WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

FALL 2013

In this issue:

From the Desk of the President

HARVESTING OUR RESOURCES AND PREPARING FOR CHANGE

By Karen Hansen

As I write this letter the changing of the season surrounds me with smells, colors, increased moisture, and changes in light. Centering with these changes seems to be called for, within and without. The summer's long lazy days are behind us, fall's rhythms are calling us forward. A sleeping grandchild next to me brings a soothing energy, a bowl of apples awaits my attention in the kitchen, a pot of chili on the stove simmers with aroma. My senses and my body's natural response to them are fully in my attention. I want to hold this awareness as I write to you today.

Many of you have recently renewed your membership in the Society, hopefully with the knowledge that it is an important piece of your professional life which aids and enhances your work. Thank you for your continued trust and support. You won't be disappointed, as this year is unfolding to be an important one for our organization, for many reasons. Along with some wonderful programming, we hope to expand our inclusion of diversity issues and find more ways to incorporate the Arts (creative writing/poetry, music, and theater) to enrich our clinical focus. If you are interested in writing about your experience in one of these areas, sharing on the listserv, or working on one of our committees, you are warmly invited to do so, as it will further the value of what we do as a Society. Contact me or any member of our Board with your ideas. As always, what you get out of your membership in WSSCSW is often reflected in what you are also able to give.

This issue of the newsletter is filled with stimulating and important resources for your professional growth and renewal. The centerpiece article by Marianne Pettersen, who reviews the book The Archaeology of Mind by Panksepp and Biven, is a riveting overview of a newer paradigm for thinking about clinical work than most of us were trained in. Becoming more aware of lived experience in our own bodies is now the gold standard for an effective therapeutic stance (hence my focus on the sensory dimension above). The book review is a great introduction to the clinical conference we are hosting with Sharon Stanley on October 19th. If you are interested in participating in the conference, visit our website, WSSCSW.org, for information on registration – there may still be a seat or two left for what

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WSSCSW

The Washington State Society for Clinical Social Work was established in 1973 and incorporated in 1988 as a 501(c)(6) to promote and advance specialization of clinical practice within the social work profession. It is an organization of clinical social workers practicing in a variety of settings including mental health clinics, family service agencies, hospitals and medical clinics, and private practice in the state of Washington. Its members span the professional life cycle from students and new professions to mid-range, seasoned, and retired citizens.

WSSCSW offers its members continuing educational opportunities, legislative advocacy including lobbying, network and professional growth opportunities and special programs for new professionals.

WSSCSW is a nonprofit tax-exempt professional organization with a board of directors composed of officers elected by the membership and chairpersons of the various committees. It is affiliated with the Clinical Social Work Association, which represents clinical social workers on the national level and actively works with them to represent local as well as national concerns.

PRESIDENT'S MESSAGE

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will no doubt be a sold out and exciting day of learning and training.

I also call your attention to the article, "Our Journey of Membership", by Sara Slater, outgoing Professional Development Chair and a current Newsletter Co-editor. Sara takes us on a delightful romp through the history of the organization, and with excellent wordsmanship, highlights the best stuff that the Society is capable of. She and Carolyn Sharp have been major contributors to the culture of the Society, and her love and affection for this process comes through loud and clear. So does her call for the benefits of pitching in and getting involved in Society work and activities. We are always open to the interests of new volunteers. The pay ain't great, but the intrinsic rewards are fantastic.

Two articles – one by Laura Groshong on HIPAA changes and one by Tanya Ranchigoda on DSM-5 changes, are essential reading for your professional knowledge. Change seems to be in the air, within our profession and in health care, with the major revisions of the Affordable Care Act coming on board soon. Harvesting resources to help us make changes is what the society is about this year. At our board retreat we chose the theme "A Year of Integration and Growth", and there are many ways this theme is already becoming a reality.

I am looking forward to another trip to "the other Washington" to meet with our fellow Society Presidents through the Clinical Social Work Association (CSWA), along with our Legislative Advocate Laura Groshong. In this time of change it is important to collaborate together with our national community. I hope to bring back a perspective that will optimally inform my leadership as I guide the organization through the year. I feel fortunate to be able to work on making a difference for the future of our profession. If you do not belong to CSWA this is the year to join. We negotiated a dues reduction last year which is still in effect; it only costs $100 to join our national organization and CSWA deserves your support and membership.

There are changes taking place within our organization as well. A heartfelt thank-you and goodbye goes out to Sukanya Pani, who must step down from her position as co-chair of the Membership/Diversity Committee. Sukanya brought a wonderful, solid presence to our diversity initiative and membership services. We will miss Sukanya and we hope she can continue to lend her voice to this process. Molly Davenport, who continues as Membership/Diversity co-chair, is looking for an effective replacement to co-chair the committee. We thank Molly for her recent hard work managing an effective membership drive. If you know someone who did not renew or are aware of a potential new member, please help Molly by directing them to her or myself for recruitment into our society.

After requesting assistance to lead our legislative presence in Olympia, Laura Groshong has been joined by Daniel Sorensen as her volunteer aide. Dan brings his experience with our Veterans Program, Here @ Home, and is

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interested in legislative work. He will learn the ropes from the Grandmother of Legislative Advocacy in Clinical Social Work, while Laura steps back a bit and becomes an actual grandmother times two this year.

Additional changes are occurring in our Professional Development Committee. Tanya Ranchigoda and Diane Stewart are leading our program of Clinical Evening Meetings, learning the job that the veteran Sara Slater performed so well over a number of years. Be sure to check the calendar for the upcoming series of interesting clinical evenings and get the dates onto your calendars. Three of the CEM's will include presenters who will augment our understanding of including somatic elements in our clinical work.

Other changes in the Society include hiring a professional bookkeeper to attend to our financial records, for which we previously relied upon volunteers to manage. Marian Harris, our new treasurer, will be the liaison between our bookkeeper and the Board, helping us stay on track financially this year. We are also excited about co-sponsoring a number of activities with other organizations this year, a new model for how to "integrate" ourselves into the broader clinical community of Seattle.

So with all these changes and all our wonderful volunteers and resources, including this newsletter (thank you Lynn Wohlers, Sara Slater and Brook Damour), and our listserv (thank you Karyn Mackenzie for your continued service in this important area) we seem set for a challenging, growing year ahead. May the fall harvest bring you the bounty of integration and growth as a professional, and may we partner with you as an organization to expand upon new clinical horizons and embodied experiences.

Your faithful servant,
Karen Hansen, , LICSW
WSSCSW Board President

Be Aware: HIPAA Rules Changed on September 23, 2013

By Laura Groshong, LICSW, Director, Government Relations

Laura Groshong is the Director of Government Relations for the Clinical Social Work Association, Legislative Consultant for WSSCSW, and a mental health advocate who lobbies for six mental health groups in Washington State. She has a private practice working with adults in long and short term psychodynamic psychotherapy.

Many WSSCSW members have taken the all-day training on Health Information Portability and Administrative Act (HIPAA) rules, offered about 25 times in locations all over the country since 2003. This training was written by Keith Myers, LICSW, David Schoolcraft, JD, and myself and has been updated every year since its inception. The changes have varied in scope and this year is a significant one in terms of LCSW's maintaining HIPAA compliance, due to mandated changes in the HITECH Act of 2010 just now being implemented. While CSWA is in the process of updating our complete HIPAA Manual (available in November), I wanted to give you a summary of the changes that took place on September 23, 2013, so that you can update encryption, breach notification statement, expanded business associate agreements, disclosure of PHI for deceased patients, and changes to the Notice of Privacy Practices (NPP). Many LCSW's have not had an update on HIPAA since the original rules came out in 2003. Here's a quick way to see if you need an update:

- Do you regularly review your compliance with HIPAA rules?
- Have you attended a HIPAA training in the last 6 months?
- Are you aware of the substantially increased enforcement penalties for HIPAA violations, especially for private practitioners?
- Have you done a complete review of your privacy and security Policies and Procedures in the past 6 months?
- Do you have a breach notification plan in place?
- Have you given your business associates an updated BAA about your HIPAA policies and procedures in the last 6 months?
- Are you familiar with the HIPAA changes that were recently enacted?

While many Society members may answer "no" to some of these questions, there is still time to make needed changes in time to comply with the new HIPAA rules. If you want a brief refresher on HIPAA Rules, go to the CSWA website and review "Changes to LCSW Practice". Below is a summary of the changes with which all LCSW's who are covered entities MUST comply and should be considered a best practice for all LCSW's who are not covered entities.

1. Breach Notification – the standard for patient breach notification used to be that any PHI disclosed had to "pose a significant risk" of harm to the patient. That standard has been raised to notify patients of a breach unless the LCSW

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BOOK REVIEW:

The Archaeology of Mind: Neuroevolutionary Origins of Human Emotions, by Jaak Panksepp, PhD and Lucy Biven

By Marianne Pettersen, LICSW

Marrianne Pettersen is a psychotherapist in practice in Seattle for over 30 years. She sees adults, couples and families, as well as supervises clinicians

"When they (my elders) named some object, and accordingly moved towards something, I saw this and I grasped that the thing was called by the sound they uttered when they meant to point it out. Their intention was shown by their bodily movements, as it were the natural language of all peoples: the expression of the face, the play of the eyes, the movement of other parts of the body, and the tone of voice which expresses our state of mind in seeking, having, rejecting, or avoiding something. Thus, as I heard words repeatedly used in their proper places in various sentences, I gradually learnt to understand what objects they signified; and after I had trained my mouth to form these signs, I used them to express my own desires!"

- St. Augustine (343-430AD), epigraph to Wittgenstein's Tractatus and epigraph to Chapter 13, Coda, The Archaeology of Mind

"The ancient neural territories below the neocortex constitute our ancestral mind - the affective mind, which is evolutionarily specialized and that we share with many other animals. It is 'archaeological treasure', for it contains the sources of some of our most powerful feelings. Those ancient subcortical brain systems are precious, multihued 'jewels' for anyone wishing to understand the roots of all the basic values we have ever known and will experience in our lives. The affects are the foundations upon which the beauty and ugliness of life has been constructed."

- Jaak Panksepp, The Archaeology of Mind

The term affective neuroscience was coined by neuroscientist and author Jaak Panksepp, PhD, who has been in the forefront of research in this new area. Panksepp is a proponent of an emphasis on affective, bodily-based experience in mental health, which he and coauthor and psychotherapist Lucy Biven feel would lead to a more integrative approach to psychological and psychiatric problems.

In his latest book, The Archaeology of Mind: Neuroevolutionary Origins of Human Emotions (2012), an updating and popularizing of his earlier book, Affective Neuroscience: The Foundations of Human and Animal Emotions (1998), Panksepp and Biven are on a mission to help us explore and understand two main points: (1) our affective experience arises from exactly the same ancient, ancestral, deep neural affective substrates as other mammals and probably extends as far back as birds. And (2) if we designed our scientific research and therapeutic endeavors around this knowledge, it would result in a much more effective understanding and approach to human problems of mental and emotional well-being in psychology, psychotherapy and biology-based treatments, than currently exists. Panksepp is not reticent to take on what he regards as "old assumptions" in our field.

Panksepp wants us to really "get" that, first and foremost, we are animals. He cites a substantial volume of research, his own as well as others, to illustrate this thesis. The long held, and in his view, stubborn insistence (in the scientific community and beyond) on defending the assumed wide gulf between ourselves and other species (not only other mammals) has only served to derail us in our pursuit to understand ourselves in a more complete way. Humans may be more capable of reporting on their states of mind, but the affective experience of all mammals arises from the same deeper neural substrates, he says. Our affective experience is not different. "All mammals are intensely affective creatures."

Panksepp and Biven propose a new and clear model that they feel achieves these goals. Needless to say, this book review has greatly summarized descriptions; see the book for the extensive elaboration of the scientific underpinnings of these systems. First, the primary-process, ancient, emotional deep brain region - their main concern in this book - is the origin of the instinctual emotional responses generating raw affective feelings. It manifests evolutionary memories that are the basic emotional operating systems of the brain. This is made up of seven affective systems that he has defined as: SEEKING, FEAR, RAGE, LUST, CARE, PANIC/GRIEF and

PLAY. Second, upon this "instinctual" foundation is the secondary process – the limbic region - that facilitates experiential learning and memory mechanisms which interpret emotions. The limbic system links external perceptions with associated feelings and acts as a series of "way stations." This is followed by tertiary processes - higher cortical functions expressing emotional thoughts and deliberations - as well as diverse cognitions and thoughts that allow us to reflect on what we have learned from our experiences.

This is what Panksepp refers to as the "nested brain hierarchy." He explains that "the ancient feeling states help forge our memories in the first place. New memories could not emerge without the underlying states that allow animals to experience the intrinsic values of life." Fear does not begin in the amygdala (limbic system, secondary) contrary to what most of us have learned. It begins in an ancient region that we share with animals. As we know, the neocortex is capable of inhibiting primary-process emotionality. It tends to keep it in the "subconscious" realm until it is needed to deal with major-life challenging situations. We know this often fails in people when high levels of emotions occur. Panksepp and Biven feel that psychotherapists too often primarily depend upon cognitive regulation of emotional feelings and they propose that this doesn't allow for knowing and addressing primal deep affects. It may simply apply a band-aid.

This model suggests that where we often begin in therapy or where we focus - on the secondary and tertiary regions - is insufficient in treating difficult emotional states. For example, when we approach trauma only via the verbal realm (tertiary process), are we hitting the glass ceiling? Perhaps without explicitly engaging the primary process region we are only skimming the surface, or as a friend of mine likes to describe it, "reading the Cliff Notes, thinking that it is the book." Would you get the emotional beauty and suffering of Romeo and Juliet from reading the plot summary? As long as we insist that the only gateway to understanding emotions is through language (tertiary), then we remain cut off from what Panksepp believes we can achieve, and that is "a true undergirding of mental life." As the philosopher Wittgenstein said, "words reach out to their referents without ever touching them." Trying to access these deep emotional states through language alone creates the "Cliff Notes" of our full and human experience without the realization that this is not the "whole story."

Panksepp offers a scientifically-based challenge to our assumption that focusing so heavily on the verbal narrative output and interpretive processes is sufficient to understand the nature of human suffering and provide healing. Perhaps it only provides relief. He wants to point us towards more catalytic and deep healing processes that transform suffering in a timely manner.

Ultimately, the secondary and tertiary realms are without a doubt, crucial aids in the integration of the work. We all have had patients who have not responded enough to our therapeutic endeavors; Panksepp suggests that these cases may require a broadening of our scope of knowledge and therapeutic methods to include the primal neural substrates in the body.

The authors extensively outline all seven primary affective systems, devoting a chapter to each one. There are many interesting concepts here about the relationships between one or more systems (SEEKING, PLAY, GRIEF, etc.) and, for example, depression, ADHD, addiction and even schizophrenia and bipolar disorder. Would direct stimulation of the SEEKING and/or the GRIEF systems have an antidepressant effect, he asks? Worth reading also is Chapter 12, in which Panksepp shares with us the fact that his two bouts with cancer and their horrific treatments led to PTSD. He describes participating in the EMDR, a somatic treatment, for this condition and considers the treatment successful in his case. He sees the possibilities for EMDR reaching the primary-process circuits directly, although he feels more study is needed.

While I have attended seminars and conferences where Panksepp has presented, I became interested in reading this book during a small group training provided by Sharon Stanley, PhD., who recommended it. The breadth and what for me were challenging aspects of brain science research in this book propelled me to consult with others to deepen my understanding of this material. Some of that consultation is reflected in this writing. Stanley will be presenting at the WSSCSW's fall conference on Oct 19th. She has devoted her research and clinical work to the primacy of the body as the gateway for the treatment of trauma states. She says that somatic practices facilitate the integration of fragmented neural states and strengthen the ability to self-regulate. Somatics, she believes, is a practice of "mind-body integration, drawing on phenomenological research and ancient wisdom." She has immersed herself in indigenous cultures, whose people, she says, "found

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it essential to be fully embodied and intuitively connected to others for survival and healing of trauma."

In Stanley's Somatic Transformation, we are taught to be observant primarily of body phenomena (" 'gut' knowledge that moves up from the viscera, into the heart and up to the face") as the clearest communication of affective and right hemisphere experience. She states, "The somatic empathic psychotherapist attunes and resonates with unconscious, dissociated, emotionally charged memories held in the implicit body memory of the traumatized person."

Stanley teaches that it is the therapist's ability to become aware of their own somatic states, by making a somatic inquiry, which then allows her/him to be in the intersubjective field of the patient's actual emotions rather than "in the reporting of the emotions." Without this self-in-the-moment therapist experience/state, we will not be linked therapeutically with the patient's traumatic, embodied and "stuck" affective state. In Stanley's trainings it is a critical part of the training process to learn how to access and tolerate these states in ourselves - not something many of us have addressed in other kinds of trainings. Perhaps this is partially the reason it seems so easy to fall into the secondary and tertiary states with patients; it can be where we more comfortably dwell in our professional and cultural lives.

Defense mechanisms are born and live in the tertiary processing system. If the goal of therapy, especially when we are talking about trauma, is to liberate people from limiting habitual perceptions of self and the world and from the habitual responses linked to them, then must we go deeper into the brain-body-mind?

The new paradigm models of Panksepp's research and Stanley's Somatic Transformation are entirely compatible; both encourage us to draw attention in therapy to the deeper origins of human experience, particularly human traumatic ones. In my opinion, Stanley's work is a very logical methodology for achieving this. Panksepp and Stanley both strongly encourage moving the traditional pathology models way off to the side. Taken together, they may offer us a better model for understanding deep affective states as well as effective, somatically focused methods to bring to the therapy experience. In the past, bodily experiences in some theories were not considered useful to explore in their own right but were considered just a symptom of "primitive" psychopathology. Panksepp states, "My viewpoint is that substantial therapeutic effects can be achieved in affective disorders by direct manipulation of primary-process emotional circuits, through psychological, somatic and physiological approaches." Somatic work illuminates the limitations of the more traditional view that lasting change can only be achieved by working on emotional dynamics through the gateway of language.

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In reading The Archaeology of Mind, it is clear to me that we are in new and gutsy territories here. In closing, I wanted to highlight the PAG, the periaqueductal gray, also known as "central gray," discussed in the book. Panksepp considers the PAG, a structure which lies at the very core of the midbrain (ancient, affective area), to be the "Grand Central Station" for our affective life because "it is richly connected to both higher and lower brain functions." It is a kind of "dark energy" that is not easily visualized with modern brain-imaging technologies but it has been done. He makes the case for it being the "epicenter for emotional arousal" - critically important for the concretization of the abstract concept of the "core SELF" which he describes as the neural foundation for the creation of all affective life; who knew it had anatomy? He asks for "perhaps, some poetic license" as he speculates about the midbrain being the neural foundation for the concept of the soul.

Several years ago, at a day-long presentation of Panksepp's in Seattle, at the end of the day he showed us a series of remarkable brain scans. The first image was of a brain of a person who had just died. The subsequent images were over a three day period post-mortem. The rest of the brain was dead, but the PAG continued to show activity into day three. I'm reminded of the Tibetan Book of the Dead, but that's another story.

New territory, indeed.

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can prove that there is a "low probability" that PHI has "been compromised", i.e., that it has been read by a non-covered entity. For groups of more than 500 patients, the Office of Civil Rights must be notified. SOLUTION: Encrypt all PHI on computers, smart phones, tablets, etc., so that if they are lost or stolen, no information can be 'breached.'

2. Breach Letter – If any information is disclosed unintentionally, i.e., sent to the wrong email/bricks and mortar address, patients must be notified. SOLUTION: Have a letter ready to inform patients within a week that their information has been comprised. Additionally, you must ask the unintended recipient to destroy the information.

3. Business Associate Agreement – Business Associate Agreements must be signed with anyone who sees your PHI, i.e., billers, accountants, computer technicians, etc., and the business associate, as well as the covered entity (LCSW), is now responsible for any breaches on the part of a business associate or any subcontractor of a business associate. SOLUTION: Update Business Associate Agreements with a due date and indicate the new responsibility to notify you if any breach of PHI occurs through loss, theft, or unintentionally by the business associate or a subcontractor. A sample BAA can be found at the HHS website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html or add the new information to the CSWA-developed BAA.

4. Disclosure of Deceased Patient PHI – a patient's family is now entitled to the deceased patient's records if the family has a need to see the record. SOLUTION: Keep Medical Record up to date in the case of any patient death and be prepared to disclose.

5. Changes to NPP – Patients have a new right to request electronic copies of information held electronically that must be accounted for in policy and reflected in the NPP. Additionally, individuals have a new right to restrict disclosure of PHI to an insurer if it is paid fully out of pocket by the patient. Policies and the NPP must identify this right. Fundraising activity must now be described in the NPP, with an opportunity to opt-out. Marketing policies are tightened with any marketing of patient information requiring prior authorization. The NPP must now include notice that any breaches will be reported, and breach policies need to be updated to reflect the new standard for determining whether or not a breach is reportable. SOLUTION: For the HHS NPP template, go to http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html or add the new information to the CSWA-developed NPP.

6. Enforcement Penalties – Enforcement of HIPAA violations by the Office of Civil Rights has been significantly increased. Each violation will have a monetary penalty of $100-$50,000 with a cap of $1.5 million, depending on whether the violation was out of ignorance, mistake, or intentional. SOLUTION: Maintain careful protection of PHI and require all business associates or subcontractors to do the same.

To get the new template of the Notice of Privacy Practices (NPP) and the Business Associate Agreement developed by CSWA, you can go to the "Members Only" section of the CSWA website (www.clinicalsocialworkassociation.org) and download the documents. You must be a member of CSWA separately from the Society to access the Members Only section ($100 for WSSCSW members.) You can join at the website.

New NPP and BAA forms were due to be given to all current and new patients, and all current and new business associates, respectively, by September 23, 2013. Forms should be completed as soon as possible if you haven't done it yet. Please let me know if you have any questions.

Our Journey of Membership: A Conversation between Colleagues

By Sara Slater, LICSW

Sara Slater has been working in mental health, hospital, community agency settings and private clinical practice for the past 20 years. She currently provides counseling and psychotherapy for adults, adolescents and couples, with offices in Seattle and Bellevue.

Since I myopically imagine myself as never really growing any older, it was a bit of a shock to sit down with colleague and friend Carolyn Sharp and count up our collective years of participation in the WSSCSW. Why, we are teetering on being long time members! Or at least medium-time, with our combined twenty'ish years. So what have we seen and learned in our varying roles, and what has membership meant to us?

Since joining in 2005, Carolyn has been both Treasurer and President; in the latter role she has also been the ad hoc membership and ethics chairs, as well as loyal Professional Development think tank'er, helping to create educational themes for the year.

I entered in 2003 by way of what was the nascent New Professionals committee, and went on to join the Board, first as Communications Chair, and then Professional Development Chair. Now I'm delighted to serve on the newsletter committee, with lofty assignments interviewing Presidents both future and past.

What brought us to this organization are two common stories: one about re-connecting with Seattle after a hiatus in Boston; the other a decision after the birth of a child to leave a high profile, high stress role to start a private practice. Each of us was warmly welcomed at different annual membership parties by WSSCSW hall-of-famers Kevin Host, Laura Groshong, Marianne Petterson and Karen Hansen, among others. And in the finest manner of "six degrees," longtime WSSCSW'er Carrie Smith factors into both of our experiences (you'll have to ask about that). So it quickly became clear that ours is a pretty welcoming society.

It was when I joined the Board that I first met Carolyn: she the fledgling Treasurer, me, the totally green Communications Chair, both of us battling a significant dose of imposter syndrome. So began the mutual support for which the WSSCSW is so beloved.

What we also discovered was that social workers really are a bunch of collaborative, intelligent, generous and encouraging folks, who generally possess an excellent sense of humor and never let each other go hungry. And what we learned was that we could take on roles initially uncomfortable, but ultimately ones in which we could stretch, grow, and begin to see ourselves a little bit differently. Hurrah for breaking the isolation often associated with clinical practice, and for the unexpected take on professional development.

Over the past ten years, Carolyn and I noted, WSSCSW membership has nearly doubled, to about 230 today. This is happening because of a series of focused, formalized efforts to bring in a new generation, to become relevant to a broader array of clinicians in different practice settings, and to cultivate a more diverse body of clinical colleagues, the latter resulting in an initiative chaired by Marian Harris that included a groundbreaking update of our organizational by-laws.

It has been inspiring to witness such intention.

With growth, one of the obvious challenges is retaining the intimacy of the organization. As we broaden the richness of our collective experience, how do we stay connected?

Technology was and is the tool that links us, via the WSSCSW listserv, widely cited as the single most valuable resource of membership. What that resource represents, of course, is the collective wisdom, experience, knowledge and heart of the group, in a way that connects more of us, more easily. Which simply mimics the wider cultural trend. So what gets watered down? Face to face dialog. Collaborative opportunities. Deeper knowledge of one another. In short, relationship.

But not, Carolyn and I have discovered, when we get involved. Through our various roles, we've both met many amazing colleagues, some of whom have become dear friends, trusted consultants, and valued mentors.

And not, we agreed, when we notice the fragmentation related to rapid growth and address it, through a series of meetings and events intended to bring folks together socially. We can only guess at how many members attending these various opportunities in the past few years have been impacted as they matched listserv names with faces. We are certain, however, that hearing "oh, I know your name from the listserv, how nice to finally meet you!" goes a long way toward building something good.

We have seen how Professional Development also offers those rare face to face opportunities, as well as the chance to discuss relevant topics of the day. Over the past few years, the Clinical Evening Meeting series drew a large number of panelists from our own membership, who led dialogs that harkened back to the organization's original brown bag discussions at the Golden Coin. Last winter, PD also provided a little anxiety containment as we all grappled with the infamous CPT code changes, as it will with all the changes yet to come. And when many of us were just barely recognizing the impact of social media on our practice lives and our clinical relationships, Laura Groshong and her handpicked digitally aware faculty addressed this gap.

Mutual support, breaking isolation, and staying relevant. These things continue to be why we remain involved.

What we learned was that we could take on roles initially uncomfortable, but ultimately ones in which we could stretch, grow, and begin to see ourselves a little bit differently.

Advocacy, too, Always the organizational mission to be active in mental health legislation, economic viability, and protection of client rights, we have been fortunate indeed to have been led by our incredible lobbyists, Laura Groshong and Lonnie Johns-Brown. The stories shared at this year's annual party about the many accomplishments of these two formidable leaders were both inspiring and humbling. Even as Laura sort-of retires to await the arrival of two new grandbabies (never one to do things halfway!), the ground she has paved in Olympia remains strong, making it easier for others to take up the critical work to come. And we are reminded once more of the power of collaboration and mentorship so available to us in this organization.

We're seeing it, too, in the innovative thinking of a young, strong new Board, successfully recruited by current President Karen Hansen, a group which well represents our growing, changing membership. At the Board retreat this past spring, an idea emerged which focused on supporting members in starting their own subgroups of "meeting pods" (e.g. medical social workers), essentially facilitating community building that takes into account the needs of a robust, more diverse membership. This certainly keeps our roots in mind.

The organization is only as strong as its membership, without a doubt.

On an individual level, I know that being involved has changed me for the better—certainly through the relationships developed, and absolutely through the roles and what I've learned about myself. As Carolyn says, "I have benefitted from the supports of the community—the consultation, the advocacy, the friendships and the collegial relationships have all deepened my work. I strongly believe in the work that clinical social workers do, and I think the Society makes it easier to do what we do, and so I want to give back."

You are welcome to join in the fun anytime. You won't go hungry.

The DSM-5: A Quick Overview of the Changes

by Tanya Ranchigoda, LICSW

Tanya Ranchigoda is a part-time lecturer in the graduate School of Social Work at the University of Washington and has a private counseling practice where she focuses on supporting individuals and families with adjustment to chronic/terminal illness and significant life transitions, grief and loss, crisis intervention, and family relationships. She has presented on psychosocial impacts of illness and has volunteered as a mental health specialist at an orphanage in Honduras.

Recently, I taught the course "The Assessment of Mental Health Disorders" at the UW School of Social Work, using the DSM-5 for the first time. Below is a summary of some of the changes you can expect as we transition to the new version of the manual. The information I will be highlighting was gathered from the DSM-5 and several DSM-5 CE events I have attended in the past six months.

A. Development of DSM-5

Some controversy occurred during the development of DSM-5. Allen Frances, MD (Chairperson of the DSM-IV Task Force), and other key DSM-IV task force members were not invited back to participate in the DSM-5 Task Force. Other key concerns include a lack of transparency and limited outside consultation with non-task force members, a lack of continuity from the DSM-IV, and a rush to certainty in field trials. (Paris, 2013)

DSM-5 Task Force Member Make-Up:

- 16 countries represented, predominantly European
- 88% male
- Invited participants were predominantly well-published researchers in academia, not clinicians

B. Changes to DSM Organization

The DSM-5 has been reorganized into three sections:

1. DSM-5 Basics
2. Diagnostic Criteria and Codes (now 20 classifications, instead of 17)
3. Emerging Measures and Models

The Five Axis Diagnostic System has been eliminated as it was not consistently being utilized in the way it was designed and it provided unreliable results:

- Now all disorders meeting criteria are to be listed, leading with the primary disorder of concern to be treated
- With the absence of Axis V (GAF), levels of functioning can be rated using scores for severity and disability through assessment measures listed in the back (DSM-5 Cross-Cutting Symptom Measure and the World Health Organization Disability Assessment Schedule); these measures are somewhat complex and it is unclear how they will be utilized in the future

C. Key Clinical Changes

The disorders will be ordered differently.

There are two categories of mood disorders:

1. Depressive Disorders, and 2. Bipolar and Related Disorders

Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence are no longer a separate section and are incorporated throughout the manual.

Criteria for several categories have been expanded, which could lead to more frequent diagnosis.

> *Example: In ADHD, symptoms should be present before age 12, rather than age 6 as listed in the DSM-IV-TR*

The grief exclusion for diagnosis of major depression has been eliminated; it is now left up to clinical judgment to determine if MDD is present in addition to the normal response to a significant loss.

There is no longer a categorical difference between substance use and addiction. The terms dependence and abuse are now captured under Substance Use Disorder.

The addition of Disruptive Mood Dysregulation Disorder, a condition mainly defined by frequent outbursts of rage in children older than age 6 who are more likely to be angry and irritable rather than sad or manic; this was an effort to lean away from diagnosing pre-pubertal children with bipolar disorder.

Pervasive Developmental Disorders, Autism, and Asperger's are now under the umbrella of Autism Spectrum Disorders with the following specifiers:

- With or without accompanying intellectual impairment and
- With or without accompanying language impairment and a Severity Scale of (1-3)

Dementias are now classified as neurocognitive disorders, rated by severity.

Somatic Symptom Disorders replace Somatoform Disorders and are classified differently.

PTSD criteria has been expanded to include: "learning that the traumatic event(s) occurred to a close family member or close friend" and "extreme exposure to aversive details of the traumatic event" (APA, 2013).

Other notable changes:

- "NOS" is now "Other Specified" or "Unspecified"
- The other specified category is used in situations in which the clinician chooses to state the reason why the presentation of symptoms does not meet the criteria for a specific disorder: e.g., "Other Specified Depressive Disorder", "short-duration depressive episode"
- Or "Unspecified Depressive Disorder"

D. Some general shifts

There is a shift to look at individuals through a more dimensional lens, rather than categorical.

The manual is beginning a quest for greater diagnostic validity; all disorders have a KAPPA score of ≥ 0.4, except for Cyclothymia (Klott, 2013).

There is now a Cultural Formulation Interview and clinician instructions on how to use the assessment in the Emerging Measures and Models Section. This tool has been field-tested for diagnostic usefulness among clinicians and acceptability among patients.

A proposed evolution of the Personality Disorders section was tabled for the DSM-5 and moved to Section III of the manual under "Alternative DSM-5 Model for Personality Disorders," (a personal disappointment for me).

E. Changes to be implemented in the future

ICD 9 and ICD 10 codes are both listed in the DSM-5, but utilization of the ICD-10 codes will not occur before October 2014; ICD 11 codes are due to be utilized in October 2015, which will most likely be in conjunction with DSM-6.

* Please take note that these highlights are not a comprehensive review of all changes made in the DSM-5, but rather the ones I focused on while teaching.

NEW MEMBER PROFILES

By Sukanya Pani

The Membership and Diversity Committee would like to introduce the Membership Profile section in the newsletter to recognize the diversity, varied work and interests that the society members represent in our community. This is a great way to introduce yourself, know your colleagues and connect with fellow Clinical Social Workers. If you would like to introduce yourself and highlight your work, please email Sukanya Pani at sukanya.pani@gmail.com or Molly Davenport at molyush@hotmail.com.

ANDREW BRYANT, LICSW

Andrew, a Seattle native, is happy to be back in the Pacific Northwest after five years in New York City, where he received his MSW from Hunter College with training in Structural Family Therapy and psychiatric social work. He worked at the Bedford-Stuyvesant Family Center in Brooklyn, providing child and family therapy and supportive case management and leading therapeutic groups for boys and parents. Moving back to Seattle, Andrew opened a joint private practice with his wife, North Seattle Therapy & Counseling, in the Phinney Ridge/Greenwood neighborhood. He provides adult, couples, and child/adolescent therapy, and his wife, Clarice Wirkala, specializes in child and adolescent therapy. Andrew is looking forward to sharing ideas and learning new skills through involvement with the WSSCSW, and the broader community of mental health clinicians in the area.

JOSH CUTLER, LSWAIC

Josh is the Program Director at Banchero Disability Partnership, a non-profit supported living provider serving adults with developmental disabilities and mental illness. He also has a small private psychotherapy practice in Ballard. Josh has been in the mental health field for over ten years and has particular expertise working with young adults; he previously worked as a program coordinator and psychotherapist at Sound Mental Health. Josh received his MSW from the University of Washington in 2011 and is a Developmental Disabilities Mental Health Specialist and Licensed Social Work Associate - Independent Clinical, on track to become an LICSW by early 2015.

DAWN DICKSON, LICSW

Dawn received her MSW from the University of Washington in 1993 and has an undergraduate degree in psychology. She has twenty years' experience in healthcare providing counseling, therapy, and group process, focusing on acute and chronic illness, grief and loss, depression, anxiety, stress management, life transitions, trauma, and adjustment to change. Dawn opened a private psychotherapy practice in the Fremont Professional Center in May of this year. She has a long history of study in indigenous healing practices and Jungian theory. She works with adults and blends psychodynamic therapy with a Jungian focus and mindfulness-based therapeutic practices to help clients meet their therapy goals.

PEGGY ENTROP, LSWAIC

Peggy graduated with an MSW from Loyola University Chicago in May 2012. She has been working with a chronically mentally ill population in the standard supportive housing program at Sound Mental Health for the last year. She is interested in eventually transitioning into outpatient therapy in a private practice setting, and pursuing a PhD.

BRIAN K. HALL, LSWAIC

Brian earned his MSW with an emphasis in addiction and anxiety issues from Eastern Washington University in 2010. He has over 18 years of clinical experience in a variety of settings, including correctional facilities and methadone programs, and has worked extensively with at

risk youth. Brian opened a private practice, C'd Soil (pronounced "seed soil") Counseling, earlier this year. He has offices in Bothell and Everett.

SUZIE LYONS, LICSW

Suzie graduated from the GSSW at the University of Utah in 2002. She has worked in a methadone clinic and as a counselor in the University of Utah counseling center, and she had a supervisory role at a county operated short-term crisis facility for the chronically mentally ill. She moved into private practice as a result of her desire to treat trauma in a safe and effective manner.

VERONICA MINAI, LICSW

Veronica graduated from the University of Washington School of Social Work with an MSW in 2008. She received additional training in Trauma Focused Therapies and Psychoanalysis, and currently works at KCSARC (King Co. Sexual Assault Resource Center). She is venturing out to start private practice part time in Fremont. Her specialty is working with children and adults struggling with PTSD, depression and anxiety. She also provides therapy in Spanish. On her off time, she enjoys dancing, making art, sailing, skiing, swimming and bike riding. She looks forward to meeting other WSSCSW members.

ALICE MORRIS, LCSW

Alice relocated to the beautiful Pacific Northwest recently with her husband, for his career. She is exploring this lovely part of the country while transferring her LCSW from Colorado. This is her first move without her children (age 22 and 28), and she is enjoying apartment living in downtown Bellevue. Alice's "people" are adolescents; she has worked in child welfare as well as community mental health. She enjoys individual, couples and family therapy. She is informally trained in DBT and plans to attend the upcoming EMDR conference in Austin. Alice looks forward to meeting local social workers and learning about agency settings where she can use her skill set.

DARYN NELSON, CPC

Daryn is a graduate student at the University of Southern California School of Social Work Virtual Academic Center, where she attends online and live webcam classes. She is concentrating on Mental Health Services and is interested in the applications of interpersonal neurobiology, attachment and mindfulness for social work practices. She is training in emotionally focused therapy and interpersonal neurobiology as key ingredients to future work. She is a Certified Professional Coach and currently interns at Native American Youth and Family Services in the Healing Circle (Domestic Violence), in Portland, OR. She notes that she is a work in process....

Ashley Rousson, LSWAIC

Ashley is a recent graduate of the University of Michigan's School of Social Work, where she studied Interpersonal Practice and Mental Health. She interned with the University Health System in the Child and Adolescent Inpatient Psychiatry department. She has studied extensively on topics related to intimate partner violence (IPV) and has facilitated groups with male perpetrators and court-involved female survivors of domestic violence. She is new to Seattle and looking forward to the next opportunity in her social work career.

NEW MEMBERS

The Membership Committee wants to welcome these new and returning members, as well as the new members whose profiles appear above.

DENISE GALLEGOS
LILIANA GODINEZ
SILE GRACE
LISA LARSON
GIGI WICKWIRE

We look forward to meeting and getting to know each one of you.

SEEKING WSSCSW ETHICS COMMITTEE CHAIR

Please contact President Karen Hansen if you are interested in exploring this opportunity.

c: 206.369.9705
o: 206.789.3878
karenhansenmsw@gmail.com

CLINICAL SOCIAL WORK ASSOCIATION MEMBERSHIP

WSSCSW is an affiliated group of the Clinical Social Work Association (CSWA). CSWA advocates for our practice at the national level, providing analysis of macro social work issues which affect us all every day. CSWA membership also confers other valuable benefits, such as free consultative service for legal and ethical questions and discounted comprehensive professional liability insurance.

Please consider complimenting your WSSCSW membership with a CSWA membership.

CSWA member dues are $35 for students, $60 for emeritus members, $85 for new professionals, and $100 for general members.

More information is available at http://www.clinicalsocialworkassociation.org.

Calendar of events, 2013-14:

The Northwest Alliance for Psychoanalytic Study and WSSCSW are collaborating to bring you this eagerly awaited conference:

SHARON STANLEY, PhD

BEYOND ABSTRACT LANGUAGE:

The Truth of Face-Heart-Brain Communication and the Five Practices of Somatic Transformation

Saturday, October 19th, 2013
9am – 4pm
University of Washington, School of Social Work, Room 305 A & B
Sharon has practiced as a psychotherapist and educator of psychotherapists for over thirty years. Her quest for healing complex trauma has been personal, cultural and professional. For the past fifteen years, Sharon has developed and taught courses to mental health professionals in body-centered principles and practices for the healing of complex trauma.
There still may be a few seats left. Contact Robin Westby at 206/467-2611 or robinwestby@gmail.com

CLINICAL EVENING MEETING SCHEDULE: 2013 - 2014

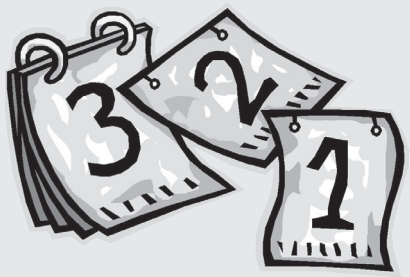
November 12, 2013
Laura Groshong, LICSW: "The Potential Impacts of the Affordable Health Care Act to Clinical Practice"

January 29, 2014
Tanya Ruckstuhl-Valenti, LICSW and Morgan Vanderpool, MSW, RYT: "Alternate Psychotherapy Practices for Addressing Trauma: EMDR and Trauma Sensitive Yoga"

February 25, 2014
Norma Timbang, LICSW: "Reframing Layers: Beyond Surviving Trauma and Historical Trauma"

March 25, 2014
Kim Friedman, MA, LMHC, CEP: "Psychodrama: An Exploration Into Embodied Clinical Work"

Clinical Evening Meetings are an opportunity to network with mental health professionals in the society and be exposed to cutting edge clinical information while gathering CEU's. The meetings will take place at the University of Washington, School of Social Work, Seattle Campus, Room 305, from 7:00-9:30pm.
Light refreshments will be served.



There is a $10 fee per meeting for WSSCSW members, $15 fee for non-members, free for students. You can register online at WWSSCSW.org.

If you have any additional questions, feel free to contact the co-chairs of the Professional Development Committee, Tanya Ranchigoda, LICSW or Dianne Broderick, LICSW.

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