Clinical Update

California Society for Clinical Social Work

Volume XLVI Number 1, Sept/Oct, 2014

INSIDE Update

Understanding Children's Temperament to Enhance Clinical Practice
By Ruth Jaeger, LCSW

When my daughter was five years old, I remember feeling that my husband and I were very bad parents because she seemed to be unempathic and selfish. If plans needed to be changed for any reason, even because I was ill, she'd wail "but you promised" so intensely that I was sure we had created a very spoiled, unlikeable child. As I learned about temperament I understood that what appeared to be lack of empathy was really a fixation on a previously anticipated activity.

Temperament is a child's innate way of approaching and experiencing the world. It is the nature of the nature versus nurture argument about development. Understanding a child's temperament helps us understand and anticipate how a child behaves in response to parents, caregivers, and the environment. When parents, teachers, and clinicians understand a child's temperament they can work with the temperament rather than be in conflict with it. When we acknowledge that there are individual biological differences in children's responses to their environment, we can accept a broader definition of what is normal.

Temperament was first recognized as a factor in children's behavior in the 1950s by Stella Chess and Alexander Thomas. Chess and Thomas were psychoanalytically trained therapists who noted that many of the children referred to their practice for behavioral problems came from good environments with parents who were responsive and caring. Their models for understanding and treating pathology didn't explain what they saw in their office.

(Continued on Page 16)

2014 - 2015 CSCSW Board of Directors

OFFICERS:

President
Leah Reider, LCSW
lreider@clinicalsocialworksociety.org
President Elect
Conrad Fuentes, LCSW
cfuentes@clinicalsocialworksociety.org
Past President
Michael Rogers, LCSW, BCD
mrogers@clinicalsocialworksociety.org
Secretary
Ellen Eichler, LCSW
eeichler@clinicalsocialworksociety.org
Treasurer
Golnaz Agahi, LCSW
gagahi@clinicalsocialworksociety.org

DIRECTORS:

Joan Berman, LCSW
jberman@clinicalsocialworksociety.org
Rebecca Danelski, LCSW
rdanelski@clinicalsocialworksociety.org
Gloria Gesas, LCSW
ggesas@clinicalsocialworksociety.org
Ruth Jaeger, LCSW
Rjaeger@clinicalsocialworksociety.org
Laurel Quast, LCSW
lquast@clinicalsocialworksociety.org
Jean Rosenfeld, LCSW
jrosenfeld@clinicalsocialworksociety.org
Russanna Rowles, LCSW
rrowles@clinicalsocialworksociety.org
Dolores Siegel, LCSW
dsiegel@clinicalsocialworksociety.org
Nancy White, LCSW
nwhite@clinicalsocialworksociety.org

Mentorship Committee

Golnaz Agahi, LCSW – Southern, CA
Gagahi@clinicalsocialworksociety.org

Ruth Jaeger, LCSW – Northern, CA
rjaeger@clinicalsocialworksociety.org

Code of Ethics Committee Chair

Myles Montgomery, JD, LCSW

DISTRICT MEETINGS:

EAST BAY DISTRICT:

Coordinators:	Anita Barnes, LCSW; Inger Acking, LCSW
Coordinator Phone:	510-562-1071
Coordinator Email:	anitabarnes@access4less.net
Date:	September 12, 2014
Time:	7:00 pm
Presenter:	Karen Pernet, LCSW
Topic:	Filial Therapy: Integrating Family and Play Therapy
Location:	Towne House Wellness Center, 629 Oakland Ave., Oakland, CA

This workshop will introduce professionals who work with children and families to Filial Therapy. Filial is a well-researched and highly effective psycho-educational, skills training model that integrates the magic of non-directive play therapy and direct parent involvement in the change process. The therapist trains the parent to become the healer of his or her own child in a process which enhances the parent/caregiver and child relationship. The focus is on the present-emphasizing appropriate skills for positive parent/child relationships. There will be a case presentation to demonstrate Filial Therapy.

Karen Pernet, LCSW, RPT-S, has been practicing for over 25 years. In addition to Filial Therapy, she provides psychotherapy, play therapy, and sand tray therapy to people of all ages. She is co-founder of two play therapy training programs: *Growth through Play Therapy* and *Connecting to Play Therapy*.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future meeting: To Be Determined

FRESNO DISTRICT:

Coordinator:	Gabrielle Case, LCSW
Coordinator Phone:	559-224-2495
Coordinator Email:	gh.caselcsw@gmail.com
Date:	**September 6, 2014**
Time:	9:15 Registration/networking; program begins at 9:45
Presenter:	Kris Clarke, PhD
Topic:	Concepts and Attitudes towards Substance Misuse and Treatment in Finland
New Location:	CSU Fresno, Rm 129 of the Psychology and Human Services building

(Continued on Next Page)

DISTRICT MEETINGS (Cont'd):

FRESNO DISTRICT (Continued):

Finland has one of the highest rates of alcoholism and suicide globally, but is consistently rated as one of the happiest places in the world. How does social work view and treat substance misuse, which drives high rates of intimate partner violence and child maltreatment? This session focuses on how substance misuse is conceptualized, viewed and treated in Finland. It will give an historical and cultural overview in the context of the Nordic welfare state. The session also focuses on evolving modalities of treatment.

Kris Clarke is a Social Work Professor at California State University Fresno Department of Social Work Education where she teaches graduate courses in qualitative research, and undergraduate courses in diversity and oppression and macro practice. Her research focuses on migration issues in social work, harm reduction, and LGBTQ issues in social work education

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Date:	**September 27, 2014**
Time:	9:15 Registration/networking; program begins at 9:45
Presenter:	Panel Discussion
Topic:	Clinical Social Work Across Fields of Practice: Panel Discussion
New Location:	CSU Fresno, Rm 129 of the Psychology and Human Services building

Panel discussion will be preceded by a Meet and Greet for the purpose of networking and introducing students to the many professional opportunities in our community. Detailed information to follow

Date:	**October 25, 2014**
Time:	9:15 Registration/networking; program begins at 9:45
Presenter:	Anne Lewis, PhD
Topic:	Professional Wills
New Location:	CSU Fresno, Rm 129 of the Psychology and Human Services building

Detailed information to follow

GREATER LOS ANGELES DISTRICT:

Coordinator Name:	Lynette Sim
Coordinator Phone:	(310) 394-7484
Coordinator Email:	lsim1@verizon.net
Date:	**Saturday, September 6, 2014**
Time of Meeting:	10:30 to 1:00
Presenter:	James Long, M.D., PhD
Topic:	**Child Custody Evaluations: The Essentials**
Location:	3267 Corinth Ave., L.A. 90066
RSVP:	Via Website or, to Judy at messingerlcsw@gmail.com, 310.478.0560

DISTRICT MEETINGS (Cont'd):

GREATER LOS ANGELES DISTRICT (Continued):

Even if you don't do direct practice with children & families, chances are custody disputes are a part of what you may hear about in your office. This can be a high conflict, emotionally trying time for people, including the therapist. Therapists can get in trouble when wanting to advocate for a parent or child & this presentation will present the basics of the custody evaluation process & the advantages & disadvantages for families going through it. You will also learn about the training necessary to become a custody evaluator as well as the credentials needed & procedures to follow. Strategies to handle the stressors created by the custody evaluation will be discussed.

Dr. Long is Board Certified by the American Board of Psychiatry & Neurology & is a Special Master in Child Custody Matters. He is in full time private practice treating children, adolescents & adults.
Dr. Long is a psychopharmacologist as well as a forensic specialist and provides consultation to colleagues.

Future Meetings:
Nov. 15 **From Now On: Seven Keys to Purposeful Recovery** -Andrew Susskind, LCSW

MID-PENINSULA DISTRICT:

Coordinator:	Virginia Frederick
Coordinator Phone:	650-324-8988
Coordinator Email:	ginnyfred@aol.com
Date:	**Friday, October 17, 2014**
Time:	12:00 – 2:00 pm
Presenter:	Gordon Wong, MD
Topic:	**Depression and Bi-Polar Disorder – a Differential Diagnosis with Special Focus on New Medication**
Location:	Jewish Family and Children's Service 200 Channing Street, Palo Alto (corner of Channing and Emerson) Parking available – 913 Emerson in underground parking (press button to be admitted) as well as parking at 200 Channing and on street.

It is important to consider the differential diagnosis in a patient presenting with new onset mood episode of depression. In particular differentiating between bipolar depression versus major depression is important because medication treatment is very different and confusion between the two can worsen the condition. A variety of new antidepressants for treatment of depression and mood stabilizers For treatment of bipolar disorder have emerged in the last few years and their review of how the compared to more traditional treatment will be useful since these new agents will become more popular over the next few years

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future meetings:
November 21, **Evaluation and Treatment of Sleep Problems** – Chad Ruoff, MD

DISTRICT MEETINGS (Cont'd):

NAPA SONOMA DISTRICT:

Coordinator:	Kathy Frishberg, LCSW, BCD
Coordinator Phone:	707-321-3147
Coordinator Email:	kfrish1@hotmail.com
Date:	**Friday, September 19, 2014**
Time:	6:00 – 9:30 pm
Presenter:	Karin Wandrei, PhD
Topic:	**Open Relationships: What Every Psychotherapist Needs to Know**
Location:	Call or Email Kathy by **September 18**, to RSVP and receive directions

Polyamory? Swinging? Consensual non-monogamy? More and more we encounter stories about people engaged in these kinds of open relationships in the media and increasingly in our therapy practices. In this training you will gain an understanding of what these terms mean, and about the clinical issues that clients in open relationships bring to therapy.

This course meets the qualifications for 2.0 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Coordinator:	Laurel Quast, LCSW
Coordinator Phone:	707-321-3147
Coordinator Email:	kfrish1@hotmail.com
Date:	**Friday, October 17, 2014**
Time:	12:00 – 1:30 pm
Presenter:	Adrianne B. Casadaban, PhD
Topic:	**Brain, Mind, Self: Framework to Sustain a Health Self**
Location:	Kaiser Department of Psychiatry, 3554 Round Barn Blvd, Santa Rosa, CA

While no introduction can convey the full set of foundational skills, this presentation of my Brain-Mind-Body Self Adaptability Frame is designed to start clinicians immediately using practical psycho-education, co-guided corrective experiences, and skills. This understanding can help psychotherapists plan and carry out additional components of a treatment plan which address more complex psychotherapy needs of clients with multiple or difficult-to-treat diagnoses or who have not responded to single method work, such as those including complex trauma, ADHD, dissociative, manic, disordered personality, severe anxiety/panic/phobic, developmental/attachment trauma, and addictive-like-conditioned symptoms/problems.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future Meetings:
November 21, **Aurora Psychiatric Hospital** – Marcia Katz

DISTRICT MEETINGS (Cont'd):

SACRAMENTO/DAVIS DISTRICT:

Coordinator Name:	Nathan Stuckey
Coordinator Phone:	(951) 285-6322
Coordinator Email:	nstuckey13@gmail.com
Date:	**Saturday, September 19, 2014**
Time of Meeting:	10:00 a.m.
Presenter:	Dr Susan Taylor
Topic:	**Comparing and Contrasting Various Models of Suicide Prevention**
Location:	Friends Meeting House, Sacramento, CA

Detailed information to follow under separate cover

Coordinator Name:	Nancy White
Coordinator Phone:	(916) 335-2150
Coordinator Email:	ncw007@att.net
Date:	**Saturday, October 18, 2014**
Time of Meeting:	10:00 a.m.
Presenter:	Dr Paula Smith
Topic:	**Emotional Brain Training**
NEW LOCATION:	Arden Dimick Public Library 891 Watt Ave, Sacramento, CA (Corner of Watt & Northrup)

Detailed information to follow under separate cover

SAN DIEGO DISTRICT:

Coordinator Name:	Ros Goldstein
Coordinator Number:	(619) 692-4038, #3
Coordinator Email:	goldsiegel@gmail.com
Date:	**Thursday, September 4, 2014**
Time of Meeting:	5:30-7:30 PM
Presenter:	Valerie Piacitelli, LCSW
Topic:	**Eating Disorders: The Puberty Principle**
Location:	Jewish Family Service, 8804 Balboa Ave., San Diego, CA

This presentation is designed to help clinicians understand the predisposing factors in pre-teen and adolescents that lead to eating disorders. It is also designed to help parents and clinicians understand how to navigate this highly impactful transitional stage of development in an effort to increase self-esteem and decrease eating disordered behaviors by creating acceptance and sense of belonging. The focus is on prevention and knowledge being power before an eating disorder fully develops.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

DISTRICT MEETINGS (Cont'd):

SAN DIEGO DISTRICT:

Date:	**Thursday, October 2, 2014**
Time of Meeting:	5:30-7:30 PM
Presenter:	Eugenia Weiss, PhD, LCSW
Topic:	**Bereaved Military Families**
Location:	Jewish Family Service, 8804 Balboa Ave., San Diego, CA

Dr. Weiss will present on "Bereaved Military Families: Supporting Resilience in the Face of Veteran Suicide". A resilience-based approach to military families coping with unique grief reactions to veteran suicide will be presented. Examples of how social work clinicians can adapt solution-focused and narrative techniques with a bereaved military family will be delineated.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

SAN FERNANDO VALLEY DISTRICT:

Coordinator:	Gloria Gesas, LCSW
Coordinator Phone:	818-990-1053
Coordinator Email:	gegesaslcsw@gmail.com
Date:	Sunday, October 21, 2014
New Time:	9:30 am – 12:15 pm
Presenter:	Robyn Altmann, LCSW
Topic:	**Working with Victims of Domestic Violence and their Children – Part 2**
Location:	Sherman Oaks Galleria – 15301 Ventura Blvd, Sherman Oaks, CA parking will be validated

Domestic violence can happen to anyone, regardless of gender, ethnicity, race, sexual orientation or income. This presentation will cover the dynamics of domestic violence, warning signs of abusers, as well as the impact upon children. Best practices techniques for intervention will cover the dynamics of domestic violence, warning signs of abusers, as well as the impact upon children and male victims. Best practice techniques for intervention with both adult victims and their children will be covered. She will be able to cover additional topics not discussed during last year's presentation. The meeting will be interactive.

Robyn Altmann, LCSW is the Clinical Supervisor for Jewish Family Service-Family Violence Project and manages the clinical programs at all sites including 2 emergency shelters, a transitional shelter as well as the Sherman Oaks outpatient counseling center. She is responsible for supervising the implementation of Trauma Focused CBT.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future Meetings

December 14, **Coming Home-Challenges for the Returning Veteran** - Debora A. Presser, LCSW
February 8, **Sexual Addiction** - , Joseph Verrone, LCSW

American Association for Psychoanalysis in Clinical Social Work (AAPCSW)
Orange County Chapter

Early Registration Requested
Saturday
October 25, 2014
10:00 – 4:00 (lunch provided)
USC School of Social Work, Irvine
($100.00 before October 1st, $110.00 after)
5 CEUs

Criminalization of the Mentally Ill: A Way Out

More than one-third of the entire prison and jail population in the United States is estimated to have serious mental illness. That means there are more than 350,000 people in our country with serious mental illness who are in jails and prisons—**ten times the number of people in psychiatric hospitals**. The justice system keeps people with mental illness locked into a revolving-door cycle of incarceration, without ever providing the mental health treatment people need to get out of the system. Every stage of the legal-justice process perpetuates this cycle, setting people up for failure. In this day-long seminar, experts from a legal, psychiatric, and social work perspective will inform and deepen our awareness of this growing problem and offer both legal and policy interventions to break the cycle. This Seminar will also allow for small group dialogue and discussion. Our Panel will include:

Lori Rifkin, Esq, is a civil rights lawyer with over a decade of experience to ensure that people are treated in accordance with the Constitution's precepts of freedom, equality, and justice. She has worked on behalf of prisoners and parolees across the country in her role as a private civil rights lawyer, an ACLU staff attorney, and a senior trial attorney in the Civil Rights Division of the U.S. Department of Justice.

Conrad Fuentes, MSW, LCSW, Clinical Associate Professor, Field Education, USC, School of Social Work. Having been a youth at high risk, Conrad will speak in an up-close and personal manner about his early trauma experiences, particularly in the midst of a gang culture with many of his peers having been sent to jail. Having access to psychotherapy and other mental health services changed his life and the path that he took in becoming a licensed clinical social worker. Today, he is dedicated to working with youth at high risk.

Edward Kaufman, MD, has worked in prisons and jails intermittently for 50 years. He has been the director of two mental health systems in correctional facilities and an evaluator of prison psychiatric care in many settings. He is currently writing a book on the evolution of criminalization of mental illness and possible solutions to this raging epidemic.

After attending this Seminar, participants will be able to:
1) Identify the stages of the legal-justice system that keeps the mentally-ill person in prison
2) Identify legal and social policy interventions to break this cycle

For Information Contact:
Karen Redding, LCSW, PhD.: 949-715-7007 (kredding@mac.com)

Please return this form with a check made payable to: **AAPCSW-OC**
c/o Paula Clark, LMFT
19600 Fairchild Road, Suite 130, Irvine, California 92612

Name : _____ Phone: _____

Address:_____ Email: _____

President's Column
By Leah Reider, LCSW

This promises to be a very exciting year for CSCSW, with many events planned. We will hold our Biennial Conference in Irvine on May 16, 2015 addressing topics of sexuality with our clients, including a wide range of issues throughout the life span. The primary presentation will be by Stephanie Buehler, who authored *What Every Mental Health Professional Needs to Know About Sex* (Jul 29, 2013), followed by a variety of more narrowly focused break-out sessions. We hope that as many of you as possible will attend. More information will follow.

We will also hold several Law and Ethics workshops given by Myles Montgomery, a board advisor who is an attorney and an LCSW. His previous workshops have been very well received and highly rated. Many people have taken advantage of the free 15 minute legal consultation provided by Myles, a free benefit of membership. In addition, we will be hosting a webinar regarding the Physician Quality Reporting System, a Medicare program which provides incentives to providers who utilize this system.

I am delighted to report that we have a new East (San Francisco) Bay District that meets in Oakland. We encourage our members who live in the East Bay to attend the monthly meetings that promise to be very interesting. We also have five dynamic new Board members, all of whom are ready to roll up their sleeves and work on committees or wherever they are needed. We are glad to have more representation from southern California. They are: Golnaz Agahi, LCSW, Orange County; Russana Rowles, LCSW, Greater Los Angeles; Rebecca Danelski, LCSW, Greater Los Angeles; Joan Berman, LCSW, Mid-Peninsula; and Gloria Gesas, LCSW, San Fernando Valley.

Our website is constantly being updated. You may have noticed that we now have a job posting page and that people who live in the vicinity of the job are being notified by email. All district pages are being updated to include pictures of the District Coordinators and bios of the presenters. Also, members will receive reminders of their license renewal dates.

Our wonderful mentorship program will continue. Experienced social workers mentor newer social workers and help to introduce them to the profession, sharing their know-how and knowledge. If you are interested in having or being a mentor, you may contact our Sacramento office at www.clinicalsocialworksociety.org.

We will publish an expanded newsletter every other month, rather than ten issues a year. This will give us the opportunity to include more features and clinical content while reducing our cost. The district notices in the newsletter will include information for two months, and members will continue to receive eblast reminders that will now provide more detailed information about the meetings.

As always, if you have questions or comments on any of our programs, please contact me at lreider@clinicalsocialworksociety.org or call the Sacramento office, 916 560-9238. This will be a very full year, with 8 districts holding ongoing meetings, as well as our workshops and conference. If you have ideas for workshops, please let us know.

Leah Reider, LCSW graduated from Wellesley College with a BA in psychology and has an MSW from UC Berkeley. She worked at Jewish Family and Children's Services in Belmont and Palo Alto for 15 years and now has a private practice in Palo Alto, where she treats children, adolescents, and adults. She can be reached at lreider@clinicalsocialworksociety.org

INSIDE THE INSTITUTE

A Message from Mario L. Starc, MSW, PhD
Academic Dean

This is my first opportunity to greet you as the new Academic Dean of the Sanville Institute for Psychotherapy and Clinical Social Work. I am honored to follow in the footsteps of the Deans who have served before me, and I am grateful to our outgoing Dean, Dr. Whitney van Nouhuys, for her help in the transition. I am pleased that she will be continuing on as part of our core faculty. We will be having some receptions in the Fall to provide an opportunity for us to get acquainted. In the north it will be September 7 from 5pm to 7pm and in the south it will be later in September or October. We will let you know.

Our most recent graduate Dr. Maureen Clarke received her diploma, and presented her research, *Life Beyond 80: What Provides Meaning And Satisfaction,* as the opening to our Spring convocation on Aging. Her address and the convocation were well received, and included a number of very illuminating cross-cultural presentations on the theme as well. Again congratulations to Dr. Clarke.

The Sanville Institute is offering two new extended education classes in Northern California this Fall, both being taught by Sanville graduates. Dr. Beverly Burch will teach *The Relational Unconscious in Cross-Cultural Psychotherapy*, and Dr. Paula Holt will teach *Shame and the Practice of Psychotherapy: Grounding the Elusive Experiential*. We are excited by these inaugural courses and hope they are the beginning of more public classes.

In addition, the Sanville Institute is organizing a low-fee clinic that will provide psychotherapy and consultation in the North. It is modeled in similar ways to our clinic in the South, which has been successfully in place for some time. Please contact me at mstarc@sanville.edu if you would like more information.

Our Fall convocation in Berkeley will take place on Oct. 11. This will be our semi-annual Law and Ethics offering, currently entitled *If It Isn't Illegal, Why Doesn't It Feel Right?:The Ethical Attitude Revisited.* It should prove an interesting weekend, kicked-off by our annual Michael Wolff concert for the Elise Blumenfeld Fund on Friday evening.

Visit www.sanville.edu for more information regarding the events above and information on our PhD and certificate programs.

We are a state-approved educational 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.

Observing Psychotherapy Through Multiple Lenses
George Rosenfeld, Ph.D.

Within an integrative framework there are multiple lenses through which psychotherapists may filter what is happening in sessions. Compatible with many theoretical frames, these 11 lenses influence outcome and the selection and timing of therapist contributions. They are described to sensitize new therapists to their importance and remind seasoned therapists about the usefulness of including these lenses in viewing the therapy session. These lenses are not the only filters that therapists rely on.

Professional responsibilities: What happens in session needs to be observed through the lenses of legal and ethical obligations and personal values. We maintain an awareness of such legal and ethical responsibilities as the need to report abuse, safeguard client confidentiality, protect the client and others from harm, avoid dual relationships, secure client participation in directing the course of treatment, and minimize surprises through ongoing informed consent. It is important to scan for medical issues that contribute to problems to avoid mistakenly treating a medical concern as an emotional problem, such as treating low thyroid as depression or treating headaches as emotionally caused when they have an organic basis. These responsibilities inform the boundaries and therapeutic frame that therapists maintain.

Client capacities: diagnosis, intellectual and developmental level: These client characteristics influence prognosis, and aid in forming realistic expectations and goals. Diagnostic categories are predictive of different capacities to change and are associated with particular interventions. Intractable problems may require acceptance, while more changeable problems might be more responsive to interventions. We might anticipate that an Hysteric client might respond to reassurance and a Paranoid client might be expected to reject having the truth of his paranoid conclusions disputed. We may have very different treatment expectations for early vs late onset Oppositional Defiant Disorder diagnoses. Depressed clients without a bipolar history might benefit from a medication that would be detrimental for a depressed client with such a history. Often a diagnosis identifies the client's strengths and beliefs, upon which interventions can be based.

The client's intelligence and developmental level of maturity need to be constantly considered because they impact the client's ability to understand and employ the therapist's ideas. A concrete thinker needs concrete suggestions. A client at the level of moral development based on consequences may not benefit much from exposure to more mature reasoning based on empathy or mutual agreement. A client with low intelligence may need repetition and reward. A client with impaired executive functioning might need structure in the environment to compensate for deficits.

The therapeutic relationship: The depth of the relationship with the therapist co-varies with outcome. The client's feelings about the therapist and treatment progress can be difficult to notice. The therapist needs to identify ruptures in the relationship and feelings of disappointment with treatment in order to repair these threats to progress. Sometimes changes in client affect, posture, enthusiasm, tone, and facial expression can be the only hints of problems that can derail treatment. Hill, et al. (1996) found that therapists "became aware of their clients' dissatisfaction only after the clients abruptly and unilaterally stated that they were terminating therapy" (p. 216). We continually assess the strength of the relationship and assess if the relationship is strong enough to allow for a particular intervention.

Repairing ruptures in the therapeutic relationship can lead to moments when the client realizes that the therapist really cares, and to opportunities to correct transference distortions that underlie the client's problems (Safran, et al. 2002). For instance, a client might incorrectly project on to the therapist the belief that the therapist thinks he is dumb or crazy and then feel wounded, reject the therapist and withdraw. Correcting this rupture might motivate the client to question his similar conclusions about how others view him. While we build the therapeutic relationship with

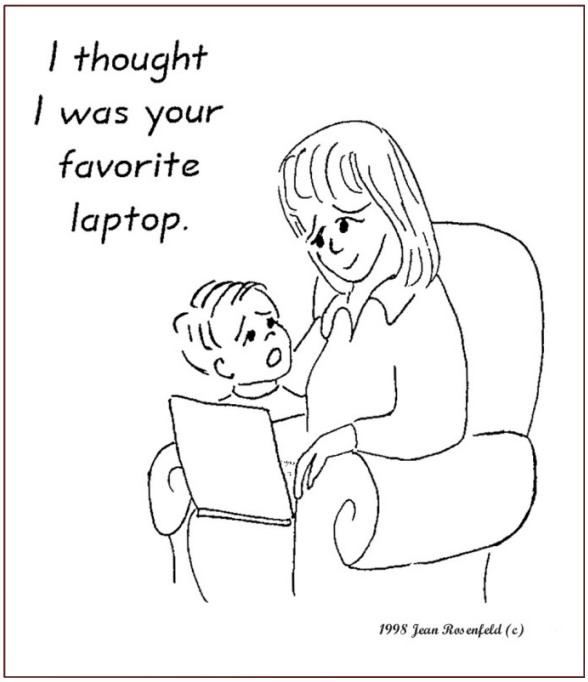
(Continued on Page 18)

Rhymes and Reasons

On Children
by Kahlil Gibran

Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you, yet they belong not to you.

You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow,
Which you cannot visit, not even in your dreams.
You may strive to be like them, but seek not to make them like you,
For life goes not backward nor tarries with yesterday.



Parenting in Stepfamily Life: It's A Challenge

Susan Davis-Swanson. PhD, LCSW

Creating a stepfamily can be daunting to all involved. Usually, at first, the new stepparent goes out of his or her way to be accommodating and to befriend the kids, hoping for acceptance; and the biological parent is relieved and delighted to have someone to share the parenting. In this "Fantasy Stage," according to Patricia Papernow, all things seem possible and future problems will be easily worked out. The real issues that ultimately come with stepfamily life haven't yet been fully realized. These complications lead to many broken relationships, some relationships failing after many years of living together.

In the "Awareness Stage" problems and issues become evident. As the couple grapples with them, a typical pattern emerges: the dynamic of the Insider/Outsider. As one stepparent put it, "I feel when the kids are over that they and their dad are safely inside the hot air balloon and I'm hanging by a rope outside of the basket." Dr. James Bray identified this pattern in his 10-year research study on stepfamilies, and stated that to not understand this underlying dynamic of stepfamilies is to truly not understand stepfamily life.

In the "Awareness Stage" problems and issues become evident. As the couple grapples with them, a typical pattern emerges: the dynamic of the Insider/Outsider.

Insider/Outsider

Kevin and Julie have been engaged for a year and are struggling with stepfamily issues. Kevin has a very close relationship with his seven year old daughter, Lisa, and is fiercely protective of her. Julie feels that Kevin is unfairly reactive to any questioning, correcting or mild criticisms, incurring her fiancé's anger and accusations that she "doesn't love Lisa." The increasing tension when Lisa comes for her weekly visits results in Julie feeling hurt. She is becoming increasingly resentful when she is expected to take care of Lisa or take her to school. It is very painful for Julie to feel like an outsider when she hears Kevin on the phone with Lisa's mother sharing "something adorable" that Lisa has done. Kevin has fears that Julie is not "maternal" and questions whether he should have a child with her. Julie is contemplating leaving the relationship.

Kevin unrealistically wants Julie to "love" Lisa as he does. Along with wanting Julie to be a wonderful parent to Lisa, he also feels that this will prove that she loves him. Julie wonders about her own capacity to love a child. "I don't know who I am anymore. I know I'm loving; I love my nieces and nephews and I love kids, but I tried so hard to be with Lisa and maybe he's right, maybe I can't love her, maybe something's wrong with me." This can harm an important aspect of a stepparent's (particularly a stepmother's) sense of self.

The process of forming an attachment between a stepparent and stepchildren can be difficult. Stepparents usually do not have the early attachment years; and even when they do, they are usually sharing it with a biological parent who may be very much alive and involved. Because of this, the stepparent often "leans out" of the system in their struggle to find a place, further preventing an attachment from forming. For both the parent and the new partner the family that they are forming does not feel as they expected and fantasized, and this often leads to feelings of dissatisfaction and failure.

During these times of growing discord, the biological parents typically become fiercely protective of their children and when the children react to the stepparent negatively, they become more wary and guarded. Parents can get away with saying, "I can't stand Brian right now, he's being so difficult," but stepparents cannot say that as they will be perceived as not liking the child. This often increases the triangulation as the parent and the children bond closer and the stepparent feels like an unwelcome stranger in their own home. What the couple does need to learn is that they are perpetuating the Insider/Outsider dynamic that is the fabric of stepfamily life. This offers a growth opportunity for them as they understand that what they are experiencing is a normal part of stepfamily life.

A parent cannot walk in the shoes of a stepparent, and cannot be expected to. This creates distance in the

(Continued on Page 20)

Book Reviews
by Ruth Jaeger, LCSW

Raising Your Spirited Child
by Mary Sheedy Kurcinka, MA,
William Morrow, Revised Edition November 28, 2006

and

The Highly Sensitive Child
by Elaine N. Aron, PhD,
Boradway Books, 2002

In the December 2009 *Atlantic Monthly,* David Dobbs describes two kinds of children in "The Science of Success." Most children are like dandelions. You can throw their seeds anywhere, it doesn't matter how much sun they get, how much wind, how much water. They can grow and flourish anywhere. And then there are orchid children. They need just the right amount of water, just the right amount of sun, and just the right amount of care to grow and flourish. Children with challenging temperaments are like orchids—requiring just the right nourishing to flourish. Two books for parents incorporating concepts about temperament are great resources to help these orchid children thrive.

Since 1992, *Raising Your Spirited Child* by Mary Sheedy Kurcinka, MA, has provided tremendous relief and guidance to parents of the ten per cent of all children previously labeled as having "difficult" temperaments. Kurcinka's reframing of temperamentally very challenging children as spirited encourages parents to view their child from a more positive perspective. *Raising Your Spirited Child* was revised in 2006 to include new research on neurodevelopment.

Kurcinka bases her book on the landmark longitudinal studies of Stella Chess and Alexander Thomas which identified nine inborn traits that impact how children react to their environment. The book's premise is that biology is not destiny and that although children are born with defined temperament traits, it is parents who can create new neural pathways through their interactions with their child. Kurcinka shows parents how their responses to their child's temperament can lead to different ways of responding to their environment. Parents are cautioned that when parents reprimand children for their energy, sensitivity, or non-compliance due to slow adaptability, they send the message that it is not ok to be who they are.

Raising Your Spirited Child offers detailed descriptions of the nine temperament traits. The discussion about each trait focuses on reframing the trait in positive language. For example, with a child who is slow adapting, a parent is encouraged to say "you like to be organized" or "you need to know what to expect" rather than "it has to be your way." Each section also includes the things that parents can do to work with a trait, in other words, how to create a good fit between the child's temperament and the environment. And, finally, Kurcinka recognizes that parents, too, have their own temperament traits and offers suggestions on how to meet their own temperament needs.

Kurcinka discusses many of the common parenting struggles, explains how each temperament trait can contribute to the struggle and then offers suggestions to avoid those struggles. She encourages parents to predict whether a certain task will create a struggle (ie. getting dressed) and which temperament trait contributes to that struggle. Parents are then advised how to alter the setting and expectations to better fit the child's temperament to set the stage to work with the child for successful resolution. In contrast to most books about children's sleep which are generic for all children, the section on bedtime includes strategies that account for different temperament traits contributing to bedtime difficulties.

Raising Your Spirited Child is an invaluable resource for parents of children with challenging temperaments because it recognizes that individual differences require different parenting strategies. It provides support for parents with spirited children in the face of grandparent or other adult criticism of their child or their parenting. And it offers hope that good parenting can help even the most temperamentally challenging child succeed.

(Continued on Page 21)

Legal Update
***Tarasoff*: Reviewed and Updated**
By Myles Montgomery, JD, LCSW

Mention of *Tarasoff* usually leaves clinicians with a mixed sense of vagueness and anxiety. Truth is, the case provided a landmark decision, which spawned a change in the legal standard for breaking confidentiality when a client expresses intent to harm another person. However, many therapist are not aware that this case prompted an important statute and a smattering of cases that both expanded and restricted its scope.

The underlying facts of the *Tarasoff* case are relatively straightforward. In the summer of 1969, a University of California, Berkeley student, named Prosenjit Poddar, expressed to his therapist – Dr. Moore – his intention to kill a girl, Tatiana Tarasoff. At the time, Tatiana was on vacation and had not yet returned to the University. In response to this threat, Dr. Moore contacted the University police, who assessed Prosenjit and determined him not to be a threat.

However, in spite of this warning, Prosenjit obtained a gun and shot Tatiana after she returned. The Tarasoff family brought an action in negligence against the Regents of the University of California and against Dr. Moore, personally. While the case ultimately settled among the parties, the decision was closely watched to learn what kind of duty was owed from a therapist to a person with whom he or she had previously had no contact but whom, the therapist knew, may be in danger. By now, it is common knowledge that this duty does exist, resulting from the statute arising directly from the Court's holding in the case.

Besides being an important case, its final decision illustrates the tension that exists between client confidentiality and the need for access to information concerning public safety. The following language from the case acknowledges this tension but resolves the matter on the side of public safety:

> the public policy favoring protection of the confidential character of patient-psychotherapist communications ***must yield*** to the extent which disclosure is essential to avert danger to others. ***The protective privilege ends where public peril begins*** [boldface and italics added]. *Tarasoff v. The Regents of The University of California*, 17 Cal.3d 425 (1976) at 442.

Perhaps the most important aspect of this case is the Court's recognition of "special relationship" between a psychotherapist and his or her clients. This relationship requires a greater responsibility for therapists, as they have more access to information potentially affecting the safety of others.

The Resulting Statute

Following the *Tarsasoff* decision, the California legislature drafted Civil Code §43.92, which was signed into law. Of most interest to practicing clinicians is frequently how liability may arise. Regarding liability, the statute reads as follows:

> (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.
>
> (b) If there is a duty to warn and protect in the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

It should first be noted that that this statute applies exclusively to those defined as "psychotherapists" under California Evidence Code §1010, which includes the following: psychiatrists, licensed psychologists, LCSWs, MFTs, credentialed school psychologists, supervised assistants, trainees, interns and students engaged in social work, registered nurses with master's

(Continued on Page 22)

Understanding Children's Temperament to Enhance Clinical Practice

(Continued from Page 1)

Chess and Thomas conducted The New York Longitudinal Study to better understand the differences in children's behavior. From this seminal work nine temperament traits have been identified: sensory threshold, activity level, intensity, biologic regularity, adaptability, mood, approach/withdrawal, persistence and distractibility. It is the combination of these traits that determine a child's temperament.

Temperament can be assessed through clinical interview, child observation or parent questionnaires. Each method has its own methodological problems. The clinical interview is compromised by parent subjectivity. The child observation is limited by the amount of time the observer can devote to an observation and the limited temperament challenges that can be engineered during an observation. There are several parent questionnaires available which rely on parents' subjective experience of their child. Clinicians using any of the temperament assessments need to take into account that different parents' experience, mood, expectations and time spent with the child impact parent assessments. For children to age five, The Preventive Ounce, www.preventiveoz.org, is very user-friendly. For older children, The Carey Temperament Scale is valid to age twelve. Although there are questionnaires to assess temperament in adolescents and adults, there are so many environmental factors that have influenced behavior by adolescence, that it is questionable whether temperament can accurately be determined after puberty.

Using temperament as one of many factors in assessing children's behavior, we can often move away from pathologizing to normalizing.

The critical concept in working with temperament is creating a good fit between the child's temperament and the parent or the environment. When a parent understands that a child's challenging behavior is a byproduct of his or her temperament then the parent reacts to the child's behavior with more understanding, empathy and effectiveness. Goodness of fit allows clinicians to consider how the child's temperament interacts with the setting or the person without blaming either as being the culprit in misbehavior.

Using temperament as one of many factors in assessing children's behavior, we can often move away from pathologizing to normalizing. I once consulted with the father of six year old, Emma, who was certain that his daughter had a very serious mental illness. He walked her to school daily. One day he decided to alter the route. Emma became so distraught that she refused to continue to school and sat in the middle of the street inconsolable. He tried again another day, and again she refused to proceed. He was especially concerned about her behavior because her mother had suffered a post-partum depression and there was a family history of mental illness. After he completed the Preventive Ounce temperament questionnaire, it was evident that Emma's strong reaction to changing the route was due to her temperament. She was very slow to adapt to change, was intense and withdrawing from new experiences. It was the combination of these traits that provoked such a strong response to a change in what she had grown to expect. It is certainly possible that her mother's post-partum depression and family history of mental illness will impact her development, but in this instance, it was her temperament that provoked such an unexpected strong reaction.

Another compelling example of how a child's temperament response to a parent's behavior can be misconstrued as pathology is that of a three year old girl whose mother was concerned that she was displaying symptoms of Obsessive Compulsive Disorder. Numerous times during the day Anna asked her mother to take a shower, comb her hair and change her barrette or clothes. After her mother completed a temperament assessment, we learned that Anna was slow to adapt to transitions and had very low intensity. As I reviewed Anna's temperament with her mother, she had an "ah ha" moment. Mother noted that although now she was a stay at home mom, she had previously been a very busy, successful attorney and was accustomed to doing many different things in the course of her day requiring numerous transitions for Anna. Anna's behavior served the purpose of slowing things down and reducing the number of transitions. After reducing the number of different activities in which they participated in the course of a day, mother reported that Anna's seeming obsession with showering and grooming had ceased. On follow up, she observed that when she increased their activities, Anna reverted back to her "compulsive" behaviors.

Four year old Joey offers an example of how the setting can impact a child's behavior. When I consulted the parent I learned that Joey had recently begun a new preschool because the parents thought it would better prepare him for kindergarten and his older sister had thrived there. Unfortunately, once he began in the new program, his developmentally appropriate interactions with peers regressed. He began hitting, biting, and withdrawing. Joey had previously been in a small family child care setting which the parents described as very calm and quiet. Joey's temperament assessment revealed that his threshold for sensory stimuli was very low; he was very easily overwhelmed in settings where there was a lot of activity and noise. His aggressive and then withdrawing behavior at the new school was his response to an environment that was over stimulating for him. His sister had thrived in the same school because her sensory threshold was much higher. It was not a good fit for Joey. The parents were determined to keep Joey at the school because it offered a highly regarded pre-kindergarten program. We discussed how they could work with the teachers and Joey to identify quiet spaces at the school where he could retreat when he felt overwhelmed. They also worked with the teachers to help Joey learn how to calm himself through deep breathing. The parents decided that they could reduce his hours at the school to allow him more time at home away from the highly stimulating school.

Joey's temperament assessment revealed that his threshold for sensory stimuli was very low; he was very easily overwhelmed in settings where there was a lot of activity and noise. His aggressive and then withdrawing behavior at the new school was his response to an environment that was over stimulating for him.

When a parent understands his or her child's unique temperament it allows the parent to consider that the child's behavior is neither abnormal nor bad. When a first child is temperamentally challenging, parents easily compare themselves to other parents with "easier" children and are often certain that it is their poor parenting that has created a child with challenging behavior. As they deal with other's criticism of the child's behavior they feel increasingly incompetent as parents. When the second child has a challenging temperament, the parents are at a loss to understand why their previously good parenting is not working. It is easy to blame the child until they understand that the more challenging behavior is caused by different temperament that requires different parenting. Acknowledging that there are innate temperament differences increases parents' sense of their own competence.

Understanding children's temperament can significantly reduce parent-child conflicts. When a mother understands her son's slow adaptability to transition she can prepare him for the transition without creating stress about non-compliance. When a father understands his daughter's withdrawing trait he can be more supportive of her trying new activities without pushing her more quickly than she can manage. When a child is slow to adapt to change, parents can avoid power struggles by recognizing the child's desire for routine and structure. Reducing parent-child conflicts can create increasing family satisfaction leading to improved mental health for both parent and child.

When working with parents about their child's unique temperament in order to develop appropriate parenting strategies, it can often be useful to discuss a parent's own temperament. Although it's doubtful how accurate temperament questionnaires are in assessing adult temperament due to the numerous life experiences which impact behavior, understanding how temperament traits impact parents in their interactions with their child can lead to increasing tolerance for their child. When a parent understands that she is highly adaptable to change and thrives on lack of routine or structure in contrast to her child's lower adaptability, she can consciously make decisions about planning and preparation that more easily fits her child's temperament. Parents whose own temperament is very intense are frequently very aware of how their intensity increases their child's. When they view their child's escalating tantrum as a reaction to the parent's intensity, they can more consciously work to reduce their intensity.

As clinicians we improve our ability to help the families with whom we work when we integrate biological causes for their behavior into our case formulations. Considering the influence of temperament on behavior is one of the tools at our disposal to better understand and help our clients.

Ruth Jaeger, LCSW, has a psychotherapy practice in San Rafael, focusing on work with children and parents. She is also the Clinical Health Educator and Temperament Specialist in the Department of Pediatrics at Kaiser San Rafael where she works with parents to help them with their children's behavioral problems. She can be reached at ruthjaegerlcsw@yahoo.com

Observing Psychotherapy Through Multiple Lenses
(Continued from Page 11)

hope and understanding, we try to avoid fostering the therapeutic relationship by colluding with the client by triangulating others, such as siding with an adolescent against his parent or repeatedly siding with one family member against another in family therapy.

Seeking client feedback about progress and the health of the therapeutic relationship has been shown to be one of the most powerful things a therapist can do to improve outcome. Studies in support of improving outcome by soliciting client feedback can be found at: http://www.slideshare.net/scottdmiller/measures-and-feedback-2013-compatibility-mode.

Levels of motivation: Interventions need to be appropriate to the client's readiness to change. Some clients are highly motivated to change and are ready to seek solutions. They may be so ready that they improve despite the therapist, by selecting useful ideas from the many that the therapist offers and from their own explorations.

Other clients may so successfully deny, minimize, and rationalize that they have little awareness of their problems. They may have entered therapy because others wanted them treated or because they want the therapist to change others. These low motivation clients may need help to foster engagement and look at how their lives could be better. Miller, et al (1993), Miller & Rollnick (2002) and Patterson & Forgatch (1985) found that when therapists use active-listening and focus on understanding the pros and cons of change from the client's perspective, clients talk twice as much about committing to change and express half as much resistance than when therapists confront client resistances and try to persuade clients to change. It is important to avoid the common miscalculation of providing low motivation clients with interventions before they are ready to utilize them. Problem-solving is not a priority for someone who does not recognize that he has a problem.

It is important to avoid the common miscalculation of providing low motivation clients with interventions before they are ready to utilize them. Problem-solving is not a priority for someone who does not recognize that he has a problem.

Problem domains: Arnold Lazarus proposed that a problem nests in multiple domains, all of which need to be a focus of treatment for the problem to be fully ameliorated. Following Bennett Braun's BASK mode (1988) which alerted the clinician to treat a problem's components (behavior, affect, sensation, and knowledge), Lazarus (1989) extended the focus to seven components: behavior, affect, sensation, images, cognitions, interpersonal, and drugs/body to which he ascribed the mnemonic, the BASIC-ID. For example, after a client has desensitized to the affects of a trauma, she might still be triggered by images or sensations of the trauma. Another helpful lens was proposed by Albert Ellis (1984) who focused treatment on the ABCs of a problem: the Antecedents, Behaviors and Consequences.

Levels of anxiety: Clients who experience minimal anxiety in treatment may lack motivation and thus not benefit from therapy unless their anxiety is raised. Anxiety might be raised by confrontation of behavior and defenses and by asking questions about more anxiety loaded domains that upset the client. Other clients may experience too much anxiety and feel so overwhelmed that they disclose too much, shut down or withdraw from treatment. John Briere (1996) described the optimal level of anxiety as "the therapeutic window" in which treatment is most possible, where feelings can be expressed without triggering old destructive behaviors, such as self-injury, suicidality, and dissociation. In order to keep the client within the therapeutic window of optimal anxiety, therapists can monitor their use of confrontation, support, humor and reframing, and ask questions to focus the client's attention on different domains of their problem.

For example, in addition to encouraging the use of anxiety-management skills and offering support, anxiety might be lowered by shifting a client's attention away from overwhelming affect caused by describing a traumatic incident to answering a question about where the incident took place (knowledge) or about co-occurring smells or sounds (sensation). Rather than having to stop processing material, the client might be able to continue to desensitize to other aspects of a trauma without becoming overwhelmed by anxiety. Alternating between describing a traumatic incident and drawing a picture (image) of the event might keep anxiety within the window. Moving between the past, present and future can be another way to control anxiety while keeping the client focused on treatment

issues. As therapy shifts between time and/or elements of the BASIC-ID the client may be able to maintain a working level of anxiety so therapy can be productive.

Stages of therapy: Therapists act differently in each stage of treatment. In the beginning the focus might be on fostering engagement, assessing, avoiding confrontation and power-struggles, building a therapeutic alliance, identifying concerns, providing psychoeducation and fostering hope. The middle part of therapy might involve working on changing, adjusting to difficulties, acquiring new skills, and developing new patterns. Toward the end of therapy the emphasis might be on celebrating and consolidating gains and coping with termination.

Time remaining in session: Therapists adjust their agenda to the time remaining in the session. The beginning of a session might be devoted to re-engaging, reviewing previous issues and clarifying the focus of the session. The middle of a session might focus on doing the most anxiety provoking work. The end might involve an ending ritual, helping clients return to a functioning state so they can leave and face their obligations, illuminating take-away lessons, summarizing aspects of the session or developing homework assignments.

Environmental support: Although the therapist can be an important resource and support, the power of the client's family, associates and community resources cannot be underestimated. Therapists think about how these entities and the client's culture encourage and impede progress and can be called upon to facilitate growth. Without the support of the clients' environment, new beliefs and behaviors can be squashed. For instance, trying to be more assertive can threaten important relationships unless the environment is prepared to welcome the changes.

Transference and countertransference: Psychotherapy involves a struggle within the therapist between objectivity and countertransference. Transference refers to the unconscious life scripts, the feelings and expectations from past relationships that the client brings to the session. Countertransference refers to the therapist's feelings about what is happening in session and how the therapist's personal story and needs are connected to the client's drama. As Anais Nin put it, "We don't see things as they are. We see things as we are."

If we worry about being competent we might push clients too hard, be too goal-oriented or avoid seeking client feedback. If we need to be liked by clients we might not push enough. If we need to be accepted by colleagues we might hide our worries and errors. Noticing transference and countertransference material requires the therapist to constantly look for patterns while observing the client, the therapist, and the interaction between them.

We need to monitor how our personal feelings get expressed in our choices, comments and goals. We guard against reenacting our past relationships, selling clients our personal solutions to their problems and using clients to meet our needs. For instance, we may unrealistically see the client as similar, assume he or she has the same feelings, resources and thoughts we have, and/or want him or her to behave the way we did or wish we had.

Content and process: Content is what is being said and expressed, what seems to be going on taken at face value. A late client is just late. A cigar is just a cigar. Process suggests a deeper meaning, a subtext, a bigger picture. Process involves noticing patterns, such as, the father dominates and controls, the client keeps trying to please the therapist, or the client treats the therapist similarly to how he treats his mother. The client's complaint about how her previous therapist never helped her might be seen as a request for certain care and a warning to the present therapist, as well as a description and expectation of how others have treated, and will treat her. Noticing process can lead to identifying important patterns that need attention.

Summary: Outcome may depend on the therapist's ability to continually attend to professional responsibilities, client strengths and weaknesses such as diagnosis and developmental level, the therapeutic relationship, the client's level of motivation and anxiety, the multiple domains of a problem, the stage of therapy, the time remaining in session, environmental challenges and supports, transference and countertransference patterns, and session content and process. Using these lenses throughout therapy can support progress. Overlooking any one of these lenses can derail treatment.

George Rosenfeld, Ph.D. is a psychologist practicing in Sacramento. He is the author of *Beyond Evidence-Based Psychotherapy: Fostering the Eight Sources of Change in Child and Adolescent Treatment,* published by Routledge. He teaches in graduate programs at CSUS and the University of San Francisco. He can be reached at geo.rosenfeld@gmail.com. References available from author

Parenting in Stepfamily Life: It's A Challenge

(Continued from Page 13)

couple. The person they fell in love with, who showed up as the person they can share the most with in life as a partner, becomes the very person who doesn't understand their most difficult challenges. Once couples understand this, they can talk about the issues with this acceptance as the backdrop. While the parent may not ever truly understand how hard it is for the stepparent, and how unappreciated she or he feels, the parent can at least accept that this is a problem for most couples in stepfamilies. Rather than pulling away, they can come toward each other in understanding. This helps the stepparent to not feel as much on the outside, and the parent to not personalize the stepparent's behavior. Allowing that it is normal for the stepparent's feelings to be changeable and that some flexibility in the relationship is needed can go a long way to helping the stepparent find a comfortable place in the family. "Sometimes I want to be with you and the kids and sometimes I just need to be away." Once they both accept that it is normal for the stepparent to have all of these very complex feelings, they can begin to work together.

The person they fell in love with, who showed up as the person they can share the most with in life as a partner, becomes the very person who doesn't understand their most difficult challenges.

Dan moved in with Karen and her twin boys, age 8. The boys only see their father one or two weekends a month; he usually takes them out for movies and video games, but leaves the parenting to Karen. Karen felt hopeful when she saw the twins' attachment to Dan, who played with them often when they were dating, would help them with their homework and spend time with them. But after Dan moved in, he decided that Karen was too "permissive" and started "laying down the law" with the kids. This has led to conflicting feelings and Karen's increased protection of her boys, which infuriates Dan. Both of them have started to feel that their relationship is a mistake.

As we talked, Dan was able to identify feeling on the outside most of the time. This surprised Karen, who had been angry that he wasn't more a part of the family. She felt she had to assure her boys that Dan cared about them because none of them knew how to act when Dan wasn't happy and friendly. When he became frustrated or upset that the boys hadn't done their chores, or were still up until 10, the bad feelings were reinforced. Dan is beginning to want to "run away." As they talked about their anger and hurts, I asked them how they hoped this would feel. Dan then talked about loving the boys, "They're great kids, but Karen is always trying to protect them and protect them from me." Karen has felt guilty that their Dad isn't more involved with their lives and wanted Dan to be the man that is there for them, yet she was unwilling to give him any role other than what she wanted it to be. As she understood that this perpetuates his feelings of being the outsider, she began to understand. Dan too understood that while he wants a role in disciplining, he also has to make sure the kids understand his true affection for them.

With increased understanding of each other's feelings and positions, the couple began to work on some parenting solutions together, such as agreeing on some house rules around bedtime, chores and t.v. watching. It took some time for Karen to work with Dan instead of against him; but they came up with several house rules that Karen agreed to enforce. House rules make it easier for the couple and the kids, because as one stepchild put it, "I could accept the rules of the household but I could never accept my stepfather's rules." After a while children, particularly younger ones, will accept the consequences enforced by the stepparent, particularly if there is a generous amount of positive attention as well. This will also help to normalize the household and begin to build their sense of "family."

House rules make it easier for the couple and the kids, because as one stepchild put it, "I could accept the rules of the household but I could never accept my stepfather's rules."

When couples understand this Insider/Outsider dynamic in their lives and begin to work together, they will have more experiences of working together as a team. This will reinforce their couple bond. New norms and traditions take time. Researchers have found it takes approximately 7-1/2 years for most stepfamilies to begin to function like a family. Time and patience reap many wonderful rewards.

Susan Davis-Swanson, Ph.D., LCSW is the founder of The Stepfamily Center in Beverly Hills, California. She has published over 40 articles and lectured on the topic of remarried couples. An attachment based therapist, she is also an experienced trauma practitioner, practiced in EMDR and somatic therapies. Visit her website at www.stepfamilycenter.com or contact her at 310 274-2780. Referenced available from author.

Book Reviews: *Raising Your Spirited Child* and ***The Highly Sensitive Child***

(Continued from Page 14)

The Highly Sensitive Child by Elaine N. Aron, PhD, focuses on the fifteen to twenty percent of children who have been found to be highly sensitive. Like Kurcinka, Aron offers parenting advice for children whose behavior is more challenging to manage and encourages parents to understand their own temperament in order to help the child manage his or hers.

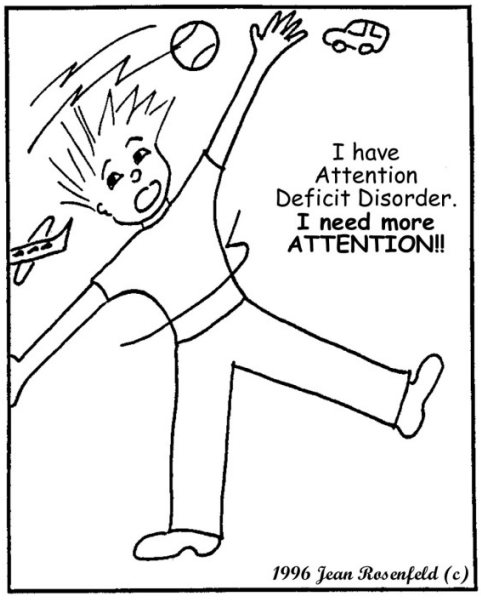
Aron refers to children with low sensory threshold as HSCs in a book designed to help parents with their child who is easily overstimulated by his or her interactions with others or by the environment. She stresses that these children are very empathetic and intuitive, but they need parents attuned to their special needs in order to manage in a chaotic, stimulating world.

After describing the Highly Sensitive Child and the parenting challenges, Aron devotes separate chapters to each developmental stage discussing the unique needs of HSCs at each stage, making it an easy reference for parents during each life phase. She helps readers understand how high sensitivity impacts such childhood tasks as sleeping through the night, toilet training, beginning school, and making friends and offers guidance as to how parents can help their HSC with each task.

Like the children described in *Raising Your Spirited Child* who are easily prone to temper tantrums, the HSCs are also more likely to suffer from somatic complaints due to stress and withdraw from group activities. Aron's suggestions offer important tools to parents to prevent these unwanted outcomes.

Raising Your Spirited Child and *The Highly Sensitive Child* are invaluable resources for parents of children with challenging temperaments. Both authors recognize that individual differences require different parenting strategies and provide support for parents with spirited and highly sensitive children in the face of criticism of their child or their parenting. Of course, as with all self-help books, the authors assume that the parents will be able to make the necessary alterations to their parenting to have a better fit with their emperamentally challenging child. For parents who are overwhelmed by the more conscious parenting that these books suggest, psychotherapy is crucial to deal with the underlying blocks to change. For those parents who are able to alter their parenting, both books offer hope that good parenting can help even the most temperamentally challenging child succeed

Ruth Jaeger, LCSW, has a psychotherapy practice in San Rafael, focusing on work with children and parents. She is also the Clinical Health Educator and Temperament Specialist in the Department of Pediatrics at Kaiser San Rafael where she works with parents to help them with their children's behavioral problems. She can be reached at ruthjaegerlcsw@yahoo.com



Legal Update - *Tarasoff*: Reviewed and Updated

(Continued from Page 15)

degree in psychiatric mental health nursing, and degree in psychiatric mental health nursing, and individuals providing mental health services under Cal. Family Code § 6924

In reading the remainder of the statute, it is clear what the specific duty for a psychotherapist entails and how this duty is carried out. Specifically, those qualified as "psychotherapists" are not subject to monetary liability except under the specific circumstance identified in the statute.

Here, the duty calls for a clinician "to protect and to warn, ***and*** to predict" only when 1) a **patient** has **communicated** to the psychotherapist 2) a **serious** threat of **physical violence**, and 3) against a **reasonably identifiable** victim or victims. The statute also states that a psychotherapist fulfills this duty by making reasonable efforts to communicate the threat 1) to the victim or victims ***and*** 2) to the police.

Extensions Of Tarasoff

Since this statute was enacted, several cases have come along to define, expand, and limit the application of the duty described in this statute. Most notably, in the case of *Ewing v. Goldstein* (120 Cal.App.4th 807 (2004)) communications made by the family members of a client also prompted discharge of the duty. In *Ewing*, the father of a client told the therapist about the client's desire to seriously harm another person. After the client killed the victim, the victim's family sued the therapist for failing to warn the victim. The California Court of Appeal found for the victim's family and ruled that communications made to the therapist by **a patient's family member** for the purpose the patient's therapy should also be construed as a "**patient communication**." In effect, this decision expands the *Tarasoff* duty, to warn, protect and predict, to include communications from third parties close to client.

Limitations To *Tarasoff*

By contrast, the Court of Appeal **refused to include the duty of *Tarasoff* to apply to instances when a client is suicidal**. In the case of *Bellah v. Greenson* (81 Cal.App.3d 614 (1978)) the family of a woman who intentionally overdosed sued her treating psychiatrist – who knew she had expressed some suicidal ideations. Although the Court refused to apply the *Tarasoff* duties, described in Cal. Civil Code §43.92, in such situations, it did acknowledge that the special relationship between therapist and clients does require that a therapist take reasonable steps to prevent a threatened suicide. Lastly, the case of *Goss v. Allen* (22 Cal.App.4th 354 (1994)) is instructive with respect to how California Courts are willing to apply the *Tarasoff* holding and interpret Civil Code §43.92. In *Goss*, a treating psychiatrist was sued for failing to take reasonable steps to prevent a patient's suicide attempt, after the client's attempt resulted in permanent brain damage. In response, this psychiatrist sued the client's previous therapist for failing to inform him that the client was suicidal. While the initial therapist argued he owed no duty to provide this information, the Court disagreed and found that this information should have been made known to the second treating therapist. Again, the Court recognized the special relationship between therapist and client to require reasonable steps to be taken in order to prevent a client's suicide. Thus, "reasonable steps" may include warning subsequent clinicians of a common client's suicidal ideation. It is interesting to note that the *Tarasoff* holding was looked to as a shield and not a sword in this case.

The Take Away Message

The line of cases springing from the *Tarasoff* case are as significant as the original decision. So, reading all of these cases together, what is the underlying message for practicing clinicians? To begin, California Civil Code §43.92 remains on the books and good law. Even if it is not committed to memory, clinicians should be familiar with its language. As for the cases that followed, they are also worthy of consideration; although none of them resulted in the creation of new legislation, they are still available for reference in a legal brief, therefore, binding law. The *Ewing* case expands the source of reportable information from the individual client to his or her immediate family members. The *Goss* case applies the reasoning in *Tarasoff* that, because of a special relationship between a therapist and client, reasonable steps are required to be taken to prevent harm to suicidal clients through diligent communications between current and subsequent treating clinicians. Finally, the *Bellah* case refuses to extend Civil Code §43.92 to instances in which clients report suicidal ideation.

Myles Montgomery, JD, LCSW is a practicing social worker and attorney in Sacramento. He teaches law and ethics at Alliant International University and is a board member and leads seminars on law and ethics for CSCSW. He can be reached through CSCSW's main office at 916-560-9238

Classifieds

JOB OPPORTUNITIES

∞∞∞∞∞∞∞∞∞∞FAMILY ALLIANCE FOR COUNSELING TOOLS AND RESOLUTION (FACTR)/ SOUTH BAY∞∞∞∞∞∞∞∞∞∞

Part-time, contract, Forensic Social Worker needed to conduct hardship and mitigation psychosocial evaluations on behalf of immigrants at FACTR. www.factr.org Must be culturally proficient, highly organized, timely, capable and willing to provide expert testimony in court. Spanish, Tugaloo, and Chinese speaking, and other- first language, licensed clinical social workers or licensed marriage and family therapists preferred. Contact: Karita M. Hummer, LCSW, karita@factr.org

OFFICE SPACE

∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞RANCHO PALOS VERDES OFFICE SPACE AVAILABLE∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞

Therapy offices available, hours flexible, handicap access, utilities included, waiting room, convenient location, great price, Rancho Palos Verdes, contact 310 200 4633.

∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞ SHARED OFFICE SPACE IN LAGUNA HILLS ∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞

Furnished 12 X 15 office for rent part-time. First floor wheelchair accessible. Close to 5 and 405 freeways. Suite of 4 offices with separate waiting room, reception and kitchen areas. Referrals possible. Please contact Sandra at (949) 770-2258 for more information

California Society for Clinical Social Work

Did you Know?

If you join **CSCSW** you will receive:

- The bi-monthly Clinical Update newsletter free electronically every month
- A free 15 minute legal consultation anytime during your membership year
- Option to purchase an additional hour legal consultation for $25 for use during your membership year
- Access to our free Mentorship Program
- Free CEU's and education from our District Meetings
- Free Eblasts and reduced pricing on advertising
- Reduced pricing for our online DSM 5 CE presentation Click here for DSM 5 workshp information
- Reduced pricing for our Law & Ethics CE presentation Click here for Law & Ethics workshop information

And much, much more…….

If you are interested in becoming a member or would like more information regarding California Society for Clinical Social Work, please Click Here

The Clinical Update
P O Box 1151, Rancho Cordova, CA 95741
916-560-9238 * 855-985-4044 Toll Free * 916-851-1147 Fax
Website: www.clinicalsocialworksociety.org
Email: CU@clinicalsocialworksociety.org

Executive Director: Luisa Mardones, Executive Director
Managing Editor: Jean Rosenfeld, LCSW, Sacramento
Editorial Staff: Cindy Esco, Executive Administrator

California Society for Clinical Social Work
P O Box 1151
Rancho Cordova, CA 95741