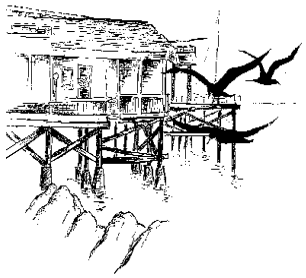
# *The Monterey County Chapter*

**California Association of Marriage and Family Therapists**

## November / December 2021 Newsletter



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## In This Issue...

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## *Jennifer Farley*

## *2021 Board President*

*We are in the final stretch of 2021! I hope all of you and your loved ones are healthy and happy as we head into this holiday season. Currently, I am feeling a bit conflicted. On the one hand, I am slurping down pumpkin spice lattes (yes, I admit that I'm in love with that autumnal beverage) and excitedly decorating my home with a myriad of pumpkins and gourds. On the other hand, I am also sitting with the lie of the story of Thanksgiving, and sorting through how to celebrate without avoiding the atrocities imposed upon the indigenous peoples of this country.*

*As therapists, we are tasked with being witness to our clients' stories, and we also create a safe space to support clients in facing difficult truths. Our country has difficult truths to face as well, and we must hold space for those truths and encourage safety in allowing those truths to be told in an effort to promote genuine healing.*

*In researching ways to bring particular acknowledgement to indigenous peoples as Thanksgiving approaches, I found some ideas that were repeatedly suggested by Native Americans:*
*1) Take some time to read/learn about native tribes that are/were local to your area.*
*2) Donate to charities that are founded by and focused on helping indigenous peoples.*
*3) Learn about the reality of how indigenous peoples were treated by the settlers.*
*4) There is also encouragement to approach food in ways that are in alignment with a more indigenous way of life. For example, learning about native plants and creating Thanksgiving dishes inspired by what lives on your local land… easy to do here in CA!*

*I offer this as some "food for thought" in continuing to come to terms with the reality of our country's history and how as therapists we have both a unique role and capacity in bringing intentionality to how we acknowledge, honor and celebrate moving forward.*

*Gratefully,*

*Jennifer Farley*

# Member Article

## Couples Corner

*offered by EFT trained therapist* **Amy Somers**

"The cave you fear holds the treasure you seek."
-Joseph Campbell

Connection in a couple must come from love, right? This is the consensus: confront our fears independently and move forward into love. Seems simple enough. Get rid of the dark and move into the light. What if, instead, fear offers connection? What if the vulnerability of sharing our biggest fears is a shortcut to secure attachment?

My husband and I work with a couple that lives with a life-threatening illness. Life-and-death situationsbring up fear in all of us: the ultimate non-negotiable boundary, the worst-case scenario (or so we aretaught). We, as a culture, are terrified of death, as if the bogeyman came out from under the bed andsat down next to us. We are ill-prepared for this natural part of living and more likely to move into fight-or-flight. Fear overcomes and consumes, promotes disconnection and isolation.

We encouraged the couple share their fears around death. Both were terrified. They squirmed, argued, and got lost in content. We gently invited them in again. The feminine was the first to lay down her armor and present her mortal fears. She spoke slowly, shook, cried, and eventually stopped speaking all together. Her ugliest, scariest demons crowded the room. A great quiet paused all of us as we held space for her fears to simply exist. Seconds passed. Her husband reached out. He asked permission to touch her, then consensually held her as she released some more. The room cleared. The demons dissipated. She became calm and connected. To him. She visibly shifted, energetically, as did he. He softened. He was genuinely glad and asked what she needed, how he could support her.

The bravery she embodied was inspirational and it moved me to tears. No solution was offered or needed, just the illumination of the cold, dark cave of her mind. The couple sat there together and brought the light of connection, of knowing she was not alone. Seemingly counterintuitive and the last place they wanted to go; fear brought them to love through vulnerable connection with each other.

# Guest Article

## Selfless Caregiving May Heighten Vicarious Trauma

*Cultivating insight can help caregivers build resilience to loss.*

Author: Elizabeth Young

KEY POINTS

Emotional identification with someone who experiences trauma can increase the likelihood of vicarious trauma.
Victims of vicarious trauma may minimize their own experience and lack insight that they too have been traumatized.
Vicarious trauma can increase susceptibility to grief and depression.
Cultivating insight about one's reactions to caregiving can help caregivers build and maintain resilience.

Melissa and I were similar in many ways: the same age; fiercely independent; betrayed by our bodies. We used the same coping strategies: kept busy to quell our anxiety, sought companionship for comfort, relied on chocolate to self-soothe. She had a powerful sense of humor that made us both laugh; I have a powerful spiritual faith that kept our hope alive. We were sisters. Not biological sisters, but soul sisters.

As Melissa's strength faltered, we went to cancer research hospitals: first for a consult about any new chemo (nope), and then a couple of months later for a last-ditch about surgery (nope again). In between those trips, I stayed with her, keeping loneliness at bay. One night, we had to go to the rural hospital as she seemed about to die.

As Melissa attempted to stand at the registration desk in the emergency room, she suddenly cried out, "Help me! I'm having a heart attack! Help! Help! Help!"

I got behind her as she wobbled, ready to catch her if she fell. After what felt like a year and might have been a full minute, the security guard arrived with a wheelchair, which Melissa slid into, weeping and whimpering. A nurse came through the door to the ER examination room and the medical staff took over.

Melissa continued in great distress, crying out periodically as her heart rate spiked to 170 beats per minute. "Help me!" I seemed to be the only one listening to her. The nurses and the doctor were busy trying to figure out what was going on with her heart. We realized that they didn't know; a wave of panic ran through me as the telemetry showed the irregular rhythms and high speed of her heart, her face showed her fear, and the doctor exuded no confidence.

On and on, the alarming diagnostic procedure went. While the staff kept looking at changing patterns on the screen, I kept moving around the gurney, holding Melissa's hand, touching her shoulder, resting my palm on her sweaty hair. Contact seemed essential.

"Am I dying?" she whispered at one point.

None of the professionals answered. She and I both took their silence to mean "Yes." I leaned over her. "I'm here with you, Melissa. You are not alone." She grabbed my hand and held it tight. One of the nurses said briskly to me, "Excuse me. You need to go to the other side of the bed so I can get at this IV." I walked around the bed as they gave her medication that briefly slowed her heart. For a moment, Melissa was back to her calm and capable self. We all relaxed. And then, boom! The pulse climbed and the arrhythmia returned. Tears leaked from her eyes, and she cried out, "I can't do this again." And then, "I don't want to die!"

I stood beside the gurney, out of the way and close to her, holding the round metal side rail with both hands. I suddenly needed to tighten my grip—my vision blurred, darkness—

I woke up on the floor, confused, questions pounding me from the doctor and nurses. I was eased off the ground and guided to the gurney next to Melissa's as my head swam. "Elizabeth, are you all right?" The head nurse's voice was loud, clear, kind. But she was supposed to be paying attention to Melissa! I lied and said thickly, "Yes. I just need to lie down. Melissa needs you."

One nurse moved from Melissa to me, and the rest of the team returned to full focus on her. Melissa was silent, glazed over, out of her body. A wave of fear rolled through me. I whispered, "She's not dead, is she?" My nurse laughed. "No, she's right here with us. We're taking care of her. Let's get you set now, okay?" and she slid an IV into my arm.

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Eventually, the medication they were giving Melissa calmed her heart; her pulse and rhythm returned to normal. I got normal too, my blood pressure stabilizing and my blood sugar rising. The staff went away to decide what to do with her.

I looked over at her gurney. I could only see the back of her head. "Melissa," I said quietly. She seemed far away. "I'm sorry," I said.

"I was worried about you," she said. "I told them that you were going down, and the doctor thought I was talking about myself, and I said, 'No, she is,' and down you went. The doctor caught you right before you hit the floor."

Shame blushed up my face. "I can't believe I did that."

She laughed, a welcome sound, turning her head to me as much as she could, so I could see the side of her face. "It's a good story," she said. And then disappeared into her inner depths again.

"What's going to happen?" I asked in a while.

"I think you'll be sent home. I hope they admit me. I'm exhausted, and scared that the rhythm might get off again."

"Yes, I understand." I thought of her consult with the doctor at Dana Farber just 18 hours earlier, with the dashed hope that she might qualify for a drug trial. Then the terror of the arrhythmia. The absurd concern that I was ill. And now waiting.

"It's been a crazy day." She lay back and stared out into the room. "I'm just glad you're okay."

The doctor discharged me. I should drink water and be careful driving home.

"Stay at my place the rest of the night, okay?" Melissa asked.

"Of course. But what about you?"

"They will figure it out." As she spoke, the doctor arrived and said, "We're trying to find a place for you. I guess you could go home."

He sounded doubtful, and Melissa immediately said, "No. No, I can't. I'm too weak. And scared." He nodded. I realized he was scared too.

"The nurse is trying to get you a bed at University Hospital."

"Why there?" I asked. It was 2 hours from her home and 40 minutes from me.

"Because they have a cardiology department," he said simply, "and we don't."

"That's fine," Melissa said. "That's good. I want to see a cardiologist."

Eventually, I slept in her bed with her cat. At 5:15 a.m. I got a text from her: "At Uni, waiting for a bed."

That crazy night, I didn't know that I had been traumatized by Melissa's near-death experience, her grueling decline, her ongoing withdrawal into herself. I prevented myself from acknowledging the shame of having fainted at her bedside. I failed to recognize that I was pierced by anticipatory grief. I couldn't tolerate the fact that although she didn't die this time, she was rapidly moving toward death. I couldn't let myself see that I would lose my soul sister soon.

This lack of insight is, of course, common in vicariously traumatic situations. My case was classic: My strong emotional identification with Melissa increased the likelihood of vicarious trauma occurring. Being so focused on her experience prevented me from attending to my own reactions. And as often happens, the vicarious trauma eventually became problematic for me, especially in the context of the death of my dear friend. Months after Melissa's death, I made a series of aberrant decisions leading to problematic behavior that evolved into an episode of severe depression.

Being present with Melissa was a choice, and one I will make again with people I love. But next time, I'll be present with myself too.

https://www.psychologytoday.com/us/blog/adaptations/202111/selfless-caregiving-may-heighten-vicarious-trauma

# Guest Article

## Transferring Ethnopharmacological Results Back to Traditional Healers in Rural Indigenous Communities – The Ugandan Greater Mpigi Region Example

Research Translation

In: Video Journal of Education and Pedagogy

Abstract

In ethnopharmacology, scientists often survey indigenous communities to identify and collect natural remedies such as medicinal plants that are yet to be investigated pharmacologically in a laboratory setting. The Nagoya Protocol provided international agreements on financial benefit sharing. However, what has yet only been poorly defined in these agreements are the non-financial benefits for local intellectual property right owners, such as traditional healers who originally provided the respective ethnomedicinal information. Unfortunately, ethnopharmacologists still rarely return to local communities. In this video article, the authors present a method for transferring results back to traditional healers in rural indigenous communities, taking the authors' previous studies among 39 traditional healers in Uganda as an example. The authors' approach is based on a two-day workshop, and the results are presented as original footage in the video article. The authors' work demonstrated a successful method for ensuring bidirectional benefit and communication while fostering future scientific and community-work collaborations. The authors believe it is the moral duty of ethnopharmacologists to contribute to knowledge transfer and feedback once a study is completed. The workshop method, as an example for science outreach, might also be regarded as a valuable contribution to research on education theory and science communication.

Keywords: research translation; ethnopharmacology; traditional medicine; traditional healers; workshop; Mpigi; transfer of results; Uganda; medicinal plants

### 1 Introduction

Across the globe and throughout history, plants have been used by humans as a source of medicine and natural remedies (Bussmann et al., 2018; Kigen et al., 2019). The World Health Organization defines traditional medicine as "the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, used in the maintenance of health and in the prevention, diagnosis, improvement or treatment of physical and mental illness." (who, 2019) Traditional medicine continues to be of great importance to all human beings (Yuan et al., 2016).

In the developing world, over 80% of the population still relies on medicinal plants as their primary source of healthcare (Bussmann et al., 2018; Kigen et al., 2019; F. Schultz et al., 2020; who, 2010). Even in the modern Western pharmaceutical industry, traditional medicine still plays a key role in drug discovery (Atanasov et al., 2015; Balunas & Kinghorn, 2005; Heinrich et al., 2015; Porras et al., 2020; Fabien Schultz, Godwin Anywar, Huaqiao Tang, et al., 2020). For instance, nearly 50% of all drugs that are currently fda-approved in the US have been derived directly or indirectly from natural sources (Li et al., 2019; Veeresham, 2012).

Here, the science of ethnopharmacology seeks to investigate the medicinal use of plants, animals, macrofungi, microorganisms, and minerals through pharmacological, socio-cultural, and anthropological methods. Ethnopharmacology is a highly interdisciplinary field of research (Heinrich, 2014; Heinrich & Jäger, 2015), encompassing a) field studies (such as ethnobotanical studies in local communities, interviews, surveys, and the first time documentation of medicinal use, ritual use, or religious aspects), b) the pharmacological assessment of recorded and collected medicinal species in a laboratory setting (so-called "bioactivity studies"), and c) drug discovery of pharmacologically active natural products via pharmacognostic approaches. These activities may be expanded to include community work, as we believe ethnopharmacologists should also act as advocates for the respective indigenous communities with whom they collaborate.

Throughout history, the intellectual property rights of indigenous peoples have not been recognized, and questions concerning the ownership of biodiversity following the development and commercialization of pharmaceuticals have arisen. The Nagoya Protocol and the Convention on Biological Diversity provided international agreements on financial benefit sharing and recognized each nation's sovereignty over the biodiversity resources within its borders (Alexiades & Sheldon, 1996; Balick & Cox, 2020; Heinrich & Jäger, 2015; Heinrich et al., 2018). But what about non-monetary benefits? What about the transfer of knowledge in both directions? Unfortunately, even today, ethnopharmacologists rarely return to the local communities after a study has been completed and published (Maregesi et al., 2007; Fabien Schultz, Godwin Anywar, Barbara Wack, et al., 2020). Thus, the successful collection of plant samples and ethnopharmacological information from traditional healers and other community members often marks the end point of this one-sided collaboration, despite the fact that this data will still be analyzed, interpreted, and published (see Figure 1). This problem was previously addressed in a book by Herman et al. (Herman et al., 2018).

cont'd on pg. 8

Laboratory studies may follow, leading to unique significant discoveries that would certainly be of interest to the local study participants and could even empower them locally while fostering an equal partnership (Cordell, 1995; Unander et al., 1995; Vandebroek et al., 2011). If the scientists ever return, then in many cases it is only because of an entirely new study, aimed at extracting new information for their research. We believe that ethnopharmacologists therefore have the great responsibility of keeping this collaboration and the communication with their local informants bidirectional. Information and knowledge should be shared, creating a benefit for both the scientists and the local study participants.

1.1 Previous Ethnopharmacological Studies

In this video article, we would like to introduce a method for transferring the results of laboratory analyses and ethnobotanical surveys back to traditional healers. Our approach is based on a two-day workshop, using our previous studies from the Greater Mpigi region in Uganda as an example. A total of 16 medicinal plant species were investigated as part of an ethnobotanical survey among 39 traditional healers from the Greater Mpigi region. This past study has recently been published in the Journal of Ethnopharmacology (Fabien Schultz, Godwin Anywar, Barbara Wack, et al., 2020). Traditional healers from 29 different villages, including one from a small island in Lake Victoria, were interviewed. The study involved the first-time documentation of preparation and administration methods and the identification of a total of 75 medical disorders that are treated with these medicinal plants. In this study, information was obtained using questionnaires that were specifically designed to collect in-depth data on each species. Figure 2 shows three photographs from this field study, giving examples of local plant diversity.

In another follow-up study that was published, we applied the Degrees of Publication (DoP) method as a novel tool for literature assessment in ethnopharmacological research (F. Schultz et al., 2020). There are numerous field assessment tools in use today. However, none of these tools are able to help researchers determine which species merit the costly laboratory studies that would be required for their further investigation, e.g., pharmacological assays and the isolation of bioactive natural product compounds.

The introduction of the DoP method has filled this gap. In the context of the aforementioned ethnobotanical survey, the DoP method made it possible to classify six of the 16 medicinal plant species as "highly understudied" and three as "understudied."(F. Schultz et al., 2020)

At the Makerere University herbarium, taxonomic identification was accomplished based on the herbarium voucher specimens that were prepared during fieldwork. Following the fieldwork activities, samples of all 16 plant species were taken to the laboratory, where extracts were produced. Various pharmacological investigations followed on the basis of the use reports provided by the traditional healers (Schultz, Anywar, Tang, Chassange, Lyles, Garbe et al., 2020; Schultz, Osuji, Wack, Anywar & Garbe, 2021; Schultz, Osuji, Wack, Anywar, Scheel et al., 2021). These included antimalarial, antibacterial, and antiinflammatory bioassays, among others (see Figure 3). These unique investigations led to a large number of interesting results.

During our fieldwork, we explicitly asked the 39 traditional healers about their motivation for collaborating with us (Fabien Schultz, Godwin Anywar, Barbara Wack, et al., 2020). The specific questions that we asked were: "What are your future expectations from our scientific findings, and what do you expect from us researchers?" Participants were invited to give multiple responses. Their answers were fascinating. Despite the fact that these traditional healers live in relatively poor circumstances, only 5% stated that they would like to benefit financially from the scientific information gained. On the contrary, there was a high demand for feedback on the results of the survey and the laboratory studies, which we regard as the transfer of knowledge. The majority of the traditional healers said they would like to improve and continue their collaboration with us researchers. Nine percent were interested in a collaboration for improving their treatment of patients, and 11% wanted to strengthen their collaboration with us. The second most common expectation was to receive feedback on the findings of the pharmacological studies that followed the fieldwork. In addition, more than a quarter of the traditional healers mentioned that they would be interested in finding out whether scientific evidence could be found for the claimed medicinal properties of the investigated plants, as such evidence would boost their confidence in the respective treatments (Fabien Schultz, Godwin Anywar, Barbara Wack, et al., 2020).

cont'd on pg. 9

Their responses indicated that there is a vital need for feedback from ethnopharmacologists after a study is completed, as well as a strong interest in continued collaboration and participation in the research.

## 2 Methods

The results of the laboratory work and the ethnobotanical survey were shared with the traditional healers through a two-day workshop in November 2019. All of the traditional healers who had initially participated in the field study were invited to the workshop (Fabien Schultz, Godwin Anywar, Barbara Wack, et al., 2020). In order to contact them again, we used the network of the ngo prometra Uganda (www.prometraug.com). Together with prometra, we organized transport and food. The workshop took place at the local prometra headquarters in Buyijja, Buwama sub county, in the Greater Mpigi region. Written informed consent for the filming and publishing of the video footage was requested and obtained from all participants shown in this video article. One of the possible reasons why so few scientific findings are transferred back to indigenous peoples and traditional healers is that scientific articles are often incomprehensible and inaccessible to them (Jaeger, 2005). Therefore, one major challenge was to explain the scientific results in a way that was appropriate to their level of understanding. Western researchers face the same challenge in the context of science outreach activities among the general public in their home countries. However, when such outreach activities are organized in other countries, there should also be an emphasis on cultural appropriateness. Our strategy for conveying complicated scientific results was to explain the assays and results figuratively and in a simplified manner, using everyday examples.

Another challenge was the local language Luganda, which is why multiple translators were present at the workshop.

The workshop was divided into three parts:

–Day 1 (morning): Transfer of results in a classroom setting using a laptop and projector (results explanation)
–Day 1 (afternoon): Group discussion and questions from healers in the garden
–Day 2 (all day): Group visits to some of the healers' homes

The healers visited on Day 2 were traditional healers who had participated in another study within the Greater Mpigi region, and the video footage was intended as an example of how the bidirectional communication and continued collaboration could be established.

## 3 Results

The results from each of the three parts of the workshop were presented separately in the video article as video impressions.

### 3.1 The Workshop

#### 3.1.1 Day 1 (Morning): Transfer of Results in a Classroom Setting Using a Laptop and Projector

For example, after we asked the workshop participants for permission to film them, one of the traditional healers asked us how the video would benefit them. Responses were given in the original video footage shown in the video article. During the first part, we presented the outcome of the initial questionnaires, as well as various results from our diverse lab studies (antimalarial, anti-inflammatory, antivirulence, antibiotic, cytotoxicity, and genotoxicity assays). Figure 4 shows a photo of the organizer of the workshop, Fabien Schultz, and some of the 39 traditional healers during the results-explanation part of the workshop. The limitations of in vitro studies were explained during the presentation of lab results, along with the explanation that follow up studies were needed in the future in order to fully verify the pharmacological effects in vivo. The presented lab studies provided initial scientific evidence for the potential therapeutic efficacy of the medicinal plants used by the healers in the Greater Mpigi region.

#### 3.1.2 Day 1 (Afternoon): Group Discussion and Questions from Healers in the Garden

The traditional healers wanted to know more about the testing methods and what they could learn from them when it comes to preparing their medicines, which led to a very interesting discussion. The questions from the healers focused on the limitations of science, the scope of laboratory experiments, regional differences in the concentrations of active ingredients in plants, and even the role of spiritualism in traditional medicine. Figure 5 shows a picture from the group discussion under a tree in the garden.

cont'd on pg. 10

3.1.3 Day 2 (All Day): Group Visits to Some of the Healers' Homes

This video footage gave impressions on how the traditional healers find and harvest some of the forest plants investigated in the laboratory studies, how they process these plants, how they sell them on the market, and how they treat patients. The group visits to their homes led to bidirectional communication, strengthening trust and interest in future collaborations. New research topics were identified via brainstorming methods, and traditional healers expressed their interest.

3.2 The Broader Frame of the Study

Within a wider frame, this study also addressed the open research movement and science communication strategies, in general, because the workshop method is an example for science outreach. According to a study by Iyengar & Massey (2019), "gatekeeper" actors are a critical factor regarding "post-truth" issues between researchers and the general public because they tend to manipulate information for different motives. In the study, the authors conclude that a direct and constructive communication between the general public and scientists can prevent "gatekeeper" actors from emerging and misinformation from being spread. Moreover, another study by Dyer et al. (2020) concluded that direct contact with scientists is more likely to enable public outreach of higher quality when it comes to important issues. Thus, the presented workshop, where participants strongly requested to receive expert scientific feedback on their traditional practices, helped to circumvent the emergence of misperceptions of scientific knowledge and distrust in the scientific undertaking.

4 Conclusion

Conducting a workshop for traditional healers and indigenous communities is an efficient way to transfer the results of ethnobotanical and ethnopharmacological studies back to local study participants. This video article, showing a workshop along with visits to some of the healers' homes, demonstrated a successful method of how bidirectional benefits and communication is possible as a starting point, fostering future scientific and community-work collaborations. Of course, our approach and workshop concept may not be suitable for all local and indigenous peoples, cultural backgrounds, or situations that may emerge during various aspects of ethnopharmacological research throughout the world. It is meant as an example, and as always, scientists' individual approaches need to be adapted to the given circumstances. What remains a fact is that very few scientific findings are transferred back to the traditional healers and indigenous peoples who originally laid the foundation for the advanced ethnopharmacological research endeavors. For example, it is possible that subsequent laboratory studies could even reveal that some medicinal plants pose a threat to local communities, because they are toxic and harmful to patients as a direct outcome of treatment. We believe that ethnopharmacologists should contribute to improving local herbal drug use, help reduce health hazards derived from medicinal plants, care and advocate for local communities, and create and maintain good relationships for future collaborations.

Acknowledgements

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Author Contributions: Fabien Schultz (F.S.) designed the overall strategy of the study, conducted the workshop, and wrote the manuscript for this video article. Inken Dworak-Schultz (I.D.S.) edited the video, produced the voice-over, and acted as head of video production. F.S. and Godwin Anywar (G.A.) organized the workshop. I.D.S., G.A., and Alex Olengo (A.O.) filmed during the workshop, at the lab, and at the traditional healers' homes. A.O. translated the interviews from Luganda to English. F.S. and I.D.S. interpreted the video footage. Leif-Alexander Garbe directed the study. All of the authors watched, revised, and approved the final video article.

Conflict of Interest

Written informed consent was requested and obtained from all participants of the workshop and all participants shown in this video.

cont'd on pg. 11

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. The content is solely the responsibility of the authors and does not necessarily reflect the official view of the funding agencies. The funding agencies had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript/video article.

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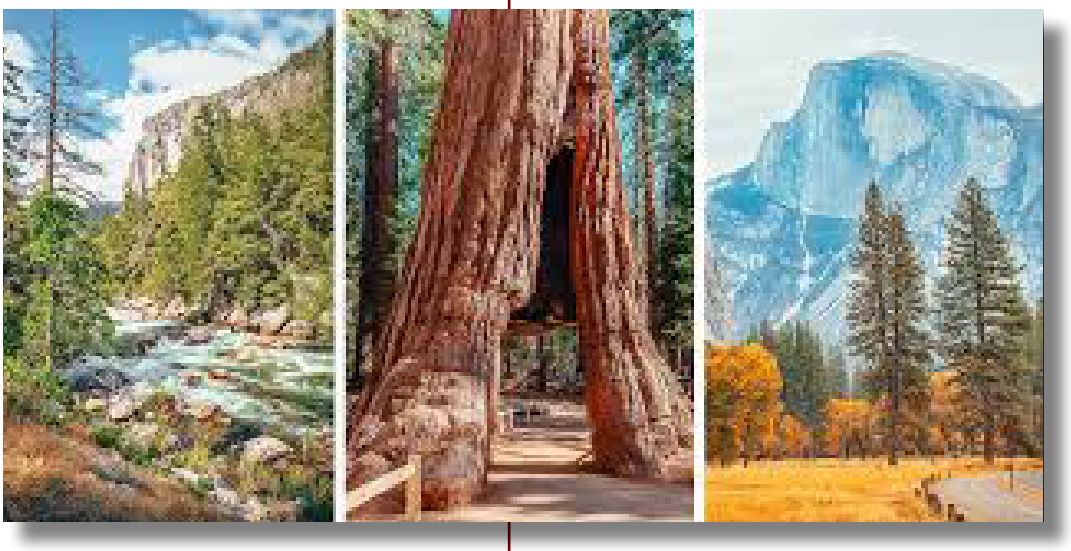

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*I can professionally master and process your spoken word files, remove most noise/s, even add the music and/or soundscape that best suits you and your clients' needs. I have been producing and mixing music for 18 years and can help you bring more dynamic elements and add life to your audio*

**Contact:**
**ross@shinealight.info**
**for more info, samples of work, and/or pricing**

**MC-CAMFT**
**P.O. Box 3092 Monterey, CA 93942**
**www.mccamft.org**

## NEWSLETTER ARTICLES AND CONTRIBUTIONS INVITED

Make sure our newsletter reflects your experience as a clinician in our chapter. Contribute to your newsletter through book reviews, opinions, CEU experience, events, clinical expertise, announcements, successes or other relevant information.

***Contact Ross Farley III, newsletter editor, ross@shinealight.info, 831-313-4043***

## NEWSLETTER ADVERTISING

Advertisements including classifieds and flyers must be placed prior to the advertising deadline. All ads must obtain approval by the Newsletter Editor, Advertising Chair and the MC-CAMFT Board President.
Advertisements should be submitted by email attachment as a Word document with the exact wording desired. Submission and approval for all advertisements, including payment, is due by the 12th of the month preceding publication.

## NEWSLETTER DEADLINES

Newsletters are published at the beginning of the month, every other month (January/February, March/April, May/June, July/August, September/October, November/December). Deadline to contribute articles and advertisements is the 12th of the month preceding publication.

**MC-CAMFT**
**Mission Statement**

MC-CAMFT is dedicated to the advancement of marriage and family therapists, to the promotion of high standards of professional ethics and qualifications of its members, and to expanding the recognition and utilization of the profession in Monterey County.

She slept
with wolves
without
fear, for
the wolves
knew a lion
was among
them - R.M Drake

***MC-CAMFT is pleased to acknowledge the service of its***
**PAST PRESIDENTS**

1989 Jane Ellerbe
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