GEORGIA SOCIETY FOR CLINICAL SOCIAL WORK

VOLUME 30, ISSUE 11

VOLUME 30, ISSUE 11

SPRING 2011

SUPERVISION ACROSS THE LIFESPAN OF THE CLINICAL SOCIAL WORKER

BY ALYCE WELLONS, LCSW AND BARBARA NAMA, LCSW

I had the experience of being in a supervision group for a decade, from ages 30-40. During this time, I worked part-time at a job, began building a private practice, left the job, and finally began practicing full-time. Many, many other things happened during that decade that became crucial in my development, externally and internally, as a psychotherapist. During those ten years, I would go out into the world, practice, learn, and grow--and always return to supervision. At first, the voice I heard was hers, her educating, containing and supporting. But slowly over the years, my own voice began to emerge. Through the safety, mirroring, and constancy she provided, I was able to learn to internalize her wisdom and find my own voice. Over that decade, I explored more actively, engaged more deeply, and regulated my own experience. One day, unexpectedly and with much grief and sadness, I realized it was time for me to go out into the world on my own. Over all the hours we spent together, there were many things she said to me that gave me the confidence and support I needed. Since any supervisor could say those words to her supervisee, there must have been other elements to the relationship that made it so powerful--boundaries, safety, trust, and caring. I felt genuinely cared for by her. And it was this experience that has then allowed me to be the safe haven and container to my own clients and supervisees. Alyce E. Wellons, LCSW

In supervision that is psychodynamically based, the focus is generally two-fold: 1) concrete learning such as assessment, treatment planning, theoretical conceptualization, and cognitive understanding of the therapy process and 2) therapist use of self within the treatment relationship. With less experienced supervisees, the emphasis tends to be on the former. As the knowledge base expands, the process within the therapy comes more to the forefront. In this article we will discuss the influence of both the relationship between the supervisor and the supervisee and the process that occurs between the two on the growth and development of the supervisee.

The relationship between supervisor and supervisee is a very important and powerful one to examine. The therapist, if practicing clinical or educational supervision as outlined in our previous article (GSCSW, *Clinical Page*, Spring, 2010) establishes a learning alliance with the supervisee, it is within this relationship that much of the work--education and examination--will take place. It is important for the supervisor to think about what is important in creating safety and trust within the relationship. Attachment theory informs us that creating a secure base, safe haven, proximity maintenance, and separation distress are very important to establishing a relationship between supervisor and supervisee (Bennett, 2008). Adults have general attachment styles based on their internal working models from childhood and tend to seek out people who "get us:. It is important in this relationship as a safe haven and a secure base, enabling the supervisee a place to explore new ways of viewing his/her clinical work. Students are likely to get more activated and seek closer proximity to supervisors in the beginning of their work. The more supported supervisees feel, the more they are likely to engage in exploration in their own clinical work with clients. In a "secure circle of security," the supervisor is attuned to the supervisee's exploratory or safe haven needs; this is a dynamic--a mutual exchange between two people in their specific relationship. (Bennett, 2008).

The relationship of the supervisor and supervisee not only creates a holding environment within which the supervisee

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CALENDAR:

April 21st 7pm –9pm Job Panel at Hillside Hospital

May 6th NASW/GSCSW Spring Conference at Ridgeview Institute

May 9—Midtown Mentorship Group

June 3—6pm—End of the Year Party—see back page

Fall 2011 GSCSW Salon—home of Margaret Gunn

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PRESIDENT'S MESSAGE

Hello Fellow GSCSW Members,

It is with great excitement and sadness that I am writing my final President's Message to this wonderful organization.

First, I want to thank you all for allowing me to serve as your President. My involvement with the Board of Directors and each of you has increased my pride in being a part of GSCSW and in being a social worker. Our membership has the most amazing, dynamic, dedicated, and loyal social workers who have worked hard, serving on the Board and volunteering in our community. I cannot express my gratitude at serving alongside each one of you over the past five years. Thank you for all you have taught me!!

GSCSW is so fortunate to have the incoming leadership and style of Barbara Emanuel LCSW. I know her vision and plans will lead GSCSW forward with new things to come for our organization. It is with great pleasure that we welcome her as our incoming President on July 1, 2011.

Thank you again for the honor of being associated with this great organization!! I look forward to seeing you all at upcoming events and in our community.

Alyce E. Wellons LCSW

President, GSCSW 2007-2011

"Thank you again for the honor of being associated with this great organization!"

PRESIDENT ELECT'S MESSAGE

It is with such a sense of honor, humility and gratitude that I begin to move towards my presidency of GSCSW. I continue to be amazed by the vigor of our organization: the youthful enthusiasm and passion of our newest members and clinicians, and the original vision of those who founded GSCSW: to create a society of like-minded social workers whose goal is to inform, provide and support the best clinical work possible. I recognize that I have giant shoes to fill. Alyce Wellons, LCSW has guided the Clinical Society with such a graceful way of bringing people together and allowing members to serve in a way that both suits their strengths and pushes them to grow. I am so grateful to have served alongside Alyce while learning what it means to be president of this organization. I am excited and energized about the work of the next two years! Please do not hesitate to talk with me if I may be of help to you in GSCSW.

Barbara Emmanuel, LCSW

President-Elect

GSCSW—2011

FROM THE EDITOR

As we welcome Spring, GSCSW is also about to welcome a new President and several new committee members. Our clinical society continues to embrace and offer professional development and support to social workers with all levels of experience and areas of specialization. Our organization can provide a base of support for all of us as we professionally address the many struggles that people face in our country and in our world. At the Clinical Page, we welcome ideas for articles from our membership and thank those who have already contributed.

This Spring Edition of the *Clinical Page* features several articles related to an ongoing theme of self-care and finding ways to nurture ourselves over our professional careers in social work. Our cover article, "Supervision Across the Lifespan of the Clinical Social Worker" reinforces the value of clinical supervision and consultation throughout our careers.

I had the opportunity to attend the Spring Salon in March and share a few thoughts in an article included in this issue of the *Clinical Page* titled "How to Be A Social Work "Lifer". I'd like to thank our LMSW Committee, Laura Carmody, LMSW and Stephanie Beatty, LMSW for helping to organize these enjoyable and informative gatherings among our membership.

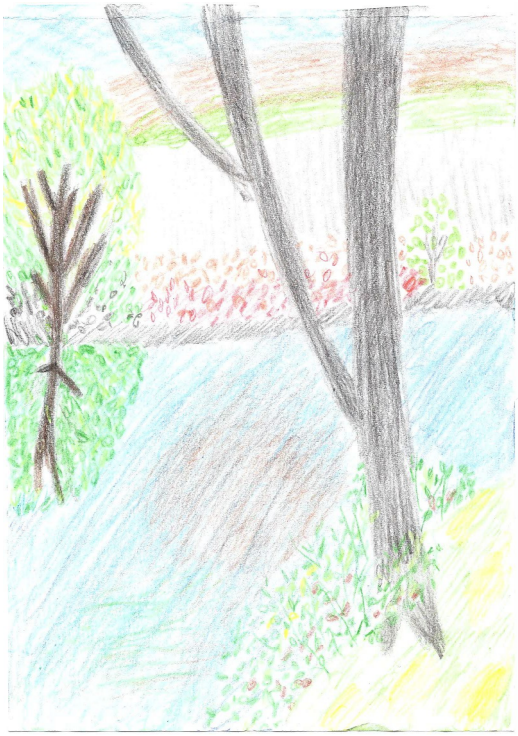
Our "On the Business Side" column discusses two common mistakes that social workers who are considering private practice might make when they work towards their goals. The article also suggests a way for social workers who are considering entering private practice to first become a "happy hybrid".

"The Therapist's Chair" features a remarkable look at how our unique attachment styles play a role in managing issues related to infertility. Attachment theories and emphasis on early bonding and connections are an area of practice that is getting much attention in our field in recent years and months. We also have an article that discusses the brain's plasticity and how attachment in the psychotherapy relationship can work towards facilitating healing. In addition, our Spring *Clinical Page* shares an article that discusses the 1013 and its many implications for clinical social workers.

Tell us what you think about the articles in the Spring Edition of GSCSW's *Clinical Page*. We want to know your ideas and appreciate the feedback of our members. E-mail comments and article ideas/submissions to kptantillo@yahoo.com.

Happy Spring!

Karen Tantillo, LCSW



"FROM THE THERAPIST'S CHAIR"

IRÉNÉ CELCER, MA, LCSW

Attachment Styles: The Different Meanings of Infertility

It has been my experience that knowledge on attachment theory and attachment styles is an invaluable tool when working with infertility patients. Attachment styles can impact the way in which patients choose treatments, the type of treatment selected, as well as how long the patient is willing to remain in treatment. Consideration of such styles provides a strong contributory argument to avoid a "one size fits all" approach to infertility counseling.

Understanding Attachment Style

Attachment theory poses that a bond between an infant and its caregiver begins at birth. This bond or attachment is based on an instinctual need of the infant for survival. For human infants and other mammals, the bond is shaped by the caregiver's quality of the care. Infants "use" the caregiver as a secure base from which to operate and explore the world. If the base (and the care) is not secure, because the caregiver is erratic or distracted, the bond between that infant and mother or father or guardian would also not be secure. Interestingly, studies have shown that the style in which humans are made to attach as infants is the style they will display later on as adults, even if it is an unhealthy one. However, humans can change over time and through experience attach in healthy ways, even if their primary attachment was dysfunctional.

"Attachments are the modes in which we have actualized being social animals since birth."

Insecure attachment can appear in many ways. Some of the most commonly seen attachment styles include:

- Insecure, where a person may appear dependent, where others describe a person as needy or clingy. Another person who is also insecurely attached may seem aloof and in total control of situations where in fact, upon a deeper look, she has stifled her needs to the point of not recognizing them.
- Disorganized, where a person may appear angry, aloof, or have intense oppositional feelings toward those close to them.

Attachment styles are not only unconscious; they are embedded in our limbic system, the neuronal fabric of who we are, like the hard drive of a computer. In essence, they are a product of our interpersonal history as well as unique temperament. Attachment styles just "are." Patients relate through their attachment styles. Therapists relate through their attachment styles. We all do because we cannot avoid it.

Attachments are the modes in which we have actualized being social animals since birth. Since actualizing being social comes in different flavors for every family and every individual, individuals will act differently according to their own styles, as well as their personalities. And, since families are about building, fostering and constructing attachments, the reality of a barrier to building a family with child will resonate with troubling experiences from the past for those with problematic attachments.

For better or worse, infertility is about attachments in a concrete way, too. And those who come to our office with an infertility story are more often than not in attachment emergency mode. They are in pain, in trouble, in crisis. And humans in crisis are not, in general, at their best, even when all outward appearances make them seem to be. When in crisis, we may act and do things that may seem out of character. However, from an attachment perspective, the things we do may make total sense. For example, a preoccupied patient might feel devastated about the loss of a cycle and scream at her therapist in a rage. Alternatively, a dismissive patient with a failed cycle may stop coming to the office altogether. A traumatized patient with an ambivalent attachment style may feel glad after she miscarries and feel guilty that she feels glad. So

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"THE BUSINESS SIDE"

BY MARGO GELLER, LCSW

How to Become a "Happy Hybrid"

The journey from employee to self-employed is best done very slowly. As they say "slow and steady… wins the race". I define a hybrid as someone who has a full time or part-time job (a regular paycheck!) and a private practice, on the side. Many people will remain a hybrid throughout their career.

If you listen to successful people tell their career story, it may sound like it was no big deal to get clients and become a happy hybrid or self-employed professional. For most people that is absolutely not true. Our memories can deceive us. Everyone has some amount of fear about building a successful private practice. The two most common mistakes newly self-employed professionals make are not maximizing their marketing resources and undercharging. The third is not getting help from someone who knows business!

When I first went out on my own in 1991, I continued to work at Jewish Family Services, as an independent contractor, working 6 to 10 hours a week. I slowly built a small private practice. I paid for office space, by the hour, until I had enough clients to share an office with another therapist. My business mentors were members of my family who were either self-employed professionals or entrepreneurial business owners.

The "hybrid" experience was mostly satisfying for me, although at times I questioned if it was the best thing for me. It could be isolating, at times, and I missed being part of a team. Emotional support from my professional peers was not so easy to find. I couldn't walk down a hallway and find a large selection of other therapists to talk to. I valued the flexibility and freedom to create my own schedule and to be more creative with my services, but actually missed "water cooler chatting" and surprisingly staff meetings, too! I didn't get to have fun saying, "What a waste of time that was", or I can't believe, so and so, said such a stupid statement.

The journey began and my confidence grew, especially when I saw my first client and their check cleared! I chose an office suite where no one specialized in working with older adults. I had a niche, and it was perfect! I developed some unique programs to make it easier for senior housing programs to know about my work and make referrals. I planned my schedule, so that I was available during less desirable hours, such as Saturday mornings and early on weekday mornings. It fit well with my lifestyle since I had a young child who got out of school in the early afternoon.

Taking the hybrid route into private practice can reduce your stress, particularly your financial concerns and worries. If you don't have another source of income, be sure that you have some savings to pull from if you need to. I always recommend that you have at least three to six months of living expenses in the bank. Just basic good living!

Be sure that you feel good about your decision and share your excitement by telling positive stories with passion! Remember that stories sell and selling is the transfer of enthusiasm. Education and marketing your services through writing, teaching and speaking are three of your best marketing tools.

Try it out. You can always change your mind and make a different decision. If you do it right, you will probably like it a lot!

In her practice, Margo helps self-employed professionals take their career or business to the next level of satisfaction and success. She is the author of *The Love Club: A New Approach to Business Networking* and can be reached at margogeller@gmail.com/ www.margogeller.com

"FROM THE MEMBERSHIP"

LORI KVAM, LMSW

Getting Started as a Social Worker

Entering the clinical social work field after graduation can be a time of promise and anticipation. Those first few months after graduation can often bring a clear and well-deserved sense of individual self- worth, accomplishment, and pride. Yet, these feelings can subside as we transition out of a student role and into that of a fledgling professional. After you do land a job, the exhilaration can take form again. I've started my first social work job! Yet, as the demands of an entry-level social work job set in, a new challenge begins. What I have found from the shared experience of myself and many others new to the profession, is that working within mental health systems can be both challenging and highly stressful. The point of this essay is not to whine about the difficulty in creating a career in clinical social within mental health provider systems. After all, we must gain experience and start somewhere and the most logical place is an entry-level clinical position. My goal, instead, is to raise awareness of the challenges involved during this entry-level tenure in lower strata social work jobs , and how we can find real meaning during this time.

Our place on the job hierarchy does matter according to Dr. Robert Sapolsky, a world renowned neuroscientist and author of *Why Zebras Don't Get Ulcers*. Sapolsky spent decades studying the effects of stress on baboons in Kenya. He believed that blood samples from these distant relatives, would provide an increased understanding of the effects of stress on humans. What Sapolsky found was that baboons, like us, organized their tribes hierarchically. What speaks to a new social worker like me, is that the lowest ranking baboons were found to have the highest levels of 2 major stress hormones, adrenaline and glucocorticoids, in their blood. Those at the top of the hierarchy had the lowest stress hormone levels. Another study by the British government directly linked this study to humans. The British civil service collected data from 28,000 civil service workers, ages 20 – 64, over a period of 20 years. This research, now referred to as the Whitehall study, collected information on employees with stable jobs that were not "industry type jobs" such as meat packing or other physically demanding jobs. The study's remarkable findings were that the lower you are in the hierarchy, the higher your risk of heart disease as well as other diseases.

This study reminded me of a big difference in my own social work graduating class. Our cohort was comprised of many DFCS lower-level workers and only 2 DFCS supervisors. The lower-level DFCS employees were tired and spoke to many areas they felt the social service organization contributed to a high burnout rate. Yet, the two supervisors both stated several times, "I love my job." One of the two was higher ranking in DFCS and not surprisingly, she was the most vocal about her employment satisfaction. Like those in the Whitehall study, these 2 women reported lower levels of stress and greater job satisfaction.

It does seem that the often espoused advice of self-care is still quite relevant, especially while working in difficult, entry-level clinical social work jobs. Sue Monk Kidd, and author of The *Dance of the Dissident Daughter,* speaks of the golden nugget available within lower level jobs. "Until we look from the bottom up, we have seen nothing." For me, this does not mean standing passively and holding out a collection plate for an increased caseload and lower pay. What it means is that the time is ripe for me to practice what I preach. I must take time and remember to breathe, and to fully breathe regularly. I add humor to my Netflix queue all the time. I am mindful of my thoughts, especially the self-defeating ones, such as "I have so little choice in where I work." It is easy to hold generous, gentle thoughts when your plate is full of fruit. Not so easy when you're having trouble finding the tray. And so I perform a quick cognitive shuffle and remind myself that in reality, I am just arriving in this field. It is time to take notes while at the bottom and to cultivate kindness for myself and the families that I work with who are in their own ways looking up from below. And as I gain experience, I move forward with a strong and gentle sense of where I am, step by step by step.

THE SIGNIFICANCE OF THE 1013 FOR CLINICAL SOCIAL WORKERS

MOSHE GITTLESON, LCSW

Licensed clinical social workers in the state of Georgia are authorized to "sign a 1013". This means that based on the sworn statement of a LCSW, a peace officer may be directed to take custody of an individual and transport him/her to a psychiatric emergency receiving facility. An emergency receiving facility is a mental health facility recognized by the state where a patient must be evaluated by a psychiatrist or psychologist within 48 hours to determine whether involuntary treatment is necessary.

The signing of a 1013 creates a balancing act between three basic social work principles that conflict with one another during the 1013 process. On one side is the principle that social workers are to empower patients to make life decisions for themselves. By signing a 1013 we are taking that power from the patient, albeit temporarily. On the other side is the notion that social workers have an obligation, if possible, to prevent self-inflicted harm to a patient. So if we do not follow through on the 1013 and the patient harms him/her-self or others, we have not fulfilled this obligation Third, social workers have an obligation to society to prevent harm to a client's family and community. Allowing a patient to leave your office with the patient subsequently harming others is a potential tragic consequence of not signing a 1013.

This is the complicated clinical and ethical background that the LCSW finds themselves when we attest that our patients are mentally ill and that they pose an imminent danger to harming themselves or others. As an LCSW you are authorized and expected to make this decision independently. Authorization to sign a 1013 was given to LCSW in recognition that we provide much of the mental health care in Georgia and that frequently we are the only available licensed mental health providers. When possible this crucial decision should be done with consultation from either another LCSW or one of the other professionals (physician, psychologist, clinical nurse specialist) who are authorized to sign a 1013.

By completing a 1013 you are swearing that you have examined the patient within 48 hours of signing the 1013. An examination commonly means that you have conducted a face to face interview with the patient. Completion of the 1013 requires that you have determined that your client is mentally ill. Mental illness is not defined on the 1013 so the common standard is that if a patient has an Axis I diagnosis either by history or your diagnosis. Second, you must determine that your patient presents an imminent danger of harming him/herself or others as manifested by either recent overt acts or expressed threats of violence which present a probability of physical injury to that person or others. Another reason for a 1013 is that you determine the patient to be so incapacitated by their mental illness that they are unable to care for themselves so as to create an imminently life threatening crisis.

So if you are in private practice or working in an agency it would be helpful to have the following:

- A copy of a 1013 (available at www.centralstatehospital.org/forms).
- The telephone number for the sheriffs department of the county in which your office is located.
- The telephone number of the crisis line for your county.
- The telephone number of the nearest public and private emergency psychiatric receiving facilities.

Maintaining a relationship with law enforcement, psychiatric facilities and the nearest hospital emergency room can expedite this process and contribute to your safety and the safety of your patients.

Even once you have completed the 1013 and have contacted the sheriff's department to transport the patient to an emergency receiving facility, you still have a considerable number of decisions to make. Below is a partial list:

- Do you tell the patient that he/she is being transported to an emergency psychiatric facility?
- If you decide to tell the patient when do you tell them?

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OUR HISTORY

Left to right, front row:

Carole Walton,, Linda Weiskoff, Sara Page, Marty Wakeland, Barbara Emmanuel

Left to right, back row:

Amy Garnett, Ramona White, Bob Frederick, Cynthia Smith, Stephanie Swann, Alyce Wellons

The first ever President's Luncheon was held this year on Friday, March 4, 2011. Eleven of the Past Presidents attended the luncheon, including our first President, Bob Frederick, LCSW. It was a wonderful time to see and meet each other, catch up with old friends and colleagues, and meet new ones. We also welcomed our President Elect, Barbara Emmanuel, LCSW into her upcoming term, beginning July 1, 2011.

Thank you to all our Past Presidents whose vision, passion, and hard work laid a foundation for the thriving and solid organization we have today. We are grateful for your social work skills of trailblazing, gathering resources, and advocating for clinical social workers.

GSCSW PAST PRESIDENTS

Bob Frederick 1980-1981

Carole Walton: 1981-1982

Diane Davis: 1982-1983

Carolyn Rashe: 1983-1984

Gail Mullinax: 1984-1985

Amy Garnett: 1985-1986

Jeanne Bedell: 1986-1987

Cynthia Smith: 1987-1988

Ramona White: 1988-1989

Marty Wakeland: 1989-1991

Neila Rivers: 1991-1993

Carole Walton: 1993-1995

Cheri Reis: 1995-1997

Margot Davis: 1997-1999

Linda Weiskoff: 1999-2001

Elizabeth Mauldin: 2001-2003

Sara Page: 2003-2005

Stephanie Swann: 2005-2007

Alyce Wellons: 2007-2009, 2009-2011

Barbara Emmanuel: 2011-2013

HOW TO BE A SOCIAL WORK "LIFER" AND SOME OTHER REFLECTIONS

KAREN TANTILLO, LCSW

Our Spring Salon was a stimulating and informative sharing of minds among many GSCSW social workers with various backgrounds, specialties, and levels of experience. I was delighted to attend this informal gathering on a Sunday afternoon in late March at the home of Linda Weiskoff, LCSW, Clinical Director of the Heartwork Counseling Center. In addition to Linda and Sara Page, LCSW (both former GSCSW Presidents), a seasoned panel of social work "lifers" included Sharman Colosetti, LCSW and Randy Oven, LCSW.

As clinical social workers, we certainly must strive to find our passions in the work, be available and present to the vulnerabilities that clients present, and also truly learn how to care for ourselves. Randy Oven summed up some of his thoughts about spending his career in the social work field and resiliency:

1) Show up
2) Be present
3) Make your best effort to maintain balance
4) Say the truth with as much wisdom and compassion as possible
5) Let go of the illusion of control

I felt a connection to the stories and insights shared by this experienced panel of clinicians, all of whom have spent their careers dedicated to social work. After getting my MSW in 1989, I proceeded to work for the next ten years in a variety of mental health settings and programs. I came into the field of social work young and idealistic, striving to learn more, yet trying to figure out ways to manage the intensity and emotional demands of the work. I was a twenty-something "wounded healer" (as per Carl Jung), forging ahead and not fully knowing what kind of balance that I needed. As I entered into a different season of life and started to have a family of my own (ie. three beautiful children), I made a difficult decision to "retire" from social work, not fully sure if I'd ever return to the field. I felt validated listening to the salon panel's thoughts about self-care and how the seasons of one's life can affect the type of work that we take on.

Clearly, self-care remains an important part of the work towards being a "lifer". Physical exercise and meditation can be key. One member of the panel values her daily walking regimen while another teaches water aerobics and had found high-impact aerobics to be useful when she worked at a rape-crisis center. Nurturing relationships with our supervisors/consultants, peer groups, writing groups, colleagues, and our therapists can sustain and nurture our ever-developing professional selves. Supervision and consultation make our work easier and surely keep our clinical skills growing and developing, a worthwhile investment in so many ways.

Professionals who have accrued many years of clinical and life experience continue to search for ways to renew their spirit and stay grounded in offering good clinical work. Finding and sustaining interests, relationships and passions that might be totally unrelated to our direct work is yet one more important component of self-care. One of the salon presenters even shared her own passion for making and selling cheesecakes. "Cheesecake represented something different", Linda Weiskoff wisely shared at the Salon.

Social work can be such a diverse career offering so many different types of settings and client populations. Certainly private practice might be an option for those with an MSW degree and clinical licensure, but it's not necessarily the best fit for everyone (bringing with it much professional responsibility/liability and a need for cultivating marketing skills). Whether we choose private work or a more community-based setting, however, developing and honing our entrepreneurial and business skills continues to be important for any social workers in the field. One social work "lifer" that attended the salon added that 40% of practitioners in human services will become employed as independent contractors in the next ten years and need to carefully advocate for themselves.

I'm now returning to the world of professional work after taking years "off", definitely older and hopefully wiser, continuing to search for the illusive balance that is a good fit for me, trying to find a way to contribute, make a difference and, of course, earn money for three college educations. If you can continue to identify and recognize your own needs and continue to find your own balance, social work can truly be an incredibly rewarding and creative profession for life.

Courtesy of psychotherapy.net

In addition to her work with children, adolescents and families in private practice in Alpharetta, Karen Tantillo, LCSW enjoys writing and editing for GSCSW's *Clinical Page*.

CURRENT TRENDS IN PSYCHOTHERAPY

CURRENT PSYCHOTHERAPY FOCUS ON THE BRAIN'S PLASTICITY

FRED CRIMI, LCSW

In the past ten years there has been an explosion of scientific information supported by physical evidence and rigorous scientific research suggesting the need to view human development through the lenses of social neurobiology and psychoneuroimmunology. It is imperative that we shape the practice of psychotherapy by understanding the interaction between our social and physical environments, body, mind and spirit. In fact, the resolution of emotional trauma and subsequent behavior change will follow a transformative physical experience.

In the field of psychotherapy we recognize that the therapeutic alliance promotes healing. The evidence suggests that it matters not what form of psychotherapy you practice as long as the therapy embodies the qualities of a healthy attachment. For example, in *Attachment and Psychotherapy,* David Wallen provides ample scientific evidence on how the brain responds to an attached and attuned psychotherapist who can facilitate healing.

In light of recent research such as this, we have learned that the brain's plasticity makes it possible for relationships to reshape and heal past emotional damage. In his book, *The Neuroscience of Human Relationships,* Louis Cozolino addresses questions like: how does therapy work and how does social interaction re-shape the brain even later in life.

As therapists we are actively co-creating and co-regulating the therapeutic environment. Attunement and attention to the client's physical and emotional presentation, as well as our own reaction, foster the relationship aliveness and the potential for reorganization and healing.

From a cellular level Alan Fogel suggests that "connections within and between cells, within and between the interaction of the body and environment including the brain, must be involved in the ruling of developments with a change either in body or behavior." It is evident that the author believes neither cognition nor an irrational detached experience creates meaning. Meaning is derived as a result of the situation experienced within the entire body.

Our body is where experience is encoded and stored, either unconscious implicit information or conscious explicit information. Daniel Siegel, an eminent social neurobiologist, tells us that the amygdala, located within the emotional center of our brain, is where implicit information is stored. This unconscious, preverbal and nonverbal material has its origins in early childhood and can present the therapist-client dyad with an instantaneous flood of feelings which we define as an abreactive event.

Our task as practitioners is to co-create a safe environment so treatment can continue. In addition we want to help the client understand how a flashback can present an opportunity for a rewiring or reorganization of his memories. This process causes an active firing of neurons which can present a painful and unwelcome occurrence necessary to potentiate a neurological reorganization.

It is once again pointed out that the brain's plasticity creates the possibility for a re-wiring or re-learning. An example of this would be the client feeling the support and comfort of a sensitive, caring attuned therapist, a surrogate for the parent who may have been missing at the time of the child's initial trauma. The active attachment of an attuned therapist will allow the client to feel his feelings, and it is this shared felt experience that helps reshape the brain's processing of the heretofore unconscious memory.

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SUPERVISION ACROSS THE LIFESPAN OF THE CLINICAL SOCIAL WORKER

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but is also a vehicle for understanding what may be transpiring within the therapy that the supervisee is presenting. As the supervisor and supervisee relate around cases, a parallel process can develop, in which the dynamics that are present in the therapy dyad are emulated or enacted within the supervisory dyad. We all tend to have characteristic and automatic responses, which at times are inappropriate because they do not respond to the other in an attuned way, "…characterological adaptations and relational patterns are persistently, automatically enacted in all relationships: therapeutic, supervisory, and personal. By consciously studying such patterns, supervisors gradually recognize the problematic relational templates supervisees utilize" (Schamess, p. 432). This is not to say that the supervisor is actively asking about personal issues. But rather, the supervisor is listening through a filter of transference and countertransference that enables her to hear more clearly what the supervisee may be struggling with in the therapy and to recognize the relational issues being evoked in the supervisee that may be contributing to an impasse. As the supervisor listens and reflects, this allows the supervisee to hopefully have the experience of being "held in mind" and to develop a non-defensive capacity for self-reflection, which is essential to the psychodynamic therapeutic process.

As noted above, one of the primary functions of the supervisor, especially in the early stages of supervision, is modeling of listening, reflecting, and interactive skills. Through this process, as case material is discussed, the supervisor is also engaging in another important function, which is to tolerate and manage the affect of the supervisee. Just as in a therapy relationship, in which the therapist can contain and metabolize the feelings that arise within the patient so that she can better tolerate the affect and handle it more constructively, so too, the supervisor does this with the supervisee. This enables the supervisee to develop more of a capacity to recognize and manage the emotional reactions various patients evoke in them. The development of this skill enables the supervisee to listen on a deeper level to what the patient is communicating, rather than reacting too quickly, thereby short-circuiting the exploration. Over time and with experience, the supervisee develops the ability to recognize when her vulnerable areas are getting tapped into and can use the "internal supervisor" (Casement, p. 47), i.e., an internal dialogue about the experience, to contain and modulate her use of this affect, hopefully to move the treatment forward.

Even the most seasoned clinicians have experiences of being flooded and paralyzed by certain dynamics. The use of supervision and consultation over their professional careers is an invaluable tool in the ongoing process of self development as a clinician.

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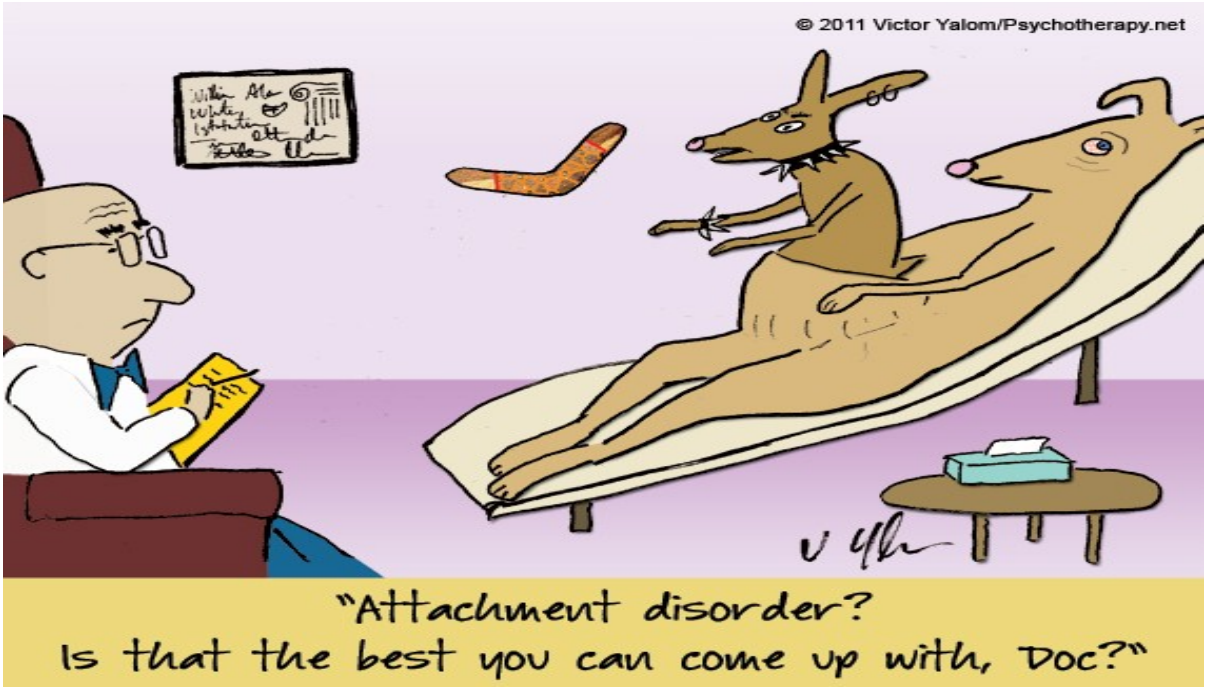
NASW-GSCSW JOINT SPRING CONFERENCE: "DIFFICULT ETHICS CASES IN CLINICAL PRACTICE" FRIDAY, MAY 6 2011

The Professional Education Committee is excited to have Dr. Fred Reamer, Professor at Rhode Island College-School of Social Work, to be our guest speaker for this year's Spring Conference presenting "Difficult Ethics Cases in Clinical Social Work". He is a renowned expert on ethical issues in social work, with numerous books and articles published over the years. Recently, Dr. Reamer recalled for some of our GSCSW members what sparked his interest in ethical issues back in 1976 when he was working on his PhD. At that time, his work and primary interests were criminal justice and correctional settings. While social workers in those fields were wrestling with complex ethical issues, he began to realize that there were challenging issues confronting our profession more broadly. Fascinated by these many issues, he took doctoral-level courses in moral philosophy. Since his first book on ethics was published in 1982, Dr. Reamer told us "...my interest has broadened to include a wide range of subjects, including ethics-related risk management, malpractice and liability issues, ethical decision-making, the use of ethics audits, and the development of ethical standards. I was privileged to have chaired the national task force that wrote the current NASW Code of Ethics".

Key topics will include boundary issues, dual relationships, conflicts of interest, confidentiality, privileged communication, informed consent, clients' rights, practioner impairment, and termination of services. The conference will include discussion of relevant ethical standards, statutes, regulations, case law, supervision and consultation.

The conference will be held at Ridgeview Institute on May 6, 2011 at 9am. All attendees will receive 5 CEU's for ethics. For more information on this event and to register online, please visit www.naswga.org. (Please note: space for this event is limited and filling up fast! Register now to reserve your spot!)

HUMOR



CURRENT PSYCHOTHERAPY FOCUS ON THE BRAIN'S PLASTICITY

CONTINUED FROM PAGE 11

There is nothing easy about healing emotional wounds, especially when one is in the middle of what his body is telling him are painful, scary and sometimes debilitating feelings. As we all know from Jung, there is no coming to consciousness without pain. In addition to talk therapy the client must feel his feelings and his body will lead the way.

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THE SIGNIFICANCE OF THE 1013 FOR CLINICAL SOCIAL WORKERS

CONTINUED FROM PAGE 8

- Do you tell family members?
- If you do tell them and they or their family members arrive at a safety plan, do you still act on the 1013?
- Do you allow the patient's family or friend or an ambulance service to transport the patient to the nearest emergency receiving facility out of concern that they may be traumatized by being handcuffed and transported in a law enforcement vehicle?
- Where should the patient wait while waiting for transport to prevent elopement?
- Do you arrange for the patient to be sent to a private facility? If so, contacting the admissions department of the facility will aid in this process. They will likely verify insurance coverage and consult with their physician regarding admission.
- Do you instruct the transporter to send the patient to an emergency department to rule out any medical problems or do you send the patient directly to an emergency receiving facility?

Other issues remain after the hospitalization is completed:

- Do you have a release to remain involved to help with discharge planning?
- If the patient wishes to continue care with you, the issues of surrounding the 1013 will need to be discussed.
- What do you need as a clinician to continue with a patient whose problems are severe enough to necessitate the signing of a 1013?

The patients who present with the issues addressed in a 1013 are some of the most complex and challenging patients we work with as social workers. I hope this article provokes discussion about how to best serve these individuals.

Moshe Gittelson, LCSW is currently the Director of Admissions at RiverWoods Behavioral Health System and the Employee Assistance Program coordinator for Southern Regional Medical Center. He has worked as the program manager for inpatient mental health and substance abuse facilities, as an EAP provider, and a private practitioner in the Atlanta area for over 25 years. He can be reached at moshegittleson@bellsouth.net

FROM THE THERAPIST'S CHAIR

CONTINUED FROM PAGE 5

the unique attachment style will, in part, determine the decisions a patient will make.

Patients have a varying range of thoughts, feelings and beliefs about why they are infertile and their attachment styles deeply impact how they relate to their reproductive endocrinologist and the clinic staff. Patients routinely carry within them guilt, blame, fears, anguish as well as a dose of love to provide with a touch of ambivalence to dish out. Of course, they bring all of it when they come into our offices and it is our role to help them through the maze of such complex feelings.

The Impact of Attachment Style on Decision Making

For one patient, a cancelled or failed IVF treatment cycle may mean that she will not stop cycles until a viable pregnancy is achieved, even when such treatment may be iatrogenic or against her doctor's better judgment. For another patient, a failed cycle might mean she will go straight to adoption, ignoring and submerging any desires she might feel for a genetic connection to her offspring. Such deep desires, thoughts and feelings regarding a genetic connection are important to consider because they may help explain the haste or procrastination that patients sometimes display during IVF treatments. Helping a patient develop an understanding of her own attachment style can help facilitate decision making when it comes to IVF treatment.

Which will it be? Adoption, egg donation, sperm donation, surrogacy, life without parenting? To answer these questions it is important to understand how attachment style may influence treatment decision-making. For example, a patient who might be clingy and is insecurely and ambivalently attached to her husband might fear being left by him, if she does not do what she imagines he wants. She may rush into a building option family without the proper thinking process or, without taking herself into account. So as you can see, each person's psychological makeup brings a different set for factors to the decision making process.

To be helpful to infertility patients, the therapist will need to grasp the human story behind the story. By this I mean that it is important to determine how this individual patient constructed the meaning of her journey, given her particular attachment style. An adult who grew up with an avoidant attachment style and grew up to be an adult with a dismissive personality style may believe that he is okay ignoring his needs to form a certain kind of family and thinks he can defer the decision to his wife. It is important to understand the story behind people's decisions so we help this client to take into account their needs. In essence people can ignore their wants and needs and forclose them (or force them into others) due to the wiring of their attachment styles.

One Size Does Not Fit All

Different patients may need to move at different speeds and follow different pathways. So, it's the infertility therapist's job to help the patient understand exactly which roads to take and how fast (or slow) to go. And this is a dynamic process, where a patient may sometimes need to go in reverse and reconsider a decision or to change her speed. This is why the Procrustean bed has no place in the consulting room.

Occasionally, you'll run into patients who demand to know the "right" way or the "best" option or the "preferable" technique. This is not unusual when infertility therapists operate under a medical model that sometimes connotes certainty, absolutism, and parsimony when it comes to medical decisions. Many patients view the culture of infertility treatment as "medical," and so yearn for the expert to convey the "correct" treatment. This is particularly the case when a patient presents with a dependent attachment style. Within such a culture and when faced with such a personality style, it's important for the infertility therapist to emphasize the unique nature of the patient's case and the complexity and difficulty of the decision making process. Patient's who want a quick fix will not find it in your consulting room.

So the infertility therapist must consider a complex array of historical, cultural, interpersonal, and intrapsychic factors when trying to understand the special impact of attachment style on a patient's course of treatment. Only with such an understanding can the therapist help patients make better decisions about the course of treatment.

In addition to her practice, Ms. Celcer is currently involved with Endangered Species: The Female Body, an international meeting -of-the-minds in London, Buenos Aires, New York, and Sao Paolo to challenge the toxic visual culture that doesn't acknowledge the diversity of women and girl's bodies. Her forthcoming book is a pocket volume of tips to educate families with tots, tweens, and teens about their relationship with food and eating. She can be reached at icelcer@icelcer.com/www.icelcer.com

COMMITTEE REPORTS

TREASURER

It's been a pleasure to continue serving as your Treasurer in 2011. I would like to thank Trisha Clymore, Administrator, for all of her help since I took office seven months ago. We continue to maintain a healthy portfolio of accounts which include checking and money market accounts and a CD. Our membership dues continue to pay for wonderful benefits including free professional education opportunities which include refreshments.

Please feel free to contact me with any questions that you may have.

Theresa Schaffer, LCSW - treasurer@gscsw.org

LOW-COST SUPERVISION

With the help of the LMSW Committee, the web page for supervision has been updated. Supervisors were asked to review, update, and clarify their profiles, making it easier for people looking for a supervisor to search for a match online. There have also been several calls to me directly over the past few months for help in matching with supervisors and for help in clarifying supervision requirements for licensure.

In June, I will be passing the torch of Chair and welcome Jamie Bray, LCSW and Christina Kasper, LMSW as the new co-chairs of this committee.

Barbara Nama, LCSW—bnamalcsw@aol.com

LMSW

The LMSW Committee began 2011 with a great start, collaborating with the Mentorship Committee to launch GSCSW's first ever "Salon" series, informal gatherings offering conversation, collective wisdom, and knowledge. The next salon will take place in the Fall at the home of Margaret Gunn. A specific topic has not yet been decided but suggestions are welcome.

Our Facebook page, "LMSWs and MSWs of Georgia Society for Clinical Social Work", continues to provide a space for new social workers to connect, exchange information, network, and learn more about GSCSW. Check it out!

The LMSW Committee has again joined with the Mentorship Committee to host this year's Spring job panel on April 21, from 7-9pm, at Hillside Hospital. The panelists will represent a variety of arenas including medical, schools, addiction, private non-profit, private practice, managed care, hospice, and veterans. Plan to attend!

Stephanie Beatty, LMSW and Laura Carmody, LMSW—lmsw@gscsw.org

MENTORING

The GSCSW's Mentorship Program continues to match experienced clinicians with those newer to the field. We encourage those seeking to be matched with a mentor to attend the free monthly mentorship group meeting before completing an application. The final group of the season will be on May 9th in Midtown from 7:30- 9:00pm. The mentorship groups will resume in September for the 2011-2012 school year.

Midtown Mentorship group:

- Facilitators: Phyllis Glass, LCSW and Sharon Harp, LMSW
- Location: The office of Phyllis Glass, 1904 Monroe Drive, Suite 120, Atl
- Date/Time: 2nd Monday of odd numbered months, 7:30-9 PM
- Contact: Sharon Harp, LMSW at (404) 727-7415

Smyrna Mentorship group:

- Facilitators: Ephrat Lipton, LCSW, Tara Guest Arnold, PhD, LCSW and Sonny Magill, LCSW
- Location: The office of Tara Guest Arnold, 4015 South Cobb Drive, Suite 250, Smyrna 30080
- Date/Time: 2nd Monday of even numbered months, 8:30-10 PM
- Contact: Tara Guest Arnold, PhD, LCSW at (404) 964-6629

The mentorship groups will resume in September for the 2011-2012 school year!

COMMITTEE REPORTS

ETHICS

The Ethics Committee would like to thank the Professional Education Committee for organizing what we anticipate to be a very thought-provoking Spring Ethics Conference. We look forward to following up on potential areas of interest raised during this conference. All seems to be going smoothly as GSCSW enters the new technological realm of Facebook . We will continue to keep an eye on the ethical issues related to increased technology. This past year has been a quiet one regarding ethics consultations so please remember that we are available for consultation to our members whenever an ethics dilemma arises.

Emily Gosterisli, LCSW and Beth Collins Himes, LCSW , Co-Chairs ethics@gscsw.org

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We are continuing to encourage everyone to be a member of the GSCSW online community through the listserv. The benefits include:

- Giving and obtaining referrals and resources
- Jobs and workshop postings
- Office space announcements

If you are not a member, please send an email requesting an invitation to join the GSCSW listserv to: admin@gscsw.org

Sample email:

"I am a member of GSCSW and would like to join the listserv. My email is: youremailaddress@sample.com."

Someone will respond to you regarding the status of your request. We look forward to hearing from you online!

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Members and Non-members are welcome to advertise in the Clinical Page and on the listserv.

GSCSW
P.O. Box 13838
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END OF THE YEAR PARTY

Please come to GSCSW's Annual End of the Year Party.

This is a time when we come together, celebrate a year well done, and meet up with new and old friends and colleagues. It is casual, partner's welcome, and bring a dish to share!!

Where: Home of Alyce Wellons, LCSW and Sharon Burford, LCSW

805 Ponce de Leon Terrace, NE

Atlanta, Georgia 30306

Bring: A dish to share

When: Friday, June 3rd at 6:30 pm

Hope to see you there!