relationship (Lambert & Barley, 2001) and the client, each of which is sufficient to create change as well as to derail treatment. The medical model minimizes the client's role in fostering or limiting change, because it does not adequately focus on the client's level of motivation and capacity to change that can determine outcome. Some clients are so motivated to change that the therapist's role is to keep out of the client's way. Some clients cling to irrational thinking and are so defended and embedded in their patterns that change is elusive. Interventions are the most powerful when they are tailored to the client's goals and motivation to change. The effectiveness of interventions can depend on the clients' anticipation that an intervention will be of benefit because it makes sense to the client. That is, the intervention matches the client's theory of change and beliefs about the causes of his or her problems. My greatest error in therapy has been to offer interventions before the client is ready to use them.

Furthermore, the concept of a treatment of choice for particular problems may not be supported by the research. The Consumer Reports survey ("Mental Health," November, 1995), the National Institute of Mental Health (NIMH) Treatment for Depression Collaborative Research Program (Elkin, et al., 1989), and meta-analyses of comparisons of active treatments (Luborsky, et al., 2002; Miller, Wampold, & Varhely, 2008) indicate that there is

not a significant difference in the effectiveness of different treatments based on different theoretical orientations. Because the difference between therapies is small or nonexistent (about one-tenth of a standard deviation of the difference between treatment group means), the sources of change appear to reside in the factors that effective treatments have in common, not in the unique aspects of each treatment.

Go slow. Especially at the start of treatment I feel a pressure to initiate rapid change and clients wanted me to help them right away. But for some clients their symptoms protect them from discomfort that can overwhelm them. Their symptoms may be defenses that they need. We should not ask them to abandon a lifeboat until another comes along.

I hesitate to challenge established defenses until clients are armed with the skills necessary to handle new anxieties. Before being exposed to anxiety, clients may need the skills to handle the anxiety generated by change. These stress-management skills might include being able to: 1. Self-soothe (breathe, deep-muscle relaxation), 2. Pace (regulate stimulation in session and in life) 3. Use grounding skills, and 4. Obtain and utilize social support. Also, it is important to make sure they leave the office stable enough to deal with their world.

I have had clients who thought their role demanded they reveal their past traumas early in treatment. In the process of trying to be a good client, they exposed themselves to more anxiety than they could handle and they left the session in a dissociated state. In ignorance I thought we had had a great session because they shared so much, and I was surprised when they failed to attend the next session. I should have slowed them down, supported their defenses, taught coping skills, and more actively managed their exposure to anxiety.

I want to monitor the client's anxiety and keep it at a level that motivates him or her to productively participate in treatment. If clients do not have enough anxiety they are probably not motivated to change. If they are too anxious, they cannot benefit. John Briere conceptualized regulating the client's anxiety in terms of keeping the client within "the therapeutic window." He described effective treatment as needing to take place within the space between (a) too much anxiety when the client's self-capacities are overwhelmed with affect so that the client cannot benefit from the session, and (b) not enough

anxiety when the client lacks motivation and the therapist provides support in a way that interferes with needed desensitization or the processing of anxiety-provoking material.

Use active-listening as a primary and fallback strategy.

When I am not sure what to do I channel Carl Rogers and try to provide emotionally attuned reflecting of the client's emotional state. This is not easy. It can be a challenge to remain present and focused on the client in the face of the feelings the client elicits. Attunement is not totally expressed through language, but by almost instantaneous responses of tone, gesture, and posture similar to the way parents mirror and soothe their pre-verbal child.

Therapists who have not experienced this type of caring in their life may find it more challenging to provide this to

their clients. It has even been speculated that they may not have fully developed the neurological structures to easily provide the accurate empathy that helps clients to feel seen and accepted. As we help our clients to build these neurological pathways, perhaps we are building them in ourselves.

Conclusion: Irrespective of our stage in our careers, we can strive to be more effective psychotherapists if we cultivate the abilities to listen to and respect each client and his or her theory and pace of change; manage our anxieties; foster hope, reasonable goals, expectations, and a therapeutic relationship strong enough to allow uncomfortable emotions to be processed; and develop the courage to pursue self-awareness and seek feedback from our clients.

George Rosenfeld, Ph.D. is a Clinical Psychologist at Families First in Davis, CA. He is the author of *Beyond Evidence-Based Psychotherapy: Fostering the Eight Sources of Change in Child and Adolescent Treatment*. Routledge, 2009. He can be reached at geo.rosenfeld@gmail.com.
References are available from the author upon request.

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Book Review

Coming Home to Passion: Restoring Loving Sexuality In Couples with Histories of Childhood Trauma and Neglect

By Ruth Cohn (2011).

Reviewed by Michelle J. Frisch, Ph.D., LCSW

Continued from Page 9

at the earlier stages of work where the cycles of escalation are still frequent and fierce.”

Cohn names many of the subsections in her book after rock and roll songs from the 60s, 70s and 80s and challenges the reader to identify the 63 song titles that are peppered throughout the book. She calls it “Meet the Coming Home to Rock Musical Challenge.” Some examples are Imagine, Satisfaction (the easy ones), and Owner of a Lonely Heart and Human Touch. As someone who could not have gotten through my adolescence and young adulthood without rock and roll, Simon and Garfunkel and Bob Dylan, the first thing I did when I got the book was to go through and see how many of the songs I could name. In thinking about this, I am not sure if this device is a distraction along with the many exclamation points throughout the book, or Cohn’s effort to create a fun balance to the horrific trauma many of the readers have suffered. I’m willing to give this caring and thoughtful author the benefit of the doubt and so will choose the latter.

I had the opportunity this past June to hear Cohn present her work. She is a deeply caring woman and it is clear that she has done a lot of work on herself and thinks deeply about her couples. She uses herself and her own marriage as one of the case examples, which I

found refreshing. It is hard to write a book for both lay people and professionals, and at times Cohn struggles to accommodate the two audiences. What comes through brilliantly is her warmth and intense desire to help. A longtime student of Bessel van der Kolk, Cohn has a vast knowledge of the effects of trauma and neglect on the brain and does a great job of explaining the neuroscience. But the professional reader will note a lack of useful citations.

Coming Home to Passion is an easy to read contribution to the literature on couples and trauma, a book that our couples can understand and a useful adjunct to couples therapy. Cohn concludes her book with the subtitle *Don’t Stop Believing* [by Journey!] where she implores her readers to engage in Gottman’s 5 to 1 ratio of positive sentiment override and to use one of her favorite catch phrases, “Stay in your own yard” to avoid escalation and a downward spiral. Although the book may read like a self-help manual asking questions at the end of each chapter such as, “What attachment style do you think you are?” Cohn recommends throughout the book that couples seek professional help. One takes away from this book that marriage can be extremely challenging if there has been trauma in one’s childhood. Cohn helps us see that these challenges are normal, understandable and can be healed.

Michelle J. Frisch, Ph.D., LCSW is in private practice in Napa, CA where she treats adults in individual and couples therapy. She has been a guest lecturer on object relations and attachment theory applied to couples and plans to do more teaching. She is on the board of The Sanville Institute. She can be reached at mfrisch1@comcast.net and 707 927-5899.

District Meetings (cont'd)

South Bay/Torrance District

Coordinator David Kuroda
Coordinator Phone 310-540-9128
Email dkuroda@gmail.com
RSVP David Kuroda @310-540-9128
Date: September 17, 2012
Time: 12:00 to 2:00 pm
Presentation: **Sandcastles Workshops: Helping Children of Divorce Rebuild**
Presenter: Sharon Baker, LCSW & Rev Diane Rehfield
Location: 3333 Skypark Drive, 2nd Floor, Torrance, CA

The award-winning program by Gary Neuman, "The Sandcastles Workshop" is one of the truly outstanding programs for children of divorce in the nation. It is one of the few programs for children in this area. In this presentation to professionals, Sharon and Diane will present the important aspects of this program. It's been featured by Oprah Winfrey and its material is used in many parent education programs.

Sharon Baker, LCSW, BCD, has specialized in family relationships for over 30 years as a psychotherapist, family life educator and collaborative coach. She has been a board member for LACFLA and is a member of the practice group "Alternatives: A Collaborative Divorce Team, and was a founding member of "A Better Divorce." Sharon is a member of the LACFLA training faculty. She has a private practice in Rancho Palos Verdes. For over 14 years she has been a regular presenter for the PACT Program (Parents and Children Together) in the Los Angeles Superior Court in Torrance.

Rev. Diane Rehfield, MFT, is the director of family ministries at the Rolling Hills United Methodist Church. The church decided years ago that helping parents with the important job of raising children was a priority, and the church has since become well known in the community for its quality parenting classes. In 2007 the church became licensed as a provider of Gary Neuman's Sandcastles program. Diane is an ordained elder, and a licensed marriage family and child counselor. She was in private practice for 12 years, and in addition to her work at Rolling Hills United Methodist Church, is currently the pastor at Walteria United Methodist Church in Torrance, California.

The lunch meeting will be held at the Torrance Memorial Medical Center, Thelma McMillen Center for Chemical Dependency, 3333 Skypark Drive, 2nd Floor, Torrance CA 90505. The cost of the lunch without reservations, paying at the door, \$17. If reservations are made by 5 pm, September 12, 2012, the cost is \$13. Parking is free in the parking structure or in the rear lot. This will be a 1.5 hour presentation.

Members of the Society for Clinical Social Work may earn 1.5 CE credit by attending the presentation, without cost. LCSWs and MFTs who are not members may earn the credit by paying a nominal fee of \$15. Attendees are requested to make reservations, and to cancel 24 hours in advance if unable to attend. For information and reservations, please call David Kuroda, [310-540-9128](tel:310-540-9128), or send an e-mail message to dkuroda@gmail.com. Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences. PCE Provider #1

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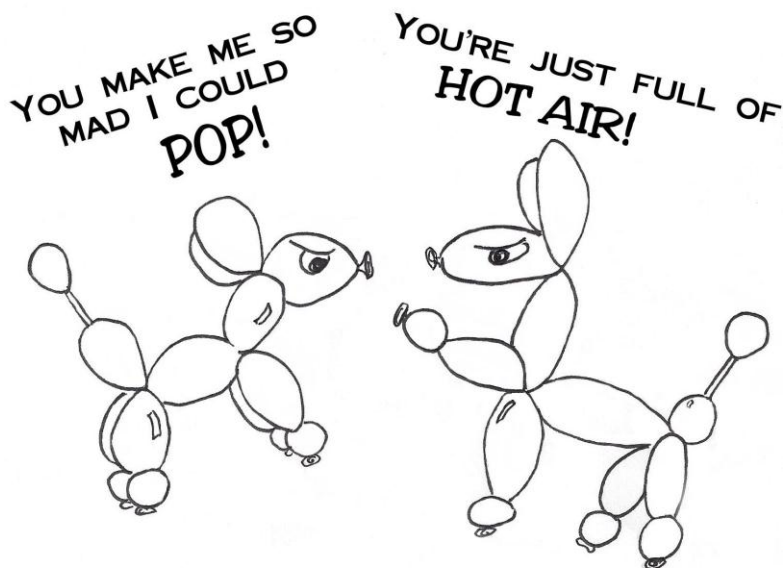
CEU conference by Postpartum Health Alliance. Two conference tracks to choose from. "Maternal Mental Health 2012: Special Challenges During Pregnancy and the Postpartum Period" and "When Babies Die: Caring for Women and Families with Pregnancy and Neonatal Loss" will be held concurrently at UC San Diego School of Medicine on October 13, 2012 from 8am-5pm. Lunch provided. 7.5 CEUs available for each track. Cost starts at \$65. Go to postpartumhealthalliance.org for more information. Register at PHA2012.eventbrite.com or perinatalloss.eventbrite.com.

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