WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

SPRING 2013

In this issue:

From the Desk of the President

HELLO COLLEAGUES AND HAPPY SPRING!

By Karen Hansen

By the time you are reading this we will have launched another Seattle Spring, complete with increased light, warmer weather, and the color and fragrance of blooming bulbs and flowering trees. I hope you experience the renewal of energy and hope that often come with the gifts of spring in Seattle. Our Clinical Society is also renewing itself, with program planning and new volunteer Board members to take us further into the year.

Speaking of renewal, I have just returned from the Twelfth Annual Conference in Los Angeles, sponsored by the UCLA Lifetime Learning Institute and entitled, How People Change: Relationship and Neuroplasticity in Psychotherapy. In addition to enjoying the warmer weather and earlier spring of L.A., I was privileged to hear about cutting edge research and its application to psychotherapy with individuals, couples, and children.

I was struck by how enriched we all have been by the last decade of brain imaging technology and its applications to the work we do every day. Much of what we have always known has now been documented in research trials and brain imaging. This further emphasizes the importance and efficacy of the clinical work we do and also has relevance to our society and to governmental policy decision making. Never before has so much been brought to bear on the value of the attachment relationship and of resolving the traumas that interrupt or freeze development. We are uniquely positioned to be making a significant difference because this is what we address directly in our offices. I am proud to be a Clinical Social Worker and to represent us as knowledgeable professionals in our work.

Since my last two President Letters were more political, I'd like to take the opportunity to bundle a few take home messages from the conference. They may whet your appetite to explore some of the developments in brain research and the attachment experience in the field of psychotherapy. Infant research and fMRI's now give hard data about what constitutes secure attachment in the early developmental years. This information offers hope in the evidence for the brain's neuroplasticity, making recovery from disrupted insecure attachment possible, given the right conditions are met in therapy.

Needless to say, most of the issues we face with our clients, whether we work in a health care setting, in schools, or in the broader mental health arena, are the result of an insecure or otherwise disrupted developmental process. Another major determinant of these issues is trauma - either singular or in concert with developmental difficulties. Our most difficult cases involve a complexity of these factors layered upon each other in multiple experiences recorded in the brain's neural networks. And there is the genetic contribution, now complicated by evidence for the epigenetics of gene expression. The latter refers to how specific genes can be turned on or off as a result of significant environmental factors, including trauma.

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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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So, here, as promised, are a few tidbits from the conference. Daniel Siegel discussed his hypothesis of the mind as an organizer of information and energy flow, and said that the more integrated complex systems can be, the more stable they become. Daniel went beyond the individual in this argument, incorporating relationships, families, communities, and societies. His assessment of how energy connects us all bordered on the spiritual for me. He has coined the term "Mwe" to describe the essence of this construction, and proposed that future conferences may focus on this cross-integration of the individual and global mind (i.e. the "me" and the "we"). The concept of attachment took on a widening dimension in this interesting talk.

Irving Yalom, the group psychotherapy guru and Professor Emeritus of Stanford, presented and summarized his long career of integrating psychological understanding, practice, philosophy, and fiction. He defined fiction as "the lie that tells the truth about the human psyche." He has used fiction to teach about the truths that are evident in psychotherapy. He read an essay about a psychotherapy session with a woman who cried three times in the session. Each tearful episode was a teaching point in the session and in the essay. Yalom emphasized the importance of taking risks moment to moment in each session to keep the process alive, consideration of issues of death anxiety that may be unspoken in the patient material, and the importance of addressing regrets that may need reinterpreting to allow the patient to move through their grieving process.

Peter Levine, the somatic trauma teacher and therapist, showcased his work with trauma victims. He utilized video to teach about treating a traumatized veteran of the wars in Afghanistan and Iraq. This patient demonstrated a profound, recurrent shoulder and chest shudder as a symptom of his trauma, along with unresolved distress and hopelessness. Levine worked to address the man's physical posture of collapse, retraction, and stiffening - his body's response to an explosion that killed many of his buddies. Somatic empathy and gentle interventions, including a group process with other trauma patients, released his rage and tears, re-instilling his hope for living. In a later interview the man confessed he found the initial process of somatic work strange and hard to take seriously, though in the end he was renewed to a sense of whole body and psychological functioning. Next, Levine showed video of his work with an 18-month-old with birth trauma who could not digest his food and had not fully physically bonded with his mother. After gentle and specific interventions which helped the baby "push away" with his limbs in a controlled manner, the child released the energy from the birth shock by crying and deep sighing. Subsequent to this brief treatment the child shifted both his physical and verbal behavior towards body molding with his mother and new language practice. This treatment also averted a scheduled intubation procedure which would have further traumatized the child. Both of these vivid cases revealed the power of addressing body somatics with patients who have severe trauma.

John Norcross, a Psychology Professor and researcher at the University of Scranton, presented a summary of his writings on the case

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Classified ads are $10 for every 25 words, $20 for 50 words, etc. Articles and ads should be emailed to Autumn Halliwell at abhalliwell@live.com or Lynn Wohlers at wohlers13@gmail.com.
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for Evidenced Based Practice. He has edited a volume of studies on the efficacy of psychotherapy across many diagnostic and therapeutic dimensions.

In a methodical and thorough manner, he fleshed out the reality that the relationship is the main contributor of the curative process, along with the person of the patient and the person of the therapist. In an article entitled What Works for Whom (Norcross, J. C. and Wampold, B. E. (2011), J. Clin. Psychol., 67: 127–132.), Norcross spells this out with research specificity. He was part of an A.P.A. Task Force working towards "identifying elements of effective therapy relationships (what works in general) and identifying effective methods of adapting treatment to the individual patient (what works in particular)." In his conclusion he states that the therapy relationship makes substantial and consistent contributions to psychotherapy outcome, independent of the specific type of treatment, accounting for why clients improve or fail to improve. He includes the importance, therefore, of repairing ruptures in the therapeutic relationship. Treatment guidelines must include behaviors of the therapist that facilitate the relationship. I will write a separate article to highlight more about this essential body of research, in a later newsletter.

What was compelling about this presentation was the obvious limitation of Evidence Based Practice research which does not consider these important factors (such as the Milliman Guideline authorizing eight sessions for treating an anxiety disorder). The evidence in his book Psychotherapy Relationships that Work (Oxford University Press, 2011) will hopefully become part of the arsenal of data that will help push back the insurance industry as it seeks to limit coverage and distort what the "evidence" says about what constitutes effective treatment for our patients. I brought back a copy of John Norcross' book for Laura Groshong, and he inscribed it, "To Laura, to help you advocate for our mental health coverage (and our clients)". We need more researchers like Norcross!

There were many other compelling presenters that I cannot summarize in this brief letter, including Pat Ogden and Stan Tatkin. The final presentation of the three day conference was from the much respected integrative psychobiologist Allan Schore. In a talk he titled, "What's love got to do with it?" Allan documented the essential nature of the attachment process in the first year of life, as a requirement for normal development of the right prefrontal cortex. He noted that brain activity during the maternal-infant bonding process is now being documented by fMRI's. Schore cited research which indicates that the secure attachment process breaks down if mothers return to work and leave their babies in day care for more than twenty hours per week, or leave them with babysitters over twenty hours per week. He made direct reference to the serious differences between maternal and paternal leave policies in the United States, compared to other industrialized nations. He concluded that infant, child, and adolescent mental health issues are severely affected by this type of early maternal/infant bonding disruption. I awoke in a disturbed state this week, realizing the negative impact that my young mother clients who return to full time work less than a year after birth may be having on their infants. I also reflected on our affluent country and the mental health issues generated by families being too focused on the work ethic and material success.

I hope this summary inspires you to continue to learn and grow as a clinical social worker. Our job in the Society is to promote and support that in all of you. As I write, we are developing our Fall Conference and planning our last Clinical Evening Meeting. All of what we are and do was supported by the research I learned about at the UCLA Conference. I look forward to the dialog and professional growth we will share in the year ahead. And may spring renew and sustain you in your work!

At Your Service,
Karen Hansen, LICSW
WSSCSW Board President

ASSOCIATES EVENT

By Stacey De Fries, MSW

The Associates Committee hosted an evening of networking and inspiration on January 31 for our Associate members at Year Up in Seattle. Panelists, including Keith Meyers from Wellspring, Michelle Pomarico from US Medicine and Lisa Farsje from the Veterans Administration, shared their best tips and advice for Associates as they advance into their social work careers. The following topics were addressed: How did you get to your current professional position? What is the best career advice you ever received and why? What three skills do you think are critical for clinical social workers to practice and master as they work toward full licensure? Aside from required continuing educational requirements, what other professional development opportunities do you recommend pre-licensure candidates participate in? Taking your agency as an example, what makes job applicants stand out and how can candidates strengthen their applications? How do you view networking's role in securing clinical social work jobs and experience? The panelists' answers were helpful and very interesting. Attendees also enjoyed a delicious light meal and door prizes, and some Associate members agreed to participate in Committee and Board activities. If you are interested in planning the next Associates event, please contact Associates Chair, Stacey De Fries at sdefries@uw.edu.

Laura Groshong in conference with NASW Lobbyist Bob Cooper, preparing for their presentation for the Senate Commerce and Labor Committee on March 20.

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 LOBBYIST IN ACTION:

THE EFFECTIVE WORK OF LAURA GROSHONG

By Karen Hansen

On Wednesday, March 20th, I had the privilege of traveling to Olympia to observe and participate in a hearing in front of the Senate Commerce and Labor committee. This work session began an investigation into including Masters level therapists for coverage of injured workers who pursue claims through Labor and Industry. Laura Groshong and lobbyists for other mental health groups (counselors, marriage and family, NASW) collaborated to present convincing data documenting why such coverage should be authorized. This was the first time I saw Laura in action in Olympia, where she travels on our behalf several times a week when the legislature is in session.

Previously only psychiatrists and psychologists have been authorized to bill Labor and Industries for services to injured workers. In 2010, 15,000 such visits took place; none were covered by Masters level clinicians. I recently learned about this issue when a physician-authorized referral to me through Labor and Industries was denied. This case was used to demonstrate the problem to the committee. An interesting fact: Washington State DOES allow coverage by Masters level clinicians for Crime Victims Services, but NOT for Injured Work coverage.

I was in the group of lobbyists and organization presidents, as I was presenting the case example to the committee hearing the evidence. In the process, I learned about the necessary collaboration Laura Groshong organizes and facilitates each time a bill is under consideration. This is how she represents WSSCSW s interests, and this is also how we advocate for the needs of our client/patients. I saw her skill at managing relationships with other group members, her attunement to effective communication, her confident understanding of the mechanisms of the legislative process, and the respect she has in her circle of influence. Laura has been involved in Olympia for several decades as our lobbyist and legislative chair and represents CSWA (Clinical Social Work Association) at the national level. We are fortunate to have her level of skill and expertise at the state and national levels. Through the years, her work has made a significant difference to us as individuals and as a group.

The outcome of this hearing is not fully known at present. Most likely a bill will be introduced in next year's legislative session; it is too late for this year's session. The wheels of legislative change often turn slowly. It was clear to me that the evidence for our case was persuasive and convincing, although admittedly I am biased - in politics evidence is only one of the factors that determine the outcome of an issue. I am confident that we stand the best chance possible with this issue and many others, when Laura is involved. Thanks so much Laura!

The Position Paper prepared by Laura Groshong and submitted to the Labor & Industries Committee on March 20, 2013, can be found on our website: www.WWSCSW.org.

THE ETHICS OF UNPAID SERVICES

By Melissa Wood Brewster, LICSW

For many of us in private practice, managing the business side of our work is quite challenging. We're all too familiar with the confession that we didn't go to business school despite choosing to start our own business. In addition, we are constantly navigating the road of working as a healing professional while also needing to make money. We tend to do this work out of a passion to help others, but reality is always reminding us that money is important, too. So what do we do when a long-term client who is in great need of support owes us money, but shows no sign of paying it?

For example, a client of three years has built up a large, unpaid balance with a therapist. Although the client currently pays for sessions on time (at a discounted rate) she has not yet paid off her past debt, nor is there any sign of that happening. The therapist is still seeing the client and is struggling with how to address the financial issue.

One may think this is a fairly simple problem to solve. If we provide clients with a disclosure statement and collect a signed contract before beginning treatment, then we should just refer back to the contract, and perhaps even refuse to see the client until the debt is paid off. However, given the uniqueness of our work and our passion for helping others heal, this solution becomes harder to swallow. We struggle to compare ourselves to other service providers when it comes to collecting fees. The intimate and emotional nature of the relationship we have with our clients requires holding clear boundaries, but our deep sense of caring may lead us to confuse those boundaries at times. For example, one member asked, "Is it ok for me to wear my clinical and business hat at the same time?"

Money is hard to talk about in most relationships. To start, it can be helpful for us as professionals to get clear about what money means to us, and what, if anything, we associate with it in our own lives. That will help us differentiate between issues belonging to us and issues belonging to our clients. When a client is suffering, one member pointed out, "Our hearts get tugged." If we need to confront a client about money we instantly fear triggering abandonment in our clients - or we, ourselves may be triggered. So the question remains: can we speak with our clients about money and financial expectations in our work together AND still exhibit presence, care, and support, all at the same time? Absolutely.

Our Code of Ethics can serve as a helpful guide. Under "Termination of Services" it reads, "Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client." The key to this statement is "if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client." We must discuss these issues with clients and do it in a way which honors the therapeutic relationship and helps the client grow. We often see ourselves as the all-giving mother figure, but a healthy mother sets clear expectations and boundaries. Most of our clients need that model in their lives.

It is important to acknowledge any feelings we may have regarding our unpaid services, such as anger or resentment. If left unsaid or misunderstood, these feelings will surely affect our treatment with the client, however subtly. We can use our feelings to inform us. It may not be appropriate to disclose our explicit feelings to the client, but we can share our own needs in the therapeutic relationship, including the need to support ourselves financially. Only by supporting ourselves can we afford the time and resources to be available to help others heal and grow.

We may want to consider other approaches to resolving financial issues with clients. One could end treatment with the client until the debt is paid off. Alternatively, one could establish a payment plan with the client, agreeing that the debt will be paid off by a certain date, and if it isn't, treatment will end at that time. It may feel difficult to initiate the process of resolving a financial issue with a client, but

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HIDDEN TRAUMA:
Using Therapy to Help Integrate Childhood Poverty

By Brook Damour, LICSW, MSW

Most trauma is associated with shame and secret keeping in one form or another. The comedian Darryl Hammond, of Saturday Night Live fame, wrote a book about his on-going abuse by his mother as a child. He said that one of the reasons he wrote the book was to address "the agreement between perpetrator and victim in which the victim agrees to remain silent because he's in fear." (1)

Victims of assault, war, domestic violence, and other forms of abuse often describe feeling deeply shamed by what has occurred to them. They often feel that to move on in their lives they must try to forget what has happened to them, or at the very least, hide it carefully from others so that they will not face stigma. Victims of trauma are often silent.

One area of trauma that is not always recognized as trauma is the experience of growing up in poverty and economic hardship. I make a case that this is a form of trauma to one extent or another, because of the amount it can distort and limit a person's self-esteem, opportunities, and sometimes, their ability to develop at a pace with their peers. It is particularly haunting because poverty is generally not something that has a single perpetrator, like physical abuse might, but is the result of a great many factors that are difficult to tease apart and understand. As such, the trauma from poverty can take on a particularly mysterious, phantom-like quality for those who experience it. To use Hammond's words, when the trauma you deal with is poverty, it's hard to say who the perpetrator is that keeps you silent and fearful. And when your whole family has been in poverty, it is often confusing to try to understand who was victimized and how that victimization was passed on intergenerationally.

A person can try to mimic what they think they should be, but keeping part of their identity secret can lead to profound pain.

While certainly some of these issues can be mitigated (a few possible mitigating factors might be a healthy, supportive family environment, high quality social services, educational enrichment programs, mentorship and connecting with people who model successful behavior), the reality is that many people who struggle with poverty in the U.S. do not have enough protective factors to allow them to feel safe and whole. This can also be true for people who have grown up poor and have been resourceful enough to escape the poverty. Because poverty is often stigmatized and pathologized, there can be a tendency to hide experiences with poverty from others, much like hiding other forms of trauma. People often feel ashamed, marked, and somehow bound to their history of poverty in silence because of what they fear it might say about them. Poor and working class people are commonly stereotyped as being lazy, not intelligent enough to do "higher class" jobs, courser, and even damaged. Who would want to openly carry around those labels?

I propose that for people who have grown up poor and found ways to move out of poverty, there are other special considerations. Many people with a poor background describe feeling "survivor's guilt," a sense of not deserving to have prospered, a feeling of responsibility for people they care about who still struggle. This feeling of responsibility can be particularly difficult because it can lead to challenges with maintaining boundaries with others. It can be likened to people of multiple cultural backgrounds who describe feeling like they are from two worlds. People who have grown up poor and then earned their way out of poverty live both in a world of poverty and a world of more privilege. Where do they fit when they have experiences in both worlds? How do they bridge those experiences to feel whole? If you have had these experiences, you may have survival skills and strengths that have allowed you to succeed to some extent but still feel held back internally, fearful, ashamed, and confused about who you are.

In my study of social class as it impacts therapy and people's growth toward wellness, a common concern is the fear that even though a client has accomplished things in the world and earned what they have, they still feel false or unworthy. To some extent, poverty seems linked to feelings of unworthiness, and often, inferiority and uselessness. Poverty and disenfranchisement are not such different words. Growing up poor means there may be limited role models to learn from about how to be assertive and navigate the cultural complexities of earning money. To be able to succeed in American society, where assertiveness is valued, you often have to find ways to "fake it" when you feel unworthy, if

you want to "make it." For some this takes the guise of observing others who look successful and trying to imitate them. This is a double edged sword because it can help a person succeed but it can also feel unnatural and strange, which can lead to a profound feeling of falseness and feeling like an imposter. It all circles back to secret keeping about trauma, and trying to integrate the pain from the past with current circumstances. A person can try to mimic what they think they should be, but keeping part of their identity secret can lead to profound pain.

Therapy can help begin to make peace with these two worlds - the world in which you grew up without enough money, and the world in which you may actually have enough. Much like our work in other areas, careful attention to trauma and pain surrounding childhood social class can help people integrate different parts of their identity that may cause them pain, so that they do not have to keep secrets, feel shame, or dismiss their own experiences and worth.

These are some areas I now include in assessments to better understand if childhood poverty may be an important issue to consider in therapy:

- do clients feel tremendous guilt about the good things they have?
- do they feel responsible for and often struggle to maintain boundaries with friends and family members who are struggling?
- do they express feeling phony (what Donald Winnicott described as a "false self," someone who pretends to be "as if" they are the person they think they need to be, but the false self doesn't match how they feel on the inside, which may be empty, shameful)? Do they look good on the outside but feel terrible inside? In this case, the role of attachment takes on more layers than being solely shaped by a primary caregiver. When social class is a source of feeling false, both the family and society at large begin to impact early development of self.
- do they experience anxiety about scarcity, even with a relatively stable financial state? This may manifest as nightmares about losing everything, or hoarding things that were sources of scarcity in childhood, such as food. Do they feel unsafe most of the time, unable to protect themselves, or as if everything good might get taken away? Here, manifestations of past deprivation can dovetail with PTSD symptoms.
- do parents with a history of poverty find they are puzzled about how to instill the value of material things provided a work ethic in their children? Are they anxious because of memories of when their own family could not provide enough for them?
- do fears about and memories of scarcity while growing up impact present functioning, and hold the client back?

I have found the way childhood poverty impacts people as they grow up, even if they are no longer poor, to be an important part of recovery and growth for clients. As we all know, creating safety is usually about more than money and our current situations; it is also often about integrating the past, and social class in childhood is an often ignored, but vitally important part of this. If you do not already, I invite you to consider the importance of your clients' social class history, particularly the parts of that history that still sting, as you help them to grow.

1) Gross, T. (Producer). (2011, November 7) Fresh Air [Radio Show] Philadelphia: National Public Radio, WHYY-FM.

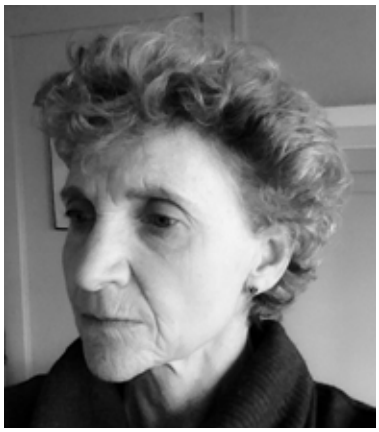
About the author: Brook Damour, LISCW, worked for five years in community mental health and now has a private practice in downtown Redmond, WA. She is particularly interested in nutrition and mood and how client experiences with poverty impact mental health, therapy, and attachment. Comments and responses are welcome and can be sent to brook@middlemarchtherapy.com.

SOMATIC TRANSFORMATION: Dr. Sharon Stanley's New Approach to Healing Trauma; Three Members' Views

By Lynn Wohlers

Whether we see clients in the context of ongoing private sessions or cross paths just once at a homeless shelter, trauma is more likely than not a defining factor in the problem at hand. Dr. Sharon Stanley, a psychotherapist and educator with offices on Bainbridge Island, has developed and honed an interesting new approach to healing trauma. She calls it Somatic Transformation. The "Somatic" here reminds us that trauma is often, if not always, locked into the body: as Bessel van der Kolk says, "The Body Keeps the Score." "Transformation" gives hope that what has been frozen in time internally may be transformed, allowing movement towards healing the whole person.

The intersubjective relationship is all important in Stanley's work, which focuses on the right brain attributes of non-verbal, affective information processing and unconscious processes to actually change neurobiological patterns, promoting calmer, more resilient responses. In the two year certificate training, clinicians deepen their understanding of and attunement to clients' emotional/physical adaptations to trauma, and practice interventions that help people learn to self-regulate through attending to their own bodies.



Marcia Robbins

Recently I had the opportunity to speak with three WSSCSW members – Marcia Robbins, Jenny Gardon and Meira Shupack - who have trained with Sharon Stanley. I asked each of them how they came to Somatic Transformation, how taking the two year training has changed their practice, and how it has changed them personally. Here are excerpts from the interviews:

Marcia Robbins speaks about how she came to train with Sharon Stanley:

I've been in my present practice since 1994. I trained in various orientations, all interesting and helpful. I found that I was more and more interested in the neuropsychology and neurobiology fields that were growing. I had read a lot about it and gone to some lectures. I felt like, 'That's what I'm missing, that's what I'm hungry for.' I didn't know much about Sharon - I had never met her - and I committed to the training without knowing much. I talked to a few people who knew her and I looked at various other options, some that required going to L.A. to train. A dear friend and colleague of mine, Janet Carter and I decided, "Let's just do it." So we started our two year training program five years ago. I finished my two year training and am a facilitator now. That involves helping clarify things during trainings, making comments, doing practice sessions. I've learned a tremendous amount through the facilitation. It's been wonderful to take the course over and over again. Sharon, although she's taught this - I don't know, twenty times or something - changes it every time. She's always including new information. Each time it's new. It's really exciting.

Jenny Gardon on how she came to Somatic Transformation (ST):

I've been doing psychotherapy a really long time. I have three decades [of social work practice]; the first was family work and family systems, in community mental health with kids & families. Then there was a good ten years of studying contemporary psychodynamic and relational work, in private practice. I was in supervision with psychoanalytic people. You know there's a lot to recommend such deep work, and there are limitations. Much of my third decade has been more focused on using what neurobiology and attachment research is teaching us. I'm a pretty physical person and I was already drawn to meditation, a bit of hypnotherapy. So when I heard about Sharon's training, it was so timely. It sounded great to me. So for me it wasn't as big a switch as I think it was for people who come from a more traditional psychoanalytic background. It sort of supported and helped me organize some of the things I was doing a little bit by the seat of my pants. That was a really nice feeling. I knew this [body-based work] was valuable and here was a good way to use it, a more organized approach. It felt really good and natural for me, not that I claim to have mastered or utilized all of it, but the part that I took in felt organically right to me. Before I started that [ST training], I was studying with Stan Tatkin, who was also using a lot of the Shore stuff and attachment and neurobiology. It's all very, very rich material for practice and I love bringing the body in more. It feels right and intuitive to me.

Meira Shupack on how she came to ST:

"I did a two year internship in 2006-2008 with the Northwest Psychoanalytic Clinic [now the Alliance Community Psychotherapy Clinic]. I loved it [psychoanalytic work] for the idea of containment and holding the client, and conceptualizing, and being able to have a theoretical framework. What didn't ever really work for me was - even though with a Kleinian, or a newer analytic approach, there's more encounter between clients and therapist - I am too spontaneous. There's something about the empathic, spontaneous, reading-soma thing that I was doing anyway. I always felt bad about doing it because it didn't fit nicely into the model. My consultants and advisors seemed a little worried about the approach I had. I probably interpreted their concern more harshly than they meant; analytic training by its nature has a burnishing-you-by trial aspect.

Jenny Gardon

One of the things that was great about our internship was that they brought different people in to teach. Sal Ziz did this presentation on attachment. He showed us pictures of brains; what was happening in the traumatized or the non-traumatized brain. He had a way of speaking about attachment and soma that seemed somehow really humane. There was a kind of a grave reality and humor. I credit him with bringing me to ST. I loved what he said. I wanted more of that kind of grave, humorous, real thing he was communicating about, that was important between clients and therapists. [The idea] that implicit communication was really important, and affect regulation was something we were going to try to be conscious of in the room, fit more naturally with what I was thinking about as a human, with understanding myself, and with what I felt I was seeking to do therapeutically. Sal said suggested that I take the training. I finished the internship, I worked for a year and did a small private practice, and I started taking the ST training. So I hadn't had a lot of experience committed to a [particular] approach to clients in the room - I hadn't been practicing a different way for thirty years and then got this ST training. It wasn't hard for me to integrate it into my other training. It was a huge relief to find a way to practice that was more congruent with just my authentic being, and my personality."

Meira Shupack

Meira Shupack discusses using ST in private practice:

It's interesting because every person comes in wanting a different thing in the room. So I practice differently with every client. There's one client, a man from a working class family, not a guy who talks about philosophy but a guy who wears a baseball cap and talks about meeting a girl and settling down. We do a little talking, we do a little fixed action patterns, finding the movement. He's a very high anxiety client, so maybe [we work on] finding the movement for his anxiety. He showed me that his anxiety felt like this. (Meira swings her forearm upward in front of her chest, palm flat, then thrusts her hand suddenly towards me.) I asked him to slow that down. He slowed it down, and he slowed it down, and he kept doing it, slowing it down. And he said he had this sensation of a wash of peace.

How exactly did the gesture come up?

I asked him if the anxiety had a texture or a color or a movement, or anything he could imagine for the way it might look, feel or appear. He came up with that, then we slowed that down, and he kept doing it, and as he did that his whole appearance changed. He's a big, compact, bundled-up-in-his-anxiety guy, and he kind of just melted into the couch. He got this surprised, gleeful look, a calm wonder. He went from calming himself by listening to heavy metal music, to calming himself by thinking of the gesture. He said, "It just doesn't overtake me anymore." Slowing down this self-generated movement changed him, not trying to control things. And we talked about what it feels like, so it goes right - left brain; a sort of psycho educational piece. With him, a lot of it is my knowing his attachment story. There's a lot of gazing with him. He's so hungry for personal connection, that there's a lot of just being together, and him feeling what it feels like to be felt by another person. This is a guy who goes to monster truck shows, and underneath all that is a sweet tender little boy who remembers being shamed, who comes to sit in my room, just to be cared for.

Can you say more about how the gazing practice you described?

It's all about affect regulation, implicit communication, and feeling in to what a person needs in the moment. For him it's having a quiet space away from the disorganized, incredibly anxious life he's normally in. Coming from a chaotic family, this little boy never had gaze. [There was] a hunger that he always had seemed to have lain right below the surface. It was getting to the level of knowing that

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he could come in and drop down into this place that he always had in him, but lay just below the crazy anxiety, the family history. Once we get there, what he has available to him [is so valuable]. We've talked about the expectant system he's had, that wants to be loved and attached to. When that system doesn't get used, it starts to kind of close up, but it's there and it can open up. He loves the image of himself as a flower. He talks about "When I'm like this." (Meira gestures with her hands like a flower opening and closing.) He has all this [non-verbal] language, all this stuff that he brings back. HE comes up with it.

And is it possible that without the ST training you might not make as good use of it?

And I might not have gotten to it. We might have spent a lot of time talking about the relationship between his mother and himself, his parents fighting, and how that felt. That comes up a little bit because it's an issue. But he comes here and says, "I know what I get here, I feel like I'm learning to be me, learning to be IN me," in a way that the world he's from didn't really ever care about. The trauma is still in him, taking the guise of anxiety and fear and extreme worry about being judged. We sit here and deal with whatever is in the present moment. He comes back and reports an easier week. He says someone gave him a compliment and he was able to take it in as opposed to dismissing it. I don't say, "Well, next time someone gives you a compliment [you should accept it]."

You don't give a behavioral instruction…

Exactly. And we're not spending a lot of time talking about what it was like to be a boy and not get food. Mostly we do the attachment repair in the attachment relationship that we have here. A lot of it is in the implicit relationship that he is asking for. He would not have imagined the movement he came up with, the effect it had on him, or that just being with me in this positive relationship state [would have been possible]. I don't think he thought that was what he needed to heal. When he came in, he said, "I just need to get control over things." The language was all about control and locking it down. But what he learned from himself - and I'm always reminding him it's from himself - is that this authentic being is there. It was always there; I just respond to that. I'm happy to be there with him and happy to feel peace with another human being. But he would not have known that, had he not engaged in the process. I just think it's amazing work. I don't think it's the only amazing work. I think it IS amazing work.

I always have postulated that our clients are the best supervisors ever. They always tell us what they can tolerate and what they can't and what they need. If we only are open to listening, and to feeling in to them, maybe listening past the word. I know that in a pinch, I am glad I have the psychodynamic approach to fall back on, to conceptualize. But I'm also so relieved to be in the room in this true way, knowing that it really has an impact. And that's some of the work I'm really proud of.

Do you use ST more with some clients than with others?

I would say all the things I do may be within the field of ST. You might not be able to explicitly go to the body with someone because they're too traumatized and it feels too scary to go to the body, so for those people, then knowing that, keeping an eye on that, and on what's going on in my body [is what's important]. So while we are talking, my stance is being highly [aware], tracking that as best I can.

Attending to your bodily sensations and how you feel?

And my micro sensations, so that I can notice and examine my own facial expressions. A big clue with some clients might be that if I tense up here, (gestures to her jaw) then maybe they're bracing. Bracing around here is probably really young, early attachment stuff, nursing. You get a sense of what different kinds of bracing might indicate. They often do, they might not. It might be something they don't want to even get near. That may be OK. You're not trying to dig, you're trying to allow something to unfold. I might stop someone at a particular moment and make an inquiry as to what's happening. Or maybe I pause and ask myself what's happening in me, to figure out what we're doing in this moment, and if there's anything I need to do. Often I don't need to do much. There's holding I need to do, there's being active - and not being active. You just have a stance of positive inquiry; you're curious and really in a project with the client. It's a kind of collaboration.

Rather than your acting as an authority?

And saying, "You know, that tension in your jaw…" Knowing that the tension in the jaw may be about [their] early childhood might impact what you do - you might ask someone to jut their chin out, raise their eyebrows, or get some movement here in the jaw - or you might just notice that that is where they or you are holding tension. It's being willing for clues to mean something or not to mean something, but being aware that there are clues. It's having that [awareness] help you hold the client, flexibly enough so they don't feel dropped, or missed. I think it's great work. I love it. I love Sharon and I feel incredibly grateful, and I learn from all different people.

Marcia Robbins on using ST in her practice:

I worked with a woman who struggled with a lot of self-esteem issues and tended to feel very separate from the rest of the world: "Everyone has more than I do, everyone has more to offer than I do, everyone is

more loveable than I am." She had a very rejecting mother who hated being pregnant, hated nursing, and would say, "You made me fat" and give her the silent treatment. It could be days before her mother would talk to her, even as a four year old child. She would just be waiting. She knows that story, but how to impact the sense of being an isolated, immobilized child? So we worked with that frozen position, letting her really feel what that is, and we also worked with a time when she felt unfrozen. We worked with both experiences in her present life: the feeling that I'm nobody, then a time when she was laughing with her son.

And then you would ask how her body felt?

How her body felt those times. To oscillate, to go back and forth. What is that like when you're happily laughing with your son? - when feeling uncomfortable? - and slowly going between those two [states]. As she did that, she made this motion with her hands. I said I'm interested - what's going on in your hands? She was taking her hands as if she was holding a ball. So I said, "Slow that down," and she started feeling this motion, and she had an image of a beautiful blue ball in her hand - a magical, luminous ball. She had this image of herself as a little child locked in her room, with no toys and no friends, but she had the blue ball, and she felt so much better having the blue ball.

She came back the next week and said her brother came over and he was teasing her. She felt small, and so awful. Then she thought, "Oh, I'll just roll my blue ball and knock him over!" We hadn't talked about how she should use the image. It was IN her body. Before, she thought she had to stay entangled in being small until someone rescued her, but now the feeling [of being small] was coupled with having the blue ball, which she never had before. A cognitive therapist would say, "Think about how wonderful you are. Think to yourself, 'My son loves me, my son loves me.' Then when your brother teases you, think 'My son loves me, my son loves me.'" But the important thing was that it all emerged from HER, from her body.

We have brought in movement, little shifts. Trauma, big or small, is frozen, encapsulated. So if we bring some movement in, everything starts to shift. And how much easier for me as a therapist to just be curious about the experiences, rather than saying to myself, "I have to come up with something. Here's what you should do. Here's your homework, and I hope it works." I pick up a lot if I can stay embodied, rather than trying to be "smart." So it's a lovely journey to travel with her.

It's a real intersubjective space rather than top down, head to body, or authority to patient. [It's] being aware of the body's information. If an experience isn't transformative, it isn't embodied and is more a habit to try to practice. In my own little evidence based practice, since I've been working in this way, I see people really feeling themselves changing, which is very different than [just] their behaviors changing.

Sometimes people come in with a very tight little window: "I don't want to get upset." Or they are explosive. You're trying to expand that window. We need that experience of feeling the arousal and putting the break on it. When I taught my kids to drive, the break was important! As mammals, the part of the nervous system that quiets the aroused state is something we need to survive. The ventral vagal system enervates the face, the larynx, the heart, and that's the part that responds to others. For example, hearing a [strange] sound in the house at night, then realizing it's only your cat - there's the hyper arousal, the [urge to] flee. But then the ventral system realizes it's just my fuzzy cat, and the whole system quiets down. Those are important experiences to have. A baby who wakes hungry and cries is hyper aroused, then the mother comes in and in seeing the mother, the baby is calmed. Trauma is when we stay in the state of hyper arousal. And often, if we stay in the hyper aroused state long enough, we then drop into the hypo arousal. We just feel, "Never mind." Like the failure to thrive, an almost catatonic state, "I can't do it anymore." You'll see that in session. "Oh my god!", and then they're just gone. Those are things we want to avoid recreating in the session because it reinforces the neural pathways [of trauma]. What they say in neurobiology is, "What fires together, wires together." So if I'm firing this pathway over and over again, it gets wired and concretized.

And it will be easily triggered.

Right - rather [than re-triggering that], we start to fire some other routes, and pretty soon the energy starts to move along these new routes. Being able to step into the high arousal and knowing we can come back down, everything feels better. I can get anxious if I know I can come back. I can get scared; I can be aroused, with the safety of knowing I'll have all my wits about me. That's very different from thinking I'm going to stay in that place. And it's both the hyper and the hypo arousal that are dangerous. In a way, the hypo arousal can be more dangerous and a space in which one is less likely to reach out for help.

Jenny Gardon on using ST in her practice:

Do you bring aspects of ST into your work with everyone?

I think it informs how I work with everyone. There are particular practices that Sharon teaches us – and Pat Ogden has a set of them, Stan Tatkin has a set of them - so I use those, more or less, with different people. I don't want to say that it fits more with some people, but some people are more resistant and it's harder, so then you have to, as Sue Johnson would say, "Slice it thinner." You have to

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take a smaller step. I would say the changes that are true across the board are that I use much more of what I feel and know about their somatic experience, their facial expressions, and other things that go on in the room. I sit closer to people. You know I think there's a set of data, if you like, that you have here (moves closer) that you don't necessarily have from here (rolls chair back). It's not just literally what you see; it's a kind of attunement. I got these rolling chairs when I was working with Stan Tatkin, thinking it was mostly for couples, to help them regulate and modulate, and of course I sit in them myself. Clients prefer the couch, so they're static and I'm the one on wheels, so I have to be aware of that. I'll talk about it - I won't just roll up into their face. For example, one person I work with is very uneasy with closeness and she's quite defended. When there is a tender moment, of course my impulse is to sit close to her. But she has told me that that frightens her. In the past I might have said, "Could I sit a little closer?" and she might have said "Yes," but the rest of her said "No." So instead I acknowledge what a tender moment it is. I let her know that I felt close, connected, but I was honoring her comfort level.

I got these rolling chairs when I was working with Stan Tatkin, thinking it was mostly for couples, to help them regulate and modulate, but the truth is, I use them a lot myself. The trick is that clients prefer the couch, so they're static and I'm the one on wheels so I have to be aware of that. I'll talk about it - I won't just roll up into their face. For example, one person I work with is very, very uneasy with closeness and she's quite defended. When there is a tender moment, of course my impulse is to sit close to her. But she told me in numerous ways that that frightens her. I might instead just acknowledge what a tender moment it is. I think in the past I have said, "Could I sit a little closer?" and she might have said, "Yes" but the rest of her said "No," and then I said, "Looks like maybe I should just stay where I am, but I want you to know, here's what I am experiencing." There's an example where I both did and didn't use it. I let her know that I wanted to be close, but I was honoring her comfort level.

Another thing I learned from Sharon that I use a lot and hold in my mind is the idea of oscillation. I think one thing some of us used to do, and thought was the right thing to do, was to get people to talk about traumatic events. There is a need to talk about them, but when we just let clients dive into the deep end there's a high risk that they're going to be re-traumatized, and tell their version of the story without necessarily any healing. The healing is going to come from a couple of things. One is being in relationship, changing the experience of being isolated during the trauma, because the isolation, being alone, is such a huge part of what's traumatic about a trauma. It does seem very important, if someone's going to tell about a traumatic event, to do it in a careful and deliberate way so they're not just zooming through it, and either feeling the trauma again or else shutting down in order not to feel the trauma. That keeps it all locked up. There's no progress. The idea of oscillation is partly to keep things fluid so that people are not stuck in any one mode or kind of experience. They're not stuck in fight; they're not stuck in freeze.

So, if you see them going too far, being over or under-aroused, you would…

There are several ways to oscillate. If someone is hypo-aroused you bring in a bit of stimulation, if someone's hyper-aroused you try to settle them down. I consider it my job to stay even more alert to how they are doing as they tell the story than to the story per se. So I slow them down, but a lot of people don't want that. The skill of interrupting well is important because it can be pretty frustrating,

When you need to tell your story…

Yes. They're coming for help because just telling it over and over obviously isn't enough. So there's addressing the arousal level, but there's also taking a break from the story. We're not just diving into the deep end; we're going around the edges of it. You go into it a little bit, and you watch them. Are they staying connected to you? Are they connected to themselves? Then maybe you take a little break. Maybe in the trauma there's a side detail you can borrow to take a little excursion, a little detour which could be organic. Or you could very directly say, "Let's pause for a minute, see how you're doing, maybe take a break and come back to this." It could be as explicit as that. My hope is, and I think the theory is, that you want to keep their capacity for change safe.

Philip Bromberg talks about this – he says that mental health is the capacity to stand in the spaces between your different states, and know that you exist in different states. The state you're in right now is not all of who you are. It's related to the idea of being fluid. Part of what happens when people have a problem with dissociation or with out of control anger is that they get stuck in it. So the therapist helps them get more facile, and more fluid and able to switch to another state, and get back to where they left off. So we want fluidity.

Would you say the need for fluidity was something you always were aware of, but the ST training gave you more tools to get there?

Yes, though I wouldn't have used that language. Your comment makes me think of a client who gets really stuck in dissociation.

She could see my efforts and I could see hers, but it was very hard to reach her. Now that she feels more free to use me and the office however she needs, she gets up and walks around the office a bit. She would literally change her state. It's wonderful. Physical activity, nature, favorite interests, support people, images, and all kinds of things can be paths out of a difficult place. Once clients are more in charge of their capacity to change their mental state, then difficult states like trauma, anger and flashbacks aren't quite as imprisoning.

Another really useful idea from Sharon is the idea of thwarting. Even that word is kind of a mouthful.

It's an interesting word.

Yes. She has some very specific physical interventions she uses when people feel thwarted, but even before that, just that concept - it labels a very common experience. I think the labeling can be really useful. Particularly in abuse situations, where people feel so ashamed and so much of the isolation is around shame. People feel they let that [the trauma] happen. This isn't unique to ST; good therapists all over the globe are helping people have compassion for the situation they were in and remember what they tried to do. When you can remember what you tried to do, then you're no longer a passive victim. You may not have been successful, but you were doing what you could. Sharon does some really nice physical interventions. She says part of what happens is that when we don't get to complete a motion in the experience [of trauma], it gets frozen. So someone might be thwarted, and [I can say], "Look at your hands, they are in fists. Is there something your fist wants to do?" Then the client might experience the resistance she had at the time of the assault. Maybe there was an urge to push away, but maybe the perpetrator had a knife. So there's this idea of completing the action in slow motion. I've done this with a number of people and it does seem to help release something. It's [a matter of] getting around to the thing you wished you could have done.

"If you could do what it was you needed to do - look at your fists - you were trying to protect yourself! Is there something your fist wants to do?" Then the client might offer some resistance. Maybe there was an urge to push him away, or maybe he had a knife, so there's this idea of completing the action in slow motion. I've done this with a number of people and it does seem to help release something. It's getting around to the thing you wished you could have done.

That makes me think of Bessel van der Kolk.

Yes, Sharon talks about him; the movement. I don't think that's unique to Sharon; I'm sure other people use it too.

Has ST training increased the use of your own bodily sensations in session?

It does help me use them more, but even before using my feelings, is that ST has helped me value and trust my sensations more. Sharon talks so much about right brain to right brain communication. If I'm sitting with a client and I feel a flood of sadness, but they're talking about something seemingly unrelated, I'm more likely to pay attention and listen to what they're saying through that lens. Without saying "I'm feeling you're sad," I might trust my feeling enough to ask a question, or wonder how something feels. That often helps people drop down into their feeling and open up. On some level, if I'm feeling it and they're not, there's a little bit of resistance in them to their own feelings. But I can bring it back to them - I didn't invent it. It was just below the surface. If I only listened to their words, and didn't trust my feelings, I would have missed it.

I just feel a whole lot more congruent. There was a way in which I used to feel I had to keep a distance and formality. It often didn't feel very authentic to me. I feel much more free to be authentic. That doesn't mean my behavior is loose. It's kind of subtle, more genuine. If I feel tears coming up, I don't try to hide them; I might even say "Oh, I feel tears too." Also while I don't go around initiating hugs, if someone asks for a hug, I won't refuse. Guiding principles of humanity, and kindness resonate with me, so much more than than "neutrality" whatever that is!

Or boundaries?

Yes Boundaries in certain situations, absolutely. Somebody might ask me to do something that I wouldn't do, but there's the matter of authenticity. Why wouldn't I do it? Because it didn't feel right to me.

Marcia, Jenny and Meira discuss how ST has transformed their personal lives:

Jenny: It's hard to pick exactly what contributed to what, and I think even before Sharon, the training with Stan had a big impact on me in terms of the need for, the possibility of, regulation. And of course my own therapy before that. I take more responsibility for my own upset and regulation. My partner and I have a rocky relationship. We used to set each other off all the time. Now we're much more deliberate in how we attend to each other's experience. Now we talk about things differently and resolve things much more quickly. And I see it in my relationship with my parents too. My father is a very unregulated and unhappy person. He's still a hard person to be with, for me, but I hold it a little differently, I set more internal boundaries, in response to what I know about his impact on me, and I'm more aware of how I upset him too.

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Marcia: Although I gained a tremendous amount from my own therapies, and especially from the psychoanalytic ones, I came to feel that I wanted my body to be integrated into the work. My head would be there, but I would have this pent up need for my body [to be active]. I would want to go running afterwards. There was something unsatisfying. I feel like for me, just doing this work, I have a much different relationship with my body. [There's been] lots of shifting of my old, over-wired, over-concretized concepts of the world and myself. Staying in that more embodied place, at the optimal level of arousal, I find that I'm more creative and less tired than I used to be. That's of great value – especially as I get older. It's been very valuable, very valuable.

Meira: It's huge in my personal life. My twenty-year-old is in the process of reexamining everything in her life now and bringing it back to me. If I was hyper aroused when she was telling me all the ways that I failed her…

There would be a few buttons pushed?

There still are. But I can tolerate a lot more. Being able to take her in, in this way, is transformational for our relationship. I'm extremely lucky to have a twenty-year-old who shows me how I need to be stretched, how I need to be there. I can look at how I have not acted optimally because I did not have access to all my parts. I did the best I could, and if I could have done it a different way I would have. There is a grieving process, an acceptance that we can both be in together, for the fact that I didn't always know about this stuff and that she had a younger mother who was doing the best she could. That's a fact. So there's an allowance for more humanity, more frailty, more forgiveness. I can't say exactly how much of that awareness came out of the ST training but I can track the maturation. There has been a big, exponential shift since I started doing ST. I don't think it's just because I aged. I do think it's because in order to do the work with clients, you do it on yourself. The idea of client and therapist: we're in this together. I look at narrative in a different way, and I look at my own narrative in a different way. I know what we have access to and what we don't have access to in our different states of arousal. The more I'm in a state of safety, the more my own trauma resolves, the more that level of openness gets bigger. I can operate in the world and in my own life in a more truly related [manner], truly as me, with access to more of myself.

A few thoughts on the trauma of racism:

Meira: One of the things I was heartened to see [in ST training] was that racism was included as a trauma - a global trauma. War, torture, inescapable attacks, etc. are modules [within the training program], and racism, which I found helpful. The fact that she takes this into account is really a strong value for me. It's important that I'm learning from a person who has an awareness of how those things play a part and impact day to day living - trans-generational trauma, all those things. I think a lot of times theoretical frameworks may not give weight to the impact of institutional trauma and racism on daily existence. People have to live with it. [There's a tendency to say] "We'll talk about that when we do the diversity training." But if you're going to learn about trauma, you've got to learn about that [the trauma of racism]. That feels heartening to me because you can't do an a-contextual therapy. Because it's all in that lasagna. Sharon describes it as a lasagna that we have to take apart. That's what actual trauma looks like - all these little pieces. It's so small and tender, and in order to take out a little granule of tomato sauce from the ricotta, you have to be careful. How can you do that? It's not easy. Everything is melded together. So with that awareness, you can't say that things are discreet. ST throws out the idea of a discreet trauma. And there are never cases in which people don't have trauma; everybody had hardship if you look at trauma in a big way. It's a different way to understand it.

SAVE THE DATE!

This fall on October 19th, WSSCSW will present a Fall Conference on the topic of Somatic Empathy and Transformation: A New Approach to Mind-Body Integration and Emotional Processing. The conference will be held at the newly remodeled HUB on the University of Washington Campus! Details will be forthcoming.

Resources:

http://www.somatic-transformation.org/index.html

http://www.allanschore.com/

http://en.wikipedia.org/wiki/Polyvagal_Theory

http://www.amazon.com/Polyvagal-Theory-Neurophysiological-Communication-Self-regulation/dp/0393707008

http://www.stephenporges.com/

http://www.allanschore.com/pdf/SchoreAttachHumDev.pdf

http://www.wawhite.org/uploads/PDF/E1f_5%20Bromberg_P_Standing_in_the_Spaces.pdf

BOOK REVIEW:

Gestalt Therapy: 100 Key Points and Techniques by Dave Mann

By Bill Cooper, LICSW

Gestalt therapy is probably the most misunderstood therapy in current practice. It's hard to begin an article about it that doesn't sound defensive. By way of context let me explain. Several years ago I signed up for my first Gestalt training, hopeful that I would learn some dramatic techniques to make my therapeutic work more interesting. Among other things, I naively anticipated learning how to teach my clients to shout and hit pillows. I've since trained in the Gestalt model for over four years and I have yet to see anyone hitting pillows, talking to an empty chair, "being" whatever or demonstrating any of the other Gestalt techniques some clients had the dubious opportunity to experience in the sixties and seventies.

Instead, Gestalt training has helped me to learn how to listen closely to my client, to do what I can to allow the client to become more aware and accepting of their experience, to think holistically and intersubjectively about my client's experience, to honor the I-Thou relationship, and many other humanistic (and effective) interventions.

Trying to understand Gestalt therapy can be difficult. For instance, during a lull in one of my own therapy sessions, I facetiously asked my therapist if he was doing Gestalt therapy. Without missing a beat he said, "I'm interested in your experience."

In addition to doing therapy with a gestalt therapist, how can one begin to train in Gestalt therapy? An excellent guide and text is Dave Mann's Gestalt Therapy: 100 Key Points and Techniques (Routledge, 2010). Mann is a Gestalt therapist in the United Kingdom, active in training gestalt therapists in Europe, and a former assistant editor of the British Gestalt Journal.

The most striking quality of Gestalt Therapy is its conciseness: there are a hundred brief chapters, most about two pages, on just about every topic relevant to Gestalt therapy. The book is arranged into six sections: 1) Theoretical Assumptions, 2) Beginning the Therapy Journey, 3) The Therapy Journey, 4) Transitions Along the Way, 5) Ethics, and 6) Research.

Gestalt Therapy is not a text with ponderous academic language; it reads easily and speaks directly to the reader. The following paragraph is typical of Mann's accessible writing style:

> I see many areas worthy of consideration as I sit facing a fellow human being experiencing discord in their situation. How can I make sense of the way the client makes and breaks contact? How does this relate to their perceived malfunctioning field of relationships? How does this person affect me and can I make any sense of my reaction in relation to what is presented? The possibilities may be endless, but the answers and choices of direction lie on the surface if we only pay attention to what the client is telling us in all the ways in which they communicate. Our reactions to their way of being with us and theirs to us give us all the raw data we need, and will be evident from the first moment we meet in the way in which we body forth to one another (p. 117).

In this excerpt Mann brings to our awareness some values and areas of concern characteristic of Gestalt therapy: the importance of the present moment and contact, awareness of the field (situation), the clinician's attention to the obvious (as well as a reluctance to interpret), a deference to the client's understanding of the situation, and the importance of the co-created relationship between therapist and client. Mann has a strong curiosity about his client and a willingness to explore their experience together. These issues and more are covered in detail in the book. It is truly a concise overview of current Gestalt theory and practice.

Gestalt therapy has its challenges. It has often been criticized for lacking a developmental theory, an issue Mann discusses in the text. Also, Gestalt research does not have a strong tradition of quantitative study, making it vulnerable to criticism in this age of worship of all things scientific. And like some other theoretical orientations, training in the discipline is often outside academia, making it somewhat isolated. Finally, the history of Gestalt therapy has its controversial practices and personalities.

Mann's text makes quite clear that contemporary Gestalt theory and practice bear little resemblance to the Gestalt encounters of the sixties. I recently watched a therapy session on You Tube from that era, of Fritz Perls working with the client "Gloria". I was struck by what I saw. In many instances in their heated encounter, Gloria was very perceptive and honest in her objections to Perls' behavior, e.g. when he called her behavior phony. Despite her awareness and strengths, she received little validation from Perls. It was clear to me as I watched the video that Gloria was in significant emotional pain, and I became angry at Perls' unwillingness to mitigate it. As the session concluded I could only think, "Thank god those days are behind us." It's doubtful that this type of therapy was ever truly representative of Gestalt therapy.

Gestalt Therapy: 100 Key Points, by Dave Mann, is a gift to the field of Gestalt theory and practice. Like other important writers, such as Lynn Jacobs, Donna Orange and Gary Yonteff, Dave Mann has brought clarity, guidance and encouragement to the professional therapist who is both compassionate and committed to helping his or her clients. If a therapist wants to learn about Gestalt therapy, she could do no better than to start with this book.

FORCED ADAPTATION: Turning Challenge into Growth and Fulfillment

By Carolyn Sharp, LICSW

Like many of you, I am finding that my private practice is feeling the 'crunch' of the changes that are taking place with insurance reimbursement. The reductions in reimbursement rates, the change in CPT codes, and the impending move to mandatory Electronic Health Records and Accountable Care Organizations will dramatically and permanently change the ways we do business. Because the full impact of these changes on my ability to earn what I need to support my family is not yet known, I have been developing new and different ways to serve my community and reduce my dependence on insurance reimbursement. Despite the growth and benefit of these changes to my practice, it has been anything but simple.

These adaptations to my practice have been fraught with challenging emotions and decisions. I have found myself angry, resentful, scared and insecure. I waver between my plan of mindfully approaching impermanence and change and my kicking and screaming attachment to the ways things "should get to stay." This has surprised me, as I have had to make many adaptations and changes as a result of events in my life, and none of those felt as difficult as the changes I am currently making. Asking how I apply my wisdom and experience to support my ability to make a living has felt somehow less legitimate or acceptable than changing and growing as a result of what happens to me personally. Why is that? How do I support myself in this struggle?

We want to help our clients develop and grow, and if we don't talk about difficult things with them, we miss that opportunity.

As the first rumblings of healthcare reform were on the horizon two years ago and I grappled with this problem, one adaptation I made was to return to seeing couples, a client base that is willing to, and often must pay out of pocket. Since graduate school I had only seen couples as parent pairs in my parent coaching practice. I was immediately anxious and hesitant, feeling rusty, unsure about my skills, and out of practice. But bigger than these fears was my lingering reluctance to change my way of practice; adding couples to strengthen my business felt wrong somehow. I believed my identity as a social worker would be compromised by my pursuit of clients in the name of financial stability. The notion of social worker as business person felt like a contradiction. The process of reconciling my identity as helper AND businesswoman has been long, but the adaptation and acceptance has strengthened my practice in many ways.

As I began seeing couples again I immersed myself in intense training so I would be grounded in the newest theories and approaches of Couples Therapy (thanks to the brilliant Stan Tatkin!). Then my fears about actually providing this service dissipated. I remembered the unique challenges of being in a romantic dyad and how one counseling skill set can transfer to and enrich a new set. Seeing couples has deepened my individual and family practices and vice versa. I was excited and enlivened by studying, applying a beginner's mind and a student's eagerness to everything I did. Now I am happily enjoying the couples I see, as well as my new identity as a Couples' Therapist. Yet the questions of the origin of this adaptation still dogged me. I still felt nagged by guilt and anger that my hand had been forced into this change. That led to exploring other adaptations I have made over the years, thinking about whether they have been positive, and if so, how this is adaptation is different.

I have expanded my work multiple times over the eight years I have been in private practice. Originally a Child and Family Therapist, I found the blending of personal and professional roles too close when my daughter became the same age as many of my child clients. I closed my practice to new individual children and moved my focus to adults and families. I felt no hesitancy or guilt over this change.

Following my brother's successful treatment of what was initially a terminal cancer diagnosis, I began encouraging referrals from people facing similar health challenges. In this case personal experience deepened an interest and skills in working with seriously ill and dying people. I intentionally adapted and expanded my practice, pursuing a new interest in

which I felt confident in my ability to join my personal and professional experiences in order to serve people. Why was adding couples therapy different? What was wrong with blending my need for financial stability with this professional challenge?

Two years into my renewed Couples Therapy practice and a year into changes in healthcare reimbursement, the question of how and why I adapt and change is answered in a parallel process, revealing itself whenever I pay close enough attention. In both examples of making a change in my professional life after a challenge in my personal life, the personal events caused unanticipated ripples. Many personal challenges that have impacted my professional self were both unwelcome and unexpected, yet they often brought incredible growth. And as I struggled with 'unwelcome' changes to healthcare reimbursement, my clients brought similar struggles they experienced in their own 'unwelcome' challenging circumstances.

Through mindfulness and the psychobiological approach to couples work I learned from Stan Tatkin, I help clients learn to work with what IS, trying to optimize happiness in the face of difficult circumstances. We work to understand the challenge of accepting what they can make out of their current lives using the skills and supports they have in place. So once again it is through my work with clients that I gain the perspective I need in my own life and work. As our clients' must, we too need to adapt to challenges in order to grow, or face the possibility of stagnation, or even regression.

In thinking about my own challenges I see that change comes painfully and often reluctantly. As with our clients, we often cannot see the end point of our struggle; how can this have a happy ending? Health care changes, while bringing much struggle and difficulty, do promise a more equitable health care system in the end. As social workers, of course we support the opportunity for more people to have better healthcare, even if it means we may make less money as providers. At the same time, the ability and willingness to flex and adapt my practice has been painful and difficult, and will likely remain so for a time. But I already feel the growth occurring as I learn to have healthy, open discussions with clients about financial arrangements, speak more confidently about my work, and broaden my knowledge and comfort with new types of clients. I cannot yet say that I happily embrace, or even accept all the changes to the structure of private practice in mental health. But I fully embrace the necessity and wisdom of being an active participant in the changes, and I am working to own my changes and adaptations toward growth.

Ethics

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taking responsibility for not discussing it previously and sharing your realization of how important resolving the issue is to your working agreement and mutual respect, will likely strengthen the therapeutic relationship.

Like most ethical issues, there is not one right answer for how to address financial issues with a client. There are several things to consider, the most important of which is talking about it. Part of our job is to model for our clients the importance of talking about difficult topics and the ability to "survive" when we do. As one member put it, "We want to help our clients develop and grow, and if we don't talk about difficult things with them, we miss that opportunity."

NEW MEMBERS

The Membership Committee wants to welcome these new and returning members (since 9/1/12). We look forward to meeting and getting to know each one of you.

Sue Anderson
Zane Behnke
Shellie Black
Victoria Chaudhry
Kathyrn Chociej
Robin DeBates
Vivian Dinnel
Erika Falit-Baiamonte
Danny Gellersen
Phaleen Hanson
Michal Keidar
Kendra Koeplin
Paula Lehman
Jenelle Limbeck
Dawn Merydith
Carole Milan Davis
Susan Moini
Sharon Perry
Kim Richan
Mary Roy
Kathy Shimada
Daniel Sorenson
Diane Broderick Stuart
Norma Timbang
Susan Weisberg

MEMBER PROFILES:

By Sukanya Pani

Kathyrn Kemp Chociej

Kathyrn Kemp Chociej is the Shelter Manager at a confidential domestic violence shelter of the Domestic Abuse Women's Network (DAWN) in South King County, Washington. She is a third-year MSW student at the University of Washington, Tacoma, and is interning with Gender Diversity (http://www.genderdiversity.org/). This follows an 18-year career in corporate communications for Fortune 100 companies.

Her focus is on gender justice issues. While she was an intern at the Veterans Administration Medical Center, she helped start a support group for transgender veterans. Her capstone is focused on cross-systems interventions for gender variant youth and their families.

When she is not advocating for others, she loves to laugh, have dance parties with her kindergartner, and garden.

Kim Richan

Kim Richan worked in Democratic politics, mostly in Washington DC, but also around the country, managing political campaigns before becoming a clinical social worker. The two most important aspects of her work were to network with stakeholders and constituencies and to manage communications for candidates and Members of Congress.

Kim graduated from the UW School of Social Work in 2009 and took the unusual step of opening her private practice right after graduation. Relying on her communication and networking skills to speak to prospective patients and referral sources about her approach and how she might help, Kim built her private practice quickly. She now advises other therapists on how to start (or jumpstart) the marketing aspect of their practices.

Kim now has a psychodynamically oriented private practice in the Madison Valley neighborhood of Seattle and feels grateful every day she is able to do this humbling work.

EVENT OF THE YEAR!

The WSSCSW Party

Wednesday, June 6, 2013

6:30 to 9:00 PM

ALL MEMBERS ARE INVITED

We will have a free catered dinner, a chance to meet old friends and make new ones, recognition of our great volunteers, the Honorary Member Achievement Award, and more…

Exciting venue to be announced

CALENDAR OF EVENTS

The WA State Coalition of Mental Health Professionals and Consumers and WSSCSW are collaborating to bring you the popular conference:

"I GOOGLED YOU!" STAYING CLINICALLY CENTERED IN AN ONLINE WORLD PRESENTED BY LAURA GROSHONG, LICSW

Saturday, April 27, 2013
9:00 AM to 4:30 PM

Almost everyone in the world today, including mental health professionals, has some kind of online identity. Mindful crafting of our online identities is crucial to developing solid treatment relationships in which treatment boundaries are maintained. An awareness of the meaning of Internet communication with clients is also necessary. What has come to be known as "social media," or websites which allow people to discuss in varying levels of detail their personal and public lives, has changed the world.

For more information about the conference and how to register and pay online visit the WSSCSW Events Calendar For information and how to register manually, download and print the brochure: "I Googled You!" Staying Clinically Centered in an Online World

WSSCSW and The WA State Coalition of Mental Health Professionals and Consumers www.wsscsw.org

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Violent Death Bereavement Society and Washington State Society for Clinical Social Work present:

TRAUMATIC GRIEF AFTER KILLING WITHIN THE FAMILY: A DILEMMA OF DUAL ATTACHMENT TO VICTIM AND PERPETRATOR

Friday, May 10, 2013
8:00 AM to 5:00 PM

At the Washington State Criminal Justice Training Center, Burien

This training will present an in-depth picture of the long-term effects on remaining family members when one violently murders another. Featuring a foremost researcher on homicide, attachment and meaning making, training participants will learn about the complexities of working with this unique group of survivors while engaging in treatment discussions after viewing survivor interview case illustrations. Mental health providers, victim advocates and clergy professionals who work with these grieving survivors will collaborate with other group members to develop a staged evaluation and treatment strategy, interweaving resilience reinforcement as a prevailing influence for homicide survivors.

http://traumaticgriefafterviolentkilling.eventbrite.com/

BOARD RETREAT

Saturday, May 18, 2013
9:00 AM to 1:00 PM

A retreat for team building and program planning.

For committee members and Chairs
UW Tower, 22nd Floor

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