

# Clinical Update

California Society for Clinical Social Work



Volume XLV Number 10, June, 2014

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**The Newsletter is taking a break for the summer – it will be back in September. Have a great summer.**



### Historical Contexts of the DSM-5

By Anne Petrovich, Ph.D., LCSW

One of the first attempts to classify mental patients began in 1844, when the American Medico-Psychological Association (forerunner to the APA) undertook a statistical classification of institutionalized mental patients for the stated purpose of improved communication among government agencies. Over the next one hundred years, four major editions of the original work led to the psychiatric classification system we now know as the DSM. In the 1840's, when it all began, *idiocy*, was the single classification for mental illness; but by 1880, seven categories of mental illness were officially recognized: mania, melancholia, monomania (psychosis confined to one obsessive idea or subject), paresis (late manifestation of syphilis, characterized by progressive dementia and paralysis), dementia, dipsomania (irresistible periodic craving for alcoholic drink), and epilepsy. At the request of the US Census Board, this early APA developed, in 1918, "The Statistical Manual for the Use of Institutions for the Insane," containing 22 categories of somatic-biological clusters, reflecting care in mental hospitals of patients who often had severe physical problems. This manual was used to survey institutions continuing until World War II and after, and was adopted by the newly formed National Institute of Mental Health (NIMH) in the 1950's. Up to this point the focus was on patients with severe somatically based illness who resided in mental institutions.

By 1952, however, there were major theoretical and political shifts in the psychiatric community. The somatic tradition had yielded to psychodynamic and psychoanalytic perspectives, which increasingly emphasized the role of environment and less severe forms of disturbance that could benefit from

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Published by and for the members of the  
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## DISTRICT MEETINGS:

### Greater Los Angeles District:

Coordinator Name: Lynette Sim  
Phone Number: (310) 394-7484  
Coordinator Email: [lsim1@verizon.net](mailto:lsim1@verizon.net)  
Date: Saturday, June 7, 2014  
Time of Meeting: 10:30 to 1:00  
Presenter: Kim Cookson, Psy.D.  
Topic: **The Trauma Resiliency Model (TRM): Processing and Healing from Trauma**  
Location: 3267 Corinth Ave., L.A. 90066  
RSVP: [messingerlcsw@yahoo.com](mailto:messingerlcsw@yahoo.com) or 310.478.0560

This presentation focuses on TRM as a mind-body approach that explores the concept of resiliency and the restoring of balance to the body and mind after traumatic experiences. It will include a brief overview of how trauma is processed in the brain differently than ordinary events and will describe some of the body based resiliency skills which clinicians may use. When the focus is on normal biological responses to extraordinary events, there is a paradigm shift from symptoms being described as biological rather than as pathological or as mental weakness.

Dr. Cookson, a clinical psychologist has a private practice in West L.A. and is the Trauma Training Director at Southern California Counseling Center. She is a Certified EMDR Therapist, an EMDR Consultant and a Trauma Resource Institute Trainer.

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:

Sept. 6, James Long, MD, **Child Custody Issues**

Nov. 15, Andrew Susskind, LCSW, **From Now On: Seven Steps to Purposeful Recovery**

### San Diego District:

Coordinator's Name: Ros Goldstein  
Phone Number: (619) 692-4038  
Coordinator's Email: [goldsiegel@gmail.com](mailto:goldsiegel@gmail.com)  
Presenter's Name: Katharyn Morgan, MFT  
Presentation Title: **The Art of Professional Resilience**  
Location: Jewish Family Service, 8804 Balboa Ave., San Diego  
Date: Thursday, June 5, 2014  
Time: 5:30-7:30 pm  
CE credits earned: 1.5

## DISTRICT MEETINGS (Cont'd):

### San Diego District, (cont'd):

We will review literature that examines therapist well-being and resiliency, then apply self-assessment measures, mindfulness techniques, and art-making activities to evaluate individual professional resilience. We will examine both the 'costs of caring' and the 'gifts of giving' and learn to recognize and regulate "somatic empathy," the psycho-physiological aspects of empathy that may put us at risk for burnout and compassion fatigue. Professional resilience will be enhanced by 1) becoming more conscious of and more in charge of how we are 'affected' and not 'infected' by our clients' emotional and somatic states and 2) being able to 'picture' our most resilient selves.

Katharyn Morgan has spent 30 years serving the counseling needs of children, adults, and families in Canada and the US. The use of symbolic communication through art, play, and dreams has been integral to her clinical work, her own self-care, and her international teaching experience. Katharyn has studied art therapy, mindfulness, and somatic psychology for many years and integrates these in her counseling practice.

**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: Tanya Moradians  
Phone: 818 783-1881  
Email: tmoradia@ucla.edu  
Date: June 8, 2014  
Time: 9:30 am to 12:00 pm  
Presenter: Elaine Leader, Ph.D., CGP, LFAGPA  
Topic: **Bullying**  
Location: The Sherman Oaks Galleria Community Room (Corner of Sepulveda and Ventura)  
All day parking will be validated

This presentation will focus on bullying including the dynamics underlying this behavior. It offers information about the impact of cyber bullying and how to address this issue with individuals as well as in educational settings and social media. A video will demonstrate. TEEN LINE's Outreach and a teen volunteer will speak about how bullying nearly destroyed her and how she was able to overcome its impact.

Dr. Leader received her MSW from UCLA and her Ph.D. from The Sanville Institute where she was a founding year member. She was Coordinator of Adolescent Group Psychotherapy Training in the Department of Psychiatry at Cedars-Sinai from 1972-1994. She is Co-founder and Executive Director of the Center for the Study of Young People/TEEN LINE and has been in private practice since 1970. Dr. Leader is currently Chairperson of the Legacy Advisory Board of the Group Psychotherapy Association of Los Angeles. She is also a consultant to law enforcement, adolescent-serving agencies and the media.

**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.



**The AAPCSW (American Association for  
Psychoanalysis in Clinical Social Work)  
Northern California Chapter**

**Co-Chairs: Velia Frost, LCSW & Rita Karuna Cahn, LCSW**

**Program: Romancing the Alliance: Understanding Sexual Attraction Between Client and Therapist**  
**Presenter: Linda Alperstein, LCSW**

**Date: June 14, 2014**  
**Time: 10 a.m. to 12:30 p.m.**

In our private lives, we can respond to sexual feelings without having to analyze them. While we learn about legal and ethical consequences of sexual involvement with clients, we are rarely trained to examine the *meanings* of sexual feelings in the therapeutic alliance. Yet the failure to integrate an understanding of erotic feelings into the process of therapy can diminish or destroy the usefulness of our work. In this presentation we will consider motivations for eroticized transference and countertransference, examining how needs for intimacy and distraction, or expressions of dependency, aggression and narcissism can become sexualized during psychotherapy. We will discuss the vulnerabilities involved and various therapeutic strategies that safeguard the work while respecting the needs and feelings of both client and clinician. Your own clinical examples are welcome for the discussion.

**Linda Perlin Alperstein, M.S.W., L.C.S.W.**, is an Associate Clinical Professor at UCSF in the Department of Psychiatry. She has taught human sexuality to medical and mental health professionals since 1976. She has had a private practice since 1972, working with a wide variety of couples and individuals. When California implemented a new law in 1978, requiring all mental and medical health professionals to have ten hours of training in human sexuality, she was hired by the NASW to teach human sexuality throughout the state.

**\*\*\*\*\*Location\*\*\*\*\***

120 Commonwealth Ave., (Between Euclid & Geary) S.F., CA. 94118  
Home office of Gabie Berliner, PhD, LCSW  
(call for directions) 415-751-3766

**Seating is limited: please RSVP by E-mail to: [ritakaruna@mac.com](mailto:ritakaruna@mac.com)**



## Lesbian Non-Birth Mothers/Parents: The Transition to Parenthood

By Janet Linder, PhD, LCSW

*"I like my role...I like being a father, I like being a dad...I feel like I'm actually kind of a hybrid, I'm a mom/dad...because I am a woman, even though a lot of the things I like are masculine."*

### The struggle for visibility, acceptance, and legitimacy

Across the country today there are vigorous and contentious national and regional socio-cultural and legal conversations about how to recognize and include same-sex individuals, couples, and families. In the last 30-40 years a combination of socio-cultural changes and technological advances has created opportunities for lesbian couples to intentionally choose to parent together. The law has come to recognize "intentionality" as important in establishing parental roles, rights, and responsibilities in non-traditional families. This matters because historically and traditionally the law only recognized parental rights through biology or legal marriage. The lack of legal protection (in states without same-sex marriage) of the relationship between the non-birth mother/parent and her child can leave the non-birth parent vulnerable, and dependent on the good will of her partner. The two parenting partners then find themselves in asymmetrical positions of legitimacy with the birth mother in the power position, as her maternal role is beyond question. Lesbian non-birth mothers/parents occupy a new social and familial role, in increasingly new social orders. Due to the newness of this role, coupled with the legacy of institutional and cultural homophobia, the non-birth parent is at risk to receive less support and mirroring from the outer world, her family, and in her partnership as she moves into the process of parenting.

I studied women who occupy this new parental role, the "second parent" along with a gestational and breastfeeding mother, that has historically only been occupied by men. This new parental role lacks a clear name, as indicated by a journal article entitled "In search of a name for lesbians who mother their non-biological children" (2008, Brown & Perlesz). Language often lags behind new socio-cultural changes. Terms like 'co-mother,' 'other mother,' and "non-bio mother" are frequent options even while each term is saddled with negative limitations. I use the terms of non-bio and non-birth to describe the partner of the gestational mother

**Each lesbian parenting couple must decide for themselves the names and language that they will call themselves to their child and to the outside world**

because 'co-mother' and 'other mother' connote a secondary position. The usage of 'non-bio' or 'non-birth' seems more accurately descriptive, even while some find the 'non' part overly negative.

Each lesbian parenting couple must decide for themselves the names and language that they will call themselves to their child and to the outside world. For some lesbian non-birth mothers/parents, their gender identity/expression is such that they do not wish to use traditional maternal names for themselves. I found that I needed to start using the term 'parents' in addition to 'mothers' because not all lesbian non-birth parents identified with being a mother. Clinicians need to develop awareness of their assumptions and biases based on a hetero-normative model of parenting and families. Often because of gender identity, it is important to a minority of lesbian non-birth parents to find less maternal names to call themselves, such as Baba, Moppa, or Poppa. The priority with last names is to communicate to the outside world that they are a cohesive family, and should be regarded and treated as such.

### Transition to Parenthood, traditional and non-traditional

*"She's been kind of like backseat with this whole thing. I made a lot of the decisions, like, I want the donor to look like this, I want the name to be this, and she's like okay. She really let me take...I think because she knew I'm not the one who's carrying it. I'm not the biological one, so she was like, let me give her as much as I can."*

It is common for opposite sex couples after the birth of a first child to increase or intensify gender stereotypical activities, which may lead to greater frustration or conflict. Generally, the major problem for opposite sex couples during the transition to parenthood is the gender divide between his and hers - with each partner tending to feel too alone. The Cowans (1992, 1998, 2005) found that the more an opposite sex couple

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# The DSM 5: Transitions

Presented by: Stan Taubman, PhD, LCSW

Co-Sponsored by:

CALIFORNIA SOCIETY FOR CLINICAL SOCIAL WORK &

THE SANVILLE INSTITUTE FOR CLINICAL SOCIAL WORK AND PSYCHOTHERAPY



## The DSM 5: Transitions

(6 CE Hours)

CHICO, CALIFORNIA

June 14, 2014

8:30 Registration – Workshop begins at 9:00 a.m. to 4:30 p.m.

**The Pageant Theatre**

351 E 6<sup>th</sup> Street

Chico, CA 95928

**\$65 Students\***

**\$120 Members**

**\$150 Non-Members**

This workshop is designed for the clinical practitioner who has some familiarity and experience with DSM differential diagnosis using the DSM-IV. The workshop will familiarize participants with major changes from the DSM-IV to the DSM5 including changes in the classification system, definition of mental disorder, loss of the 5 axis system, new diagnoses, deleted diagnoses, unchanged diagnoses, and criteria changes. The presentation will also identify common diagnostic errors and introduce participants to the new Assessment Measures which are included in the DSM-5 Manual. To register online click the link below or cut and paste into your browser:

<http://www.clinicalsocialworksociety.org/Default.aspx?pageId=1631911&eventId=844392&EventViewMode=EventRegistration>.

This course meets the qualifications for 6 hours of continuing education credit for **MFTs, LPCCs, PhD's and LCSWs** as required by the California Board of Behavioral Sciences. The Sanville institute is approved by the California Psychological Association to provide continuing professional education for psychologist. The Sanville Institute maintains responsibility for this program and its content. BBS CE Provider # PCE 1 CPA PAS Provider #SAN 150

**\*Student price is for students currently enrolled in a program of a mental health discipline.**

**A boxed lunch will be provided for participants that pre-register. Lunch cannot be guaranteed for at-the-door registration.**

**Refund Policy:** A full refund may be issued up until 7 days prior to the presentation date. No refunds will be issued after 5/9/14



Stan Taubman, PhD, LCSW has been in clinical practice since 1968. He currently is the Program Director of Berkeley Training Associates and teaches on the faculty of the University of California, Berkeley, graduate program in Social Work. He is the former Director of the Alameda County Medi-Cal Behavioral Health Plan, as well a Director of Management Services for the Alameda County Behavioral Health Care Services Department. His clinical experience includes private practice, mental health inpatient, outpatient and day treatment programs, child welfare and medical social work. Dr. Taubman is the author of *Ending the Struggle Against Yourself* (Tarcher/Putnam Publishing), [click here to purchase Ending the Struggle Against Yourself](#) as well as numerous journal articles addressing both clinical and administrative issues.

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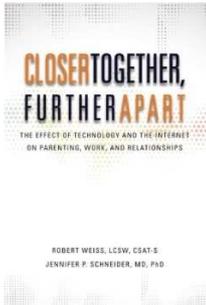
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CSCSW Member? Yes/No      Interested in Becoming a Member? Yes/No (Circle One)



## BOOK REVIEW

*Closer Together, Further Apart: The Effect of Technology and the Internet on Parenting, Work and Relationships*

By Robert Weiss, LCSW, CSAT-S and Jennifer P. Schneider, MD, PhD

Gentle Path Press, Carefree, Arizona, 2014, 208 pages

Reviewed by George Rosenfeld, Ph.D.

### **The digital world is here to stay and it is changing everything.**

*Closer Together, Further Apart* offers a rarely found balanced view of the dangers and benefits generated by the digital revolution. The book addresses the question, "Are we raising a generation addicted to technology and unable to deal with reality or are digital youth more perfectly attuned to survival in a fast moving, multi-tasking, digital world?" Their answer: The research is not in yet; although, the effect of technology on our relationships, work, parenting, medical care and evolution is profound.

Education and the workplace have been dramatically changed creating a generational divide and changing patterns of human interaction and the nature of communication, illustrated by teens who are texting constantly. Noting the paucity of research on the effects of screen time on youth, the authors characterize the American Academy of Pediatrics policy statement limiting screen time exposure for youth as possibly formulated by a generation whose views are distorted by favoring and defending the way they had been raised, as they distrust and fear the new. The authors suggest that some people may experience negative effects from Internet over-use, but maybe most will self-regulate and move on after the novelty wears off. We just don't know yet. The authors highlight that "our 21<sup>st</sup> century fears have evolved out of 20<sup>th</sup> century beliefs and experiences that often do not accurately reflect the realities of the world our children currently face." (p.69)

They present some astounding statistics about the ubiquity of digital usage, such as, "a typical young person has spent about 10,000 hours playing video games by the age of 21" with "4% of the US population averaging an astonishing 48.5 hours a week... Overall kids aged 8-18 spend 11.5 hours a day using technology" (p. 71). 21% of smartphone users

interviewed in one study said they would rather give up sex than surrender their phones (p.111). Pornography is widely sought. A 2008 survey found that 93% of male and 62% of female college students reported having seen online porn prior to being 18. The average age of first exposure was 11. It appears that one-third of Internet porn users are female. The authors correlate the use of online porn with disappointment and disinterest in live relationships in males and speculate that possibly in the future some may fall in love with and marry robots that can respond sexually. They wonder if marriage will remain popular and if it can survive the threat of online sex and romance, the emotional challenges married people have to face, and the threat marriage represents to education and careers especially for women. The authors wonder if real life partners can keep up with digital and technological partners and the accessibility of digitally arranged meetings for sex that are available on multiple online dating services and sexual hookup sites. They note that we live in a digitally enhanced world in which the boundaries between reality and fantasy are blurred so "fake is the new real."

The book emphasizes the Internet's ability to fuel behavioral addictions. For example, 600,000 American youth (14-22) reported that they gamble on the Internet on a weekly basis. The Internet offers accessibility, affordability and anonymity which facilitate sexual, gambling, gaming and shopping addictions.

The authors urge the reader to keep an open mind about the effects of digital technology and not reflexively fear or blame the "new." They caution that we just don't know the eventual positive and negative effects, but we do know that the digital world is here to stay and it is changing everything.

George Rosenfeld, Ph.D. is a psychologist practicing in Sacramento. He is author of *Beyond Evidence-Based Psychotherapy: Fostering the Eight Sources of Change in Child and Adolescent Treatment* published by Routledge. He teaches at Sacramento State University and the University of San Francisco. He can be reached at [geo.rosenfeld@gmail.com](mailto:geo.rosenfeld@gmail.com)



**INSIDE THE INSTITUTE**  
**A Message from Whitney van Nouhuys, PhD**  
**Academic Dean**

It is a pleasure for me to announce that Mario Starc will become the new Academic Dean of The Sanville Institute for Clinical Social Work and Psychotherapy, on July 1. I have been honored to serve in this position for the past five years and now I look forward to working closely with Mario, my fellow Sanville alum, during the leadership transition.

As a clinical social worker, Mario has worked in many capacities in the San Joaquin Valley and the East Bay, since he received his BA in Social Welfare from UC Berkeley and his MSW at California State University, Sacramento in 1977. He currently practices in Berkeley and Tracy, and is an Advanced Candidate at the C.G. Jung Institute of San Francisco. Since last fall Mario has chaired the Advisory Committee to The Sanville Institute's Board of Trustees, so he is becoming well acquainted with the inner workings of our Institute. He will turn his attention to building on the Institute's almost 40-year history, developing fresh ideas for its future, and helping us respond to ongoing changes in our society and our profession.

You are invited to meet Mario at one of the Institute's "introduction parties" in the early fall, in both the north and the south. We'll let you know the exact dates and locations, and the information will be posted on our website.

In the meantime, our southern contingent has planned a delightfully entertaining fundraiser on June 1 in Santa Monica – A Carnival Sideshow: feats of endurance, knife throwing, fire eating, sword swallowing, glass walking, bullwhip tricks!

And on a more serious note we are preparing for Spring Convocation and Graduation, on Saturday June 21 in Berkeley. The theme will be on aging, in keeping with the research topic of our graduate. As always, the convocation program is open to the clinical community and CE units will be available.

You will find more information about the fundraiser and the Convocation on our website, or by calling the office.

We are accepting applications for 2014-2015 and we  
welcome inquiries about our PhD and two-year certificate programs.  
Information is on our website [www.sanville.edu](http://www.sanville.edu) or call 510-848-8420.

The Sanville Institute is a private, non-profit, unaccredited school that is approved by the State of California's Bureau for Private Postsecondary Education ([www.bppe.ca.gov](http://www.bppe.ca.gov)). "Approved" means compliance with state standards as set forth in the California Private Postsecondary Education Act of 2009 [California Education Code, Title 3, Division 10, Part 59, Chapter 8, §94897(l)].



**Editorship Changing Hands**  
**By Jean Rosenfeld, LCSW**

After 17 years I am leaving my position as editor of this newsletter. Through the years I have had the opportunity to work with many talented therapists who have generously shared their ideas, research, knowledge and wisdom by writing articles for *The Clinical Update*. In the recent past our members have written about the Recovery Model, DBT, MBT, therapists' gossip about clients, infant and early childhood mental health, beyond anger management, Jungian Sandplay Therapy, women and retirement, medical masquerades, sex addiction, couples treatment, post-partum depression, the military culture, psychological theories of aging, stepfamilies, divorce, the DSM 5, challenges to evidence-based therapy, our cultural addiction to speed, handling subpoenas, useful Internet sites, book reviews, and much more. The topics reflect the wide interests and expertise of our members. I have learned a great deal that I use in my clinical practice, and editing the newsletter has increased my pride in the profession. My heartfelt thanks go to the hundreds (wow – it really is hundreds!) of people who have contributed their time and effort to making this newsletter valuable to our members. The encouragement and support from Geri Esposito, our former Executive Director, and Stephanie Peters, her Assistant, were invaluable right from the start. Sincere appreciation goes to Cindy Esco, our Executive Administrator, who is in charge of production – she will continue to do all the layout and formatting, handle the district meeting notices, advertisements, printer and e-blasts.

Although I will dearly miss helping to shape the newsletter, I am looking forward to more time to pursue other interests (hopefully without deadlines). I will continue my connection with the Society as a board member and member of the conference committee – and continue to create the newsletter cartoons.

I am delighted to pass the editorship on to Tyler Arguello, Ph.D., DCSW, LCSW, Assistant Professor of Social Work at CSU, Sacramento and an Adjunct Professor at USC. I am looking forward to seeing how the newsletter will evolve under his leadership. He brings over 20 years to the editing table, working as an independent clinician, educator, supervisor, and researcher in the field of mental health and HIV/AIDS, and working with marginalized populations. If you have been thinking about writing for our newsletter, please do not hesitate to contribute. This is an ideal time to bring forward even more voices, clinical expertise, and timely issues in practice. Contributing to our newsletter would be a great way to welcome Dr. Arguello. You may reach him at [tyler.arguello@csus.edu](mailto:tyler.arguello@csus.edu).

**Thank you Jean!**  
**From CSCSW Board Members and Staff**

We at CSCSW just wanted to say **thank you** for all of your years of dedicated service. You have been the heart and soul of *The Clinical Update* for 17 years, and through all the years it has been a professionally crafted, informative and engaging newsletter for our members. CSCSW is indebted to you for your keen eye for details, helping authors find their voice and ability to wrangle articles, as well as your wonderful cartoons. Your expertise will be sorely missed as we move forward without you. Please keep sending your cartoons, and know that your advice and critique will always be welcomed.



## *Rhymes and Reasons*

### **A Great Need**

By Hafiz, 14 C. Persian Poet

Out  
Of a great need  
We are all holding hands  
And climbing.  
Not loving is letting go.  
Listen,  
The terrain around here  
Is  
Far too  
Dangerous  
For  
That.

California Society for Clinical Social Work

Do you Know??



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

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## Historical Contexts of the DSM-5

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treatment. There was a push to develop more relevant treatments for veterans and to locate treatment centers outside of institutions in the community. The DSM I reflected these shifts in its expanded categories of illness and theories of etiology. The DSM II, published in 1968, continued the psychoanalytic theoretical influence, expanded the number of disease categories and encouraged the use of multiple diagnoses. In 1973, homosexuality was removed from the DSM and replaced by the term, "ego-dystonic homosexuality," in response to the emergence of the LGBT rights movement.

The DSM III, published in 1980, introduced the axial system of diagnosis. Axis I addressed clinical syndromes, defined in terms of descriptive symptoms, deliberately avoiding theoretical wars of causation between behaviorists, psychoanalysts, and biologically-oriented practitioners. This was an attempt to facilitate communication on the basis of observable symptoms everyone could agree upon regardless of theoretical training or preference. Axis II addressed personality and developmental disorders, Axis III medical conditions; Axis IV psychosocial stressors thought to be affecting the mental condition; and Axis V, the adaptive functioning of the client, using the GAF (Global Assessment of Functioning Scale). Specific symptoms were listed for each diagnosis, and information was added regarding age, course, impairment complications, predisposing factors, prevalence, gender, familial patterns and differential diagnostic considerations. Appendices were also added to explain technical terms, provide decision trees, and reliability data, to promote a document that was scientifically based. PTSD was added as a diagnosis, in response to activism by Vietnam vets. The descriptive, atheoretical emphasis reflected the ascendancy of behavioral theory over psychodynamic theory. Until 1980, the DSM was relatively obscure, but with the publication of DSM III, the DSM became a cultural icon, the "Bible" of psychiatry, influencing who is considered well vs. sick, who gets disability benefits,

and who is eligible for school, mental health, vocational services, damages in lawsuits, and the determination of criminality vs. mental illness in courts of law.

The DSM III-R (1987) continued and expanded the influence of the DSM. Sleep disorders were added as mental illnesses. Proposed new diagnoses (Paraphilic Rapism, Premenstrual Dysphoric Disorder, and Masochistic Personality Disorder) were not adopted but placed instead in appendices due to the opposition of feminist psychotherapists. Ego-dystonic homosexuality was removed as a diagnosis. Although 30 new diagnostic categories were added, this DSM did not include new reliability data. The DSM III-R was heavily influenced by research psychiatrists, and all its work groups and advisory committees were chaired by psychiatrists.

**In 1973, homosexuality was removed from the DSM and replaced by the term, "ego-dystonic homosexuality," in response to the emergence of the LGBT rights movement.**

The DSM IV (1992) focused on clinical, educational, and research information, with the stated purposes of providing helpful guidance to clinicians, facilitating research, and enhancing communication between clinicians. 13 work groups developed and refined diagnostic categories, adhering to a specific process designed to promote consensus vs. subjective adherence to previously held positions. The DSM IV T-R (2000) attempted to avoid adding a proliferation of new diagnoses. Its stated purpose was to update the manual in response to new research findings and to make its codes compatible with ICD-9 (World Health Organization) codes. All changes were required to be supported by empirical data and limited to text descriptions of associated features and disorders; there were no substantive criteria changes. Language was also added to clarify that the verbal distinction between mental disorder and general medical condition was not intended to mean that they are fundamentally different or that medical conditions are unrelated to psychosocial factors.

These historical change processes contained several salient characteristics. None of the changes over time

were demanded by clinicians. Each revision has become more time-consuming, elaborate, and politically complex (from 106 diagnoses in DSM I to approximately 322 in DSM V, with an increase in cost from \$2.50 to approximately \$100). With each new edition of the DSM, the changes are justified explicitly or implicitly as improving scientific credibility. The process begins by attacking the current system, even when it has been adopted recently, and ends by claiming the superiority of the new system (Francis, 2013). Theoretical wars (between psychodynamic vs. behavioral theorists and adherents to biological/neurological bases vs. psychosocial bases of mental illness) and social movements (feminism, LGBT and disability rights, veterans) have influenced what is left out vs. what is included as a diagnosis. And increasingly the vast influence of the pharmaceutical industry referred to as “Big Pharma” plays a role, along

with psychiatry’s struggle for respect in medicine (the power of the pharmaceutical industry in influencing diagnosis and treatment is beyond the scope of this article, but is nevertheless an ongoing and important topic of discussion and debate). These latter influences are considered hugely important in influencing the changes from DSM IV T R to DSM 5. It is also important to note that despite the perspectives that a variety of mental health professionals, including psychologists, psychiatric nurses, marriage and family counselors, and social workers bring to bear on the assessment and treatment of persons with mental illness, the diagnostic system has been almost exclusively controlled by psychiatrists. The DSM is a huge money maker for the American Psychiatric Association, and the process of determining diagnoses is very political. Social workers have not been at the table.

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## Lesbian Non-Birth Mothers/Parents: The Transition to Parenthood

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reports satisfaction with their chosen division of labor, the more that couple reports a higher level of relationship satisfaction, experiencing less subjective stress. For any couple, it does not matter what the division of labor is, it only matters that each parenting partner feels comfortable with it.

While partners in an opposite sex couple may feel too alone, and caught in a more rigid division of roles than they would like, two women together have other challenges. Lesbian non-birth parents differ from fathers in opposite sex relationships most likely because of gender socialization. Unlike many fathers, women in the ‘second parent’ role tend to want to spend as much time as possible with their child. (Bos, van Balen, & van den Boom, 2004, 2007). Thus, issues of competition are more likely to occur between two women than with a man and a woman. Roles and responsibilities regarding

childcare and paid work may not be so much ‘divided’ as ‘shared.’

**Racism emerged with respect to darker-skinned non-birth parents who have lighter-skinned children. It was reported that it was not uncommon for them to face uncomfortable assumptions about their role and relationship to their child, e.g. that they were nannies.**

I interviewed fifteen lesbian non-birth mothers/parents, the majority having a first child between the ages of one and two. These women were pleased with their marriages, with their children, and with their roles. (For example, if I had chosen to interview women who were separated from their first partner, with whom they began to co-parent, it would have been different). In general, the couples we see in therapy have lower relationship satisfaction because of a diminished capacity to regulate affect, empathize, and communicate, as well as display ambivalent attachments and rigid roles. An example is a lesbian couple where the birth mother does not prioritize her partner taking legal actions to assert her parental role, and upon the dissolution of the couple relationship, the birth mother

moves away, and does not allow her ex-partner access to their child.

### Acquisition of Sperm

*“So our first decision obviously was whether we wanted to do it with someone we knew, or anonymous. And for us, that was the hardest decision. We were not looking for a sort of third parent...we knew we wanted somebody with the same basic demographics as us.”*

Sperm acquisition involves decision making about choosing a known donor, an unknown donor, a donor who consents to be known by the child at the age of 18, or a sperm bank. The longer the period of insemination for the lesbian couple, the more stressful it becomes. The absolute desire of all of these women was to be able to parent together with their partner without interference from anyone else. Lesbian non-birth mothers/parents wish to be in control of parenting their children, and, not uncommonly, feel anxiety about others intruding. In the category of others were the sperm donor, the sperm donor’s mother, the parents of the birth mother, and evangelical or socially conservative parents of their own. Clinically it is important to pay attention to feelings of anxiety voiced by the non-birth mother/parent, and to reassure her and reinforce that she is a ‘real parent,’ who the outside world will come to understand and accept as time goes on. (This depends in part on geographic location, and the common attitudes and laws of each region/state. The high relationship satisfaction of the women I interviewed stemmed in part from their location in the San Francisco Bay Area, known for its tolerance of sexual orientation and gender expression diversity). Extended family mostly “came around” to accept their daughters, sisters, etc. as full-fledged parents with legitimate family lives, especially once the babies were born.

One consistent theme for lesbian non-birth mothers and parents is the desire to find a sperm donor who “looks like me.” Whether ethnicity, height, religion, skin, hair, or eye color, the non-birth parent wanted a child who could fit in her family, and who would not elicit questions about “the father” or why she looks so different from her baby. Racism emerged with respect to darker-skinned non-birth parents who have lighter-skinned children. It was reported that it was not uncommon for them to face uncomfortable

assumptions about their role and relationship to their child, e.g. that they were nannies.

### High Relationship Satisfaction

*“I think in the straight world, when you biologically have a child, you talk about it so easily...and it’s just understood, oh, you had the baby. But, getting people to understand that it’s your baby, too? Because I think I’m guilty of that too. ‘Oh, they adopted that baby? I wonder how they feel about that, or how the people around them feel about that?’ I don’t know exactly how to pinpoint it, but you do look at people who adopt babies differently. I don’t know why. Yet, I think to myself, I’m in that same situation, but I don’t think of myself any differently. I’m just as much his parent as Molly is, and Molly definitely sees me like that too. She actually gets offended when her mom will say something. I guess her mom called him (the sperm donor) the dad, that’s what it was. And she was like, “Mom, you have to understand, Peggy is the other parent.” I remember, when she was pregnant, she was very adamant about people understanding that I was 100% the parent too.”*

I identified two main factors for the high relationship satisfaction of the women in my sample. The first was the strong and steady positive mirroring by the birth mother of her partner’s legitimate identity and role as an equal mother or parent. The women I interviewed felt unequivocally supported by their partners or wives, and this connection seemed to buoy them through situations, relationships, or self-doubts that challenged their identities as a mother/parent. The second strongest factor in relationship satisfaction of the women I interviewed had to do with the concept of teamwork. Nine of the fifteen mothers/parents voluntarily introduced this concept, of the parenting couple as a team. Working together as a successful team was important to these women, and gave them much satisfaction and pleasure. Eleven of the fifteen interviewees expressed positive feelings about the division of labor between them and their partners, pre- and post-transition to parenthood. It is likely that same sex couples have an easier time with the division of labor, since how they divide things up is not fraught with the weight and history of sexism, as it is for opposite sex couples. Thus, I think it is unlikely that the division of labor is the biggest problem for same sex couples during the transition to parenthood.

**When breast-feeding goes well, and the birth mother is home with the baby for a longer time, a preference for the birth mother can develop that may be hurtful for her partner.**

*"I think we take different roles at different times...I'm kind of like the problem solver...We kind of just work in a team. It just kind of happens...it's not like anything we force or try to talk about...she makes a ton of money more than I do, she makes double what I make, and I don't feel I am in a competition for that."*

The women I interviewed talked specifically about teamwork in terms of the importance of good communication between the parenting partners. They valued it, and they felt taken care of by it. Couple therapy was used by two of the participants, who said they felt it made a really positive difference for the couple in learning how to navigate becoming a threesome. Prioritizing the couple relationship was hard to do amidst sleep deprivation, exhaustion, financial pressure, and learning to take care of a newborn baby.

*"We have to work on spending more time together. You have to make yourself take that time off. We could clean the house while he's napping. And we don't have that many days off together. But, if we can get him to sleep, during the day, we'll take that time for ourselves."*

#### **Unequal Child Attachment**

*"And April was always really good about it too... he can be kind of rude and say things, like, he doesn't want Baba...when he would do that, she would do little things to make me included... Sometimes we would go to hug, and he'd be like, 'no, Baba,' and she's like, 'yeah, I'm going to hug Baba, or I love Baba.' Just little things, you know."*

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While there has not been enough research done on these families, and especially on the lesbian non-birth parent, to identify the most difficult issues in the transition to parenthood, one of the main challenges is the issue of child preference for the birth mother. When breast-feeding goes well, and the birth mother is home with the baby for a longer time, a preference for the birth mother can develop that may be hurtful for her partner. Five of the fifteen women experienced painful child preferences within their families that resulted in feeling rejected and excluded. Of the five, three volunteered that their own experiences of significant maternal abandonment may have contributed to their suffering, and this is something for clinicians to be alert to.

#### **Conclusion**

Clinicians have the opportunity to support non-traditional families who seek therapy to resolve painful and stuck areas, as women and people in the LGBT communities tend to use therapy more than average. Clinicians should not assume that client problems are due to more marginal social locations, and yet we need to become informed by the realities of other people's lives that are different from our own. Clinical social workers' commitment to equity, diversity, and emotional healing make us well-suited to understand and help families of all kinds.

Please contact the author for references.





## The Clinical Update

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