

THE CLINICAL UPDATE

CALIFORNIA SOCIETY FOR CLINICAL SOCIAL WORK

FALL 2016



Janet Anderson Yang, PhD, ABPP gives a thought-provoking presentation to members of the Greater Los Angeles District about clinical approaches for working with older adult clients to enhance their quality of life and sense of meaning.

Clinical Methods to Enhance Meaning in Later Life

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Later life can be a time of troubling concerns, such as physical and cognitive decline, pain, loss, awareness of life ending, and approaching death. Standard approaches to mental health treatment often require physical and cognitive abilities, focus, and energy. Clinicians working with older adults may struggle in helping clients find satisfaction in the face of these declines and losses.

A number of clinical approaches can help aging adults enhance meaning in their lives. These approaches include interventions related to existential meaning, life review and reminiscence, leaving a legacy, transcendence, mindfulness, wisdom, spirituality and

religion, grappling with the end of life, creativity, and enhancing relationships. Clinical methods for helping aging clients enhance meaning and achieve the goals of later life within the context of co-existing challenges will be discussed within this article.

Existential Meaning

One approach to help aging clients is assisting them in developing altered perspectives and increasing existential meaning, wisdom, and integrity. Renowned psychiatrist Victor Frankl (1986) considered three

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Letter from the President

Dear CSCSW Members,

I am happy to report that CSCSW is stronger both financially and in the number and utility of services we now offer. We have just had our membership drive, which has brought in many new members. This is a friendly reminder to renew your membership if you have not already done so. We also welcome donations, though they are not tax-deductible. I am proud to report that we now have over \$70,000 in our bank account and continue to get membership renewals. You may also make tax-deductible donations to the Jannette Alexander Foundation, which provides scholarships to second-year social work students.

Our hardworking district coordinators attended our April board meeting and compared notes regarding their district meetings and procedures. They met separately with our administrator Donna Dietz to discuss how to streamline their procedures. There was interest in their meeting again to continue their fruitful discussion. This meeting will take place this April. Ginny Frederick, a longtime district coordinator for the Mid-Peninsula District, assembled a very helpful manual of the procedures she has developed for her district. The districts have hosted very interesting speakers and have generally had very good attendance at meetings and events.

Board members Monica Blauner and Lisa Haas have successfully restarted the Greater Los Angeles District and have organized two well-attended programs for district meetings. Debra DeCordova has agreed to be the new district coordinator for Greater Los Angeles and is already doing a wonderful job. She has organized a new steering committee, which is actively planning CEU events for the coming year. We are also looking into the possibility of starting a San Francisco District. We have put on a number of joint programs with the Committee on Psychoanalysis in Clinical Social Work and the Sanville Institute in San Francisco, but have not officially had a district there for many years.

The board nominated Monica Blauner, who is our secretary, for the position of President-Elect. I am very pleased to report that our members elected Monica. She has already worked tirelessly on many projects, including organizing the LA District and the Law and Ethics conference held in October, serving on the Marketing and Mentorship Committees, and numerous other endeavors. She will become President on July 1, 2017.

Our Marketing Committee, together with our administrator, has been working on revising our website to make it more up-to-date, useful, and user-friendly. It is a work in progress, but please check it out and send us your ideas.

We are in the process of reviving our Ethics Committee, which will provide consultations to members on ethical issues. Three of the original members of the committee have agreed to serve again. The committee will have a conference call to discuss their role prior to resuming offering consultations. They, of course, will not provide legal advice.

We welcome any members who would like to serve on our committees. The current committees are Marketing, Operations/Administrative, Mentorship, Education, and Ethics. We also hope to start a Legislative Committee, which would monitor and advocate regarding proposed bills pertaining to our profession. Since we have trimmed our staff, we are more reliant on volunteers. Serving on a committee is a great way to meet colleagues while helping the Society.

The Jannette Alexander Foundation Committee met at our board meeting to choose the five scholarship winners. Congratulations to the winners, who you can learn about in this issue on page 16!

We have scheduled three board meetings for the current fiscal year and have significantly reduced costs associated with our meetings. In addition, we have established a system of checks and balances that is working well. As I wrote you previously, we now have a part-time administrator instead of a full-time executive director and administrative assistant. We also have a part-time bookkeeper who writes checks and sends them to the treasurer for his signature.

Monica Blauner and I attended the Clinical Social Work Association Summit in October in Washington D.C. CSWA is the umbrella organization for the state societies of clinical social work. See page 7 for a description of the services offered by CSWA. At the Summit, we found it useful, productive, and energizing to share ideas with and learn from representatives of other state societies.

I am very confident that CSCSW will continue to grow and prosper. We welcome your ideas.

Sincerely,
Leah Reider, LCSW, CSCSW President

avenues of meaning, including creating a work or doing a deed, experiencing something or encountering someone, and changing one's attitudes about situations. Other authors also emphasize the importance of helping clients develop new forms of meaning after losses and trauma (Neimeyer, 2011; Horowitz, 1986).

Life Review and Reminiscence

Erik Erikson (1982) proposed that the developmental task of older adulthood is to resolve conflict between integrity and despair. The approach of death stimulates review of life to prepare for death. This involves consolidating an understanding of one's life, to be achieved through the "mourning for time forfeited and space depleted, autonomy weakened, initiative lost, generativity neglected, identity potentials bypassed, and too limiting an identity lived" (Erikson, 1982).

Robert Butler and James Birren also discussed the importance of life review. Butler (1963) suggested that later life is a time for people to review their lives, allowing a return to consciousness of past experiences, especially unresolved conflicts. By reviewing one's life, one can expiate guilt, resolve internal conflicts, reconcile relationships, and renew ideals, thereby experiencing new peace and gaining wisdom (Butler, 1963). Birren (2001) suggested that the purpose of life review is to develop an acceptable image of one's life and leave behind an acceptable legacy; that an awareness of coming death can stimulate a person to review one's life to integrate the actuality of one's life with what might have been and to reorganize attitudes toward one's life in a more positive way.

The developmental process of life review has been adapted to become a form of psychotherapy, sometimes referred to as reminiscence therapy. Life review or reminiscence therapy is a structured activity to access and process thoughts about past experiences. It often involves marking down a timeline and writing in dates and major life events, then analyzing and discussing the meaning of the events. Integrative reminiscence generally refers to reappraising losses and difficulties, reviewing values and personal meaning, and working toward a renewed understanding of the life lived. Instrumental reminiscence refers to recalling past successes, achievements, and positive adaptations, in

order to reactivate a positive self-concept.

Within life review or reminiscence therapy, techniques that can be used include marking the years and ages of the client, asking the client to recall important personal events (e.g., education, family events, work successes, loves, losses, hopes, regrets, and memorable experiences), using important world events as markers, using aids to evoke memories (e.g., photos, picture books, letters, diaries, music, and foods), encouraging the client to take a pilgrimage (e.g., to an old home or neighborhood), and writing an autobiography. These activities then evoke therapeutic conversation.

Leaving a Legacy

Another aspect of understanding the meaning of one's life is to consider what legacy the person has left. Irvin Yalom (2008) stated that one may find meaning in life and come to terms with death through understanding "rippling," or the ways in which the person has influenced others, which, in turn, consequently influence other people's lives and can impact generations to come. James Birren (Birren & Deutchman, 1991) discussed the importance of reviewing a person's legacy, which might include acts of helping others, raising children, creating art, writing, professional successes, political achievement, influencing others, and contributing to science, among other things. To this end, clinicians can help clients consider their legacies, including what they have done in their lives, these actions' impact on others, and potential effects on the future.

Transcendence

Gerotranscendence represents the ability to move beyond the immediate circumstances to form connections beyond the self, transcending the gulf between people, between person and the universe, or between person and the creator of the universe (Brennan, 2009; McFaddon, 2009). Within aging, there may be an increased emphasis on internal processes that facilitate expanded consciousness. Older adults may have more time to meditate, contemplate, and reflect (Newman, 1987). Life satisfaction may increase as a person shifts toward increased focus on the cosmic world rather than on the material world (Tornstam, 1994). Clinicians may suggest contemplative practices to older adult clients and explore the idea of transcendence with them to improve their sense of meaning in life.

"Clients can be encouraged to discern, honor, appreciate, and share with others the significant wisdom they have developed from life experiences."

Mindfulness

Developing a mindfulness or meditation practice is another avenue to help older adults gain meaning and satisfaction in their lives (Hayes, Strosahl, & Wilson, 1999). Mindfulness is the act of concentrating one's attention on moment-to-moment experience with a nonjudgmental attitude. Mindfulness is successful in treating anxiety and stress, as well as other disorders (Kabot-Zinn, 2003). Acceptance and commitment therapy (Hayes et al., 1999) and Mindfulness-Based Stress Reduction (Kabot-Zinn, 2003), among other evidence-based practices, can be useful interventions to help clients experience their lives in meaningful new ways. Mindfulness may also include encouraging the client to learn new breathing techniques, to listen to recorded meditation lessons, and/or to set up a space to meditate or connect with nature, among other possibilities. Since mindfulness can be practiced anywhere, it may be a helpful intervention for those experiencing a lack of mobility and consequent boredom or depression.

Wisdom

Due to their long lives and consequent extent of experience, older adults have undoubtedly developed substantial wisdom (Baltes & Staudinger, 1993). They have used knowledge, experience, and understanding in many different ways to confront circumstances, tolerate difficulties, and make decisions. Clients can be encouraged to discern, honor, appreciate, and share with others the significant wisdom they have developed from life experiences.

Spirituality and Religion

Older adult clients may find meaning in their lives through developing or rediscovering spirituality and/or religion. Spirituality includes a set of beliefs that may include love; compassion; and a respect for life, existence, and relationships with ourselves, others, the universe, and/or the sacred. Spirituality can extend beyond the physical and material to transcendence and can be secular in nature.

Religion includes the practical expression of spirituality in the organization, ritual, and practice of one's beliefs. Many older adults indicate interest in religion and/or spirituality; addressing these issues may benefit the client's mental health.

Clinicians need to use careful clinical judgment as to if, when, and how to talk about spirituality or religion in order not to assert their own values or proselytize

clients toward their own beliefs. Encouraging a client's positive spiritual and/or religious coping activities and exploring previous negative experiences may be good places to start. Specific instruments, such as the HOPE Questionnaire (Anandarajah & Hight, 2001) or structured guidelines ("Parameter 4.15", County of LA Department of Mental Health, 2012) may be used.

Grappling with the End of Life

Many older adults are troubled about being closer to death. Discussing this topic may be difficult. While health care providers have been encouraged to talk with patients about end-of-life wishes (Steinhauser et al., 2001), clients' fears and concerns about dying and death are often not addressed. Older adults may have concerns or fears related to pain and suffering during the dying process, what happens at the moment they die, whether they will be alone when it happens, what happens after death, and who all they will leave behind. A related case example follows:

Carol was a 69-year-old client seen in therapy by the first author at Heritage Clinic in Pasadena, California. Carol had had a stroke, was bed-bound, and fought with her husband considerably. With some help, she moved out of Heritage Clinic to an assisted living facility. Carol then began having conflict with the staff. The therapist helped the client talk about her anger and then wondered if her anger might be related to underlying fear. With enough trust established, the therapist asked the client if she was afraid of what was happening to her body. The client identified that she was frightened of having another stroke and intolerable pain. With consultation with her physician, Carol was reassured that if she were in pain, she would be offered enough medication to relieve her pain. Carol then identified that she was afraid of dying and going to hell, which surprised her to realize, as she was a staunch atheist. Her fear of going to hell was traced back to childhood messages at home and within early church lessons. The therapist helped the client challenge and resolve her belief that she was bad and would go to hell. Her fear, anxiety, and interpersonal conflict decreased, and her satisfaction in her life improved.

Clinicians may gently initiate discussions about these concerns through asking clients questions about their parents' age at and cause of death, in what way the conditions of their parents' death affect their thoughts of their own death, how they feel about being their current age, what they think about their end of life, and what they think will happen after they die. Clinicians

may then assess the client's answers and link them to their mental health concerns. In addition, clinicians may complete an advanced health care directive or a Five Wishes document (Aging with Dignity, 2011) to obtain more clinically-relevant information.

Creativity

Encouraging creativity can bring new or renewed meaning in later life. Activities may include listening to music, playing music, singing, writing, dancing, drawing, coloring, painting, or viewing art or art books. Clinicians may use a Pleasant Events Schedule to stimulate a structured discussion of creative or pleasant activities within clients' lives (Lewinsohn, 1971).

Enhancing Relationships

Later life can be a time of losses of relationships, leading to isolation and loneliness. Coping with these losses may include developing new relationships, seeking to reconnect with prior relationships, and/or working to reconcile conflicted or estranged relationships. Hargrave and Anderson (1992) describe a combination of life review therapy and family therapy in a way that can help promote healing in family relationships. Volunteering, giving to others, caring for grandchildren, and mentoring younger persons may bring considerable meaning from an interpersonal approach for aging patients.

Later life can bring about frailties that cause dependence on others for personal needs. While the increased dependency can be troubling, it may be an opportunity for enhanced relationships. Lustbader (1999) presents a beautiful example of the latter:

"A physical therapist tells how a stroke led to the reconciliation of a father and son who had not spoken in years: My patient was a large man, and the dead weight of his stroke made it impossible for his tiny wife to move him at all. His son agreed to come over and learn how to do a wheelchair transfer, but he came in looking so hostile I wanted to call off the whole thing. He didn't even say hello. I explained that he had to grip his father in a bear hug and then use a rocking motion to pivot him from the bed to the wheelchair. The son went over to the bed where his father was sitting and put his arms around him, just like I said. He got the rocking motion going, but then all of a sudden I realized that both of them were crying. It was the most amazing thing. They stayed like that for a long time, rocking and crying. This son was moved to linger in his father's arms for the first time since boyhood. Unexpected embraces, uncharacteristic

expressions of feeling, these are only some of the ways that relationships grow through frailty's demands" (p.23).

Cultural Considerations

Clinicians may help older clients find meaning in their lives through collaborative exploration of clients' cultural identities. The intersectionality theory framework provides one such way to navigate this task.

Introduced by civil rights advocate Kimberlé Crenshaw (1991), intersectionality theory emphasizes the multidimensionality of cultural identities with specific attention to the roles of power, privilege, oppression, and marginalization. From this perspective, clients find meaning in life through the sociocultural lenses through which they experience the world (Yang et al., 2016). In clinical practice, this means working with clients to unravel the complexity, diversity, and connectedness of their co-existing identities.

Some identities tend to garner privilege and power, (e.g., being white, cisgender, heterosexual, educated, male, or wealthy) while others tend to yield oppression and marginalization (e.g., being of color, transgender, homosexual, bisexual, uneducated, female, or impoverished). Due to the prevalence of ageism, old age may be associated with greater feelings of powerlessness and marginalization (Laws, 1995). Younger adults often experience greater social capital while older adults may struggle with feeling "past their prime" and "put out to pasture" (North & Fiske, 2012).

The process of exploring one's various identities may be challenging. Clinicians can help aging clients explore questions concerning the importance of these identities; when, where, and how they experienced the most and least privilege and power in life; and which of the client's identities are the most and least dominant and important to them.

A patient's various identities can give clinicians an idea of themes to explore within the therapeutic setting, but the clinician should also be careful not to make assumptions. Many people within certain groups do not subscribe to beliefs that may be associated with that group. Therefore, it is important for clinicians to let the client lead these conversations and to be aware of their own biases.

With that said, there may be certain issues that are more relevant and helpful to explore for members of specific

groups of aging clients. For example, family relationships may be particularly important for clients of certain ethnic or racial groups, so meaning may be derived from reconnecting or improving communication with family members or from mourning unmet expectations. For others, spiritual or religious beliefs may be of particular significance, so it may be helpful for these clients to explore their spiritual understanding, read religious texts, listen to religious programs, visit a place of worship, or explore the meaning of death in the context of their spiritual or religious beliefs.

In conclusion, therapists working with older adults may benefit from considering ways to help their clients enhance satisfaction and a sense of meaning in their lives. While some clients may directly indicate they want to work on developing meaning, others may not suggest that developing meaning could help them. The therapeutic work may benefit from gently approaching one or more of these avenues toward increasing meaning in life, including reminiscing and reviewing the client's life, considering what legacy the client has left, enhancing the client's sense of spirituality, exploring transcendence, utilizing mindfulness, honoring the client's developed wisdom, coming to terms with the end of life, enhancing existing relationships, and increasing creative endeavors.

Dr. Janet Anderson Yang, PhD, ABPP is a licensed clinical psychologist, board certified in geropsychology. She has been working with older adults for over 35 years. She is the Clinical Director and the Training Director at Heritage Clinic, a division of the Center for Aging Resources, a mental health clinic and adult daycare center. She provides services to older adults, supervises clinical staff, and trains mental health professionals. This includes directing Heritage Clinic's doctoral internship accredited by the American Psychological Association. Dr. Yang has published articles and conducted trainings on psychotherapy with older adults, mental health outreach, reminiscence, and other topics related to mental health and older adults.

Breanna L. Wilhelmi, MS is a PhD Candidate at the Pacific Graduate School of Psychology at Palo Alto University (expected graduation 2016). She specializes in trauma, geropsychology, and culturally-sensitive clinical practice and advocacy. Her doctoral internship is with Heritage Clinic in Pasadena, California and her postdoctoral fellowship is with Wise and Healthy Aging in Santa Monica, California. She currently provides in-home psychological services to community-dwelling older adults with serious mental illness.

Krista McGlynn, MA is currently a clinical psychology intern at Heritage Clinic, a community-based mental health clinic serving the older adult population. Previously, Krista worked as a Registered Nurse in the areas of critical care and hospice. Her future career goals include continuing her work with the older adult population and expanding her training in the area of palliative care psychology. Krista recently began a fellowship position specializing in palliative care at the Audie L. Murphy Veterans Administration Hospital in San Antonio, Texas.

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New BBS Telehealth Regulations Effective July 1, 2016

The Office of Administrative Law has approved the regulations on Standards of Practice for Telehealth, created by the BBS. These new regulations became effective on July 1, 2016 and now apply to all BBS licensees and registrants in California who provide services via telehealth. Click [here](#) to read the new regulations and view relevant documents.

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Strengthening Identity:

- CSWA is the primary organization building relationships with other clinical groups, while promoting the clinical social workers role as the “backbone” of the psychotherapy community.
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- CSWA efforts focus on developing guidelines for online clinical programs and helping set technology standards while maintaining the ethics and high standards of our profession.

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Horticulture Therapy Offers Meaning, Healing, and Hope for Millions Living with Mental Illness

Ariel Schneider, ASW

“For the meaning of life differs from man to man, from day to day, from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person’s life at a given moment” (Frankl, 1959, p. 108).

Reconnecting people with the outdoors and their food sources is gaining popularity after a long period of mainstream cultural disconnection. The local food movement phenomena popularized by such authors as Michael Pollan, Barbara Kingsolver, and Eric Scholsser, urges us to support sustainable agriculture by eating fresh foods produced by nearby farms (Alkon & Agyeman, 2011). From the White House initiative to end obesity through fresh food education to a free substance abuse treatment center in Italy that utilizes farm-based work (Pianigiani, 2013), the healing effects of the outdoors are increasingly recognized across disciplines.

Research tells us that connecting with or being surrounded by the natural world has numerous positive effects. It produces an increase in the subjective experience of vitality (Ryan, Weinstein, Bernstein, Brown, Mistretta, & Gagné, 2010), a restoration to mental clarity, and a physical healing to the body (Clay, 2001). Relatedly and perhaps unsurprisingly, these healing qualities of nature have been shown to improve functioning for vulnerable populations, including people with depression (Gonzalez, Hartig, Patil, Martinsen, & Kirkevold, 2010), dementia and Alzheimer’s (Jarrott, Kwack, & Relf, 2002), cognitive delays (Berman, Jonides, & Kaplan, 2008), post-traumatic stress disorder (Lorber, 2011), major mental illness (Simpson & Straus, 1998), and sensory integration issues (Wagenfeld, 2009), as well as for individuals involved with the criminal justice system (Hale, Marlowe, Mattson, Nicholson, & Dempsey, 2005) and living in low-income communities (Hale, Knapp, Bardwell, Buchenau, Marshall, Sancar, & Litt, 2011).

Long before the relatively recent popularization of the positive effects of being in and caring for nature and eating a diet rich in fresh plant foods, the idea existed that people with mental illness might benefit from working outside in a farm-like environment. About 200 years ago, America’s first Surgeon General, Benjamin Rush, MD, wrote prolifically about the use of farms for the treatment of the mentally ill (Lewis, 1987) and started the first hospital-based garden program in 1817 at Friends Hospital in

Philadelphia, Pennsylvania (Taylor, 2009). Years later, this approach evolved into a more institutionally-based treatment modality routinely implemented by state psychiatric hospitals. In 1936, the Camarillo State Mental Hospital in Southern California (which closed in 1997) was founded as one of many state hospitals designed to treat patients for months to years to entire lifetimes (Noxon, 1997). The hospital housed 100 “working patients” to maintain farming operations on its 1200 acres, including 304 acres of alfalfa, 227 acres of vegetables, 178 acres of grain crops, and 80 acres of orchards.

Hospitals around the country operated similar programs within the context of Moral Treatment, a period of U.S. American psychiatry during much of the 19th century that saw a shift toward more humane treatment of patients. Under this model, providers developed close personal relationships with their clients, rewarded patients’ positive behavior, and created daily opportunities for purposeful activity (Dunkel, 1983). Some cite this model as hugely successful for being the first practical effort to provide systematic and responsible care for the mentally ill in the U.S. and abroad (Bockoven, 1963). Camarillo’s program was drastically reduced in 1969, when new legislation eliminated indefinite commitments of persons defined as “mentally disabled” (Camarillo State Hospital, 1993), though it continued to house patients into the early 1990s. This time in history marked a significant shift in attitudes and public policies in the treatment of mental illness.

Following the deinstitutionalization of mental health care, therapeutic horticulture has emerged in communities around the world, but lacks any systematic backing from the mental health community. One such example is the Grow Native Nursery in the Westwood neighborhood in Los Angeles, California that partners with the VA Greater Los Angeles Healthcare System to “maximize veterans’ opportunities in the sustainable horticulture industry” (Rancho Santa Ana Botanic Garden, 2012). Located within the Veteran’s Garden, capable VA patients are invited to spend a few hours per week at the nursery, engaging in all aspects of nursery business and building skills, that they can then apply in a job once discharged from hospital care. Similar programs can be found at VA hospitals around the country (Taylor, 2009), but unfortunately they are neither representative of national VA policy nor psychiatric hospital policy in general.

One of the more exciting therapeutic horticultural projects



Left: The author enjoys time spent on a farm in Massachusetts near Smith College, where she completed her graduate work. Right: The therapeutic horticultural sensory garden at the UCLA Resnick Neuropsychiatric Hospital, the author's workplace.

currently underway is the first-of-its-kind sensory garden at the UCLA Resnick Neuropsychiatric Hospital where I work. Once weekly, adult patients are invited to interact with the garden to the best of their ability whether that means turning the soil, pruning the plants, smelling the herbs, watering, or simply watching other people complete these tasks. By patient self-report, there is an improvement in patients' mood and evidence that gardening has reduced the amount of physical and chemical restraints needed on the unit. We hope to be able to show that our integration of horticulture therapy into our regular milieu program has contributed to a significant reduction in patient heart rate and blood pressure, as well as to an overall positive experience in the inpatient unit.

Logotherapy offers a theoretical lens by which to understand the impact of meaningful horticultural therapies. Developed by Austrian neurologist and psychiatrist Viktor E. Frankl, logotherapy offers a psychological framework from which to understand how humans can persist through extreme hardship. Frankl is considered one of the founders of the Third Viennese School of Psychotherapy following Freud, who proposed a "will to pleasure" and Adler, who proposed a "will to power" (Frankl, 1969). Instead, Frankl offers a "will to meaning" based partly on his experiences as a survivor of a concentration camp during the European Holocaust in World War II (Ameli & Dattilio, 2013).

Frankl's concepts are based on three major tenets, including freedom of will, the will to meaning, and the meaning of life—all of which rest on the core assumption that humans are capable of surviving even the most horrific of experiences if they have an attitudinal belief in a higher meaning (Frankl, 1969). Similar to the phenomena around vocational horticulture, these three major concepts focus on an individual's future and the meanings

to be fulfilled (Frankl, 1959). Following diagnosis of a mental illness, individuals have been reported to feel a loss of self, power, meaning, and hope for the future (Slade, 2009), or what Frankl would call the "existential vacuum," which explains why rehabilitation efforts not addressing these feelings fail (Julom & de Guzmán, 2013). Furthermore, individuals can experience a sense of isolation, rejection, and objectification following a diagnosis. Horticultural activities provide individuals with meaning via responsibility to plants, animals, and other community members, as well as through a newfound sense of purpose.

There are a number of community-based programs, as well as a growing body of research, that address the increasing desire among individuals with psychiatric disability or mental illness to acquire vocational skills that aim to help people find meaning in their lives. In fact, Supported Employment is now considered an evidence-based practice with widely-researched outcomes and models for implementing programs in mental health agencies (Becker & Drake, 2003; SAMHSA, 2009). However, there is an underutilization of this model in mental health treatment in part due to different perspectives between practitioners and consumers about the importance of the consumers' desire to work (Casper & Carloni, 2007). In the United States, only two percent of people with serious mental illness receive any form of Supported Employment (Marshall et al., 2013).

Vocational horticulture is a form of Supported Employment that comes out of the larger field of horticulture therapy. Vocational horticulture focuses on training individuals to work in the horticulture industry, either independently or semi-independently (Messer Diehl, 2007), as a way to provide rehabilitation for individuals who historically would have been institutionalized for treatment.

There is great need for recovery-oriented alternatives, such as horticulture therapy, within the current landscape of mental health care in this country. One out of four U.S. American families experience mental illness. Unlike other ailments, mental illness does not discriminate across race, age, income, religion, or education (NAMI, 2013). For the nearly 57.7 million adults living with a mental illness in this country (NAMI, 2013), the hopes for recovery are largely dependent on an individual's access to both pharmacological and psychosocial interventions, an opportunity that may be hard to come by for those without good insurance or access to treatment (NAMI, 2013). For acute crises, psychiatric hospitals serve as places for stabilization and connection to longer-term options, which often include partial hospitalization programs, board and care facilities, or residential treatment centers, depending on an individual's diagnosis. Certainly, these options provide support to individuals who can participate meaningfully, but this is not the case for many psychiatric patients for whom symptoms or social situations are barriers to participation or follow-through.

For those who can even access these services, treatment can be isolative and prevent an individual from engaging in "real-world" pursuits. Less than 15 percent of people receiving public mental health treatment hold competitive jobs despite the 60 to 70 percent of people who would like to do so. This is in part due to a lack of vocationally-focused rehabilitative services (SAMHSA, 2009).

As a psychiatric social worker, I have often felt a sense of dissatisfaction upon discharging a patient who I believed might return to the hospital because the discharge plan failed to include sufficient recovery-oriented services. My toolbox of interventions is limited and frequently dictated by insurance policies. I often find myself wondering what alternatives exist for people to work toward recovery following discharge. I strongly believe that horticulture therapies could be one such alternative for many patients.

The current healthcare system is poised to contribute to a shift toward recovery-based mental-health interventions, including horticulture therapy, due to its monetary resources, regular access to the public, and the recent shift in the medical community toward recovery-oriented practices (Barber, 2012). People look to their doctors and mental health care providers as experts, who therefore have a lot of power when it comes to shaping their patients' perceptions. Reaching people within their chosen communities and offering interventions to meet people at the level of engagement in which they are open will further reduce the barriers to receiving care and ultimately help people feel better and live more meaningful lives.

Clinical social work's whole-person approach to care implies

that we must look at complementary and alternative treatment options, such as horticulture therapy, as we work to connect people with the services they need. Given our ethical standard to "promote wellbeing" and to make "client's interests primary" (NASW, 2008), social workers are a key link to rehabilitative services. We are not only able to provide a therapeutic experience while interacting with our clients, but also to offer options about where to receive treatment and where and how the most healing might occur. The intentional and attuned relationships we build with our clients, similar to the mentorship model employed in horticulture therapy, is core to how social workers are instructed to approach treatment.

Ariel Schneider, ASW is a psychiatric clinical social worker and researcher of nature-based therapies in Los Angeles, California. She is currently a clinical social worker at the UCLA Resnick Neuropsychiatric Hospital, where she works with adults and older adults admitted for acute psychiatric care. She studied psychology as an undergraduate at the University of California, Berkeley and completed her MSW in 2014 at Smith College School for Social Work, where she conducted her thesis research on horticulture therapy for adults with major mental illness. She has worked clinically for many years with homeless adults, school-aged children, and frail older adults in New York City, the San Francisco Bay Area, and Los Angeles. Ariel commutes to work by bicycle and keeps a small garden of succulents, herbs, and vegetables. She would love to connect with you to continue the conversation about horticulture therapy or if you are using horticulture practices in your clinical work. Please contact her at aschneider@mednet.ucla.edu.

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CSCSW REINSTATING TWO IMPORTANT AWARDS

In our ongoing campaign to revitalize CSCSW, we are bringing back two awards that were traditionally presented at the Annual Conference. We feel it is important to acknowledge outstanding contributions to the Society and to the field of clinical social work.

Nominations are currently being accepted for:

1. The **Society Member of the Year**, who does not have to be a Fellow, will receive an award for an outstanding contribution to the field of clinical social work, and thereby the Society. The contribution may be, but is not limited to, service in the areas of clinical innovation, service delivery innovation, political or public relations work, or publications, and may be a single act or continuous and extensive activity. It is the Board's intent not to specify precise criteria for this award, but rather to open up the possibility of recognizing outstanding contributions by Society members in whatever form or manner these may occur.
2. **Honorary Recognition for Contribution to the Field of Clinical Social Work**. Recognition in the form of an award will be given to an individual who is not necessarily a Society member. The award will honor exceptional work that enhances the field of clinical social work. The recipient may or may not be a social worker and could also be a legislator, a mental health professional in an allied profession, a lawyer, or anyone who, in the opinion of the Nominating Awards Committee and the Board, justly deserves recognition.

To place a name in nomination, please specify for which award the individual is being nominated and include an explanation of why you feel this person deserves this honor.

Please send your nominations by January 15 to:
info@clinicalsocialworksociety.org

Helping Healers Heal: The Use of Sandtray Therapy to Aid Therapists in Processing Vicarious Trauma

Roxanne Rae, LCSW, BCD

Many social workers engage deeply with people who have experienced trauma. The inherent nature of this work exposes us to compassion fatigue or vicarious traumatization because we use our own lives as a safe container for healing our clients. Psychology professor Daniel Stern aptly explained that “our nervous systems are constructed to be captured by the nervous systems of others, so that we can experience others as if from within their skin, as well as from within our own” (Stern, 2004).

It is in this empathetic life-to-life connection to people with trauma that a therapist’s own implicit personal resources and deficits may be revealed. At times, the effort of maintaining affective synchrony with a trauma victim will pull out the best in us. As one educator and philosopher put it, “our hearts change others’ hearts” (Ikeda, 2008). Unfortunately, while supporting our clients, we may also become hopeless, anxious, depressed, or exhibit a myriad of trauma-related symptoms ourselves.

Trauma work is intimate and requires a network of support for healers to minimize the negative impact of this trauma work on their own lives. For those of us using expressive arts therapies, we are exposed to our clients’ traumas not only through stories, but through images as well.

Healing arts practitioners can use the very techniques that they employ with their clients to help process the traumas that we experience through our empathetic resonance. We can also use these methods to explore and heal issues that arise from our own past experiences that may be evoked through trauma work.

Out of the various expressive arts therapeutic modalities, I most often work with the sandtray due to its multisensory qualities that allow access to the implicit aspect of the mind. Associated techniques within the sandtray modality enhance neuroplasticity through focused attention, novelty, and exploring emotional arousal. Sara’s story shows us one way in which this identification and processing of trauma may occur.

A busy mental health professional, Sara requested a sandtray session because she was feeling a bit overwhelmed by her work. Normally, she felt a rich satisfaction from her trauma work with teens. When Sara noticed consistently less eagerness as she prepared for work, she accurately considered it a red flag. She had a history of successfully using expressive arts methodologies to facilitate her own clarity and growth.

Sara began by making a circular sand form, like a hill, in the center of the tray. On top of it, she placed people holding hands in a circle around a candle. She then stated, “The world is so crazy, it needs some harmony.” Quickly she lit the candle (Figure 1). Then, she brought in images of abuse, torture, evil, and war. She spoke of the poor state of humanity in today’s world. Sara specifically referred to “evil atrocities in our world,” such as “rape in the Congo, the training of child soldiers, devastating natural disasters, and the existence of warlords in many regions.” She was intermittently verbally descriptive as she created her world.

Later in the session, she focused on the small, black, and hunched-over devil as it crept toward the circle of people holding hands around their light. Sara described this devil as the “creeping...sleeping of evil” toward her central figures of “harmony and peace.” She placed a red broken heart figure as a barrier between the two, saying that the heart was “so tattered the evil is likely to get through” (Figure 2). Sara made this statement immediately after pushing the heart into the sand.

Through my considered inquiry and our reflection together as she processed the experiences portrayed in her sand world, Sara became able to recognize the connections between her globally-focused observations and her personal stressors. She also realized that she had become increasingly more sensitive about and less modulated in her response to her trauma clients.

Just like the miniature group of people in the center of her sandtray, Sara felt bombarded by evil and negativity. She expressed feeling overwhelmed by the intense and graphic images of child abuse that she dealt with in her psychotherapy practice. Her heart was feeling “ragged and torn” in her attempts to hold onto her own “safe place,” while being present with her clients’

suffering. Eventually, she acknowledged not only feeling assaulted by her everyday work world and the “big world,” but also by some personal family issues. Once this realization was acknowledged between us, the focus turned to how she could strengthen and nurture herself.

During the dialogue that followed, Sara placed the “Do Not Enter” and “Stop” signs in the tray. She moved the “Do Not Enter” sign toward the “devil’s path” and “other evils,” as a way to protect her “harmony and peace.” In the end, her peaceful circle conquered all (Figure 3). Sara expressed a deeper commitment to strengthen herself to deal with her family difficulties more effectively and created a specific plan to do so.

As this story demonstrates, a therapist may facilitate a client’s active, conscious engagement with previously implicit features of a client’s life, making what is implicit more accessible. In this case, Sara was able to see and reflect on the connections between her subtle dissatisfaction with her work and her previously unacknowledged conflicts at home.

The sandtray process provides the opportunity to tap into our own inner wisdom and explore life’s alternatives. Sandtray teaches and supports awareness of our own processes and how they impact the choices we make within our environment. In this case example, Sara was able to use sandtray therapy to identify her need to work on strengthening her spiritual and social supports, on forming more effective boundaries, and on taking actions to resolve her immediate family matters.

For therapists who treat trauma, maintaining an awareness of our work’s inherent interpersonal stressors may aid us in engaging in preemptive as well as reparative self-care activities. The sandtray offers a unique and deeply personal way for us to explore issues that both stem from, and influence, our capacity to engage with and help our clients transform their sufferings.

Roxanne Rae, LCSW, BCD is the author of Sandtray: Playing to Heal, Recover, and Grow (Jason Aronson, 2013, 2015). She has more than 43 years of social work experience and is licensed in both California and Oregon. For more photographs, information about Sandtray, and to download the author’s articles free of charge, please visit www.roxannerae.com.



Figure 1



Figure 2



Figure 3

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A Stranger Abroad: A Story of Social Work in a Foreign Land and Accompanying Considerations

Laura Sherwood Higgins, MPH, ASW, PPSC

When I was an MSW student, I spent a summer in Bolivia volunteering in a pediatric health program. My plan was to shadow social workers in a medical setting, but I was invited to shadow and even assist physicians as well. A particular incident highlighted the challenge of fusing conflicting healthcare priorities and policies with cultural mores — a challenge social workers regularly encounter domestically and abroad.

When I asked if I could put the baby on its mother, the doctor looked at me as if I had just requested a dozen oysters on the half shell. Had I? Having arrived in La Paz just four weeks earlier, my communication skills were limited, and I wondered if I had been misunderstood.

I repeated my question, and the doctor shook her head brusquely and said, “Claro que no.” She needed to oversee the delivery of the placenta and stitch up her patient who had undergone a routine episiotomy; a baby did not belong in the middle of all of that. I was to wipe the baby down, dress him, swaddle him in his blanket, and set him down next to that other newborn baby, who was bundled up and squirming on a metal countertop next to the sink. I could not argue; I did not have the vocabulary or medical expertise to do so, nor was there time for a discussion. It was the dead of winter, and the unheated clinic sat at about 13,000 feet above sea level. The baby needed to stay warm. So, I held the baby as the nurse gave him a Vitamin K injection, and then I cleaned, dressed, and swaddled him as instructed.

However, I did not put the baby down on the countertop. Instead, I held him close to me, waited by the mother’s bedside as the placenta was delivered, watched the doctor finish her last stitches, and then, without asking any questions, I placed the newborn on his mother’s chest.

There were two loud and conflicting voices in my head: one called for cultural sensitivity and respect for the clinic and its policies (put the baby on the counter) and the other was talking about skin-to-skin contact, oxytocin levels, maternal-infant bonding, and breastfeeding (put the baby on his mama). The latter voice moved me to do something that could have been interpreted as disrespectful and paternalistic. Yet, despite being a foreigner both to Bolivian culture and the field of medicine, I wondered whether my instincts regarding infant and maternal care were somehow more valid than the standard care provided in that clinic.

After all, though the facility had been built to serve an



The author holding a newborn during her trip to Bolivia, where she volunteered for a pediatric health program.

indigenous population in El Alto, it seemed to me that little regard for the predominant culture’s mores existed. The medical providers spoke in Spanish, though the primary language of their patients was Aymara. The women in labor were isolated from their support networks, as family members were not permitted access to the labor ward. The clinic walls were painted white, a color that the Aymara associate with death and the burial of babies.

In this severely under-resourced clinic in a country with some of the highest maternal and infant mortality rates, used needles were haphazardly thrown in cardboard boxes, body fluids were splattered on floors and countertops, and there was a dearth of plastic gloves. Myriad issues needed attention, intervention, and resources. Suggesting that this clinic reevaluate where a healthy baby was placed postpartum was, no doubt, a low priority.

Still, there are empirically-based physiological and psychological benefits associated with keeping healthy mothers and infants together immediately following birth. Despite the doctor’s instructions, my scant medical ken, and my visitor status in Bolivia and in the labor room, I felt compelled to do whatever I could — whatever I knew how to do — to promote the health of the infant in his first moments out of the womb.

What I did felt justified on a visceral level, and it was supported by recent studies. Yet, I had meddled in a system more complex than a newly-arrived gringa could comprehend. The relationship of the clinic to the Aymara community, the expectations of the mother and her family, and the priorities and responsibilities of the health

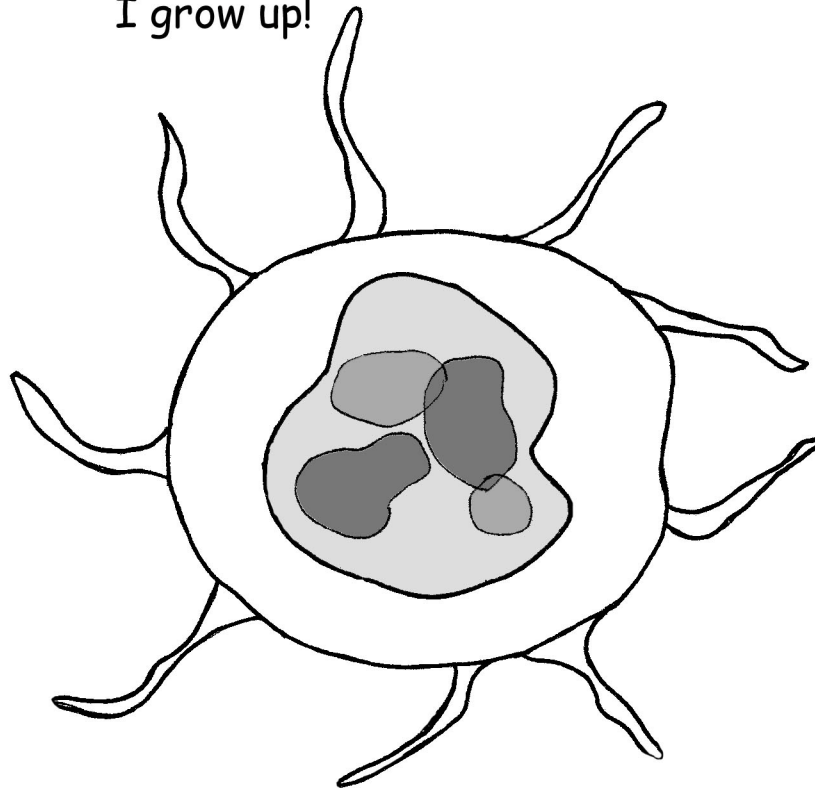
providers were all unknown to me. My actions may have been culturally insensitive, and I definitely overstepped boundaries. Even so, I think I would do it again.

Attempting to demonstrate cultural humility in a complex, culturally-diverse field elucidates a sometimes-grey area where ethics can become convoluted. When we work with disenfranchised groups within disenfranchised groups, how do we advocate for the most vulnerable group? How do we reconcile our own knowledge, expertise, and personal experience when it is contrary to the prevailing culture in which we are working? To what degree do we set aside our own expertise to adapt to policies and cultural mores? How do we make positive change while practicing cultural humility? While the answers to these questions seem abstruse and, at times, impossible to

reach, continually asking such questions with curiosity and openness seems foundational to social service work.

Laura Sherwood Higgins, MPH, ASW, PPSC has worked with children and their families as a School Social Worker in the San Francisco Unified School District since 2011. Originally from Santa Cruz, California, she received her MSW with a concentration in Health from UC Berkeley's School of Social Welfare and her MPH with a concentration in Maternal and Child Health from UC Berkeley's School of Public Health. Laura has worked in a series of positions — voluntary and paid — in the social services and health sectors, in diverse communities, and on a variety of issues, from food insecurity to mental health. Outside of work, she likes spending time in redwood forests, fly fishing, and traveling the world over.

I have no idea
what I'll be when
I grow up!



Clem the Stem Cell has an identity crisis.

2015 Jean Rosenfeld (c)

CSCSW Proudly Announces 2016 Winners of the Jannette Alexander Foundation Scholarships

We are thrilled to highlight the 2016 winners of the Jannette Alexander Foundation Scholarships. The Jannette Alexander Foundation for Clinical Social Work Education is a subsidiary non-profit educational foundation of the California Society for Clinical Social Work. Each year, the Foundation awards \$500 scholarships to graduating MSW students who demonstrate excellence in clinical studies and practice. We welcome members' nominations for the 2017 awards.

Congratulations to our five inspiring and hard-working 2016 winners, who have already made wonderful contributions to the field of social work! We are so excited to follow your continued success and contributions.



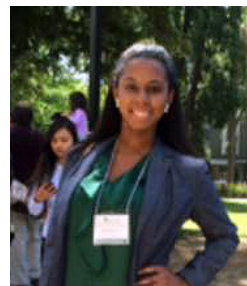
Hira Khanzada provides psychotherapy and case management services to adult survivors of trauma, as well as emergency therapeutic support to survivors of sexual assault, at the University of California, San Francisco/San Francisco General

Hospital Trauma Recovery Center. Hira completed her Master's of Social Welfare at the University of California, Berkeley, with a focus in Management and Planning, where she graduated with recognition for Excellence in Social Work Research. Prior to her work in trauma, Hira interned in the Department of Palliative Medicine at Stanford Health Care. In addition, Hira has previously served as a counselor for trauma-exposed women and families on CalWORKS. She has also worked with children of homeless families, individuals with developmental disabilities, and teens. Hira is an active member of the Bay Area Muslim Mental Health Professionals and is involved in bridging the gap between mental health services and stigma in the Muslim community. Hira is passionate about providing holistic, therapeutic care to underserved groups and to those in need. She is trilingual and provides services in English, Urdu, and Hindi. Hira graduated with a B.A. in Psychology with Honors from UC Berkeley in 2012.



Priscilla Tseng Hefley has partnered with social work agencies and advocacy groups in order to provide for the unique needs of international adoptees, foster children, and their respective families. She recently

began working for the Los Angeles County Department of Children and Family Services after completing her MSW at the University of Southern California, where she was on the Dean's List for the duration of her time there. She completed her undergraduate studies in film and television production in 1994. After transitioning to project management, she went on to complete her MBA in 2008. Following a year of AmeriCorps service in 2013, Priscilla discovered that the power of the narrative was the unifying factor between team management, the visual arts, and social justice. In order to better equip herself for the clinical needs of families and children in the public child welfare system, she decided to pursue a career in social work.



Christian Glover's passion for social work began during her undergraduate career at the University of California, Riverside. During her final year of college, she was accepted into the Criminal Law Internship Program for the Public Defender Service

in Washington, D.C., where she interned as a criminal investigator for felony cases. This experience helped her examine intersectionality and how people can be oppressed in several ways at the same time, thus making them more vulnerable to commit crime. Through this internship, she developed a passion for working with people in low-income and otherwise vulnerable communities. As a graduate student in social work at California State University, Long Beach, Christian was an intern and the first case manager at Pomona College, where she facilitated a multi-disciplinary team to discuss serious student issues, such as misconduct and mental illness. The following summer, Pomona hired Christian as a wellness coordinator. Christian is

also a counselor for Peace Over Violence, through which she has established a passion for working with survivors of domestic violence and sexual assault. Christian has received numerous scholarships and awards.



Carlos Paul Duarte II has impressive clinical experience working with at-risk youth and patients with severe mental illness in non-profit organizations, governmental agencies, and hospitals. After recently graduating from the

University of Southern California with his MSW, he began work as a Psychiatric Social Worker with the Los Angeles County Department of Health. Carlos looks forward to a life committed to serving those who suffer from mental illness, co-occurring disorders, and homelessness. He is determined to work to reduce stigma around mental illness and to help create equal opportunities for all. Carlos is a first generation college student with a B.A. in English Literature from the University of San Diego. He credits his family and Capuchin Franciscan education for providing an early foundation for his career in service and social work. Carlos and his wife, Jessica, have a 2-year-old son named Luca.



Amy Huynh's passion is helping other people, which motivated her to pursue a career dedicated to service and clinical social work. She earned her MSW from the University of Southern California last spring. As a student at USC, Amy discovered her love of

medical social work while interning at the Cedars-Sinai Medical Center, where she began working full-time as a Clinical Social Worker after graduation. Amy was born and raised in Los Angeles to immigrant parents who fled Vietnam during the country's political chaos. As a first generation college student, she attended the University of California, San Diego and graduated in 2014 with a degree in Human Development and a minor in Health Care-Social Issues and Global Health. Amy has extensive volunteer experience working with vulnerable populations, such as the chronically homeless, people living in rural Honduras, and men with substance abuse issues.



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THE CLINICAL UPDATE

Managing Editor: Abigail Reider, ASW

The CSCSW is exploring options for continuing this newsletter or converting to an online blog with more frequent contributions. In either format, we will continue publishing relevant, educational, and compelling content from clinicians on topics important to our members. We welcome your contributions. Please email newsletter@clinicalsocialworksociety.org if you are interested in publishing your writing. newsletter@clinicalsocialworksociety.org

District Updates

Our districts hold informative presentations and workshops, which are advertised on our website and through email. If you have ideas for presentations or workshops or are interested in speaking on a topic on which you have expertise, we would love to hear from you.

Greater Los Angeles District

District Coordinators:

Debra DeCordova, LCSW ~ drdecordova@gmail.com

The Greater Los Angeles District continues to increase its membership and to offer diverse opportunities for learning. We have been liaising with graduate schools and MSW alumni groups in an effort to attract even more new members. We have also expanded our steering committee and welcome any additional members who would like to contribute time and ideas to our expansion efforts. Debra DeCordova, LCSW is our new District Coordinator.

The Greater Los Angeles District is excited to announce our schedule of CEU events for the upcoming year. We hope you can join us. Save the dates!

- 11/5/16** | Stacy Korfist, LMFT – Drumming in the Clinical Setting
- 1/21/17** | Rob Weiss, LCSW, CSAT – Technology and Intimacy
- 3/18/17** | Aydin Olson-Kennedy, ASW – Working with Transgender Clients
- 5/20/17** | Kay Simmeth, LMFT – The Evidence Base for EMDR

Our meetings are held on Saturday mornings from 10:00 a.m. to 12:30 p.m. at the Betty Ford Center. As we have lengthened the meetings, participants earn two CEU's per meeting. Please be in touch if you are interested in presenting or have ideas for dynamic presenters. We also welcome your feedback regarding topics about which you are most interested in learning. We hope to see you soon at one of our upcoming meetings! Thank you for contributing to our efforts to bring together and serve Los Angeles's social workers and allied professionals.



President-Elect Monica Blauer before her presentation on mindfulness to members of the Greater LA District.

Mid-Peninsula District

District Coordinators:

Virginia Frederick, LCSW ~ GinnyFred@aol.com

Joan Berman, LCSW ~ berman.joan@gmail.com

The Mid-Peninsula District met this summer to plan this season's programs. Joan Berman, LCSW and Ginny Frederick, LCSW continue to serve as District Coordinators and chairs of the Steering Committee. The Steering Committee is composed of Nancy Fernbach, LCSW, Jennifer Lezin, LCSW, Makenzie Gallego, ASW, Leah Reider, LCSW, Charlotte Siegel, LCSW, Geri Goldman, LCSW, and Angela Riccelli, LCSW. We would like to extend our deepest gratitude to this group of very dedicated professionals for their continued time and efforts on behalf of our District. The group planned 8 programs for the 2016-17 time frame. This program includes two special Saturday presentations – a 6-hour Law and Ethics course and a 3-hour workshop on Couples Therapy. The program this year is an exceptional line up of excellent presenters. The schedule is below:

- 10/21/16** | Stephanie Brown, PhD – The Impact of Society's New Addiction to Speed and Technology on Clinical Work
- 11/18/16** | Joan Fisch, LCSW – Understanding and Helping Traumatized Clients: An Interpersonal Neurobiology Perspective
- 1/20/17** | Carol Dweck, PhD – The Growth Mindset and Mental Health
- 1/28/17** | Steven Frankel, PhD, JD, ABPP – Law and Ethics Program. Saturday, 9:00AM to 4:00PM. 6-hour CEU program.
- 2/17/17** | University of California at Berkeley – Graduate School of Social Work Faculty presenting on an aspect of Clinical Social Work
- 3/17/17** | Judith Gable, LCSW – The Commitment to Relationship-Based, Insight-Oriented Work with Multi-Cultural High Risk Youth.
- 4/21/17** | Gordon Wong, MD – Anxiety: Diagnostic and Psychopharmacology Update
- 5/20/17** | Angela Riccelli, LCSW and Velia Frost, LCSW – Couples Therapy Program. Saturday, 9:30AM – 1:00PM. 3-hour CEU program.

All programs will take place at the Palo Alto Medical Foundation in Palo Alto, Ca. Specifics as well as registration will be found on the CSCSW website.



**Attendance at
District Meetings
can earn FREE CE credit**

Members earn two CEUs at no cost. Credits for non-members are \$10 per unit. Non-members may attend at no charge (no CEU certificate). MSW students are encouraged to attend. Our meetings begin with a half-hour for attendees to network and build community.

Sacramento/Davis District

District Coordinator:

Katherine Culpepper, ASW ~ katiehr@gmail.com



Sacramento/Davis district leaders Leilani Buddenhagen and Katie Culpepper enjoy an ASW symposium last May.

As the final program of the year on May 14, the Sacramento/Davis District enjoyed a backyard symposium moderated by Mick Rogers, LCSW at the home of Jean and George Rosenfeld. The symposium was designed to elevate the voices of ASWs and other emerging mental health professionals who often serve on the frontlines of the profession. The symposium also provided the opportunity for participants to connect and engage in professional development. "Lessons from the Front Lines: A Cross-Generational Dialogue" featured three presentations by new clinicians: Suicidality Among Veterans and the Power of Providing Peer Group Support to this Population, by Katie Culpepper, ASW; An Exploration of Clients' Expectations of Immediate Results in Therapy, by Katelyn Sandoval, MFTi; and The Need to Assess for Sex Trafficking Among Children in Residential Facilities, by Terryn Middlebrook, MFTi. Seasoned social workers and recent MSW graduates alike appreciated learning from inspiring, hard-working clinicians new to the field. Hearing the perspectives of new and more experienced members was informative and enlivening.

The Sacramento/Davis District has scheduled an exciting line-up of CEU programming over the next eight months and is also continuing the ASW consultation group started by two members last year. Stay tuned for more information about our exciting upcoming events and programs!

San Diego District

District Coordinator:

Ros Goldstein, LCSW ~ goldsiegel@gmail.com

The San Diego District is very active, holding CEU programs every month, as well as other opportunities for networking and professional development. Our programs usually attract approximately 25-30 LCSWs, ASWs, and MSW students from San Diego State University and the University of Southern California.

In the past, our programs have included compelling, germane

topics, such as Self-Management and Recovery Training (SMART), Pharmacological Vs. Non-Pharmacological Treatment Options, the Hidden Impact of Divorce on Children, Compassion Cultivation, Working with Transgender Clients in Transition, and Involuntary Psychiatric Treatment.

Last March, we organized our annual "Spring Fling." Over 30 attendees benefitted from networking, learning about job announcements, and hearing a report by our state representative, Ellen Eichler, on the various programs and activities offered by CSCSW and on the BBS changes for ASWs.

Please stay tuned for information about our upcoming programs, of which we have several scheduled in the coming months. We will advertise them on the CSCSW as well as via email to our district's members. Please contact Ros Goldstein, LCSW if you are interested in becoming involved in this vibrant district!

San Fernando Valley District

District Coordinators:

Gloria Gesas, LCSW ~ gegesaslcsw@gmail.com

Tanya Moradians, PhD, LCSW ~ tmoradia@ucla.edu

The San Fernando Valley District was recently invited to be part of the "Kick-Off Day" for first-year MSW students at California State University, Northridge (CSUN). There were over 100 incoming students present who were eager to learn about our presentations and the many other benefits of CSCSW membership.

Our experience at the "Kick-Off Day" at California State University, Northridge further expanded our marketing efforts. Both Gloria's personal outreach to the faculty at CSUN and our presence at this "Kick-Off Day" event have been productive and gainful. Many social work students and graduates from CSUN are now attending our district meeting as a result.

At the event, Tanya gave an impromptu speech to students about the Society, emphasizing the clinical aspects of our organization and the advantages of joining the Society. This effort generated an enthusiasm toward membership. During our time at the "Kick-Off Day" event, we met many wonderful, enthusiastic MSW students and were impressed with CSUN's relatively new Department of Social Work and its faculty and students.

We have been invited to present to both first- and second-year MSW students at USC in October and later to alumni. Tanya and Gloria are both USC alumni.

District Coordinators Gloria Gesas, LCSW and Tanya Moradians, PhD, LCSW have a long history of service to CSCSW and the field of social work. Gloria and Tanya have been the District Coordinators for the San Fernando Valley District since its revitalization nearly five years ago. They have both been active, instrumental members of CSCSW for over three decades. They are passionate about their continued involvement in the Society and continue to convey enthusiasm and dedication to those clinical social workers who are new to our profession and our organization. Gloria was involved in outreach and marketing activities during her 20 years at Jewish Family Service. Tanya is in private practice in Encino working with the older adult population.

Fresno District

District Coordinators:

Emiliano Beltran, ASW ~ bemiliano442@gmail.com

Eleanor Speakes, LCSW, PPSC ~ espeakes41@gmail.com

The Fresno District underwent a transition in leadership during the 2015-2016 academic year. The current district leaders wish to extend a massive thank you to Lynn Lirette, Gabriele Case, Ken Katz, Anne Petrovich, Dolores Siegel, Barbara Varley, and the many unnamed people who served the Fresno District over the years.

The last year was a busy one for the Fresno District. In September 2015, we participated in a memorial service in honor of Dolores Siegel, LCSW, former CSCSW Board Member. She was a dedicated and accomplished social worker, professor, and member of the CSCSW, and is greatly missed.

During the 2015-2016 academic year, we had well-attended monthly educational presentations. We heard from Jason Fritts, LCSW on Dialectical Behavior Therapy; from Judith Tucker, MS, former District Attorney, on sexual abuse from a criminal justice perspective and implications for social workers; from Mary LeBeuf, LCSW on Shame Resilience Theory; from Alison Acton, LMFT on Eye Movement Desensitization and Reprocessing Therapy (EMDR); from Jerry Silva, LCSW, Lead Suicide Prevention Coordinator for the Veteran Affairs Central California Healthcare System, on suicide risk, Operation S.A.V.E, and assessing lethality.

This summer, our district coordinated an event in conjunction with the Department of Social Work Education at Fresno State, Fresno State Alumni Association Social Worker Chapter, and the Fresno State Title IV-E Child Welfare Program. This event was a commemoration of Barbara Varley, LCSW, DSW, who was a Professor Emerita in the aforementioned department at Fresno State and a former President and Board member of CSCSW. Dr. Varley contributed greatly to the clinical development



CSCSW member Ken Katz, LCSW shares his thoughts with attendees at a recent Fresno District event.

and practice of social work. Many close friends, loved ones, colleagues, faculty, and students shared memories about Dr. Varley. Drs. Su and Veena Kapoor, who were close friends of Dr. Varley, introduced a scholarship they started in her memory. Guests in attendance were able to make donations and take a book from Dr. Varley's library.

The Fresno CSCSW District is continuing to hold regular steering committee meetings and is actively looking for members to join the committee to help plan ongoing clinical presentations.

District Coordinator Elizabeth Speakes has joined the CSCSW Board to fill the vacancy left by Nancy Delich, Ed. D, MATS, LCSW, PPSC, a professor at Fresno State, who resigned to focus on fulfilling her academic, clinical, and research responsibilities.

We meet every third Saturday from 9:30am-12pm and offer excellent trainings, CEUs, networking, and snacks. If interested in more information, please contact us or attend one of our meetings. We would love to hear from you!

Upcoming Events

Diagnostic and Treatment Issues in Bipolar Disorder: An Update for Clinicians

(San Fernando Valley District) | 01/21/2017 -- 9:15 AM

Transgender Competency and Human Development

(Sacramento/Davis District) | 01/21/2017 -- 9:00 AM



**VISIT OUR WEBSITE
TO LEARN MORE
ABOUT
UPCOMING EVENTS**

Law & Ethics: What goes around . . .

"What goes around..." is a 6-hour law/ethics workshop focused on recent and emerging developments in law and ethics that will impact clinicians of all disciplines, including changes to child abuse reporting obligations, changes for custody evaluators, record-keeping and maintenance, emerging issues and risks regarding telehealth practice, updates on duties to inform and warn when violent behavior may occur, modifications of laws concerning "retirement" of professionals, receiving subpoenas, testifying in court, risk management for supervisors, suicide risk management, and selected "slippery slopes."

"Steve Frankel is a gifted teacher, who is able to present Law and Ethics in a way that will hold your attention. He has the latest information at his fingertips and is very engaging. You will definitely learn from Steve and will enjoy the presentation."

~ CSCSW member and workshop participant

Palo Alto Conference

January 28, 2017 | 9:00 AM - 4:00 PM

Palo Alto Medical Foundation
795 El Camino Real | Palo Alto