President's Message

Eric Ornstein

Just as spring has brought renewal to our natural world, our Society has renewed and rejuvenated itself through the creation of our new website. It is now up and running, and I strongly encourage you to check it out at ilclinicalsw.com. We have significantly improved the appearance, updated and expanded the content and made it more useful and user friendly for our members. With our new website, it will be much easier for members to renew their membership, and learn about and sign up for ISCSW workshops, seminars and conferences. I would like to once again acknowledge and thank Nikki Lively, our Public Relations and Marketing Chair, for her perseverance and hard work which made the new website a reality.

Our former board member, Geoffrey Magnus, has gotten our new website blog off to a tremendous start; by listing the books from the psychotherapy literature that he feels all clinical social workers should read. His list is particularly helpful in suggesting foundational texts to help us understand how to integrate cutting edge neuroscience findings with psychotherapy practice. I could not help noticing with a sense of pride and satisfaction that three of the authors he cites, Louis Cozolino, Allan Schore and Jon G. Allen, have been speakers at recent ISCSW conferences. This confirms my sense that we truly provide our members and the larger clinical social work community who attend our conferences, with excellent, highly relevant educational experiences that help them update their conceptual knowledge and improve their clinical skills.

Speaking of excellent conferences, I want to ask our members to save the date of Friday, June 26th. We are in the process of planning our Summer Conference. Our speaker will be Alan Levy, a social worker psychoanalyst who has been the Dean of the Institute for Clinical Social Work and an Associate Professor at the School of Social Work at Loyola University of Chicago. He will be speaking on the topic of "Enactment and Trauma", a presentation that I know our members will not want to miss. Please check our new website for more details and registration information.

We have just concluded our latest round of Jane Roiter Sunday Morning Seminars. This has been our most successful series of Seminars ever, in terms of the number of participants and the quality of our presenters! I want especially to thank Frank Summers, Ph.D., our final presenter, for his patience and flexibility in being willing to reschedule his presentation, which we had to cancel due to the 19 inches of snow that fell on February 1st. This was the only Seminar we have had to cancel and reschedule during the last 10 years!

Dr. Summers gave an outstanding presentation entitled "Living in the Dream". He used his encyclopedic knowledge of psychoanalytic theory to present a revised theory of dreaming, based on contemporary understandings of hermeneutics and existential phenomenology. He also suggested a revised approach to dream interpretation which emphasizes elucidating the patient's associations to their *subjective* experience of the dream, rather than focusing primarily on associations to the content of the dream. He provided evocative clinical vignettes which clearly illustrated the power and effectiveness of this new approach. His presentation was based on a chapter from his recent book, *The Psychoanalytic Vision: The Experiencing Subject, Transcendence and the Therapeutic Process,* which I highly recommend to our members.

The Jane Roiter Sunday Morning Seminar Planning Committee, which includes myself, Karuna Bahadur, Carol Crane, Margaret Grau, Mary Ann Jung, and Jane Pinsof, will be meeting over the summer to plan the next series of seminars. Please contact me at erico55@me.com if you have any suggestions for topics or speakers.

I wish all of our members an enjoyable and productive spring and summer and that our paths cross at upcoming ISCSW events and programs!

ISCSW Launches a New and Improved Website!

As some of you know, at our last networking event we provided a sneak peek of our new logo and newly designed website. The website was just in the infancy of its development at that point, but after rounds of design with the help of designer Steven Shay – Creative Director at ICrossing – web developer Tony Kim at Tony Kim Design (http://www.tonykimdesign.com/), and numerous contributions from Nikki Lively's husband, and from the ISCSW Board, we have finally gone public!

Our main goal for the new website is to have a place for members to interact with the Society and with each other. The website features a new "members only" section where members are invited to post topics on our discussion board, to post job opportunities, and to get materials from past conferences and Sunday Morning Seminars. We have also started a blog! Our first blog entry was contributed by Geoff Magnus, former Board member and regular contributor to our ISCSW *Newsletter,* in which he outlines what he believes are "must-reads" for all clinical social workers, whether students or seasoned professionals. **Please be sure to read Geoff's post and let us know what books you might add!**

We welcome other members to contribute blog posts on topics related to issues in our field. If you are interested in contributing a blog post, please contact Nikki Lively at nlively@family-institute.org). We also invite members to interact with blog authors by offering their comments online.

Elsewhere on the website are support resources featured to help professionals with their own self-care, as well as a variety of other resources for students and new professionals. We are in the process of creating a list of clinical social workers who specialize in providing psychotherapy to therapists. We all know that therapists need therapy too, and we hope compiling this list and having it available on our website will ease the burden of the search! If you would like to add your name to this list, or if you would like to recommend someone for this list, you can use our new website forms to contact us.

Our URL will remain the same, so you can still find us at: http://www.ilclinicalsw.com

We hope the website will enhance your membership experience, and that you love the new site as much as we do!

Nikki Lively

ORIGINAL CLINICAL ARTICLE

Supporting Caregivers:
Initial Reflections from a New Professional

David Javier Thompson

Introduction

My current patient, "Greg", and his caregivers, "Amy" and "Jack", had just arrived in the lobby. Greg had been transferred from the hospital's psychiatric inpatient unit to the partial hospitalization program where we were currently working together in order help the family better address his physical and verbal aggression towards himself and others.

After greeting them all and walking Greg to where the other patients were playing, I headed back out to the lobby. I had set up some toys in one of the consultation rooms earlier that morning to use during the play therapy portion of our family session, and asked Amy and Jack to follow me. Because patients only spent the morning and afternoon in our program each day, family sessions always started with a brief check-in on how the patients did at home. Unfortunately, between a series of tantrums, insurance coverage complications, medical concerns, and scheduling conflicts, quite a bit had happened by that morning. In turn, Amy and Jack both expressed feeling overwhelmed by the numerous elements they were juggling in order ensure that Greg could continue attending the program.

Previous family sessions and my individual work with Greg had highlighted some communication patterns between the family members that may have been factoring into his aggressive episodes. With the average patient admission to the program lasting two weeks and the central goal of restoring safety within the household through reducing the frequency of these episodes, the primary aims of our family sessions to date had been learning and then practicing new interaction and communication skills. However, the agitation and panic within the caregivers' words and their visible exhaustion that morning pushed for potentially expanding the family sessions to include helping Amy and Jack build and practice new coping tools. Additionally, the caregivers' distress and myriad of issues they were describing during this family session underscored the long-term nature of the challenges their family was facing. In turn, the program's relatively brief nature underscored the need for clinicians to keep their family sessions focused as a means of helping caregivers lay the groundwork for long-term success.

In another experience at a different organization, my first patient was already sitting in the interview room when I arrived. As part of the intake team for the refugee resettlement agency's psychotherapy and case management services, I had two 60 to 90 minute sessions to gather the information that the clinicians used in determining whether patients' needs would be best served by the agency's available services. The prospective patient, "Asil", was a 30-year-old Southeast Asian man who had been in the country for a few years working on a graduate degree. During our first session, I learned that he had filed for political asylum at the beginning of the current year due to being arrested and interrogated while on vacation in his home country during his university's winter break. Soon after filing for asylum, he then petitioned the government for his wife also to come to the country, and she was granted permission to do so. Asil also noted that their family had recently grown after the birth of their first child, a baby girl. During our first meeting, he voiced several concerns about his and his wife's asylum cases, what would happen to their daughter if they weren't allowed to stay in the country, and maintaining their daughter's connection to her heritage while growing up in a foreign country.

During our second intake session, Asil began describing some of the details from his interrogation. Immediately afterward, I realized we needed to do a torture-specific trauma assessment. The assessment included several targeted questions, and its impact relied heavily on the details provided by the patient and their specificity. In explaining this next step to Asil, I highlighted the important role that this information would play in securing the best services for him and his family, whether it was with our organization or another one with specialized services for individuals who had experienced similar trials. Answering several of the questions left Asil visibly shaken. While the information he was sharing would play a vital part in any treatment he received, his growing agitation and the pressures he described in our last session left me concerned about the impact our current meeting could have on his interactions with his family after leaving the office.

The two situations I have just described both left me wondering how to best support the family as a whole while also attending to the stresses faced by the caregivers. Working with siblings and cousins had shown that occasionally, when the older children consistently modeled how to regulate their emotions and adaptively interact with the environment, the younger ones gradually improved. This then led me to notion that spending additional time working on coping strategies and behaviors with caregivers could have similar impact on their children. The following pages will briefly cover the guiding frameworks and interventions that have proven helpful in testing this hypothesis over the past few years. The specific frameworks include systemic thinking, the person-centered approach to therapy, and the field of stress biology. The specific interventions include Parent-Child Interaction Therapy (PCIT), and the Collaborative and Proactive Solutions (CPS) model for problem solving.

Guiding Frameworks and Knowledge Base

One of my first clinical practice professors made a point of emphasizing that every person existed as a part of multiple interlocking systems, including a lone person at the top of a mountain. In turn, individuals were being constantly impacted by as well impacting the systems to which they belonged. Later, I learned that this professor's views fell in line with systems theory's view on families as being 1) comprised of components that are in constant transaction with each other, and 2) parts of larger ecological contexts that include a variety of other elements such as the geographical location, socio-political trends, and distribution of resources within a society. The interactions between these systems' components pushed for (re) establishing and maintaining their optimal level of functioning, also referred to as a *state of homeostasis* (Kaslaw, Bhaju, & Celano 2011; Nichols 2013). In turn, while instances of dysfunction served as cues that the elements within the systems were in conflict, these instances also presented opportunities for change through interventions.

In working to support caretakers in situations like the ones described in the introduction, adopting this systemic perspective required not only analyzing the function of their behaviors but also looking for the factors that created the context in which their behaviors made sense. With Greg's parents, this guiding framework pushed me to look at the larger context, which included their home, school, jobs, and neighborhood, in which their insurance complications, medical concerns, and son's tantrums existed. This systems viewpoint also pushed me to understand how these concerns and the caretakers' reactions to them were shaping these larger contexts in ways that might be exacerbating the family's current difficulties.

Asil and his family were members of multiple communities including their home country's growing refugee population and the host country's populations of asylum seekers, first generation immigrants, and new parents. What systems thinking brought to our work together was the need to ask about how he and his family were both impacted by and impacting these various groups and identities. Understanding the larger context in which Asil's worries and agitation existed helped provide a more detailed picture of the functions these emotions and reactions might be serving.

While systemic thinking fostered the desire to work toward understanding caretakers' surrounding ecologies and their roles within them, for me it lacked a guiding philosophy on approaching and learning from the direct interactions with patients. The person-centered approach to therapy pioneered by Carl Rogers and his students not only provided a foundation for understanding the interactions that occurred while working with patients, it also provided a lens on human nature that aligned with my research on human resilience. For instance, this person-centered perspective's core beliefs could be summarized as stating that humans possess a variety of resources that can be marshaled through the provision of genuineness, (radical) ac-

ceptance, and empathetic understanding, and then used to change existing patterns in thought and behavior (Rogers 1980). From this perspective, dysfunction arises out of individuals' responses to a disconnect between an aspect of their self-concept and their lived experience. This is often characterized as a battle between what "I should have done/thought/etc." and what "I actually did/thought/ etc." (Bohart & Watson 2011). For instance, Jack, Amy, and Asil all expressed frustration, anger, loss, and disappointment around what they perceived as their faulty parenting skills that contributed to their families' current issues, causing them to feel that if they had just been stronger, better prepared, or wiser and done what they should have as "good" parents, they would have figured out how to best provide for their families.

Turning to growth and full functioning, the person-centered approach sees them as occurring when people become increasingly open to experience. This journey entails one being willing to test her or his ideas and beliefs against lived experience and then learning from the dialogue with themselves and the surrounding environment that results from these tests (Bohart & Watson 2011). Despite the missteps and setbacks that occur in peoples' lives, person-centered work believes that people will continue to progress naturally toward "a more complex and complete development" (Rogers 1980, 118) even if that trajectory becomes somehow warped. This progression is often referred to as the *self-actualizing tendency*.

As in the cases described in the introduction, I often worked with caretakers under time-limited circumstances. Adhering to these beliefs around humans' inherent progression away from dysfunction in turn emphasizes the importance of eliciting and then prioritizing the caretakers' views on their current situation and then incorporating that information into any interventions. In working with Greg's caregivers, this entailed providing them the needed time and space for voicing the frustration with their and their son's behaviors and fears about what might happen if they were not able to change the situation. This information then provided specific targets around which to build and assess our work. When working with Asil, following this perspective entailed taking time during the intake assessment to acknowledge the challenges he and his family faced as well as their consequences, while also asking about what had helped them to survive these trials. His answers provided additional information that would help

agencies and clinicians to better assess their ability to support the family's specific needs and to tailor their services appropriately.

With this philosophy guiding my assessment of the caretakers' surrounding environments and direct interactions with them, I needed a lens that could help focus the families' presenting issues and their consequences. Because several of the families with whom I worked were facing various traumas and losses, the growing field of stress biology provided a knowledge base of evidence-based research upon which to draw when conceptualizing the individual, systemic, acute, and chronic repercussions of these peoples' experiences.

The body's ability to initiate instantly a cascade of physiological processes in response to actual (*e.g.,* the smell of freshly baked cookies) and perceived (*e.g.*, the risk of doing poorly on an exam) stimuli helps the individuals respond to these changes in the surrounding environment. For instance, the controlled release and containment of hormones, sending of electrical signals throughout the body, adjustments in blood flow and oxygen as well as muscle tone, and other changes that occur prepare the body to respond at a moment's notice (Barrett & Fish 2014; Sapolsky 2004). However, prolonged or constant activation of these changes can steadily degrade their effectiveness and impact the overall functioning of other systems in the body. For instance, studies with survivors of natural disasters, war, neglect, abuse, intimate partner violence, and other endangering circumstances have shown how their resulting stress can adversely impact the body's immune functioning, hormonal cycles, blood pressure levels, growth, sleep cycle, fight-flight-freeze response, and other core functions (Barrett & Fish 2014; La Greca, Silverman, Vernberg, & Roberts 2002; Sapolsky 2004). While the body is able to adapt and continue functioning, consequences such as heightened blood pressure, chronic sleep disturbances, lasting physical and mental fatigue, and a less effective immune response can predispose an individual to experiencing continued stress that may exacerbate the situation.

The concerns about their children's behaviors, challenges they face in trying to care for their families, and the task of navigating the expectations of the mental health care system all place significant strains on many of the caregivers with whom I work. In turn, many of these caregivers have also experienced some of the challenges that

can arise from constantly taxing their body's natural stress response system. In supporting them during our work together, the insights provided through knowledge of stress biology provide the grounds to advocate for mind-body inclusive interventions, as well as to provide psychoeducation on these systems when it proves useful to the families and their understanding of the challenges they are facing.

In sum, systemic thinking's emphasis on gathering information from families about their surrounding context can help in establishing the checks and balances for testing the relevance and long-term potential for change of possible interventions. The person-centered approach's privileging of patients' knowledge and view that adaptive functioning hinges on expanding one's ability to respond to new information provides distinct value in helping clinicians shape and evaluate their work with patients. Lastly, stress biology's knowledge around human functioning and development provides additional insight into the lasting consequences of families' surrounding contexts, as well as the events that occur on the trajectory toward self-actualization.

Helpful Interventions:
(Re)building Communication

The frameworks in the last section provided a knowledge base and a set of complimentary philosophical viewpoints that stressed the crucial role that verbal and non-verbal exchanges play in the health of families. Accordingly, the interventions that I will discuss that have been the most effective in helping caregivers model beneficial skills and behaviors for their children all focus on improving interpersonal communications.

The first intervention is Parent-Child Interaction Therapy (PCIT). In essence, PCIT teaches parents a specific set of developmentally appropriate interaction and disciplining skills *via* once-a-week *in vivo* sessions during which a therapist watches the family playing, provides targeted feedback to the caregivers on their use of the specific skills, and rates the caregivers' performance. Affirmations, praise, enthusiasm, and active engagement in the children's play form the heart of the interaction skills while appropriate limit setting, time-outs, and reinforcing the desired behaviors form the heart of the disciplining skills. Between coaching sessions, caregivers are required to complete homework assignments designed to help them master each distinct set of skills. The program was de-

signed to help address oppositional behaviors in children between the ages of two and seven and lasts between 14 and 16 weeks (Eyberg 2009; Nieter, Thornberry, & Brestan-Knight 2013).

While the short-term nature of each service and the limitations on the resources available at each agency prohibited working through a full course of PCIT with caregivers, there were still opportunities to teach caregivers the interaction skills and then provide coaching and feedback during play- oriented family sessions with their children. In the family session with Amy and Jack after the one described in the introduction, introducing PCIT provided them with a set of concrete skills they could practice and goals that they could work towards with their son, Greg. In order to do this effectively, his caregivers recognized the need to build new coping skills to help regulate and channel their personal frustration and exhaustion. These simultaneous tasks of working together with Greg and also working on their own challenges helped relieve some of the caregivers' anxieties because both jobs ultimately aimed to foster long-term changes that would benefit the family as a whole.

Turning to Asil, while his daughter was too young for PCIT at the time, exploring how the intervention's recommended communication strategies may or may not have fit with his personal beliefs as well as his culture's views on parenting might have still proven fruitful. For instance, the resulting conversation could have provided additional information for my assessment report to the agency's clinicians as well as Asil's understanding of some ways in which this country's mental health system and its professionals may approach parenting practices. Additionally, providing an overview of PCIT's interaction and discipline strategies may have also provided the information he needed for adapting them in ways that worked best within the context of his family and larger communities.

The second intervention that has proven helpful is the Collaborative and Proactive Solutions (CPS) model for problem solving (Greene 2014). The approach is based on two core philosophies: 1) kids do well when they can, and 2) they do not do well because the current situation is requiring them to use a skill or set of skills they do not possess in order to succeed. Thus, CPS stresses that parents' roles need to expand from being the (re)enforcers of expected behaviors to being the detectives working to identify and then help their children build these missing skills

(Greene 2014). The model then delineates a three-step process known as Plan B for families to work through in order to identify the issues that might be contributing to the current crisis and then come up with potential solutions. The opening portion, known as the empathy step, teaches caregivers to use reflective listening and other strategies in order to understand the situation from their child's perspective. The middle step, or stating the problem, focuses on helping caregivers express how the situation is impacting the child as well as others. The final portion, or the invitation step, invites the child to propose potential solutions and then work through their feasibility with their caregivers (Greene 2014). While Plan B focuses on helping children build critical thinking skills, hindsight, forethought, and the ability to compromise, it also works to help remove the power struggle that can result from parents imposing their solutions instead of effectively communicating with their child.

While CPS was not designed for a specific age range like PCIT, the intervention model's emphasis on spoken language means that the types of solutions created during Plan B conversations may vary widely based on the age and maturity of the child. Still, the process of working through all the steps of a Plan B conversation can prove helpful for children and their caregivers, and exposure to the process at a young age provides additional opportunities for everyone in the family to practice applying CPS' core beliefs and skills.

In trying to incorporate the CPS Model and Plan B conversations into their lives, Greg's caregivers encountered several challenges, in part because their son's episodes of verbal and physical aggression toward them were still occurring. They often asked how problem solving would stop Greg from hitting, kicking, and yelling. After framing that this model was one of many tools they could use and stressing that everyone's immediate safety came first, I emphasized that this problem solving process was designed to foster long-term results. For instance, the reflective listening, affirmations, open-ended questions, and other communication skills used by caregivers during Plan B's empathy step to understand the crisis from the child's perspective were meant to build more open and responsive communication patterns between family members. In this respect, Plan B also followed PCIT's aims of (re)building and supporting helpful communication between caregivers and their children through utilizing a specific set of inter-

action skills. Plan B's next step of stating the problem then encouraged parents to model for their children the critical thinking skills involved in understanding the impacts their actions have on themselves and others. Lastly, inviting Greg to suggest solutions and then working through their feasibility together in Plan B's last step provided opportunities for family members to practice weighing different options and compromising. With practice, these skills could help Jack and Amy learn to consider the consequences of Greg's actions and try out potential solutions for the issues that triggered his aggression.

As the intake therapist working with Asil, I had to prioritize gathering the information that the therapeutic and casework service teams needed to make a well-informed decision on if and how the agency could address his and his family's needs. Additionally, the complexity of the challenges he disclosed over the course of the intake interviews required utilizing our time and combined resources to help monitor his emotional state and de-escalate him if needed in order to support Asil and his family's safety. With that said, if time had permitted, introducing CPS' core philosophies and communication skills could have been helpful because they detail very specific views on caregiver-child communications. Because a growing number of professionals, programs, and patients within mental health care are also supporting these particular views, knowing the details as well understanding reasons why these various groups are endorsing them could provide valuable information on how some providers may react to similar and different views on parenting.

In sum, PCIT and CPS share the goals of (re)establishing and then enriching caregiver-child communications and attachment. While both interventions use their own specific set of communication strategies to help families work toward this goal, the dialogues created by their techniques also provide opportunities for caregivers to model critical thinking skills, engagement, and compromising skills. As a result, while both interventions may initially target currently occurring behaviors and issues, they also work to foster long-term gains.

Conclusion

Supporting Jack, Amy, Asil, and other caregivers in times of crisis has continuously highlighted the importance of having a personal epistemology of development, change, and therapy and then finding interventions that strengthen and expand that foundation.

In turn, systemic thinking pushes one to look for the interactions between the various elements within patients' surrounding contexts and the many ways in which they weave together to form their lived experiences. Person-centered work's key central tenets of seeing patients as the authorities on their lived experience, seeing humans as naturally progressing towards their most complex and complete selves, and seeing the need to foster environments that support this natural progression, provides help to guide and anchor my direct interactions with patients and their narratives. Lastly, stress biology's systematic understanding of the cascade of consequences that result from a single action cultivates a deep appreciation for the relational and interactive nature of human experience.

Together, these complimentary frameworks all call for utilizing interventions that create and support the internal and external environments where the dynamism of lived experience ultimately supports individuals' growth. With communication's potential to mold physiology, intra-psychic processes, interpersonal relationships, geographic contexts, and socio-historic legacies, utilizing interventions that work to strengthen these vital elements like PCIT and CPS may help caregivers build knowledge and tools that allow them to create contexts in which they and their families can continue to grow. Additionally, even when experiencing crises like those faced by the caregivers in the introduction, effective communication skills may still help them access the resources and services needed to start alleviating the situation and continue moving forward.

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The Cutting Edge...

Reviews of Recent Literature

Brainwashed: The Seductive Appeal of Mindless Neuroscience. (2013). S. Satel & S. O. Lilienfeld. New York: Basic Books.

Having been trained in the neurosciences, I have been very excited about neurobiological approaches to psychotherapy. Before I read Allan Schore's *Affect Regulation and the Origin of the Self,* I had no coherent way of explaining what happens in psychotherapy to my patients or to anyone else. Even worse, I had no model of psychotherapy that made sense to me. Psychotherapy without a model can be a rudderless ship. Therefore, the neurobiological model of psychotherapy meant quite a bit to me. However, I didn't realize that while I was enthusing over this model, there was a cultural and commercial neurobiological movement afoot going in a direction that might raise real causes for concern.

I began to notice that some of the books by researchers I was reading were not only reporting on research, they were also selling the authors' wares. For example, while I was very impressed with Lieberman's *Social: Why Our Brains Are Wired to Connect,* I was bothered by his last chapter, which seemed to be an advertisement for his consulting firm.

Satel and the Lilienfeld point out that the neurosciences have made a premature entry into marketing, mental health and addiction policy, the detection of deception, and criminal law. The opportunity to make a buck by utilizing "neuroscience magic" has produced a lot of snake oil and medicine shows. I even know psychotherapists who advertise their wares by claiming to be using the latest neurobiological science. I am also frustrated, because many of those who are writing books on these new applications seem to be more interested in making money than anything else. Furthermore, because of the proprietary nature of their data, much of what they claim hasn't been peer reviewed, and they don't give enough information for the reader to make any judgments about what these authors are doing.

Given that, I've found Satel and Lilienfeld's critique of neuroimaging to be very enlightening. I love brain pictures, and I have often shown patients beautiful fMRI's to let them know what is going on in the brains of people with their same symptomatology. This allows me to share a graphic model of psychotherapy as well as the changes in cognitive and emotional processes that we can expect to occur in the course of our treatment. Patients often find this very useful. However, it is important for me to remember that these are not real pictures of real brains. These are drawings of the hypothetical brain space that show areas where there are statistical differences in oxygen consumption, either between people of different diagnostic groups or between people performing different experimental tasks. Satel and Lilienfeld show how, in some studies, authors look for specific differences in specific brain areas. In other studies, authors look for any differences that exist between different brains or brains in different situations. Sometimes, investigators only look for significant differences between patients in different situations.

Satel and Lilienfeld comment on how, if the computer is given a lot of data and sophisticated statistical programs, it will always find statistical differences, even if no differences really exist. To demonstrate this using an extreme example, author Craig Bennett put a dead Atlantic salmon in an fMRI. He "showed" the dead fish pictures of people and "asked" them to identify their expressions. That is, when he put a picture of a human face in front of the dead fish, he took an fMRI and compared it with a picture that he took

when there was no picture of a human face in front of the dead fish. He repeated this many times. There are random variations in the way the machine read the dead fish's brain. Putting these random variations into a sophisticated statistical program, he was then able to find one small area in the fish's brain that appeared to activate in response to the pictures. In other words, he showed that a statistical artifact can make it appear that there is a spot on the dead fish's brain that has responded to the task. He was able to identify a specific area in the fish's brain which lit up when it performed this task. He showed that the programs that are used in brain imaging studies can uncover differences that really don't exist. As an aside, he won the 2010 Ignoble Prize for this work.

As a social worker, I am totally unqualified and uninclined to analyze the methods used in the brain imaging studies. Therefore, I have a tendency only to accept results that fit my clinical intuition. If results that are contrary to my intuition are shown to be true, I have to go through a very thorough reevaluation of my thinking.

As Satel and Lilienfeld point out, a lot of statistical data can almost assure "significance" in any set of experimental data. When investigators in brain imaging do meta-analyses, they have access to the raw data of any study they review. Pooling this data can produce very pretty pictures and very high correlations between brain activity and clinical phenomena: many studies report correlations of .75 or above; and medicine is full of widely accepted correlations of .3 or lower. Examples of this are 1) the association between smoking and lung cancer, and 2) the correlation between cholesterol and heart attacks. Bennett was moved to do his experiment on the dead salmon, because he was suspicious of the high correlations that neuroimaging produces.

The pictures shown in brain imaging studies are not the pictures of anyone's brain. Likewise, pictures in brain imaging studies do not represent what happens in one person's brain. What these pictures do represent is a statistical analysis of many trials of many subjects, and in certain cases, meta-analyses from many different studies on many different subjects. The computer generates data in a three-dimensional space where there is a statistical difference in oxygen depletion. These positions are then drawn onto a stereographic map of a standardized brain. This is similar to applying lipstick by finding the average distances from the lips to the tips of the noses on 100 people and then using that average measurement from the tip of your nose to your lips to apply your own lipstick.

Of course, good experimental design and continuously improving techniques can make much of the data we get from brain imaging studies very useful. However, the graphic clarity of these pictures can be misleading. Several courts have ruled that these images cannot be shown to juries in "my brain made me do it" defenses, since such pictures create a sense of specificity and certainty that might be misleading to juries.

In their chapter on marketing, Satel and Lilienfeld point out that psychologists have always had a role in the field of marketing. In the 1930's, Ernest Dichter convinced General Mills to design a cake mix that required adding an egg in order to assuage a homemaker's guilt about using a mix. This was a very successful marketing strategy, and this was followed by decades of brouhaha about subliminal marketing.

In his work, Lieberman has demonstrated that in brain imaging, the medial prefrontal cortex lights up to a greater extent in a subject when he or she is shown an effective ad. The brain can tell an advertiser which of its brands are making an impression. It also has been shown that the medial prefrontal cortex lights up more when people believe they are tasting an expensive wine (rather than a cheap one), or Coke rather than Pepsi. This is good news for advertisers, since it demonstrates that perception of a product or positive emotional memories associated with a product correlate with enjoyment more than the actual taste differences. In another marketing experiment, it was shown that enjoyment of "the idea" of a product

correlates with activity in the nucleus accumbens, which is sometimes thought of as the pleasure center, while concerns about the cost of a product correlate with activity in the insula. I wonder if the next time I buy chocolate, the price will have been set because someone compared the activity of these two areas in a group of test subjects.

Since there is so much bigger money to be made in neural marketing, much of the experiment data is not published and is proprietary. I wish this were not so, since the same sort of data could be used to evaluate the short-term effectiveness of psychotherapeutic interviews. I am convinced that I have a very good sense of how my patients are responding to a session. However, there is data showing that there is almost no correlation between a therapist's perception of how well a session is going and the patient's perception of the session. Our field could use some help from neuroimaging studies.

I had a problem with Satel and Lilienfeld's treatment of the neurobiology of addiction. They point out that neuroimaging data has promoted the idea that addiction is a brain disease. This has made it easier for politicians to support funding for addiction research and treatment. However, the authors fear that this will encourage addicts to avoid taking responsibility for their own behavior. They even cite some lower court cases where alcoholics have tried unsuccessfully to use this "brain disease" theory as a defense. After years of learning from patients who are working 12-step programs, I am convinced that the idea that addiction is a brain disease and the consequent powerlessness this gives one over his or her addictions are very useful in dealing with addiction. I have used images of an alcoholic's brain responding to pictures of alcohol to demonstrate to patients the nature of alcoholic thinking.

On the other hand, their discussion of neuroimaging and the electroencephalographic methods in lie detection is interesting. Some of the newer methods in laboratory situations may have a sensitivity and specificity of 90%, as opposed to the 80% and 70% respec-

tively, for polygraphs. Even though polygraph data is not admitted in court, statistically it is as accurate as cross-racial witness identification, which is admitted in court. Satel and Lilienfeld cite the case of a woman in India who was convicted of murder on the basis of a new "certain" method of electroencephalographic lie detection. The case was thrown out when the same method showed that two other women were guilty of the same murder using the same technique.

Lie detection works best when the "guilty knowledge technique" is used. This is true of both old-fashioned polygraph and more recently discovered neuroimaging. Information about the crime is withheld from the public and the device measures the subject's emotional or cognitive reaction to these withheld pieces of information connected with the crime. Right now, neurobiology tells us more about the underlying *process* of recognition than of deception *per se*.

There is much that is potentially useful for psychotherapists to learn from research on deception. After all, understanding the neurobiology of truth and lies would involve understanding the neurobiology of constructing a narrative. Constructing a narrative is a very important part of almost any psychotherapy.

As an aside, the book's chapter on lie detection also includes the story of Charles Moulton, who invented the polygraph *and* created Wonder Woman. As a teenager, he was inspired in different ways by the images of early feminists chaining themselves to fences. Later, as an undergraduate at Harvard, he invented the polygraph. He then entered a long-term polyamorous relationship with feminist activist and Planned Parenthood founder Margaret Sanger's step-daughter and another woman. He is said to have based Wonder Woman partially on Sanger. Wonder Woman's "golden lasso of truth" is a fantasy version of his lie detector.

And finally, Satel and Lilienfelt's chapter on psychopathy is interesting, although I feel it unfortunately does not contain enough information to be clinically useful. It points out that currently we do not have

enough information to use neurobiological data meaningfully in criminal court. However, if it were ever to happen that we could gather enough information to characterize psychopathy neurologically but still have no way to treat it, we might be in a rather serious ethical dilemma.

All in all, the book is a very good read and a cautionary tale to people like me who are occasionally too glib in the way they use neurobiological data when talking about psychotherapy.

Geoffrey Magnus

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An all-day conference presented by

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Cultural Competence Platform...

This column was originally created by Henry W. Kronner, Ph.D., a current member of ISCSW and the former Cultural Competence Chair of its Board. As an Associate Professor at Aurora University School of Social Work, he encourages present and former social work students from his courses on Cultural Diversity to submit their writing and opinions here. In addition, as part of an effort to further our cultural competence and understanding, **we hope that all ISCSW members will consider contributing articles, essays and opinions to this** Cultural Competence Platform *column.*

Rethinking Cultural Competence* for Social Work

*The author considers this essay to be in dialogue with Laurence J. Kirmayer's essay,"Rethinking Cultural Competence".

Cultural competence is a guiding value for social work education and practice. The NASW lists cultural competence as an ethical responsibility, stating that social workers must develop "a knowledge base of their clients' cultures," "demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people," and "seek to understand the nature of social diversity and oppression" (NASW 2008). These adjurations touch on fundamental ideals of social work practice: a recognition that individuals and communities are embedded in broader contexts, a commitment to advancing social justice, and a belief in the importance of explor-

ing diverse perspectives (NASW 2008). Nevertheless, there remains ongoing debate as to what actually constitutes culturally competent practice and how it might advance the mission of the social work profession (Logan 2015).

Part of this debate reflects the diverse meanings of *culture*. The NASW defines culture as "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group." Contemporary anthropologists and cultural theorists – including McGill University professor of social and transcultural psychiatry, Laurence J. Kirmayer – challenge the notion that culture is universal, static, or inherent to any individual or group (Kirmayer 2012). Instead, the web of relationships and interplay of practices, forms of social organization, systems of meanings, and types of knowledge that constitute culture develop through interaction with broader environmental and social structures (Kirmayer 2012). In other words, culture is not a fixed attribute that can be learned; it is a practice that unfolds over time.

These theorists also emphasize the role of intersectionality in identity formation and culture (Logan 2015). Individuals maintain concurrent membership within multiple cultural communities (with varying degrees of public- and self-affiliation). For example, individuals may identify, or be identified, with communities connected by familial ties, professional membership, race, ethnicity, sexual orientation, class, disability, or shared interests. Practices and beliefs associated with the community groups may be context-specific, so that an individual enacts these cultural practices only in a particular time and place (Molinsky 2007). Far from an inherent or static characteristic, culture constantly fluctuates geographically and temporally as individuals and communities interrelate and adapt.

How does this idea of culture as practice correlate with the NASW's practice guidelines for cultural competence? The NASW (2001) defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations." The NASW's principles for meeting these goals include (1) valuing diversity, (2) having the capacity for cultural self-assessment, (3) being conscious of the dynamics inherent when cultures interact, (4) institutionalizing cultural knowledge, and (5) developing programs and services that reflect an understanding of diversity between and within cultures (2001).

Common approaches to enacting cultural competence in health care settings include sensitivity training to teach staff about cultural differences, matching clients with providers of similar cultural or linguistic backgrounds, and connecting with "cultural brokers" such as religious or community leaders (Kirmayer 2012). While these approaches can assist in developing interventions that account for differing social values, beliefs, and expectations, they can also have important limitations. Social service and mental health organizations have their own unique cultures; their practices are not value-neutral, ahistorical, nor inherently translatable across cultural contexts (Kirmayer 2012; Yan & Wong 2005). Cultural beliefs guiding social work practice can include notions about expert knowledge, what humans need to flourish, and particular understandings of how a person is shaped by his or her environment, to name a few.

Given that the cultures of a social worker and a client are multifaceted and unfolding practices, and that the profession of social work itself is characterized by its own evolving values and rituals, social workers must be wary of practices that reify particular dimensions of culture into static attributes. For instance, while matching clients with providers envisioned as sharing similar backgrounds may facilitate effective care in some instances, it may also privilege particular cultural dimensions as primary and risk neglecting diversity within cultural groups and within an individual client (Kirmayer 2012). Indeed, these

same challenges may be reflected in the experiences of professionals asked to act as a cultural broker for clients on the basis of some perceived aspect of their experience or identity (Kirmayer 2012).

How, then, can social workers engage with complex cultural phenomena in ways that advance the field's mission to enhance the well-being and meet the basic needs of all people? Drawing on frameworks developed by health care workers providing care to Maori communities in New Zealand, Kirmayer offers the notion of *cultural safety* as a possible contrast to cultural competence (2012). For Kirmayer (2012) cultural competence reflects notions of professional expertise in which practitioners accumulate and enact knowledge about identified cultural groups. Cultural safety goes beyond awareness of cultural differences to a focus on "analyzing the power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care" (158). As opposed to focusing on an enculturated "other," the cultural safety perspective tasks practitioners with "examining our own cultural identities and attitudes, and being open-minded and flexible in our attitudes towards people from cultures other than our own" (Australian Learning and Teaching Council, N.D).

This value of reflexivity is echoed in the NASW (2001) guidelines for cultural competence. In other words, cultural competence should reflect a methodology, not a body of expert knowledge about people or groups. This methodology requires that social workers assess our own systems of meaning, and the ways that these are shaped by social, historical, political, and economic circumstances that create power differences and inequalities in health and the clinical encounter" (Kirmayer 2012, 158). It also involves the core social work principles of "starting where the client is," the horizontal exchange of expertise, a humility and curiosity about a client's experiences, and the sharing of power in clinical decision-making. Through viewing cultural competence as a reflexive mode of engagement, social workers can advance their responsivity to the people with whom they work within the context of a dynamic and interrelated world.

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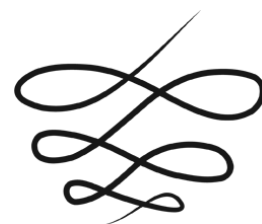
Policy and Legislation

There are several current policy issues which may affect you as clinical social workers or your clients:

- **Proposal for House Bill 4112:   Legislation for Crisis Intervention Teams (CIT)** This bill would create a standard training for Crisis Intervention Team (CIT) Training with the Illinois Law Enforcement Training and Standards Board. CIT programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness. For more information visit www.nami.org

- **Governor Rauner's Proposed Cuts to Human Services:** From NAMI http://il.nami.org/updates_&_alerts.htm

  Mental Health Cuts
  - $27M to psychiatry services
  - $16.2M to community specialized mental health rehabilitation services that divert people from institutional settings.
  - $5.5M to hospital inpatient services for people with serious mental illnesses
  - $3.6M for eligibility and disposition assessment services
  - $1.3M for integrated health care
  - $18.5M for care coordination
  - $9M mental health project reductions
  - $525K for individual placement and support
  - $167.1M to eliminate all DCFS services for youth 18-21

  Medicaid Cuts
  $1.4 Billion cut to Medicaid, making access to medical care more difficult
  - Elimination of the exemption for antipsychotics to the four drug limit
  - Elimination of adult dental services from Medicaid
  - $54.9M reduction in Medicaid managed care rates (which will filter down to provider payment cuts)
  - Elimination of podiatry services
  - Rate cuts to hospitals, nursing homes and supportive living facilities
  - Rate cuts to ambulance providers
  - Rate cuts to child psychiatric hospitals

If there are any other policy issues affecting clinical social work that you're interested in sharing and/or learning about, please email Christina James at chrissiebjames@gmail.com.

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