WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

Summer/Fall 2015

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From the President

Clinical Social Work and Social Justice

By Eric G. Huffman

Greetings! I had anticipated my first President's column to be one that describes my excitement over returning to the Board and laying out our ideas for the new year. It is impossible for me to start with that, as if nothing has happened in our world. We are all sickened, grieving and angry over the massacre in Charleston, S. C. It comes after endless shocks of killings of Black men and youth across the country. To this we add the repeated killings of the mentally ill by a system that seems completely untrained and unprepared to help them. To this we add the repeated attacks on members of the LBGTQ community (the highest number of hate crimes are currently perpetrated against Black, transwomen according to the Southern Poverty Law Center). How do we as clinical social workers think about this, and more importantly, what are our contributions and challenges?

Lara Okoloko has a wonderful, thought provoking, helpful and challenging article in this issue that I encourage everyone to read and discuss. Lara's article challenged me to consider our profession as a branch of social work and to ponder the special populations we deal with. It also prompted me to look at the websites of some of our many sister organizations. We are a family of compassion, ethics and action. At the same time, The National Association of Perinatal Social Workers looks very different from other professional social work organizations, such as the National Organization of Forensic Social Workers or the Association of Oncology Social Workers or the School Social Work Association of America or the National Association of Black Social Workers or, of course, the NASW.

It is possible to be a member of more than one of these. I was nearly a member of three but finances were too tight. All the organizations have a particular focus and reflect an understanding of how to view clients as person-in –environment, how to advocate for clients in different spheres and the need to challenge social injustice. Each code of ethics is different and the primary goal of each is different.

In our code of ethics, the Code of Ethics of the Clinical Social Work Association, the opening line reads: The principal objective of the profession of clinical social work is the enhancement of the mental health and the well-being of the individuals and families who seek services from its practitioners. The professional practice of clinical social workers is shaped by ethical principles which are rooted in the basic values of the social work profession. These core values include a commitment to the dignity, well-being, and self-determination of the individual; a commitment to professional practice characterized by competence and integrity, and a commitment to a society which offers opportunities to all its members in a just and non-discriminatory manner.

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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.

CLINICAL SOCIAL WORK AND SOCIAL JUSTICE

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Our Society Mission Statement continues this commitment:

Our Mission is to Provide:

- Clinical Training and Support
- Legislative Advocacy on Mental Health and Social Service Concerns
- Protection of Clients' Rights
- Economic Vitality for Clinical Social Workers

As clinical social workers, we begin with the individual and the family and mental health. Our starting point is different from our sister groups, but it is not our end point. We carry out these commitments by offering the best trained clinicians to our clients. We do our best to train our membership in issues of ethics, diversity, cultural awareness and therapeutic interventions. We make a special effort to mentor and train the new professionals who are students and Licensed Associates and who look to us for direction. We train our members to recognize cultural countertransference and hopefully, as Lara notes, to practice cultural humility. We make sure we ask, as Lara does, "How will I interpret the emotional reaction to events that don't pose a personal threat to me? Will I adequately recognize personal distress when the origin of the distress is not something I can relate to?" We recognize that this is frequently a question of race and ethnicity but also a question of gender, sexuality, class and of other sub-cultures that present to us.

This is where our branch of social work gets particularly complicated. We spend hours upon hours with our clients. We sometimes know them better than anyone does or has—and they would agree. Members of the Society regularly treat police officers for trauma and debriefings. I assume we have members who have police as individual clients. I assume I will have prison guards as clients. I assume some of these officers will have a different take on how they are perceived in the media. I am certain that we will have clients who are angered over the Confederate flag coming down at the South Carolina Capital and over companies refusing to even manufacture the flag anymore. I am certain that our members will help them to the very best of their ability, including giving them a referral to someone else if need be. Because we treat everyone from skinheads (as I have) to their victims (as I have), we have a special standing in social work. We always must be guardians of this standing.

A couple of years ago, Laura Groshong did a training on the role of the internet called "I Googled You." She reminded us that absolutely everything that goes online, lives online and is accessible to clients, probably forever (including this newsletter). In terms of our role as the WSSCSW, we need to be mindful that our public face is the also the face of all our members. We have nothing to hide. We are proud of our values and our ethics. I would be concerned, however, if a clinician were confronted by a client who said, "Oh, you're part of that social work group that says police are brutes!" No, we are part of that social work group that is here to heal and promote growth and to do it better than anyone else, with an ongoing commitment to learning about cultural diversity and all the needs of our

WSSCSW newsletter is mailed quarterly to members of **WSSCSW**.

Classified ads are $10 for every 25 words, $20 for 50 words, etc. Articles and ads should be emailed to Lynn Wohlers at wohlers13@gmail.com.
Newsletter design: Stephanie Schriger, stephanie@designandgraphics.biz

Articles expressing the personal views of members on issues affecting the social work profession are welcome and will be published at the discretion of the editors and **WSSCSW** board. Articles reflect the views of authors and Society endorsement is not intended.

very diverse clients. This must also include an understanding of sub-cultures within the dominant culture. So, we have much to offer and also constraints on what we can say. But it is like that in a therapeutic session, isn't it? The challenge is what to say, when to say it, and to always ask, "Am I saying this for them or only for me?"

Talk is cheap (just ask an unnamed insurance provider). Given that, there is much that we can do within the guidelines of our mission and our ethics to promote an understanding of diversity among clinicians.

Here is what we will do.

- As I am writing this, the Professional Development Committee, the Diversity Committee and I are planning our Clinical Evening Meetings (CEM) for the coming year with a focus on working with diverse clients.
- We are working on a training for our members to facilitate a language to discuss race and cultural identity, and how these affect us and our clients. We hope the training will be in early 2016.
- We are processing the recent survey to the membership on diversity, as is required in our by-laws, to see how we can improve our membership diversity and better serve our members.
- We are discussing the possibility of a Spring Conference on working with Transgender clients. This is to build on the great CEM given by Jamie Katz (we actually had to turn people away).
- We are considering ways to reach out to agencies and increase our collaboration with them. We will reach a new group of young professionals who will have fresh eyes and fresh training, and will be a diverse group. As they educate us, we educate them in our core values, and train them to be the best.
- We can continue to use the listserv to inform one another of diversity events that the broader membership can profit from. I have not seen any encouragement to participate in social justice events on any other listservs I subscribe to. This reflects our social work values and we should be proud.
- PLEASE write letters for the newsletter. Please respond to this column or others as letters to the editor. Our growth as clinical social workers can only occur through dialogue.
- Please join our sister organizations, such as the NASW, to support the broader goals of social work. We have a wonderful working relationship with them and are already co-sponsoring events. We are a team.
- In our conversations it would be helpful to distinguish racism, bigotry, prejudice and ignorance. These terms and concepts get interchanged and it shuts down conversations. I rather doubt we have racists in the WSSCSW. Each of us fits in the last three categories. If you don't think so, please attend the events planned for the coming year!
- Renew your membership so we can carry on these tasks that no one else can.

EDITOR'S NOTE

It's summer, and it may be vacation time for many of us, but the Society has been busy. We have a new President and many new Board and committee members, all working together to fulfill the society's mission. Your newsletter editors are busy, too, absorbing the changes and moving forward. Emily Fell has jumped in with a lot of energy to help organize and edit the newsletter, while Sara Slater has taken a break.

This issue gelled, almost by itself, around issues of social justice and diversity. Submissions from members reflect a keen interest in thinking more deeply (and acting, too) about cultural awareness and humility. We are launching a new feature with this issue, "Best of the Listserv." This will be an opportunity to take another look at important discussions that occur on the listserv but go by quickly and can be buried in our email. Lately there have been many lively, thought-provoking conversations on the listserv – so many that we decided to include two different threads in the issue. In keeping with the focus on social justice, you'll find a recent discussion about the Charleston shooting and subsequent controversy over the Confederate flag. A discussion about Associates who go into private practice is another topic worth a second look, particularly to members who supervise for licensure.

Perhaps next time, for the "Best of the Listserv" feature, you will see threads about particular resources that many of us find useful. Whatever we decide to do, we hope it reflects your interests. The best way to achieve that end is to hear from you, so please let us know what works and what doesn't work for you, and what you'd like to see in future issues.

Lynn Wohlers and Emily Fell

Diversity: WHO WE ARE AND HOW WE PRACTICE

By Denise Gallegos, MA, MSW, LSWAIC, Diversity and Membership Co-Chair

Earlier this year the Diversity Committee began the bi-annual assessment of the membership to determine level of diversity within the WSSCSW as mandated by our guidelines. What we found was that our organization is predominantly identifying as White/Caucasian, female, heterosexual, in private practice, (75%), over the age of 50, with a third of the membership possessing 15-30 years of experience in social work.

We are a very experienced group, with vast knowledge to share and learn from. At the time of the assessment, we fell far below our mandate of representing the diversity of the comparison communities we serve, Seattle/King County/Washington State. The percentage of members identifying as persons of color fell at about 6% of the membership, far below our designated comparisons, which range from 30-34%.

We are challenged to increase our outreach to communities of color, specifically in recruiting clinical social workers, to broaden our membership with the knowledge and ideas they represent.

The Diversity Committee also worked with the assistance of Norma Timbang and Paloma Andazola Reza, to develop a questionnaire to determine the awareness and knowledge of diversity issues among the membership. About 20% of the membership responded providing a significant sampling to garner information going forward with Diversity Education/Programming for the WSSCSW.

From this survey we learned the following:

- 100% of respondents see racism as a clinical issue.
- 56% of respondents received formal training focused entirely on racial equity, a slight majority.
- Of those who received equity training, more than 8 hours was provided.
- A vast majority, 86%, felt their practice was culturally responsive/competent.
- 95% responded affirmatively when asked if frameworks, treatments, and/or interventions addressed or incorporated diverse groups.
- At the same time almost 49% felt race was a barrier in building alliances with clients. Roughly 98% felt race was a factor in transference and countertransference.
- Close to 85% of respondents felt comfortable talking about racism, but that number was reduced by 10% when speaking of race or racism with clients.
- A minority of respondents do not see themselves represented in presenters, about 34%.
- The vast majority felt comfortable supporting a client from a different racial/cultural background.
- 79% indicated they felt competent in addressing oppression, racism, and racial inequality with colleagues.
- Race, religion, gender, ability, sexual orientation, age, and ethnicity were all identified by respondents as factors affecting clinical interaction.
- 98% of respondents felt they would benefit from additional clinical trainings on diversity and/or racial equity.

The Diversity committee is continuing to evaluate the data collected to determine implications for future programming. We invite you to respond to the survey results and continue the discussion with letters to the editors, or on the listserv. Thanks to all of the members who participated in this survey.

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.

OUR DUAL FOCUS: Clinical Work and Advocating for Social Justice

By Lara Okoloko, LICSW

The recent torrent of videos showing Black people being shot by police, as well as the church massacre in Charleston, has pushed the issue of racism to the center of national dialogue. As clinical social workers, are we taking part in the discussion?

The June 17th massacre in Charleston that killed cousins Ethel Lance and Susie Jackson; librarian Cynthia Hurd; Pastor and speech therapist, Sharonda Coleman-Singleton; AME Minister DePayne Middleton Doctor; Rev. Senator Clementa Pinckney; Pastor Myra Thompson; recent graduate and nephew of Susie Jackson, Tywanza Sanders; and ministerial staff member, Daniel Simmons Sr., was not just an act by a "loner." This act of White supremacy and terrorism is a continuation of a long history of justifying the murdering and maiming of Black people by citing a perceived threat against Whites. There is a clear connection between the shooter claiming that he did this because Black people "raped our women" (CNN TV Charleston church shooting coverage; 6/19/15) and the claims of police who kill unarmed Black people because they felt threatened and "feared for my life" (Huffington Post Chicago shooting coverage; 4/20/15). The view by White America that Black bodies are dangerous and simultaneously super-human and sub-human is as old as America itself.

In the days after the Charleston massacre the NASW posted a statement of condolence and call for change on its website. However, the national Clinical Social Work Association's website is silent on any issues of oppression, bias and race. As our state's clinical social worker chapter, I believe we have an important opportunity – indeed a responsibility - to join the dialogue. One of our members, Denise Gallegos, posted to our listserv last week, urging us to begin talking, saying, "I believe that we as individuals need to step out of our comfort, whatever that is, and engage, everyday asking questions, demanding action in whatever form is possible, using any resources we have at our disposal to bring the issue of racial injustice to the fore."

As clinical social workers, we have been taught to view our clients through a person-in-environment lens. This means that we have to have an understanding of the environment, as our clients experience it. In a national survey after the killing of African-American teenager Michael Brown last year, White people thought that his death "raised important issues of race" at half the rate of Black people answering the survey. How do these differences in perspective affect our ability to build a truly understanding and compassionate therapeutic relationship with our clients?

"For most White Americans, Black America's experience with police thuggery and abuse is the equivalent of getting hit by lightning. Most people will, luckily, never have such an experience" writes author Chauncey DeVega, "But what if being hit by lightning is a common experience among those who live in your community?" (Chauncey DeVega at Dailykos.com; 6/9/15). Considering that 75% of White Americans do not have a single Black friend, (Wonkblog, Washington Post; 8/25/14) it's unlikely that when White people watch the killings of Black people on the news – by the police or by a White supremacist - they are picturing the face of someone dear to them and worrying that this violence could touch a loved one. How does this emotional distance shape how White clinicians view the importance of these events and the emotional and psychosomatic reactions to them that our clients may experience?

Recently I was talking to a fellow White woman about the latest online video of police shooting and killing an unarmed person of color. As a White mother to bi-racial children, these videos invoke a deep fear in me about how I am going to protect my own brown-skinned son and daughter from being hurt by this violence as they get older. Feeling upset as I talked to my friend, my words picked up speed and I waved my arms about. "Ok,

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ok! Calm down!" she responded, "You are getting ME upset!" I fell quiet, feeling shut down and invalidated. When we tried to talk about it later, we had trouble seeing eye-to-eye and feelings were hurt on both sides. Our conversation made a couple of things clear to me: first, she had no intention of hurting me. Second, she may have thought we were discussing the news while I felt that we were discussing a danger to my family. Third, she did not share my experience and therefore did not share my perspective.

This small exchange gave me the opportunity to ponder how equipped I am as a White social worker to truly hear and understand the meaning of my clients' experiences of oppression, discrimination, micro-aggressions, and fear of racial violence. How will I interpret the emotional reaction to events that don't pose a personal threat to me? Will I adequately recognize personal distress when the origin of the distress is not something I can relate to?

In some ways I wonder if the now familiar educational mandate of "cultural competence" has made addressing complex issues of racism more difficult for us. "Competence" implies accomplishment or achievement. But engaging in meaningful and real conversations about racism and the differences in experience between ourselves and people of different colors means that we may make a mistake; that there will be things we haven't heard before, experiences we don't understand. Stepping into a conversation about race when we believe we are supposed to be "competent" is scary. A stance of "not-knowing" is a good one for learning but feels dangerous if it means that we may look incompetent, or even worse, racist. Maybe the alternative concept of "cultural humility" is more useful since it trades the idea of an end-point (achieving competence) for a life-long process. Cultural humility calls us to humbly and continually "engage in self-reflection and self-critique as lifelong learners and reflective practitioners."

To talk about these issues and join others in creating societal and systemic change, we must be willing to embrace cultural humility, acknowledge the possibility of implicit bias in our work, let go of outdated and invalidating notions of "color blindness" and step past our fear of being racist. The comedian duo Key and Peele say that "Racist" is like the "N-word for White people." I think this is especially true for those of us who identify strongly and proudly as liberal. Author and social worker Dr. Robin DiAngelo writes that "For White people, their identities rest on the idea of racism as about good or bad people, about moral or immoral singular acts, and if we're good, moral people we can't be racist – we don't engage in those acts" (Sam Adler-Bell, interview with DiAngelo at rawstory.com; 3/16/15). The idea that we might be "racist" is such an awful and distressing thought that we reject the charge completely and immediately, missing potential opportunities for self-critique and personal evolution.

The person-in-environment perspective is central to the social work profession's unique approach to the helping process. What distinguishes social work from other helping professions is the dual focus of "enhancing the biopsychosocial functioning of individuals and families and to improving societal conditions." This dual focus is at the heart of what I was taught it means to be a social worker. The NASW code of ethics says that our "primary goal is to help people in need and to address social problems" but the very next ethical obligation in the code is to "challenge social injustice." This means that as clinical social workers we have a responsibility to sometimes get out of the chair and advocate for systemic change. I hope that our silence as an organization does not mean that as clinical social workers we have lost the "dual focus" central to our professional identity. Let us not be silent on issues of social justice. Let us not ignore the crisis of violence that threatens our clients, neighbors, friends and colleagues of color.

Dr. DiAngelo cautions that in racial dialogue, "Listening alone leaves everyone else to carry the weight of the discussion." While learning and self-reflection are largely internal activities, there is still a lot that we can do. I call on each of us to support the work of the WSSCSW Diversity committee, to make regular space in our newsletter for articles about how racism and social injustice connect to our work with clients, to participate in local events like the upcoming Race Conference at Seattle University in October, and to continue these conversations with each other and those in our social and professional circles.

We invite you to respond to the author's ideas and continue the discussion with letters to the editors, and on the listserv.

So Many Topics, So Little Time

By Melissa Wood Brewster, LICSW

The task of writing for the newsletter seems daunting, especially for those of us who are not natural writers. Some of us are plagued by the question of whether we have something interesting or unique enough to write about. And then, of course, there is the issue of time with which we all struggle. Thus, here I am at 10:30pm the night before the submission deadline. Nevertheless, it has been disappointing to hear how there have been fewer submissions, to the point that we had to cancel one of the issues earlier this year.

As far as what to write about, I have decided that the problem is not how to find something worthwhile but how to choose. There is so much. And we, as social workers, have so much to say. In the last week alone, I have been impacted by several experiences, all of which could make a great read.

For starters, the New York Times Magazine article on antenatal depression ("The Secret Sadness of Pregnancy with Depression" by Andrew Solomon; New York Times, May 28, 2015) sheds some helpful light on the wide spectrum of what most of us narrowly think of as postpartum depression. How validating it was to read about some of the common emotions and thought processes that women experience during pregnancy. As miraculous as conceiving and carrying a baby can be, it can also be traumatic (and that's before we push a watermelon out between our legs). "We have not acknowledged," Andrew writes, "how appropriately anxiety-ridden pregnancy is, how traumatic the change in identity that accompanies prospective motherhood can be." Having been unexpectedly pregnant with twins at one time, I can relate well to this traumatic identity shift.

The Supreme Court ruling on gay marriage, timed beautifully with pride weekend, is another topic that deserves much attention. After many years, I finally managed to attend Seattle's Pride Parade again, and this time with my kids. I felt honored to be present during such a historic event. But then after speaking with a gay client about her continual lack of family support and hearing on NPR how legal clerks in the south report they are experiencing religious discrimination when asked to perform marriage ceremonies for gay couples, I realize how much more work we have ahead of us.

Finally, I was touched by the listserv dialogue, started by Denise Gallegos Leavell, about actively speaking out against racism. She has encouraged each of us to do something and not just let the topic be a passing conversation. The email chain motivated me, but I also felt stuck in figuring out exactly what to do. Well, the universe must have been listening. Last weekend, my 10 year old son participated in a lacrosse tournament with his team, which includes one tall, African American boy, a good friend of my son's. Our coaches overheard the parents of the opposing team expressing a racist remark on the sidelines. Disturbing, to say the least. We, as parents, are reporting this incident to the Washington chapter of US Lacrosse and requesting that an official statement be released to the lacrosse community that there is zero tolerance for racism of any kind.

Perhaps I should have picked one of these topics to write about more in depth. However, I couldn't choose. I know that each of you, as social workers, have experiences and learnings of your own to share as well. Please do.

BEST OF THE LISTSERV

BEST OF THE LISTSERV" will be a recurring series in our newsletter, highlighting relevant and thought provoking conversation threads from our listserv. The listserv is an important benefit of membership. As a go-to tool in our clinical toolbox, it keeps us connected and enables us to support one another as we request resources and referrals, discuss challenging subjects, and share what matters to us as engaged social workers.

These articles are excerpted from lively discussions that took place on our listserv in May and June 2015. Issues like those discussed below, which address racial prejudice in our clinical practices and institutionally, and private practice for associates, impact many society members. We thought these discussions were well worth a second look. Thank you to all the members who asked questions and offered answers; thanks too for allowing us to print these excerpts in our newsletter.

BEST of the LISTSERV: THE CHARLESTON DISCUSSION

This article is excerpted from a listerv conversation that took place in June 2015. As the society strives to increase diversity on our board, in our membership and in the populations we serve, it is so important that we talk with each other and work alongside one another. The excerpt below is a great example of our membership voicing, brainstorming and calling us to action regarding race and racism in our society and in our clinical work.

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BEST OF THE LISTSERV: THE CHARLESTON DISCUSSION

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Members,

I do not know how this world will evolve, but I believe that we as individuals need to step out of our comfort, whatever that is, and engage, everyday asking questions, demanding action in whatever form is possible, using any resources we have at our disposal to bring the issue of racial injustice to the fore. We cannot pretend it is an anomaly, nor that it does not have profound impact, the evidence is before us, around us, within us, we only have to open our eyes, our hearts, our minds and engage in change.

As a Clinical Social Worker, at UW medical center, I work for a behemoth institution, where pathology is the focus of the medical, "evidence based model." I was impacted at the thought entering work, "Business as usual." I could not do it so I called the director of social work for the medical center and asked if they were going to send anything out acknowledging the impact of the events this week. They had not thought about it but were willing to consider it if I wrote something up. So I put aside therapy notes and wrote something that was not as strong as I felt but would be acceptable in the setting. It was dispersed Friday afternoon to the large role of social workers in the UW system. I do not think it is perfect or great, but I offer it here as a humble beginning to action, in every setting. My hope and prayer, is that is sparked awareness of individual influence and the impact of collective action.

Using this flawed example, I hope some of you will do likewise making improvements along the way, in your employment, churches, social groups, to say let's be aware and do something, anything. Whatever is at the edge of your comfort zone is the beginning of an opportunity we cannot pass on in this moment of time.

(I want to acknowledge my dearest friend, Michelle Sarju, who thorough her pain, was willing to discuss with me what might be most helpful to say given the audience of clinical social workers.)

"This just hit me at my core. People cannot even go to Church. This is so complex I do not even know how to pray about this. Sunday is going to be a really scary day for Black folks. This is not a move on moment. I do not get to choose that this does not affect me."

Michelle Sarju (African American Woman) The mass slaying of nine individuals at AME Church in Charleston, South Carolina, Wednesday night has impacted communities all across the country. For the African American community, deep and profound wounding has occurred, bringing forward historic events of hate in an already racially difficult 2015. Many of us share the sorrow and devastation of this act. Today, and in the coming weeks, we especially need to be conscious of the fact that though we may strive to be in solidarity with our African American families, friends, clients, patients, we may have privilege that allows us to escape the full impact. For some the path forward may be clear but others may be frozen in place by this trauma.

As social workers it is incumbent on us to be there to listen, openly, knowing clients may be expressing the effects of trauma physically as well as emotionally, with more pain, higher distress, anger, depression, and generally elevated symptoms. We have the opportunity to be first responders in this trauma, offering support and presence for those directly impacted aware of the long-term implications for health. We know the first response to any trauma is critical for the ultimate healing of the survivor. Our conscious efforts to be aware of the impact and the multitude of reactions that may present as a result of this brutal attack is critical. Our willingness to actively engage our ethical mandate to "understand the nature of oppression" and actively "pursue social change" in our individual contact with clients and attitudes in our work will assist our clients on the path of healing.

Denise Gallegos Leavell
MA, MSW, LSWAICCo-Chair Diversity
and Membership Committee WSSCSW

Dear Society Members,

As your outgoing interim president I am heartened and inspired by the dialogue in this email thread. What and how we as a clinical society can do remains to be seen as we move forward with more and more overt evidence of deeply ingrained racism in our world and in our nation, and in our beautiful city of Seattle. I know there is so much work to do on this, and we must pull our part going forward. I know that the WSSCSW Board is committed to addressing racism and diversity issues in our organization, and to that end it is important to note we have plans for the coming year to do more than we have ever done to date to address it. In our daily work as clinicians we face issues of racism and trauma in our patients, and must respond with informed awareness.

We are not an activist organization, but we cannot ignore calls to action wherever they are possible. We are not a state that was part of the Confederacy but we are far from free from the legacy of slavery and oppression of non-whites in our midst. Thanks to Denise and the rest who have contributed to this dialogue. I know that your incoming president Eric Huffman will lead boldly in this arena going forward as well.

Karen Hansen, WSSCSW Past President
CSWA State Affiliate Liaison

Hi everyone,

The listserve has been helpful for some of us to share our anger, grief and frustration over recent events. There is a recurring theme of wanting to do something.

Here is a concrete step to take, for those interested, to stop the normalization of racism. Symbols of hate have no place in our government.

The Confederate flag is not a symbol of southern pride but rather a symbol of rebellion and racism. On the heels of the brutal killing of nine Black people in a South Carolina church by a racist terrorist, it's time to put that symbol of rebellion and racism behind us and move toward healing and a better United States of America!

That's why I signed a petition to The South Carolina State House, The South Carolina State Senate, and Governor Nikki Haley, which says:

"Symbols of hate and division have no place in our government. It's time to stand up for what's right and take down the Confederate flag!"

Will you sign this petition? http://petitions.moveon.org/sign/remove-the-confederate-3?source=s.em.mt&r_by=13431473

Thanks!
Eric

I've been in South Carolina for a few weeks now for training and will be here through the end of June. I've have had the chance to talk with several local folks of various colors, shades, and hues.

I've been surprised to hear that the issue of the flag is way WAY down on the list of concerns.

Sunday I was a part of an invigorating conversation with a diverse setting of clergy. The question was raised as to if the focus on the flag and not the shooting/hate crime is just another form of institutional racism.

Likewise, it was voiced several times that the focus on mental health is another facet of institutional racism.

Food for thought.

Daniel Sorensen, M.Div, LICSW

Additional reading on the Confederate flag debate:
Online article from the Washington Post:
Frances Berry, Mary. "The Confederate flag is just a distraction, Don't let politicians congratulate themselves for symbolic changes after the murders in Charleston." The Washington Post. 26 June 2015. Online.

Online Article from Reuters:
Reid, Tim. "For many black Americans, Confederate flag debate a distraction." Reuters. 27 June 2015. Online.

BEST of the LISTSERV: Associates and Private Practice

This discussion took place on our Listserv in May 2015. Important questions are posed and details relevant to Associates and supervisors alike are reviewed as members take on this thorny, complex topic.

Hi Everyone-

I would love to have some clarification from anyone out there who knows more about this. With some regularity I have potential supervisees contact me who are looking to be under my supervision (either group or individual) who have or are in the process of beginning a private practice before being licensed independently. It was my understanding that if the person is supervised this is acceptable. Any thoughts?

Thanks so much!
Jennifer Lee, MSW, LICSW

Hi All,

There are many issues involved in this conversation, but the one that seems most important to me is the issue of what is the "approved supervisor's" responsibility to the licensed Associate. When we started conducting our "How to get Licensed" workshops, we tried to attract only Associates. We quickly learned that supervisors generally had little idea what the law required of them, so we started including more on what supervisors need to know and letting supervisors know that they can also attend. When you agree to provide supervision to someone who is working toward licensure, you are required to sign an attestation certifying that you are indeed an approved supervisor under state law, and that you have certain knowledge of areas of their practice. I'm including the WAC requirement here. The most overlooked requirements are (5)(a)-(e) which I've separated out below.

Laura has copies of sample contracts one can use with Associates, and we include two versions in our Wellspring workshops as well. They outline the expectations and nature of the relationship on both sides. Everyone who supervises Associates should have something in place that defines the relationship. Regardless, once you agree to take on a supervisee, you take on some risk as a result, more if you don't adhere to the requirements of the WAC.

WAC 246-809-334

Approved supervisor standards and responsibilities.

(1) The approved supervisor must hold a license without restrictions that has been in good standing for at least two years.

(2) The approved supervisor must not be a blood or legal relative or cohabitant of the licensure candidate, licensure candidate's peer, or someone who has acted as the licensure candidate's therapist within the past two years.

(3) The approved supervisor, prior to the commencement of any supervision, must provide the licensure candidate a declaration, on a form provided by the department, that the supervisor has met the requirements of WAC 246-809-334 and qualify as an approved supervisor.

(4) The approved supervisor must have completed the following:

(a) A minimum of fifteen clock hours of training in clinical supervision obtained through:

(i) A supervision course; or

(ii) Continuing education credits on supervision; or

(iii) Supervision of supervision; and

(b) Twenty-five hours of experience in supervision of clinical practice; and

(c) Has had two years of clinical experience postlicensure.

(5) The approved supervisor must attest to having thorough knowledge of the licensure candidate's practice activities including:

(a) Specific practice setting;

(b) Recordkeeping;

(c) Financial management;

(d) Ethics of clinical practice; and

(e) The licensure candidate's backup plan for coverage in times when he/she is not available to their clients.

(6) Licensure candidates whose supervised postgraduate experience began before September 30, 2006, are exempt from the requirements of subsection (4) of this section.

Best,
Keith Myers, LICSW, MSW

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Well said, Keith.

When discussing this topic I encourage supervisors and supervisees to both be aware of the regulations for approved supervision and for supervisees. This is a relatively new set of regulations (started in 2006) and it usually takes about ten years to become widely known. I encourage all Associates and approved supervisors to take the course Keith offers through Wellspring to get the complete picture of how Associates should be supervised and how approved supervisors should be trained.

If anyone would like the set of forms that the Society has put together for supervisors and supervisees, let me know.

Best regards,
Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

Keith,

Thank you for this post and for the work that you are doing to help supervisors. I agree with what Laura said, it probably takes a good decade for these things to take hold and it certainly seems better than it was in 2009-2010. So thank you.

My experience with supervisors has been that they cover section (5)(a)-(e) very simply by asking that part of a case consultation also include bringing in the chart and/or files that pertain to these sections, as well as checking calendars for vacation days and looking into referrals for backup. All of which is very easy to do, and good experience for the Associate. Of course, all of this is usually easier with an Associate in an agency setting, where there is usually a manager of the day-to-day work. Then the person providing licensure supervision can simply check with that manager to ensure it is all in order.

I think the supervisors who were reluctant to work with me (which could be a non-representative sample of the supervisor population) could not wrap their mind around how they could be responsible for section (5)(a)-(e) if I wasn't actually working for them. So again, I'm glad for the work Wellspring is doing to help train supervisors in this area.

Peace,
Daniel A. Sorensen, LSWAIC

Jennifer,

The confusion here is that the law allows LSWAICs and other Associates to work privately "under supervision". That means that there is some regular supervision taking place but the Associate has their own office.

Having a private practice during graduate school would not have been legal unless it was part of a practicum which, again, was supervised by a licensed approved supervisor.

Anyone who accepts an LSWAIC who is in private practice may want to consider carefully how much supervision would be necessary to accept the responsibility for the work of someone who is an Associate.

Best regards,
Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

Thanks Laura,

That's what I thought. But is it fine for the Associate to bill insurance as well?

Jennifer Lee, MSW, LICSW

This is becoming a problem as insurers become more aware that Associates are not at the "highest level of licensure," the standard for reimbursement by most insurers. Associates should check with any insurers they bill about whether they are eligible for reimbursement. I know of a few cases where clinicians were required to return payments they received as Associates.

Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

Editor's Note: After a member remarked that private practice has sometimes been considered the highest level of practice, there was talk about the increasing number of Associates going into private practice, compared to years past when it was more common for independently licensed, seasoned practitioners to be in private practice. Laura Groshong commented:

I think those days also included many more agency positions which enabled new MSWs to get their first jobs there without going directly into private practice. I think there are some recent graduates who are more experienced because of prior work, thus more able to go directly into private practice. It is the responsibility of the supervisor and supervisee to determine what level of supervision is appropriate.

On a related note, it is not legal for a supervisor to submit for a supervisee under the supervisor's license, a question I've been asked many times.

All best,
Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

Laura, does your comment ("On a related note, it is not legal for a supervisor to submit for a supervisee under the supervisor's license.") ONLY apply to solo private practice, or does it also apply to group practice? Or is a state-licensed mental health agency the only exception to this rule?

Because it makes me wonder how this works in an agency setting. As a pre-MSW intern, I was able to see and submit billing for Medicaid clients in an agency setting, and as a post-MSW Associate, I was able to see and submit billing for Medicaid clients in an agency setting. All my cases in both instances were supervised and signed off on by a licensed clinical person (LICSW, LMHC, etc).

Kind regards,
Robin Debates, LICSW

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Yes, Robin, this applies to solo practitioners who are approved supervisors. Agencies that are licensed or certified in Washington have the right to use that license to make claims for Associates.

Regards,
Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

This all leaves me wondering where the responsibility lies? Is it up to the Associate to know these things? The supervisors? The insurance companies? It seems very odd to me that an Associate could apply and become paneled with the insurance company if it's not the "highest level" of that license. I guess I just assumed that when we go through credentialing the insurance company actually knew what they were doing and was making sure each person met the appropriate criteria. It sounds as if this isn't the case.

Jennifer Lee, MSW, LICSW

Laura,

Do I recall that the law says that Associates cannot receive third party reimbursement? I thought it was in RCW 18.225.145, but I don't find that in 18.225 at all. Perhaps this was language that was removed? Or was it never there and I read it wrong? All I can find now is RCW 18.130.039 which says "No licensee subject to this chapter may be required to participate in any public or private third-party reimbursement program or any plans or products offered by a payor as a condition of licensure."

Because if you call Regence or Premera, they will tell you that if you want to be in private practice (under supervision) in rural areas of Eastern Washington, they will credential you and put you on their panels. Like Yesterday. Heck, they may even help you to move.

And, if you read the requirements of TriCare (and, as a veteran, I would hope that everyone would) it very SPECIFICALLY says that non-independently licensed Mental Health Counselors and Pastoral Counselors "under supervision" are granted credentialing/reimbursement status as out-of-network in order to meet the mental health demands of the Military and Veteran population.

When I called DOH to ask about this (as an Associate) I was told "Whatever contract you negotiate with the Insurance Company is up to them. Just make sure they understand your status. If they want to reimburse Associates, that's up to them."

That's GREAT! But is that out of sorts with what the law says? And what about the laws that allow LMCHA (Mental Health Associates) to receive reimbursement when working under supervision, such as Medicaid in school based setting. See: WAC 182-537-0350 which allows only LICSW and LASW's the same, but prohibits LSWAIC and LSWAA's.

Daniel A. Sorensen, LSWAIC

Amen! Thank you Daniel for so articulating so well what so many of us are struggling with, particularly as it relates to supervision. There are increasing numbers of Associates vying for jobs in a limited market due to schools, like the UW, churning out more grads, Seattle U starting a program, and the distance programs growing and taking more placements. Choices for post grads are becoming increasingly limited but the supervision paradigm has remained stagnant.

Bring in the fact that new grads, often loaded with student loans, are most often hired in agencies that pay so low it is not sustainable in a city with rents that doubled in the last four years. Many of us who planned to be in agencies for our pre-independent license years are pushed to at least start taking some clients on the side, if not abandon the agency job entirely. AND now some agencies are now asking employees to sign non-compete clauses extending 1-2 years past leaving the agency. The option to go straight into private work becomes more and more appealing.

I agree, in whatever choices we make, we must do everything we can in good faith to be legal/ethical in practice, clinical and business. However, the climate has changed with little recognition and limited guidance for new professionals.

Denise Gallegos Leavell, MA, MSW, LSWAIC

Dan,

There is no language in our licensure laws and rules about whether Associates can be paid by insurers. The rules that govern this area are in the Office of the Insurance Commissioner Rules which basically allow insurers to set their own standards. For the most part, insurers require that a clinical social worker be licensed "at the highest level available" which would be LICSW for clinical social workers. This is consistent with the information you received from DOH. There is some variation for clinicians working in rural areas but that does not apply to most Society members. The best way to protect your practice as an Associate is to contact an insurer prior to submitting claims to avoid being required to return any payments made if the insurer does not cover Associates.

As for the kind of supervised work that is allowed to apply to the supervision necessary for licensure, the fact is that all social work licenses are basically clinical licenses. That means that the work being supervised must have a clinical basis. There is some leeway, as in casework provided through DSHS, but community work and other kinds of generalist practice do not meet the requirements for these clinical licenses. As an aside, the LASW is closer to a non-clinical administrative license (psychotherapy cannot be conducted except under supervision), but still requires approved supervision be for clinical work. This is because the most harm to the public is likely to be through clinical work, not macro work, according to national standards.

As for the problems Associates have with finding ways to complete their hours for full licensure, this is a universal problem across the country. As Denise notes, there are indeed many more Associate level social workers today than there were 5-10 years ago, but there are also many more Associates who are mental health counselors and marriage and family therapist Associates, i.e., about 1500 Associates in 2006 as opposed to about 5000 Associates today. This is a problem that is a difficult one to solve in the 'corridor' between Olympia and Everett where many agency jobs have ended at a time where the need for those jobs by Associates has increased. The Society will continue to work on finding ways for Associates to complete their clinical supervision and hours in a limited agency environment.

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BOOK REVIEW: Reflections on *Americanah*, a novel about race in America

By Karen Hansen, LICSW

I would like to recommend a work of fiction that is gaining attention in literary circles of late. I read this with my book group earlier this year and wanted to share it with our membership. Given the way issues of race and prejudice are dominating the media and the nation's attention, it is timely that a novel like this should be published. At the same time, our own WSSCSW is committed to increasing diversity among our membership, and diversity awareness in the work we do with people of color and differing ethnicities. Fiction, although different from works of research and scholarship, can also educate us. *Americanah* (2013, First Anchor Books) is good example of a book that informs us while being an engaging read.

The book's author, Chimamanda Ngozi Adichie, is a Nigerian woman who lives half time in the United States. She has received numerous awards for her writing; this book was chosen as one of the ten best books of 2013 by the editors of the New York Times Book Review. Adichie writes at least partly from her own experience. Her writing captures the essence of how it is to come to the land of promise from a very poor country. All immigrants suffer in the adjustments they make coming to the US, but poorer and darker skinned people suffer the most. That is the thesis for this book. Through the eyes of the main character, Ifemelu, we see how even a beautiful, intelligent, highly educated dark skinned person can find it difficult to survive without suffering trauma, experiencing discrimination, and losing hope in the process. America, the land of the free, is anything but if you are Black and poor.

Ifemelu, who seems to have everything going for her, comes to the U.S. to further her education. Her home country of Nigeria is under severe dictatorial rule and it is difficult to get advanced professional education there. Her challenges in America begin with housing, securing reasonable work to cover her living expenses, and managing relationships with men. Through her eyes we walk along with her confidently, and then watch with increasing alarm and she descends into a state of personal alienation, desperation, and confusion about her own beliefs and self-esteem. To try to put order into the chaos, she begins writing a blog which she calls, "Raceteenth or Various Observations About American Blacks (Those Formerly Known as Negroes) by a Non-American Black." In the blog she communicates her experiences, hoping to help others. The blog becomes a vehicle the author uses to present a cultural commentary about America through the eyes of an African national, Ifemelu. This is reminiscent of a clinical social work type of processing and interpretation.

Her blog gains immediate attention and puts her in touch with other like-minded individuals, many of whom are colleagues at Princeton whose ideas about race are more academic than personal. In one of her first entries she uses the categories of class, ideology, region (mainly north and south), and race to describe American tribalism. She presents a "racial hierarchy" which is essentially based upon how light or dark your skin is, but Ifemelu is confused by the fact that being Jewish does not involve darker skin but does lower the status based upon this hierarchy in America.

Further on in the blog, we hear about observations about Obama as a presidential candidate who married a dark skinned, rather than a light skinned Black woman, and how this choice was viewed by other darker skinned Black women. She noted that to be successful in America as a Black woman one had to have lighter skin, until Obama broke the mold by bringing his darker skinned wife Michelle, into the public limelight. (I wonder how Oprah fits into the picture, as a moderately dark skinned Black woman who has made it into the public eye with her television and magazine images.)

Along with the focus on skin color, there is much in the book about the issue of hair for the Black woman in America. We sit with Ifemelu in salons while weaves and hair extensions are applied, and we listen in on hair stylists talking about their unfortunate personal stories and traumas. We watch Ifemelu try different ways to manage her very kinky hair - keeping it braided, chemically straightening it (and getting chemical burns from the process), going natural, etc. We hear about skin lightening products, and who is using them and why, and the impact they have on public image. This material describes an arena that most Whites have not personally faced and do not understand.

Most importantly in her blog, Ifemelu communicates her experience through compiling a list of what it means to have White privilege. This list strikes me as something valuable to share with our WSSCSW membership. Although you may not agree with it, to me, it elegantly captures themes about some of what we may take for granted if we are not

poor and of color in America. It is especially relevant for darker skin color, as Nigerians have some of the darkest skin of all immigrant groups. It highlights how color matters in the arena of privilege in the U.S. I will quote the list here, with credit given to Ms. Adichie, who in turn gives credit to Peggy McIntosh (White Privilege: Unpacking the Invisible Knapsack: 1988).

What Academics Mean by White Privilege

- When you want to join a prestigious social club, do you wonder if your race will make it difficult for you to join?
- When you go shopping alone at a nice store, do you worry that you will be followed or harassed?
- When you turn on mainstream TV or open a mainstream newspaper, do you expect to find mostly people of another race?
- Do you worry that your children will not have books and school materials that are about people of their own race?
- When you apply for a bank loan, do you worry that because of your race, you might be seen as financially unreliable?
- If you swear, or dress shabbily, do you think that people might say this is because of the bad morals or the poverty or the illiteracy of your race?
- If you do well in a situation, do you expect to be called a credit to your race? Or to be described as "different" from the majority of your race?
- If you criticize the government, do you worry that you might be asked to "go back to X", X being somewhere not in America?
- If you receive poor service in a nice store and ask to see "the person in charge," do you expect that this person will be a person of another race?
- If a traffic cop pulls you over, do you wonder if it is because of your race?
- If you take a job with an Affirmative Action employer, do you worry that your co-workers will think you are unqualified and were hired only because of your race?
- If you want to move to a nice neighborhood, do you worry that you might not be welcome because of your race?
- If you need legal or medical help, do you worry that your race might work against you?
- When you use the "nude" color of underwear and Band-Aids, do you already know that it will not match you skin?

When I first read this list it grabbed my attention. It triggered an awareness that I had not stepped into the shoes of a non-White enough to have imagined each of these questions. I hope it will be an eye-opening experience for you too, albeit somewhat uncomfortable.

What, if anything, does a fuller awareness of privilege have to do with our work as clinicians, especially for those of us who see people of color in their practice? At a minimum, it means that in addition to the power differential between us as mental health professionals and our clients, we may also possess other forms of power and prestige that the person in front of us does not have access to. This can be enacted through the transference, making trust building for a therapeutic alliance much more challenging and difficult.

Actually, sustaining the treatment period for a positive outcome may be the bottom line. I suspect that when people of color enter therapy with a white therapist, their chances of a positive outcome rest largely on this issue and how well it is managed by the therapist. As we listen to their material, we need that awareness to be with us. When we listen to a story of harassment or mistreatment, in the workplace or elsewhere, we must consider the full reality that has influenced that particular situation. We need to continually find humility in the work with those whose skin color and ethnicity are different from ours, however highly trained and highly experienced we may be. And always, we must be willing to ask questions and to reveal our lack of knowledge, rather than make assumptions that may be incorrect. We must hold back from assuming pathology in what may actually be a reality-based experience, however different from ours.

The job of a clinical social worker is complex, and demands sensitive awareness, as we are charged with understanding and helping people whose lives may be much like ours or very, very, different. I am sure that I fall short of this challenge at times, and need help and awareness raising, from other professionals, from continual reading and learning, and from my patients, in order to question my own assumptions and keep growing. I appreciate a forum such as the Society, where we can learn and grow together towards being the best at our craft that is possible. This is where the value of a WSSCSW membership pays off beyond our original investment of time and money.

ANNUAL VOLUNTEER RECOGNITION PARTY

LEGISLATIVE UPDATE

By Laura Groshong, WSSCSW Legislative Chair

Coalition and WSSCSW Work to Develop Campaign Opposing Regence

In early July, Regence BlueShield announced their plan to reimburse the same rate for 90834 and 90837. They announced the rates that would be used a few days later and it became clear that this would result in an almost 30% loss for any LICSW using 90837 through Regence.

With the leadership of the Washington State Coalition of Mental Health Professionals and Consumers, WSSCSW and other mental health groups are developing a campaign to challenge this proposed plan. The first steps have been a meeting of 80 clinicians on July 11 to understand the issues and what can be done, after a consultation with a well-known Washington health care law firm. Then a survey was sent that almost 400 clinicians responded to, giving the community more information on how clinicians conceptualize choosing to see a patient for 38-52 minutes or over 53 minutes, as these CPT codes require.

The next Coalition meeting on Regence will be held on August 15 at Glaser Auditorium in Swedish Hospital from 9 am-12 pm. The meeting will include the results of the survey; a draft letter to OIC; summary of legal advice; assignments to five subcommittees; and the kind of question and answer period we had at the last meeting. If you plan to attend please let Cynthia Stover, Coalition Treasurer, know at cynthiastover@hotmail.com by August 12.

The subcommittees will include writing position papers; social media campaign; publicity campaign; coordinating with other mental health groups; and coordinating with other consumer groups. If you are willing to be a chair of one of these subcommittees, please let me know.

This is a mental health community project that WSSCSW is proud to be part of and hopes will bear fruit in stopping this Regence plan that will limit clinicians and harm patients.

BEST OF THE LISTSERV: ASSOCIATES AND PRIVATE PRACTICE

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I hope Associates will continue to attend the quarterly meetings held by the Society to address their valid concerns.

Best regards,
Laura W. Groshong, LICSW, WSSCSW
Legislative Chair

Thank you for this information. What do you suggest is an appropriate level/ frequency for a supervisee starting private practice who has a small practice or who is combining with agency practice? The standard I have used is my familiarity with their caseload and making sure they have malpractice insurance. There are also NASW guidelines regarding best practice for intensity of supervision depending on experience. I also ask for a copy of their malpractice policy.

Thanks for bringing up this issue. It is an important one.

Joan Willemain, LICSW

Joan,
According to TriCare's reimbursement policy for non-independently licensed counselors under supervision, they require one hour per month. And I think it also needs to be a physician, which doesn't help with Associates seeking licensing at all, but I personally see this as a value-added requirement and is kind of in line with where the Affordable Care Act is taking us with regards to the Medical Home model. Can't hurt for referrals, either.

The American Association of Pastoral Counselors (AAPC) requires 1-2 hours of supervision per month, or approximately one hour for every 8-12 hours of client contact. Interestingly, the "AAPC recognizes a full clinical case load to be between 20 and 30 client contact hours per week and expects counselors to keep their average weekly case load to less than 35 hours per week."- Membership Manual

Daniel A. Sorensen, LSWAIC

Hello All,

I found it very helpful to re-read the FAQ's under LICSWA on the DOH website. It addresses independent practice and billing insurance.

Warm Regards,
Joan Willemain, MSW, LICSW

Thanks everyone for engaging in this dialogue and especially to Laura for always having so much info and being willing to share it with us!

Jennifer Lee, MSW, LICSW

NEW MEMBER PROFILES

The Membership Committee wants to welcome these new and returning members.

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

Haneen Ahmad
Tahani Al-Salem
Lor Anderson
Ridley Beierschmitt
Radka Chapin
Mikaelyn Cottier
Robin Custer
Ann Elmore
Emily Fell
Rebecca Fishaut
Ruth Foster Koth
Crystal Garcia
Ugbad Hassan
Jennifer Hebron
Jonathan House
Kristen Hurvitz
Diedre Knowlton
Nathan Kuik
Glenn Leever
Diane Lostrangio
Eric Mann
Sarah Matthews
Denise McGuire
Courtney Miller
Maggie Milligan
Vicki Nino Osby
Lanie Riley
Michelle Rowlett
Denise Serfas
Krista Sodt
Laurie Strom
Linda Wiley
Christine Winther

EMILY FELL

Emily is a licensed clinical social worker with experience in various community mental health settings. Emily currently works part time at Sound Mental Health and has a private practice on First Hill in Seattle. Emily specializes in psychotherapy with adults who are motivated to explore and expand their identities. She receives training in psychoanalytic psychotherapy through the Seattle Psychoanalytic Society and Institute and the Northwest Alliance Community Psychotherapy Clinic. Emily is excited to have joined WSSCSW and is Co-Editor of the newsletter. Outside of work, Emily enjoys exploring Seattle and studying West African drum and dance.

DIEDRE KNOWLTON

Diedre received her MSW from San Diego State University and has experience in community clinics with adults and seniors, psychiatric hospitals with all ages and drug and alcohol dependency therapy. She currently has a private practice in NE Seattle and primarily treats mood disorders, anxiety, relationship conflicts and life transitions. Her passion for animals prompted her to create a niche that assists people with pet related issues such as pet hospice and grief, couple or family problems due to pets in the home and compassion fatigue and vicarious trauma work for animal care providers. Diedre enjoys the outdoors including hiking, gardening and horses. When she is not outdoors, she is reading with a cat in her lap and cooking for family and friends.

RUTH FOSTER KOTH

Ruth is a graduate of the University of Washington School of Social Work with over 20 years in medical social work and counseling practice. Currently, she has a private practice in Greenlake focusing on emotional eating issues, anxiety, depression, chronic illness, new medical diagnoses, and weight management issues. Additionally, Ruth is employed at the University of Washington where she specializes in bariatric surgery assessments, group work and guest lecturing within the school of medicine. Ruth utilizes interpersonal techniques, motivational interviewing, functional analytic psychology, mindfulness, and embraces a client-focused approach to change. In her free time Ruth loves to travel, garden, sing in a local choir, play piano and spend time with her family.

GLENN LEEVER

Glenn is a Social Worker, Mental Health Therapist, and activist. He has been working in social work for over seven years beginning with two years in Peace Corps Costa Rica. Glenn received his Master of Social Work from the University of Washington. He has worked at multiple agencies around the Seattle area including DESC, Consejo, YMCA Young Adult Services and YouthCare. Glenn is currently employed at Youth Eastside Services as a Bilingual Youth and Family Counselor. He continues to be passionate about social justice and equity work, in addition to inclusive community mental health and multicultural therapy. Glenn is also Co-Chair of WSSCSW Membership/Diversity committee.

Have an ethical dilemma or question?

Contact the WSSCSW Ethics Committee:

Albert Casale:
albert.casale@gmail.com

Megan White:
Megtherapy@yohoo.com

Or, contact us on the WSSCSW listserv if your question is general and can be shared.

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ANNOUNCEMENTS

CODE FRIED: ICD-10 Codes and DSM-5

A workshop presented by WSSCSW and NASW, Washington Chapter

Led by Laura Groshong, LICSW, and Tanya Ranchigoda, LICSW

Saturday, 9/19/15
At Swedish Medical Center
First Hill Campus, Glaser Auditorium
Registration 8:30; Workshop 9-12 PM

Approved for 3 CE contact hours
$50.00 members; $35.00 Associate members
Register online: http://www.wsscsw.org/eventscalendar

By October 1, 2015, all the Diagnostic Codes that mental health clinicians use will be changed with the implementation of the ICD-10. These new codes are connected to DSM-5 and the new narratives for mental health disorders.

Learn how to make the necessary changes in your practice by attending this training, a continuation of the Coalition's efforts to educate its members and the mental health community over the past five years. Don't get "Code Fried"!

Certificate Program in Clinical Theory and Practice

October 2015 – May 2016

Wellspring Family Services has offered the Certificate Program in Clinical Theory and Practice — **a 100-hour program in adult psychodynamic theory and practice** — since 1991. The program's content is practical and applied through the use of teaching cases. The major influences on clinical practice and an understanding of human development are integrated to provide a comprehensive learning experience. 100 hours of continuing education credits are available which also apply to Associates' CE mandates (approximately 20 of which may count towards supervision requirements). For more information:

www.wellspringfs.org or Roberta Myers (LICSW, BCD), Program Chair, 425 452-9605.