

Clinical Update

California Society for Clinical Social Work



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INSIDE Update

Theories of Aging and Their Relationship to Social Responsibility
By George Rosenfeld, PhD

Page 1

District Meetings

Page 2

Cartoon

Page 5

Legal Services Open Enrollment

Page 6

Kids, Safety, and the Digital Funhouse
By Robert Weiss LCSW, CSAT-S

Page 7

BOOK REVIEW

Unlearning Meditation: What To Do When The Instructions Get In the Way

by Jason Siff

Reviewed by Bill Cooper, LICSW

Page 13

Classifieds

Page 15



Theories of Aging and their Relationship to Social Responsibility

By George Rosenfeld, Ph.D.

The elder years invite a struggle to balance the seemingly divergent priorities of caring about oneself and caring for others. We could spend our final years predominantly devoted to past and present personal concerns and gratifying personal desires. However, we can also include a socially responsible concern about the impact of our actions on others and the environment. Buying, traveling, eating, working, volunteering, socializing, spending time with family, investing, using health care, dying, disposing of the body, dispersing financial assets, can all be done with different ratios of self-interest to social responsibility.

Elders face developmental challenges.

Major theorists of aging describe a complex interrelationship between concern for self and others. They suggest that elders need to overcome personal obstacles before they can attend to others, and that focusing on others can help free them from a preoccupation with personal problems.

Erik Erikson (1) emphasized the challenge in old age of resolving past issues. He proposed that integrity and generativity come to people who feel more comfortable with the mistakes they made and how they dealt with the possibilities that came their way. Erikson thought that older adults who cannot successfully manage their regrets might wallow in feelings of dissatisfaction, remain absorbed in their past failures, and continue to be unable to use their strengths to benefit others. At the same time he observed that participating in socially responsible activities could contribute to diminishing despair and regrets.

Robert Peck (2) emphasized the need of many elders to master present challenges. He focused on three developmental tasks. First, those in old age may need to redefine themselves in ways that do not relate to their occupations. The under-employed and retired face a "re-wirement" and need to create a new dream for themselves. Second, elders need to cope with limits in physical capabilities. And third, elders must struggle with their looming death.

Daniel Levinson (3) also emphasized overcoming death anxiety before growth and development could take place. He theorized that as people experience the illnesses and

Continued on Page 9)



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OFFICERS:

President

Leah Reider, LCSW
(650) 325-5867

lreider@clinicalsocialworksociety.org

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(916) 278-6809

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nunger@clinicalsocialworksociety.org

DIRECTORS

Ellen Eichler, LCSW

(619) 692-4038, Ext 3

eeichler@clinicalsocialworksociety.org

Conrad Fuentes, LCSW

(949) 437-0006

cfuentes@clinicalsocialworksociety.org

Joan Haller, LCSW

(650) 347-4089

jhaller@clinicalsocialworksociety.org

Ruth Jaeger, LCSW

(415) 924-0122

rjaeger@clinicalsocialworksociety.org

Alicia Outcalt, LCSW

aoutcalt@clinicalsocialworksociety.org

(858) 344-9440

Laurel Quast, LCSW

(707) 571-1714

lquast@clinicalsocialworksociety.org

Jean Rosenfeld, LCSW

(916) 487-8276

jrosenfeld@clinicalsocialworksociety.org

Dolores Siegel, LCSW

(559) 278-7279

dsiegel@clinicalsocialworksociety.org

Nancy White, LCSW

(916) 335-2150

nwhite@clinicalsocialworksociety.org

Mentorship Committee Chair

Nina Unger

(916) 717-8579

nunger@clinicalsocialworksociety.org

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DISTRICT MEETINGS:

GREATER LOS ANGELES DISTRICT:

Coordinator: Lynette Sim, MSW BCD

Coordinator Phone: 310-394-7484

Coordinator Email: simlcsw@verizon.net

Date: Saturday, November 16, 2013

Time: 10:30 to 1:00

Presenter: Wendy Douglas, LCSW

Topic: **Working with High Risk Patients in Today's Cyberspace World**

Location: 3267 Corinth Ave, Los Angeles, CA 90066

RSVP: Judy Messinger, 310-478-0560 or messingerlcsw@yahoo.com

High-risk patients, often those with Axis II disorders, have always been difficult to manage but the internet poses new challenges for psychotherapists. Clinicians have said "I used to be worried about a malpractice suit now I am worried about a bad Yelp review". This panel presentation will explore how access to your personal information and negative consumer reviews can impact psychotherapy with patients and your practice.

Participants will:

1. Learn at least two ways patients may gain access to therapist's personal information through the internet and how this information can put therapists at risk.
2. Be able to name at least two strategies to minimize the disclosure of personal information on the internet.
3. Will be able to identify at least three strategies for avoiding and managing negative reviews posted by patients on blogs and consumer review sites.
4. How to conduct a sound clinical practice while being mindful of the very real threat the internet can pose.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are \$10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

GREATER SACRAMENTO/DAVIS DISTRICT:

Coordinator: Nathan Stuckey

Coordinator Email: NStuckey13@gmail.com

Date: November 16, 2013

Time: 9:30 am till 12:00 pm

Presenter: Michael Rogers, LCSW, BCD

Topic: **Medication Management***

Location: Friends Meeting House, 890 57th Street, Sacramento 95819

*THIS PRESENTATION IS NOT A REVIEW OF THE BIOLOGICAL MECHANISMS AND PSYCHO-NEUROLOGY OF PSYCHOTROPIC MEDS!

This presentation will share what I learned from Kia J. Bentley PhD's articles (and her Social Work Podcast interviews) about clinical social workers' role and scope of practice related to their client's psychopharmacology.

(Continued Next Page)

DISTRICT MEETINGS: (Cont'd)

GREATER SACRAMENTO/DAVIS DISTRICT: (Cont'd)

Her ideas challenge the training of older clinicians and fit well with more newly trained clinicians originally trained in the Recovery Model. This interactive presentation will create a safe space where we can identify our biases about meds to ensure they do not interfere with our client's autonomous choice about taking them.

Come prepared to make art and share its meaning.

Michael Rogers, LCSW, BCD graduated from UNC-Chapel Hill in 1980 and has predominantly worked with children living in poverty and their families. He now works at CSUS' CAPS program treating college students during the academic year to facilitate his being a PhD fellow at Smith College's School for Social Work.

This course meets the qualifications for 2 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are \$10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future meeting: 1/18 Paul Smith, **Adult ADD**; 2/15 Dr. Andrew Bien, **DBT for Wellness & Recovery**; 3/15 Peter Cole, **Gestalt**, 4/19 – **To be Determined**; 5/17 Nathan Stuckey & Michael Rogers, **Impulse Control Disorders**

MID-PENINSULA DISTRICT:

Coordinator: Virginia Frederick LCSW
Coordinator Phone: [650-324-8988](tel:650-324-8988)
Date: Friday, November 15, 2013
Time: 12:20-2:00PM
Presenter: Stephanie Brown, PhD
Topic: **SPEEEEEEEED!! Wired UP and Hooked on Fast**
Location: Stanford Department of Psychiatry, 401 Quarry Road, Room #1206

Society has lost control. Many in the culture are living in a chaotic, frenzied downward spiral of a new addiction, chasing money, power, success and a wilder, faster pace of life. How can society be addicted, and what is the impact on our understanding and treatment of the individual, couple and family who must live and work in a culture that is out of control? Stephanie will review her developmental model of addiction and present her new work on American culture's addiction to FAST. She will outline implications for therapists and therapy in out patient treatment settings.

Stephanie Brown, PhD is a clinician, teacher, author, researcher and consultant in the field of addiction. She founded the Alcohol Clinic at Stanford University Medical Center in 1977 and served as its director developing the dynamic model of alcoholism recovery and its application to the long-term treatment of all members of an alcoholic family. A licensed psychologist with over 35 years of clinical experience, she is an internationally recognized expert on the trauma and treatment of alcoholics, all addicts and their families, and is especially well known for her pioneering work in the theory and treatment of adult children of alcoholics. She lectures widely, maintains a private practice, and directs the Addictions Institute, an out patient clinic, in Menlo Park, California. She has finished a book on addiction to speed - the fast pace of life - in the culture to be published by Penguin in 2014

Programs this year: January 17 – Paul Tang MD -- **linkAges: An Innovative, Multigenerational Program That Activates and Engages Community To Support Aging in Place** (Dr. Tang is the Vice President, Chief Innovation & Technology Officer for the David Druker Center for Innovation at the Palo Alto Medical Foundation), February 21 – Sharon Covington LCSW – **Reproductive Loss, Suffering and Resiliency**, March 21 – Clara Kwun LCSW – **Clinical Sensibilities as Seen by A Social Work Analyst**, April 18 – Laura Gomez LCSW and a team from the Palo Alto VA -- **Returning Veterans and Their Issues**, May 16 – Greg Bellow PhD and Elise Miller PhD – **Clinician's Challenges of Writing for Publication**. Greg Bellow's new book is "Saul Bellow's Heart"

Continued on Next Page

NAPA SONOMA SOLANO DISTRICT:

Coordinator: Linda Park
Coordinator Phone: 707-795-7590
Coordinator Email: lpark41@sbcglobal.net
Date: November 15, 2015
Time: 12:00 to 1:30
Presenter: Linda T. Walsh, MFT
Topic: LifeWorks of Sonoma County
Location: 3554 Round Barn Blvd, Santa Rosa

LifeWorks of Sonoma County is a non-profit mental health agency. Founded in 1996, LifeWorks is recognized and regarded as a leader in providing high quality mental health services and education to support healthy, positive outcomes for the members of our community. For the past 17 years, we have provided help to...

- Families with substance abuse issues in our Choices for Change Program.
- Children, adolescents, and adults in need of therapy in our Counseling Center.
- Gang impacted youth and their families in our El Puente Program.
- Emotionally Disturbed School-aged children in our School-Based Counseling Program.
- Children with behavior challenges in our LifeWorks Behavioral Services Program.
- Adults with Asperger's Syndrome or Nonverbal Learning Disorders in our Transitions Program.

SAN DIEGO DISTRICT MEETING:

Coordinator: Ros Goldstein
Coordinator Number: 619-692-4038 Ext 3
Coordinator Email: rosg@jfssd.org
Date: Thursday, November 7, 2013
Time: 5:30 pm till 7:30 pm
Presenter: Paul Hartsuyker, MFT
Topic: **Dreams, Our Invitation into the Unconscious**
Location: Jewish Family Services, 8804 Balboa Ave, San Diego, CA

The focus will be on dreams, as a way to understand all aspects of unconscious process, dream or not, with emphasis re-directed on response and questions from the attendees. I will begin with a general overview and will reference the creative arts and their usefulness in treatment

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are \$10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

Future meeting: December 5th, Meet and Greet and Network

SAN FERNANDO VALLEY DISTRICT:

Coordinator: Tanya Moradians
Coordinator Phone: 818-783-1881
Coordinator Email: tmoradia@ucla.edu
Date: Sunday, December 18, 2013
Time: 10:00 to 12:00
Presenter: Kim Cookson, PsyD
Topic: EMDR and Traumatic Events

(Continued on Next Page)

SAN FERNANDO VALLEY DISTRICT: (cont'd)

Current neurological research has made it increasingly clear that trauma plays a significant role in the development of negative, distressing symptomology. Trauma presents with a wide spectrum of symptoms, from Post Traumatic Stress Disorder to phobias, somatic pain, and intense experiences of anxiety and depression. Eye Movement Desensitizing and Reprocessing (EMDR) is an evidence-based treatment for PTSD. It has also gained a wider acceptance as a powerful treatment for anxiety, depression and a wide range of other complaints. EMDR works to support our natural information processing system, which can become stuck or dysfunctional due to the overwhelming effects of trauma. This talk will introduce you to EMDR. You will learn about how trauma interrupts normal processing, and how EMDR facilitates the reinstatement of normal processing. We will also look at ways that EMDR can enhance the internal resourcing of clients. Through case example, I will describe the general structure of the EMDR protocol, and how it works to facilitate the resolution of a client's negative symptoms following a traumatic event.

Kim Cookson received her doctorate from the California School of Professional Psychology in 2002. Kim Cookson is a licensed psychologist, certified EMDR therapist and a facilitator for the Trauma Resource Institute. She is currently the **Trauma Training Director at the Southern California Counseling Center** and has brought EMDR training to the Center's advanced interns and supervisors.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are \$10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.



California Society for Clinical Social Work

Open Enrollment for Legal Consultation Services
October 15 through November 13, 2013



Did you know CSCSW is now offering a free 15 minute legal consultation?*

Each member is entitled to a 15 minute consultation with Myles Montgomery, JD, LCSW per membership.

In addition for an additional \$25, you will be eligible for a 1 hour legal consultation* This benefit gives the member a one hour legal consult with Myles Montgomery, JD, LCSW to be used anytime in the membership year. This can be used in conjunction with or separately from the 15 minute free consultation available to all members.

Finally, All CSCSW members are eligible for Reduced Legal Fees: CSCSW has contracted with Myles Montgomery, JD, LCSW to provide legal consultations for a reduced fee of \$275/hour for all members. This is considerably less than the standard rates now being charged.

Members also have access to our **Legal Forum** (an online discussion group) in which they can post questions which will be networked with our members for responses and have ongoing discussions with other members. This forum will be facilitated by Myles Montgomery, JD, LCSW.

To purchase this coverage, please call Luisa Mardones or Cindy Esco at 916-560-9238.

MEET MYLES MONTGOMERY



Myles is an LCSW practicing in Davis and Sacramento. In addition to social work, Myles routinely practices probate law. Myles began working as a high school English teacher but quickly realized he was more interested in working with group dynamics and individuals. Consequently, he graduated from Sacramento State with an MSW in 2003 and went on to work for Children and Family Services in Yolo County. Throughout the MSW program, Myles became increasingly interested in policies, which effect larger groups of people. This interest prompted him to apply to McGeorge School of Law in Sacramento. Myles graduated and became a member of the California State Bar in December 2010.

Today, Myles looks for ways to build bridges between the areas of social work and law, and is a Board Member of California Society for Clinical Social Work.

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Kids, Safety, and the Digital Funhouse

By Robert Weiss LCSW, CSAT-S

Editor's Note: You may want to share this article with your clients

Life Online

Kids today engage with digital technology almost constantly. One well-researched estimate suggests children between the ages of eight and 18 spend 11.5 hours per day engaged with their phones, computers, laptops, pads, gaming consoles, televisions, and other devices. As most kids are awake only 15 to 16 hours per day, somewhere between 71 and 76 percent of their day is digital. For most parents, this statistic is almost unfathomable. As such, it is hardly surprising that adults sometime worry about their children's online wellbeing. For the most part these fears are overblown, but that does not mean they are ungrounded. After all, with the increasing sophistication of online search engines it has become incredibly difficult to monitor and/or police kids' online travels. And with the advent of GPS-enabled apps, it's getting more difficult by the day for kids to maintain their personal privacy, especially when they don't always understand the need for it.

The most common tech-related parental fears are listed below.

- **Stranger Danger:** Although the vast majority of online interactions are benign, there are at least a few predators lurking in the digital shadows. Typically such predators seek kids who appear vulnerable to seduction, usually teens who post sexually provocative pictures or videos of themselves or others.
- **Porn:** In today's world, if a child is curious about sex, all he or she needs to do is hop onto the Internet. Porn of every ilk imaginable is available to anyone, anytime, on virtually any digital device. Even kids who aren't actively seeking porn can easily stumble across it. Recent research suggests the average age of first exposure to online porn is now 11.
- **Sexting:** The digital cameras routinely incorporated into laptops and smartphones make it incredibly easy for a child to impulsively snap a provocative photo or video and send it to another

person. And once that photo or video is sent, the child loses all control over it.

- **Cyberbullying:** The deliberate, repeated, and hostile use of digital technology is a new form of childhood torture. Some kids have been bullied online so badly they committed suicide.

What's a Parent to Do?

Aware of online dangers, some parents may be tempted to simply take away their children's digital devices. This DOES NOT WORK. No matter how hard parents try to keep a kid offline, the child can still access the Internet at school, the library, a friend's house, on a device the child purchases in secret, etc. Parents who think they can separate a kid from the Internet need to think again, because it's not going to happen. Kids are going to get online and interact, and that's the way it is.

This does not, however, mean that parents are powerless in terms of protecting their offspring. In fact, there are several proactive steps that can be taken. First and foremost, as is the case with just about any aspect of a child's life, the best approach is an honest, nonjudgmental conversation. This is especially useful with sex-related issues like online porn. For best results, parents should not wait until their child reaches adolescence to have this conversation; in fact, nowadays discussing online porn in an age-appropriate way with much younger children is an absolute necessity. With a seven-year-old, parents might explain the basics of what porn is, telling the child that it is not okay to view it and if he or she encounters it he or she should immediately call for a parent. With adolescents it is more important that they understand what they see online is not real; instead, it is highly objectified fantasy focused solely on the sexual act, with little to no consideration of the person's safety (physical or emotional) or the joys of relationship intimacy.

In addition to an open-ended, ongoing conversation about life online, parents may want to install a

(Continued on Page 12)

CSCSW Advertising Rates & Deadlines:

CSCSW Monthly Newsletter:

Deadline: 5th of the month for the following month's issue (e.g., January 5 for the February issue.) Mailing date for issue will be the third week of February

Classified Ads: Are charged according to 30-word groupings (30 words = \$30.00, 31-60 words \$50.00, 61-90 words \$70.00.)

CSCSW members receive their first personal classified ad free and a \$10.00 discount on subsequent ads.

Display Ad: 1/4 page (3-1/2" x 5") \$100.00
1/2 page horizontal (7" x 4-1/2") \$160.00
1/2 page vertical (3-1/2" x 10") \$160.00
Full page (7-1/2" x 10") \$225.00

CSCSW members submitting a display ad for their own personal program or product receive a \$25.00 discount on each ad.

Multiple consecutive display ad discounts available.

Display ads should be in Word document or PDF format.

Paper ads and payments in the form of check or credit card numbers should be submitted to:

CSCSW at: P O Box 1151, Rancho Cordova, CA 95741

Electronic submissions should be sent to: cesco@clinicalsocialworksociety.org along with your credit card information.



The Clinical Update

P O Box 1151, Rancho Cordova, CA 95741

916-560-9238 * 855-985-4044 Toll Free * 916-851-1147 Fax

Website: www.clinicalsocialworksociety.org

Email: CU@clinicalsocialworksociety.org

Executive Director: Luisa Mardones, Executive Director
Managing Editor: Jean Rosenfeld, LCSW, Sacramento
Editorial Staff: Cindy Esco, Executive Assistant

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Theories of Aging and their Relationship to Social Responsibility

(Continued from Page 1)

deaths of their friends and loved ones, they begin to struggle with their mortality, and their loss of power, respect, and authority. As therapists we know that contemporary struggles are embedded in an historical context that often blurs the distinction between past and present.

Bernice Neugarten (4) emphasized acceptance in resolving problems. She found that people in their 70's who did not accept their aging, led lives filled with fears about illness and the future, or obsessed over ways to ward off aging by over focusing on diet, exercise and acting young. She found that those who could accept becoming older made the best adjustment.

Accepting our limited remaining time, our decline in physical and mental abilities, our losses, the harm done to us and that we have done to others, and the opportunities we have squandered can motivate the capacity to choose engagement over detachment, the present over the past, and accepting others along with ourselves. For some, acceptance can involve a reframe that changes the focus from loss to appreciation of remaining abilities and opportunities. For example, "I have to give up the running I love, but I appreciate that I can still enjoy walks in nature." For some, acceptance of our regrets can evolve out of appreciating the context and seeing the universality in our and others' behaviors that can lead to forgiveness and a decrease in uncomfortable affect. Sometimes acceptance follows mourning losses. However, acceptance needs to be tempered with realism, so that (a) accepting a loss does not interfere with opportunities to better a situation and (b) forgiving our self and others does not lead to reinjury or interfere with making amends. Instead of denying a problem, acceptance requires acknowledgement that there is or was a problem and, perhaps, that what happened cannot be changed. But it is not helpful to accept that there is nothing that can be done about the problem until there is nothing that can be done.

Another contemporary source of regret and despair for older people is predominantly existential. Nearly 2 million older adults die each year in the United States from chronic illnesses, such as heart disease, cancer,

chronic lung disease, dementia, diabetes, and chronic kidney disease. Meredith MacKenzie (5) found that many who face death suffer from preparatory grief which she defined as the cognitive, emotional, and spiritual responses to the understanding that one has a life-limiting disease and death is approaching. They may grieve for the loss of life itself, for the loss of small pleasures like their morning cup of coffee or their familiar routine, or for family members they will never see grow up. They may also grieve for what the loss means to those around them, such as the pain a grandchild or a spouse will feel from being left behind.

These theories about the road to social responsibility do not focus on the important biological and developmental roots of the ability to care about others. The models available in life and the media and the socialization experienced growing up may well set the parameters in which social responsibility can be expressed (6). Although we do not have a longitudinal study across the life span to demonstrate the consistency over time and place of an individual's socially responsible behavior; there is a net of research evidence to support the conclusion that in combination with situational factors, early development probably influences socially responsible behavior in the elderly. Studies indicate that empathy and disposition seem to underlie socially responsible behavior and they are influenced early by genetics (7) and parenting. The longitudinal studies available support some consistency in caring behaviors from age 5 to 25 mediated by empathy. Assuming this stability in personality continues, the roots of socially responsible behavior in older people may extend back to early development (8).

Theorists describe the elderly as examining and re-evaluating their life through a *life review* often triggered by a discomfiting narrative and the increasing awareness of mortality. A life review can facilitate a letting go of lingering problems by forming a more forgiving narrative of one's life. Some of these lingering problems were described by Bronnie Ware, a palliative care nurse who reported her dying patients' principal regrets (9). They wished they had had the courage to live a more authentic life, not the life others expected of them. The males wished they had not devoted so much time to work at the exclusion of enjoying their

elders need to overcome personal obstacles before they can attend to others, and that focusing on others can help free them from a preoccupation with personal problems

children's youth and their partner's companionship. The dying wished they had had the courage to voice their feelings even though this assertiveness may have caused conflict with others. They wished they had stayed more in touch with friends. And they regretted choosing the comfort of old habits and patterns while pretending to others that they were content. They missed not having more silliness and laughter in their lives. These regrets may indicate that we might avoid some remorse if we choose more pleasure over self-control and risk being more authentic. These regrets offer further guidance by suggesting that we should adjust our actions throughout life from the perspective of what we might regret in old age; and that our regrets seem more related to what we did not risk doing than to what we did. This lesson might inform the way we live our remaining days and challenge us to be more confident, risk stepping out of our routines and comfort zone, take pleasure in relationships and activities and be more authentic.

Perhaps Carl Jung had in mind a form of authenticity when he described the openness of older people to develop their shadow side. He emphasized the opportunity to develop aspects of personality that were previously rejected or neglected. He described successful aging as a time of increased creativity when people could become freer to cultivate the emotions, values, and roles that went unexpressed, especially the feminine side in males and the masculine side in females.

Through both retrospection and meeting contemporary challenges we may be able to reduce our preoccupation with past regrets and present trials and be freed to discover and mobilize our strengths and use them to focus on others. Shifting toward generativity could involve a devotion to something bigger than our self, and using our strengths and abilities to accomplish goals that enable purpose and engagement in our life. Rather than being opposing forces, self-interest seems to make social responsibility possible, and at the same time, an orientation toward the welfare of others can be in our self-interest by enriching our life with meaning, accomplishments, social contacts and distraction from physical and emotional discomforts. The elderly may need to cope with ageism, stereotypes and stigma before they can devote energy to generative activities.

The experience of aging is dramatically influenced by our culture. These psychological theories emphasize

The elderly may need to cope with ageism, stereotypes and stigma before they can devote energy to generative activities.

personal, developmental challenges that are imbedded in a culture in which elders may face and internalize a growing hostility that can interfere with remediating personal problems, contribute to additional problems, and impact cognitions, behaviors, and health (11). Society was not always hostile toward the elderly. Aging

for whites in America is not the same today as it was in earlier times. David Fischer (12), a social historian, wrote that in colonial times elders were few and revered. Only one in 50 were over 65. Elders held the significant religious, economic and political positions, and received special considerations. Church seating was assigned with the oldest members of the congregation near the pulpit, with the rest of the church generally seated behind them according to age. Puritans believed that old age was a sign of God's favor. They claimed to be older and powdered their hair and wore white wigs to appear older.

Today many elders dress and dye their hair to appear younger and claim they are younger. Preferential seating in churches often goes to the highest bidders or the most involved. An aging physical appearance can be viewed by some as humiliating or a creepy reminder of mortality; and anti-aging products and procedures have become a major commodity in our culture. In literature and the media when older characters appear (although they are usually invisible), often they are depicted as objects of pity or contempt. Fairytales (such as Little Red Riding Hood and Hansel and Gretel) help to inculcate society's stereotypes of the elderly so that children are aware of them by six years of age (13). With the exception of a few recent movies, aging is often characterized as equivalent to breaking down and related to being cast aside - think Abe Simpson.

Many changes in society have affected our treatment of the elderly and their options. Industrialization encouraged age discrimination against older workers through mandatory retirement, which brought mandatory poverty and "poor houses" to many. Increased geographical mobility and separation of generations in some cultures have caused the old system of family responsibility for the aged to break down. The rapid pace of societal change and the proliferation of search engines and easily accessible entertainment have made the wisdom and storytelling of the elderly seem obsolete. The recent recession has amplified the inter-generational competition for jobs and dwindling resources for the 99%. Furthermore, our competitive capitalist culture values an individual by

what he/she produces and consumes, and minimizes the worth of an elder, especially one who does not produce or lacks the money to consume.

Fostering socially responsible behavior in our clients and ourselves

Helping aging clients resolve personal issues and generate a focus on others and the planet may help their mood and quality of life. The following are some suggestions that may be useful.

Working for something bigger that benefits others can be a major contributor to personal happiness. Using our skills and wisdom in the service of a goal, aiding and mentoring others, being part of a group, feeling valued for one's contribution, all can foster happiness and distract us from uncomfortable feelings. An enlightened analysis of the causes we support is required to assure that they are well-meaning.

Ethical wills are a formal way to pass on our insight, knowledge, values, and wisdom; and may be the most important asset we transfer to our heirs. They can be letters, videotapes, CDs, DVDs, etc. and might include events and decisions that helped shape our family and what we learned from our life review. We can inform our heirs about the people who strongly influenced our life and what we learned from them (grandparents, parents, siblings, spouse, children, friends, work colleagues, people we admired, etc.), ask for and grant forgiveness, and attempt to resolve family conflicts. We may want to describe things for which we are grateful, our family genealogy, historical information that might otherwise be forever lost, special family traditions, memories of important days in our life (our marriage day...), favorite humor, recipes, books, songs, movies, etc. And we may want to include charity wishes, funeral plans, burial instructions and our hopes for the future, etc. Our ethical will can pass on guidance and may generate a higher level of cooperation and trust among family members. We may want to promote competencies in family members for things we have traditionally done for them so they will be prepared; and we may wish to give them permission to live a full life when we are gone.

Elana Zaiman (14) wrote:

Ask anyone who has received such a letter, "What is the most meaningful possession you were left by someone close to you?" That person will say, "The letter I found addressed to me in my father's safe deposit box," or "The

letter my grandmother handed me a few years before she died."

Ask me.

I was a teenager when my father handed me a copy of his ethical will. As I read his words, I cried. I was in awe of his ability to admit his weaknesses, to state his beliefs and values, to acknowledge his hopes and prayers for us, his children. I still cry when I read his ethical will. And I read it often. I read it when I'm annoyed with him, when I feel far away from him in distance, or in spirit. And always, I feel his love.

Tell the truth to family and friends. In the past the elderly lied about or hid their age and condition, so we and our clients enter old age with unrealistic models and expectations. We may want to tell family and friends, "This is what it looks like." Although we may not want to overburden family and close friends with our problems of aging, protecting them too much may lead them to feel pushed away.

Caring for the Caretakers. Almost 30% of the population provides unpaid caretaking to someone who is ill, disabled or aged (15). Paid caregivers are 90% women who are denied federal minimum wage and overtime protections in 20 states. However, in 2015 home care workers will qualify for minimum wage and time-and-a-half overtime protection. There are nearly 4 million paid caregivers in the US and they have a median annual salary of 10 dollars an hour (16). A recent Minnesota study found that over 40 percent of Minnesota's direct-care workers lived in households that relied on public assistance.

End of Life Issues. If our clients are facing end of life issues, we should not be afraid to help them explore and process their fears and grief. We can also offer information and resources to help them make decisions about the end of life. Exerting control by expressing preferences and making decisions may give relief to some. Social responsibility innervates these decisions. Although the elderly comprise 12 percent of the population, they consume over 1/3 of health care expenditures. (17) Significantly adding to the climbing cost of health care poses a threat to the nation's long-term solvency. Clients may want to discuss an Advanced Health Care directive with you, as well as the POLST (Physician Orders for Life-Sustaining Treatment) that is intended as a complement to an advance health care directive. Another option clients may want to

consider is becoming an organ and tissue donor (when renewing their driver's license or at www.dmv.org/california/organ-donor.php), or donating their body to science. Local medical schools, hospitals, and research facilities often seek whole body donations. People can also donate their brain to a brain bank which can be done by contacting <http://www.brainbank.mclean.org/Donate.html> or by calling 1-800 BRAIN BANK. Elderly people who are ill can participate in clinical trials which may allow them to access treatments before they become widely available, and help contribute to the efficacy and safety of treatments for themselves and others. Almost 150 thousand clinical trials are registered in the database maintained by the National Institutes of Health at <http://clinicaltrials.gov/>. Being a trial participant should be viewed more as an opportunity to play a role in the discovery of treatments than as an effort to find a personal benefit, because participants may be given placebos.

Professional wills offer therapists a way to be socially responsible. Ethical codes require therapists to have a professional will to appropriately inform clients,

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

Kids, Safety, and the Digital Funhouse

(Continued from Page 7)

“parental control” software program on their kid's digital devices. Doing so without first consulting the child is not recommended for a variety of reasons. First and foremost, the child will very likely resent a unilateral imposition of restrictions on his or her online movement, and who needs a resentful kid. A better approach is letting the child know what you would like to do and why, emphasizing that you do not wish to limit them, merely to protect them. Most kids, given the choice between a perpetually hovering parent and a relatively unobtrusive software will choose the latter. And let's face it, kids who “buy into” the protective process are much less likely to try and circumvent the software later on.

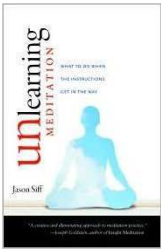
The Sexual Recovery Institute has reviews of parental

Robert Weiss LCSW, CSAT-S is Senior Vice President of Clinical Development with Elements Behavioral Health. An author and subject expert on the relationship between digital technology and human sexuality, Contact him on his website at www.robertweissmsw.com

facilitate referrals, protect confidentiality, and secure records. You need to appoint (and possibly pay) an executor and back-up person and tell them where everything is (keys, office security codes, computer and answering machine passwords, client list and schedules, files, billing records, attorney involvements, etc.). A system needs to be established so patients will be notified and referred to an appropriate clinician and protected from traumatically discovering their therapist is incapacitated or dead. Patients have the right to access their clinical records which must be kept for 7 years in California (18).

Ethical codes require therapists to have a professional will

Theories of aging describe the final stages of life as a time of potential growth and development. These theories emphasize wrestling with certain developmental tasks. These tasks involve resolving regrets about having done and not having done things in the past, as well as facing contemporary challenges and more existential end of life issues. These theories suggest that feelings of regret and despair can block engaging in socially responsible behaviors that consider the welfare of others and the planet; and, that acting in a socially responsible manner can help resolve these feelings of regret and despair.



BOOK REVIEW

Unlearning Meditation: What To Do When The Instructions Get In the Way

by Jason Siff

Published by Shambhala, July 6, 2010

Paperback, 240 pp

Reviewed by Bill Cooper, LICSW

In the last 20 years the impact of Buddhism-- particularly mindfulness meditation-- on psychotherapy has been inescapable. Training abounds for therapists to learn and teach mindfulness to their clients. Serenity and insight are often promised to those who learn and practice mindfulness. In the past, one often had to go to a Buddhist teacher to learn meditation; however, now there seems to be little doubt that in this country many of our clients prefer learning these techniques from a therapist. And many clients do benefit significantly from these practices. This is all to be expected among the humanistic theoretical orientations, but even some behavioral orientations such as dialectical behavior therapy and acceptance and commitment therapy include mindfulness in their clinical interventions to teach clients emotional regulation and exposure training.

The problem is that the experience of many of our clients has been anything but the tranquility and peace promised to those of who pursue meditation. What do therapists do with frequent refrains from our clients such as the following? "I can't do this...My thinking won't stop...I don't have the time for a regular practice...I'm not getting anything out of meditation." Adding to this, our clients oftentimes bring issues of shame and guilt to their meditation, and see themselves as "failures." In short, mindfulness for some, if not most of our clients (as well as ourselves), may not be living up to the implied expectations.

What has been missing in much of the dialogue on mindfulness has been an honest critique of some of the ways mindfulness has been taught and practiced. Jason Siff, a Buddhist teacher of many years, has written a compelling book on Buddhist meditation that addresses many of these concerns: *Unlearning Meditation: What to Do When the Instructions Get in the Way*.

Siff is a true iconoclast. To begin, he turns the usual instructions for meditation back to the meditator for reference: "Meditation is what happens when you decide to meditate." In other words, meditation is not a particular experience of tranquility or peacefulness--it's whatever is happening when you meditate, including

thoughts about lunch, feelings of all kinds and all other so-called "wandering" thoughts. Significantly, Siff broadens the definition of meditation to include *all of one's experience*. Therefore, all of one's experience when meditating, not just the serene experiences or the experiences we like, becomes accepted as material to investigate and understand. Implied here is that the authority for meditation is the meditator, not the instructions, not the teacher. The process of recollective awareness--Siff's term for his approach-- is receptive: gently watching and receiving everything that comes to mind, as opposed to many meditation instructions which he calls "generative," where the goal is to create a particular experience by, let's say following the breath.

Speaking of following the breath, which is probably the most common instruction in mindfulness, Siff has this to say, "If you've learned, for example, to follow the breath as a meditation practice, this approach isn't about abandoning that practice, rather, it's about doing it without a strong intention." A unique teaching. He's encouraging gentleness rather than discipline. Another important feature of Siff's approach is journaling. Students are encouraged to occasionally write about their experiences. This becomes an aid to understanding one's process and practice during meditation so as to perhaps answer questions such as: What's holding this emotion in place? How is it built up, or let go of? What's fueling it? What is its nature? These questions will sound familiar to many therapists and it's interesting that most approaches to meditation do not include them. Rather, in usual mindfulness practice thoughts are simply noted as "thinking," and attention returns to the chosen object, such as the breath. In recollective awareness, one's thoughts are gently explored, not dismissed.

Siff then addresses an issue near and dear to therapist: impasses. Yes, these can happen in mindfulness, too. Siff is trained in psychotherapy and has suggestions for dealing with impasses that are quite consistent with his overall approach. Personal stories often fill in needed details as to how these issues arise and are resolved. The final portion of the book is a valuable sketch of the

(Continued on Next Page)

types of basic meditative experiences: receptive, generative, conflicted, as well as and three “advanced” experiences -explorative, non-taking up, connected. There is neither time nor space to discuss these here. Siff’s discussion is necessarily technical, but clear and worthwhile for many readers who will find it helpful for understanding the types of experience one is having or capable of having while doing mindfulness. It could be quite helpful for those of us who meditate, as well as

our clients, to have this understanding about these experiences that previously have been excluded from many discussions of meditation.

Siff’s work in *Unlearning Meditation* is a valuable contribution to the dialogue about meditation and the teaching of it. Therapists and clients who want to learn more about mindfulness will benefit greatly from what is taught in this book.

Bill Cooper can be reached at Bill@BillCooperCounseling.com

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- Send your ideas and suggestions for articles and authors

If you are interested in writing for the Clinical Update:
Please contact our Editor, Jean Rosenfeld at 916-487-8276 or
Email: jrosenfeld@clinicalsocialworksociety.org

Classifieds

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Furnished office available 1-4 days per week. Recently updated interiors, spacious waiting room, includes utilities, janitorial, use of fax machine, coffee maker. Monthly rate for one day per week is \$145. Discounted rate available for 2 or more days per week. Great location near Riverpark, with friendly colleagues and opportunities for referrals. Available now-contact Arlene Costa, LCSW at 559 907-7796.

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There are two offices - one large, one small - available @ 4420 N. First Street, located centrally and with easy access to bus. The buildings are multi-use, currently housing professionals like therapists, dentists, a CPA, and a couple of agencies. For therapists looking for office space, please call Gabriele Case @ (559)224-2495.

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∞∞∞∞∞∞ Male Sexual Trauma Survivor Group Forming – San Diego ∞∞∞∞∞∞∞∞

Therapy group forming for men who experienced sexual trauma, either in childhood or as adults. Offering safety, support, understanding, healing. Contact C. Allen Ruyle, LCSW, CGP at 619-213-3000 or <http://allenruyletherapy.com>.



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