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INSIDE THIS ISSUE:

FROM THE PRESIDENT	3
EMBRACE YOUR OWN THERAPY	4
DO'S AND DON'TS OF PSYCHOTHERPY	6
PREVENTING BURN OUT	7
CLINICAN HEAL THYSELF	8
BOUNDARIES IN CORRECTIONAL SETTINGS AND SOCIAL MEDIA	10
COMMITTEE REPORTS	14

CALENDAR:

December 13 —Diane Davis Lecture—see page 13 for more information

Jan 9, 2014 —Supervision: It's Not Just for Licensure - Dan Arnold, LCSW

Feb. 6, 2014— Brainspotting: a Revolutionary Therapy for Effective Change—Cynthia Schwartzberg, LCSW

March 6, - The Inner Life of the Therapist: Impact of Family Care and Illness on Clinical Practice**
Panel discussion

Reminder: Mentorship meets at 5:45 at Hillside before the Professional Ed meetings

LETTER FROM THE EDITOR

BY: LAURA ADILMAN, LCSW, CTT

Over the past few years, as I have provided different clinical services in a variety of clinical settings, it has come to my attention how relevant and necessary it is for therapists to continue their own work as a client in the therapy room. I have been surprised in a number of instances with the wide variety of opinions I get from colleagues about continuing self-exploration through receiving therapeutic services as a client. It seems that popular opinion runs the gamut from, "I'm fine, I don't need therapy; I don't have any issues; I don't want to spend the money; I don't have any free time; I work through my issues with my friends;" and so on. We encourage our clients to expose themselves and express their feelings, often asking them to face lifelong fears in the process, and yet frequently we have not done this difficult work ourselves. One of a therapist's most useful tools is empathy. I believe it is difficult to draw on empathic concern when one has not experienced, firsthand, the risks and the rewards that come with bearing one's own soul and trusting that one's own deepest fears and secrets will be safe with strangers. While the costs of seeing a therapist can be difficult financially and emotionally, the benefits certainly outweigh them: there are fewer issues with and more awareness of countertransference, increased empathy, less burnout, increased awareness of what clients may avoid sharing with their therapists, the rewards of learning experientially how to be a therapist, and countless others.

I have been in therapy on and off for most of my life for various reasons, and I thought that I had done all of my own work. After surviving an incredibly traumatic car accident that took the lives of two of my closest friends at age sixteen, I went to therapy every week for over a year. I remember saying to my therapist when I was seventeen years old, "I'm fine; I haven't cried in months." A few years ago, I began the journey to become a Certified Trauma Therapist. I remember driving to Onsite Workshops in Cumberland Furnace, Tennessee excited to be able to spend a week on a ranch, with beautiful horses, in rustic cabins away from noise and technology. I figured I would learn some interesting stuff, have a little vacation, and get a bunch of CEUs all at the same time. I was in for a surprise. What I ended up getting after four more trips from Georgia to Tennessee, over the course of about two years, was a certification in trauma therapy and a life experience that has changed me beyond what I could have ever imagined both personally and professionally. I hadn't realized, until personally going through this experiential trauma training program, that the result of the trauma from the accident, my reaction to experiencing such a devastating event at such a formative time in life, was my having developed a safety wall of rigidity and an emotionally-based need for control that was negatively affecting most areas of my life. I may have grieved the loss of my friends while I was still a teenager, but I had not addressed the other traumas that arose from that situation that I had been carrying with me into adulthood and into my personal and professional life.

I am beyond grateful to the Spirit2Spirit Trauma Certification Program and to Onsite Workshops for exposing me to a new way of learning how to be an

Continued on page 7

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PRESIDENT'S MESSAGE

Hello everyone!

I am so honored and excited to be writing my first message as President. I joined this organization shortly after receiving my Graduate degree, and it quickly became my professional compass. I delight in seeing how we have evolved through the years and continue our legacy as a source of education, guidance and support to our community, and I welcome the opportunity to serve.

I want to begin by expressing my gratitude to our past President, Barbara Emmanuel, LCSW, who has been such a wonderful mentor and leader and to our Board of Directors who volunteer their time so generously. It is because of their hard work, talent, and dedication that I have been able to step into this position with ease. Together we continue to strive toward addressing the needs of Clinical Social Workers, both seasoned and new, and determine how we, as a group, can make a difference for ourselves as well as the clients we serve. The Board chairpersons represent their Committees who are the backbone of our organization. It is because of them that our membership is recognized, that we have great educational programming with CEU's, that we receive low-cost supervision, that we have mentors to turn to, that we have an opportunity to network, that we have our ethical questions pondered, and that we have our collective concerns represented by our lawmakers and have our needs for collegial support met. There are rich rewards for committee membership, and I encourage everyone to consider becoming involved.

This is an exciting time of change for our organization. We have already put our plan in motion to embrace webinars on our site. It is a work in progress, and we are learning that this is no small feat. We are committed to our goal of making our programming accessible throughout the State and utilizing technology to enhance the benefits of our membership. We will continue to experiment with the best way to offer this valuable service. Thanks to the efforts of our Professional Education Committee, our programming remains interesting and relevant as demonstrated by our first three monthly workshops. We are so excited about our upcoming Diane Davis Lecture in December featuring our very own Barbara Nama, LCSW, and we are busy making plans for our Spring Conference on Ethics.

At our GSCSW Town Hall, our Lobbyist, Wendi Clifton, Esq. spoke of the pressing issues before the upcoming Legislative year, which affect our practice as Clinical Social Workers. It was at this meeting that we learned the effects of the Tarasoff Law and lack thereof in Georgia. This beget another Town Hall in which we partnered with NASW-GA and were privileged to have a Past President, Stephanie Swann, PhD, LCSW represent us as a panelist. This meeting was not meant to craft solutions but to raise consciousness about the importance of understanding the juxtaposition of ethics and law. I encourage our members to resist the urge to discount legislative participation as it may not seem as enticing as our educational programming. Not only is Legislative participation a part of our Constitutional objectives for GSCSW, but also, it is historically the voices of the Social Work profession who speak for the most silent in our Country. While we are a distinct specialty, we must mindfully celebrate our roots in Social Justice. Remaining knowledgeable about the politics of our profession is a necessity.

"As you know, by continuing to grow as individuals and professionals, we become better providers for our clients."

It is so timely that our learned Ethics Committee is offering an opportunity to have group dinners while participating in ethical discussions. It was decided at our last Board meeting that this was so beneficial for our members that we should have a regular event throughout the year. This is one of many opportunities for us to engage not only professionally, but also, socially. We look forward to our upcoming January Salon, which pairs our more experienced members with those new to the profession. Thanks to our LMSW committee; the energy is palpable.

It is my vision to elevate the profession of clinical social work so that we are viewed as the quintessential providers of mental and behavioral health care. It is yet again one of our Constitutional objectives to promote our public image, and thus, it becomes a self-fulfilling prophecy.

On our Board, we have an open position for a public relations/social media position. We are a membership of diverse and talented individuals, and anyone willing to bring their skills in this arena would be welcomed. Please contact me or any Board member if you would like to get involved or if you have any questions or concerns. We are here to address your needs. I want to thank everyone who makes invaluable contributions to GSCSW and keeps our organization thriving. As you know, by continuing to grow as individuals and professionals, we become better providers for our clients.

Respectfully yours,

Annie M. Garry, LCSW

President

EMBRACE YOUR OWN THERAPY TO BECOME A HAPPIER, HEALTHIER, MORE EFFECTIVE THERAPIST: EXPLORE YOUR COUNTERTRANSFERENCE! ©

~PAMELA CHUBBUCK PHD, LICSW, LPC

"In order for us [therapists] to assist people to unmask, confront our demons, ground, and find our deep truth – our high selves - and then to be able to change the world into a kinder, more heartfelt place - we must be willing to learn and do this deep work ourselves - on an ongoing basis. There is no way around it!"
~John Pierrakos, MD (Psychiatrist, Super Shrink). John taught this concept to his student therapists.

"Counter transference issues no longer should be hidden or denied, and on the contrary, can bring the greatest treasures to both the Client and the Therapist."
~Virginia Wink Hilton, PhD

It is the #1 job of the therapist to keep the client as safe as possible, first and foremost from the therapist's own "stuff." That, of course, requires the therapist to be willing to reflect, and get help to find what his/her stuff is!
Crucial questions are: What is a therapist to do with his/her own feelings that come up when working with clients? (And they *do* come up!) How can these feelings be used to best serve the client? How to become healthier and happier yourself as you work with difficult issues? The only way to know about and work with countertransference* (*see Appendix) and become more conscious and healthier along the way is to first and continually do our own therapy.

This essential importance of working on oneself seems to be left out in current academic psychotherapy programs. Do you remember how therapists were historically trained? First they underwent their own therapy. They worked with a therapist/mentor for many years until finally the mentor said, "I think you are ready to take on a client."

Most new therapists are coming out of programs lacking the most basic experience: the student's own personal therapy – too often having not one day of personal therapy under their belts. This lack is very concerning, primarily because most new therapists tell me they feel unprepared to help clients.

Recent graduates also tell me that countertransference was skimmed over, poorly taught, or was left out of their professional academic program.

Ten years ago I surveyed all masters level MSW and counseling psychology programs in GA to discover that *none* had personal therapy as a curriculum requirement. Checking again this week I polled five of the top Georgia universities and found that policy unchanged. It was explained: "We suggest that students seek therapy *if needed.* School counseling centers are available." One recent graduate told me it took six weeks to receive a call-back when she needed an appointment at her Atlanta-area university. She felt her issue was an emergency, so she sought help elsewhere in the meantime.

I have worked with therapists for over 30 years and they consistently tell me they do not really learn how to be social workers, professional counselors, psychologists, etc, in their academic programs; nor do they learn best by suddenly finding themselves in a practicum where they feel inadequately prepared and frightened for themselves and their clients ("It feels like going cold-turkey."). Students tell me they are afraid to reveal how scary it is. While they say they don't learn most during their academic education, upon coming to therapy they tell me they do learn most by doing their own work – i.e., working on themselves in therapy.

"Therapy" cannot be learned by *reading about* therapy or taking a class to *study* therapy, or going to a *lecture about* therapy. It also cannot be learned by having a student therapy group run by another student, or a professor, in graduate school to *role-play* therapy. According to my many clients throughout the years who have been in counseling/psychology degree programs, reading about therapy is too heady – without real emotion – and it is the emotions that they are unprepared to handle both in themselves and their clients.

The classroom format has been too frightening for students to open up and be real. Students have told me that they do not feel safe or supported to really work on themselves in those academic situations. Most class therapy situations are a setup for "mask-to-mask"* therapy, where both the therapist and the client remain in defined roles and are unable to genuinely connect and also access their deeper feelings. The client cannot experience the therapist as supportive of his/her terror of feeling the deep emotions that have been suppressed and held in the body-mind; emotions which were not allowed expression in the original family system. The client continues to block unconscious feelings. Student therapists, therefore, learn to enhance the defenses that have kept them from feeling their deep issues all along. This fearful blocking is then passed on to their own clients when they are out in the work world. Vicious circle - destined to continue if professors,

CONTINUED ON PAGE 5

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CONTINUED FROM PAGE 4

mentors and supervisors don't do their own work.

A recent graduate of a top-rated GA school told me last week: "No one tells the truth, in my group therapy classes. Students quickly 'get it' that we are supposed to have it 'all together'- that we should not need real therapy – or if we do get therapy we should not have anything really too serious or grizzly to deal with from our past. And if we do, we should have dealt with it already."

I have two graduate degrees and completed three 4-year non-university trainings. I also had a few decades of personal therapy. When asked what helps me the most to be a pretty good therapist, I know clearly that it is my own experience as a client. Second to that, my training programs that focused on personal experiential learning inform my work. Third was experiencing the multiple levels of how master therapists work with clients (watching, listening, thinking, feeling, and intuiting) and role model the continual work they do on themselves.

One of my favorite mentors, psychiatrist John Bellis, MD, a former student of Harry Stack Sullivan, told me in the early 1970's that he was a lot more interested in countertransference than in transference*. John encouraged me to change my graduate paper from "The Case of the Client" to "The Case of the Therapist." My countertransference! At that time, the idea of taking on and revealing my deeper issues scared me. Today I am very grateful to John and I find countertransference most fascinating.

I see every client who walks into my office as bringing an opportunity for me to further heal, expand*, enlighten and become more conscious. Knowing about and embracing countertransference helps me learn about my client and myself. If I were not constantly learning about myself in the process of helping clients, I would have gotten bored and quit long ago.

Clients appreciate therapists who are not afraid to do their own work. They feel safer. One client wrote to me: "I trust you with my stuff because you are real – unmasked - and have done (and still do) your own work. And you don't set yourself up above me, as better than...." John Pierrakos, MD taught that the therapist-client relationship is not hierarchical; it is a learning partnership of evolution. Most of us were not taught that we can more effectively assist our client by modeling the authenticity of our humanity.

If you are a therapist, you *will* have countertransference. I still have countertransference after 40 years of working as a psychotherapist. The stuff that I don't see or am not conscious of is the "killer"; when I become aware, it is life-giving.

My countertransference is my teacher. It assists me in knowing more about my client and me, therefore making me better able to help. Gold mine! And when I have not been aware, my countertransference has been hurtful to my client. Uh oh - Land mine!

We all, at some time, have uncomfortable stuff that shows up when sitting with a client. Transference lives in the realm of the Wounded Child* with its deep unresolved painful feelings. We steer away from our feelings in sessions because they are scary, by virtue of the fact that as kids we were not allowed to have them or they were too painful – so we stuffed them down into our unconscious. If we are aware of our disturbing feelings, we may fear feeling or sharing our emotions will show our weaknesses or show us as unprofessional. It makes us uncomfortable to even feel inside ourselves. We may fear it reveals or suggests incompetence. Our culture often teaches us not to show weakness – sadness, anger, fear. Many of us, therefore, prefer to mask our feelings, pretend we don't have them. The kicker is that sometimes we are *taught* to mask our feelings; in the very professional licensure programs we hope to teach us how to handle clients' deep problems.

Current psycho-neurology informs us that we must work with clients from the "bottom up". That is - we need to be able to be aware of and know how to handle our clients' fight-flight-freeze response of their reptilian brain, and the emotions of their mid-brain. Only then can we helpfully use cognitive skills with clients. We can only truly know/feel these things by having the experience of dealing with our own traumatic biologic responses.

Becoming consciously aware enough to "see" or know when our own transference issues are being triggered is what we strive for as therapists. We may then have clarity about what our "stuff" is that we need to work with, versus what is the client's, which we can help the client explore. A client wrote: "*Literally kicking, crying, yelling, and other work to express and heal my Wounded Child, has allowed increasing clarity, compassion, and the objectivity to not take a client's anger personally, which used to bring a protective wall. I am now more undefended and even joyful in my work, for which my high self strives.*"

Luckily for our own transformation and growth, we always have a part (our high self) that wants us to bring the dark into the light. We need

CONTINUED ON PAGE 9

DO'S AND DON'TS OF PSYCHOTHERAPY

BY: FRANKLIN ABBOTT, LCSW

The only real miracle is a change of heart. – Buddha
What is needed is a gentler curiosity. -- Paul Goodman

Do write down your dreams.

Don't use intoxicants before sessions -- preferably delete for 24 hours before and after.

Do become a family anthropologist and psycho-historian.

Don't break regular appointments unless necessary.

Do reschedule if you can.

Don't let interactions with troublesome people go unreported.

Do report synchronicities.

Don't do anything every day.

Do experiment with novelty.

Don't compare yourself to anyone famous.

Do read inspirational literature.

Don't believe your therapist unconditionally. That's not trust.

Do make notes on your sessions. Buy a special book to record your responses and review it.

Don't call yourself ugly, demeaning names.

Do affirm beauty, truth and hope.

Don't under-feed, under-rest, under-sex yourself.

Do get massages, buy treats, write letters, go to movies, concerts, museums, the theater.

Don't rely on the kindness of strangers.

Do travel, keep an open heart, a clear mind, a bright spirit.

Don't commit to loving anyone who loves you less.

Do make friends, flirt, take care in your appearance, take pride in your essence.

Don't fret.

Do consider, again and again, the best of your love, your dreams, your life, your splendid, unique individuality.

Franklin Abbott is a Licensed Clinical Social Worker specializing in individual, couples and family therapy and maintains a private practice in Atlanta, Georgia.

LETTER FROM THE EDITOR

CONTINUED FROM PAGE 1

empathic, accessible therapist while simultaneously allowing me, in my role there as a "client," to also become a more fulfilled person. I now know that whenever I want or need to do a piece of work around an area of my life with which I am struggling, all I have to do is take that trip to Cumberland Furnace for an emotionally draining, intensive and extraordinarily rewarding, life changing and educational experience.

I wanted to focus this Clinical Page on the experience of the therapist as a client to help shed some light on the numerous benefits of continuing to do one's own emotional, therapeutic work while providing clinical services in the field. The beauty of our field of work, especially when working with our clients not just from knowledge gained via education or out in the field, but from a deeper, more personal place, is that we become better motivators for our clients. We earn their trust because they know we have experienced the same benefits from the work we are encouraging them to do, and I know I am a more qualified and more fulfilled human being and therapist as a result.

There is an old adage that states: "You can only take people [or your client] as far as you've gone." If there is one thing that I, as a therapist, have taken from my own experiences as a client, it is the increased ability to assist my clients in the expression of their own feelings while simultaneously taking them to deeper places thereby allowing them to achieve greater healing. I truly feel I could not accomplish that without continuing to do my own work on an ongoing basis. I hope you enjoy!!

Laura Adilman, LCSW, CTT

www.s2strauma.com/ and www.onsiteworkshops.com/

Laura Adilman, LCSW is the owner of a private practice in Midtown Atlanta where she does individual counseling with a primary focus on trauma, addiction, and mental health.

PREVENTING BURN OUT

BY: STEPHANIE COOK, LCSW

Burnout among social workers is a widely recognized problem without a simple solution. One thing social workers can do, however, is to apply some of the clinical techniques we teach our clients to our own lives in order to protect ourselves from this very real threat.

I would broadly define burnout as anything that exhausts our ability to work effectively with our clients and maintain a healthy work/life balance. Social workers are more susceptible to burnout than other professionals for several reasons.

Firstly, our job carries a high risk of empathic residue. Empathic residue is what I refer to as feeling overwhelmed as a result of caring and devoting attention to others in the course of our professional or personal work and life commitments. Over time, as we work continually in emotionally charged situations, we can become overwhelmed. We regularly listen to very difficult stories of depression, fear, trauma, anger, pain, etc. When we absorb the emotions of our clients without having a way to unwind and let go of the intensity of our work, we become particularly vulnerable to burnout. If we do not have ways of clearing our hearts and minds from what we have heard and held in the therapy office, we may even develop compassion fatigue and secondary trauma. This type of burnout may not just compromise our ability to help our clients, but it can also actively harm them.

Secondly, by constantly focusing on other people's problems, social workers often overlook their own self-care and well-being. Just like our clients, we have stressors, limitations, and demands that encompass both our professional and personal lives. Stressors in our professional lives are not just limited to empathic residue, but can also include increasing demands for paperwork, documentation, and productivity, or just too much work without enough time. Personal stressors, by contrast, encompass anything in our personal lives that cause us distress. A family illness, a broken relationship, or even a minor issue with our family and friends can lessen our ability to function effectively; it can slowly chip away at our mental, emotional, and physical health.

Despite these obstacles, social workers can proactively prevent and treat burnout. In fact, as mental health professionals, we are well positioned to use many of the skills we teach our clients to address the risk of burnout. One technique that is particularly effective in preventing burnout is dialectical behavior therapy (DBT), which is a form of cognitive behavior therapy that incorporates eastern meditative practices. A core technique of DBT is mindfulness, which teaches us to deliberately focus our attention on the present experience in a non-judgmental manner.

In my practice, I frequently use elements of DBT with clients who need to improve emotional regulation and self-destructive behaviors, but also with many of my clients who simply struggle with self-care and balance. For example, I often ask clients to complete between-session

CONTINUED ON PAGE 8

PREVENTING BURN OUT

BY: STEPHANIE COOK, LCSW

CONTINUED FROM PAGE 7

"diary cards," which cultivate awareness by tracking certain behaviors, emotions, and thoughts. By intentionally tracking behavior, habits, and emotions, these clients become more aware of what is causing them distress, which in turn makes it easier to practice self-care.

As therapists, we too can gain greater awareness by regularly taking an inventory of our own behaviors, habits, and emotions in a nonjudgmental way. Paying attention to ourselves is critical, even if it is something as simple as tracking our sleep, diet, and exercise. By doing so, we are more likely to notice any signs or symptoms of burnout, such as fatigue, muscle soreness, impatience, lessened attunement, or a weakening of the therapist-client relationship. Noticing these signs early allows us to proactively treat them before burnout sets in.

Additionally, mindfulness can help us take notice of areas in our lives that could potentially lead to burnout. For example, when you look at your schedule, do you see a balance between your personal and professional life? Have you set clear boundaries around each, to protect both? Perhaps you promised to see a client on a day when your schedule was already full or agreed to a session that conflicts with family commitments or other personal commitments. Therapists can suffer from their own issues with denial, rationalization, and poor boundaries. What starts out as "flexibility" can easily morph into consistently working additional hours to the detriment of other areas in your life. By practicing mindfulness in these areas, we can be honest with ourselves about when we have crossed such boundaries.

The problem of burnout among social workers is particularly tragic because as mental health professionals, we must be able to take care of ourselves if we want to help our clients. To put it bluntly, we need to listen to our own advice. I would like to encourage you to prevent burnout by taking proactive steps towards greater self-care and balance in your life.

Finally, if you experience signs of burnout, please realize that you are not alone and that it is treatable. Feeling burned out does not necessarily mean that you need to change careers. If you start to recognize your own tendencies towards imbalance, it may be helpful to start a dialogue with a trusted mentor or consultation group about ways you can create a plan for improving your self-care. If you need even more support and guidance, consider engaging in your own personal therapeutic process.

Stephanie Cook, LCSW is also a distance credentialed counselor, and owner of a small counseling practice located near Emory University. She offer's individual, couples, and family counseling, as well as distance counseling (online video or phone).

CLINICIAN HEAL THYSELF

BY: PATRICIA WRIGHT, LCSW

I deeply love people in helping professions, and I am honored to be counted among them. I didn't find my life's work until later in life, an answered prayer when I least expected it- another gift on gratitude's road. Though I have had several careers over my somewhat impressive life span, I was never prouder of my work as I have been as a clinical social worker. Our work is noble, and our ethics are unimpeachable and all-encompassing.
We Social workers, collectively, go out to save the world on a daily basis. We are so passionate about this that we sometimes put ourselves last. The results can range anywhere from low, but rechargeable, batteries to burnout and compassion fatigue.

I would agree with those who say that there are certain "flaws" unique to people who are attracted to this field. I have found that neglecting our own self-care is a recurring pattern among people in this line of work. Personally, my life circumstances are always showing me the negative repercussions of straying from the beautiful things that bring me joy.
Perhaps we have strong codependency traits. I confess that I do! I find that I must remember that although I have a penchant for capes, I can't really fly! I get lost somewhere in trying to do my best for my clients and forgetting my own emotional and physical limitations. Maintaining good boundaries is an issue that hits me like the waves of the ocean appearing regularly and sometimes knocking me down if I wander too far from the safety of the shore. The lesson I must learn over and over again is that I have to take good care of myself in order to keep on living my passion.

I am a relatively new therapist, and perhaps this tendency will diminish in time; however, I suspect this will be an ongoing struggle for me. I like to remind my colleagues/friends that we must do the things we ask our clients to do. I am a happier person when I do the things I explore with my clients; I often forget this. This is very humbling for me to admit, but I know it's a good thing for me to confess. It helps me remember how easy it is to default to old, unhealthy patterns of behavior. It also helps me focus on my progress; I no longer fall into this trap so easily and with such frequency.

Every time I fail to surrender to this self-imposed neglect I am stronger! Time and again I learn that when I take care of myself, I have magic for the world. A little "me" time makes me spiritual, light, and funny. When I can take the time to follow my personal self-care plan, I live and breathe creativity. I connect! I inspire! I am truly in my life's purpose doing what I was born to do!

So why do I forget to take care of myself so often? I forget about the partnership I have with my creator- the one who gave me this

CONTINUED ON PAGE 12

EMBRACE YOUR OWN THERAPY TO BECOME A HAPPIER, HEALTHIER, MORE EFFECTIVE THERAPIST: EXPLORE YOUR COUNTERTRANSFERENCE! ©

~PAMELA CHUBBUCK PHD, LICSW, LPC

CONTINUED FROM PAGE 5

to make friends with our shadow side to some degree; doing so will help us heal from the repeating patterns with which unawareness plagues us.

When we are able to work with our transference and feel grateful, hopeful and welcoming of the learning – even when it causes us some suffering – we can be good role models and more effective helpers for our clients. This will lead to our clients feeling safe, and we can then assist them to better learn from their transference with us.

Here are some examples of countertransference trouble that became Countertransference Gold when worked on by the therapist. As always, names and identifying info are changed in case examples.

Case I

Roy hired Sandra, a former student of his, to teach a form of therapy at the university. After a short honeymoon period, problems really began to show in their relationship. Sandra acted out her part by not showing up at an important faculty meeting and not telling him. Later she "blew me off" by saying that she did not like to do what he told her all the time. Roy, normally a clear, grounded man, acted out his transference issues by feeling incapacitated by the anger he was feeling. Roy felt awful and confused about what to do. In consulting with me it became clear that Sandra was acting out her unresolved father issues with Roy and Roy was treating Sandra as the sister he had a lot of trouble with in his teenage years. During our work together Roy's tough defended façade, his mask, crumbled and Roy was surprised but relieved to be able to cry about the loss of his sister during that pivotal time. He said his heart felt broken. He was then able to see Sandra more clearly as herself.

With my encouragement, he had a talk with Sandra explaining as best he could, what he saw and felt was happening. This allowed a softening and gave Sandra the opportunity to feel her own transference, which was how being around Roy made her feel small, young and helpless. She had unresolved issues with her father and Roy became the catalyst to excavating the wounds that had become her unconscious feelings. When both worked on understanding and feeling their deeper pain, things between them improved greatly

Case II

Suzanne, a therapist in her first year of private practice made an appointment for supervision.

She told me in session that she was so turned on by her very attractive, smooth-talking, dripping-with-sexuality, male client that she could not concentrate on their session. "I could not stand it!" Suzanne told me. "My client said he had so much love to give his girlfriend, and that all he wanted to do was to be with her."

As we talked about her client it was obvious to me that her client was acting very much from his mask, not really knowing about, or grounded in, his true sexuality. He was needy, desperate in fact, to be with someone - and his acting-out with sexual body language, voice, jokes, and sexual innuendos, was a cover-up. But my client was fooled. There was countertransference resonance*. She was needy also. She had not had sex with her husband for years. She wanted to be turned-on to someone – to be turned-on, period. When I questioned and encouraged her deeper personal process she realized and said, "I know those are the things I want to hear someone say to me."

Suzanne had longed for her husband to say those same things to her. She wanted to hear him say, "I have so much love to give you, all I want is to be with you and make you happy". Maybe she simply longed for love. Her own dad did not do a good job of giving her a positive foundation of love in her early years and he died when my client was 13 years old, just when a girl most needs a father to be a role model for her future relationships. She longed for her father to say those words: "I love you. I want you to be happy." She (we *all*) wanted Dad to give us inexhaustible, unconditional love.

So, Suzanne got hooked! We talked about how she was triggered and what she really wanted, and from whom. By the next session, two weeks later, she had begun to see through the mask of her client. No longer seeing him as so desirable – capable of giving real grounded love to her - or to anyone, Suzanne knew she needed to reach out to her husband for what she wanted, or to get love elsewhere – certainly not from her client. She was not pulled into her seductive client's needy snare any longer.

CONTINUED ON PAGE 11

"BOUNDARIES IN CORRECTIONAL SETTINGS AND SOCIAL MEDIA"

BY: ALEXANDRA PAJAK, LMSW

In July 2013 I attended a workshop at the National Commission on Correctional Healthcare's Correctional Mental Health Conference in Las Vegas, Nevada. The workshop, "Professional Boundaries: Preventing Overfamiliarity in Correctional Health Care Settings," addressed the challenges of creating and maintaining professional boundaries between mental health clinicians and incarcerated clients. The presenter defined professional boundaries as the line between self and client and likened a professional boundary to a fence around the clinician with gates in which a client could enter. The following aspects of correctional mental health that pose unique boundary challenges compared to other clinical settings were identified: malingering, over-involvement, and assault risk. Specifically, in correctional settings, clinicians may encounter malingering to avoid long sentences, overfamiliarity with inmates, and interacting with clients who have criminal records including charges of rape, murder, and assault. The workshop concluded with the recommendation of ongoing training in boundary-building skills, clearly stated boundary standards in a workplace, and training to educate employees on ways to identify boundary crossing with themselves and their coworkers

Although the workshop was geared toward correctional healthcare, the lessons on boundary setting can be applied to any clinical setting. In this article, I would like to reflect on the ways in which over familiarity can occur within the private practice setting, particularly with the increasing popularity of social media. I had a personal experience with this several years ago when my husband and I attended pre-marital counseling required by our place of worship. We met several times with our counselor, who provided excellent therapy throughout each session. After our third session, Facebook listed our counselor as a "suggested friend" for me. This astounded us. Our professional marital guide was right there on my laptop in our living room smiling at us through a Facebook news feed!

My husband and I both keep our privacy settings to the highest level possible and we had no "mutual friends" on Facebook with our counselor that we knew of. We chose not to "friend" our counselor so as to maintain appropriate boundaries. We discussed this with our counselor, who had not received a "suggested friend" and expressed equal surprise that Facebook connected our profiles, particularly as she has privacy settings on her profile as well. Fortunately, our counselor, my husband and I had simple headshots for profile photos. Many other people on Facebook have "selfies," photos of their children, or outrageous photos holding beer, wine, and/or being partially dressed.

What if a social worker appeared as a "suggested friend" to a client? What if a client searched our name on Facebook to learn more about us? How would a photo presentation represent us to clients? How might holding alcohol or wearing provocative outfits affect our clinical relationships with clients? What should we do if a client "friends" us? I have asked myself, what if an inmate asked a relative to login into his/her account and search for me on Facebook? At this time I am unsearchable on the site, but what if I had not known my way around Facebook's complex privacy settings? What if an inmate on my caseload asked me to take a look at his/her Facebook page, and I saw photos of something illegal? Luckily this situation has never arisen, but the conference certainly got me thinking about various ways in which social media can create boundary issues among therapists and clients.

As social workers and human beings, sometimes our own issues can affect how we interact with clients. Our countertransference can lead to the proverbial "gate" opening thereby increasing the risk of boundary crossing with clients. Although social media can aid our profession in professional networking opportunities and online support groups for clients with specialized needs, social media has also emerged as a way in which our own issues can be readily apparent to clients. Just as we are taught in school, though, about professional presentation in our offices (professional attire, not socializing with clients outside of the therapeutic relationship), so should we, as social workers, be cognizant of the ways in which our presentation in social media may affect our interactions and relationships with our clients.

Photo courtesy of James Holder.

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CONTINUED FROM PAGE 9

Case III

Fred was a relatively new client to Richard. Fred normally held his body very tightly – stiffly. When Richard, his therapist, tried to help him release emotions - when Fred got even remotely close to a feeling, Fred would get scared and contract his body even more. Richard tried all he could think of, with few satisfying results. The longer Fred did not do what Richard thought he should do, the more uncomfortable Richard became.

Maybe I should refer him, he told me. Often the feeling of needing to refer someone – or get a new therapist – is a sign to search more diligently for the transference. We worked with this thought and his feelings and Richard began to sense his fear of failure. Richard's father would berate him when he could not do things well within the first few tries. Richard was feeling like a child again. That is rarely a good place from which to be a therapist - scared and physically defended.
"Here it is," I thought.

"What are the feelings Fred is repressing, do you think?" I asked Richard.

Richard thought.

And later I asked, "And, what kind of a dad did Fred have?"
"His father was a bastard," Richard blurted. "He hit him if he did not know his times tables!"

We were silent for some moments.

"Well this is beautiful, actually!" I proclaimed. Richard looked surprised.

"OK, so your dad and Fred's dad were similar. And you probably feel scared too."

Richard did not immediately see the beauty in this but he did begin to soften and feel his fear. He cried softly. This was the healing moment for Richard and later helped him work with Fred more compassionately and reportedly, more effectively.

~

We all need our own therapy. We need constant reflection, and vigilance about our own unresolved issues - that's the tricky part – when unresolved, we often aren't aware of them, so we need to ask for help. Someone with an unbiased and objective perspective can usually see our issues before we can, just as we, as therapists, can most often see others' issues more clearly than our own.

When I feel uncomfortable about something that is happening with a client, first I look at myself. How may my unresolved feeling be impacting the therapy? If stumped, I still need help from a supervisor or therapist. Often I consult with a colleague. Sometimes I hire someone, with more experience and known to be good with countertransference issues.

I am honored to assist therapists with discovering their true selves – embrace working on themselves in therapy - and am most grateful to those who have and still assist my journey. As Super Shrink John Pierrakos taught: when we explore our own issues and work to *"unmask, confront our demons, ground, and find our deep truth – our high selves"* - we can become more conscious, expanded - and a happier, healthier, more effective therapist.

Pam Chubbuck, PhD, LICSW, LPC, Director of Core Energetics Institute South; trains and supervises therapists internationally. Author of *Passages into Womanhood: Empowering Girls to Love Themselves*; *Woman Spirit*; *GoodBye Mom - I'll Always Love You;* among others, and has published numerous articles. Pam is well known for her work with countertransference. Pam lives and works in the Atlanta metro area and Downeast Maine. Pam is offering a free *Intro to Body Psychotherapy: Reichian, Bioenergetics & Core Energetics*, Sat Feb 1, 2014 at Vitally Alive Core South (Metro Atlanta) Learn More: www.VitallyAlive.com 770-388-0086

Pam has written more extensively about Countertransference in her paper *CounterTransference - Gold Mine or Land Mine: Understanding and Working with CounterTransference (The Key to Being an Effective Therapist).* Also available at www.VitallyAlive.com

CONTINUED ON PAGE 12

CLINICIAN HEAL THYSELF

CONTINUED FROM PAGE 8

live and breathe creativity. I connect! I inspire! I am truly in my life's purpose doing what I was born to do!

So why do I forget to take care of myself so often? I forget about the partnership I have with my creator- the one who gave me this profession in the first place. I forget about what He wants for me, and I start trying to handle everything myself until I crash and burn again.

I've heard it said that the therapist is the instrument of healing and that our lives and personalities are the palette we use to paint the colors of hope for our clients. We can use everything, even our imperfections, to make the world a little better. We become experts on stress reduction, meditation, and spirituality because we are using them more and more in our own lives. Laughter is so important in my own life, and I like to take "comedy down time" just to watch silly movies or comediennes so I can laugh until it hurts.

I need to be inspired so that I can be inspiring. I enjoy reading bible verses, which I use as affirmations like, "We are fearfully and wonderfully made." I am reminded that I am a walking miracle, and I give thanks. There are many things we need to do for ourselves in the realm of self-care. Increasing the things that bring us joy should be among them. I regularly ask myself the Miracle Question: "Suppose tonight, while you slept, a miracle occurred. When you awake tomorrow, what would be some of the things you would notice that would tell you life had suddenly gotten better?" This helps me on my journey on this road of self-care and compassion.

So although I put in 12 hour work days, due to a rigorous commute, I make time to swim in the pool most evenings. Nature is important to me; it is where I hear my God the best; therefore, I try to meditate around lakes and rivers and the ocean. I am also taking more time for the arts these days; I define myself as an artist, and the arts feed my soul.

Another way I nurture and affirm myself is by exploring my own personal challenges in individual therapy. I approach therapy with the same courage I see in so many of my clients. It is through therapy that I have learned what an honor a client bestows upon a therapist when they choose to open up and reveal their true thoughts and feelings.

These are just some of the things I enjoy doing to nurture my body, mind, and soul. I deeply enjoy surrounding myself with people who are explorers too and also finding new things that bring me delight. I hope I will always model this for my clients. I am learning that when I take good care of myself, I give the world a better me! So as I am out there exploring the answers to my own miracle question, I have learned to embrace myself with compassion. Even when I miss the mark, all I have to do is I return to the healing waters and I dive back in.

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CONTINUED FROM PAGE 10

References & Recommended Reading

The Power of Counter-Transference: Innovations in Analytic Technique, Karen J. Maroda

Therapists at Risk: Perils of the Intimacy of the Therapeutic Relationship, Virginia Wink Hilton, PhD & Robert Hilton, PhD

Between Therapist & Client: The New Relationship, Michael Kahn

Love's Executioner & Other Tales of Psychotherapy; Irvin D. Yalom, MD

Core Energetics, John C Pierrakos, MD

The Pathwork of Self-Transformation, Eva Pierrakos

Healing Developmental Trauma: How Early Trauma Affects Self-Regulation, Self-Image, and the Capacity for Relationship Laurence Heller PhD & Aline LaPierre PsyD

Scared Sick: The Role of Childhood Trauma in Adult Disease, Robin Karr-Morse & Meredith S. Wiley

The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication & Self-Regulation, Stephen Porges

Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences, Peter A Levine, PhD & Ann Frederick

In an Unspoken Voice: How the Body Releases Trauma & Restores Goodness; Peter A Levine, PhD & Gabor Mate

Of course, Bruce Perry, Daniel Siegel. Candace Pert

DIANE DAVIS LECTURE- DECEMBER 13, 2014

Moments of Meeting

The Intersubjective Experience in Therapy

A troop of porcupines is milling about on a cold winter's day. In order to keep from freezing, the animals move closer together. Just as they are close enough to huddle, however, they start to poke each other with their quills. In order to stop the pain, they spread out, lose the advantage of commingling, and again begin to shiver. This sends them back in search of each other, and the cycle repeats as they struggle to find a comfortable distance between entanglement and freezing.

Schopenhauer's Porcupines by Deborah Luepnitz, Ph.D.

The dilemma of the porcupines is familiar to all of us as we struggle to find the optimal closeness or distance in relationships that enables us to thrive. Our patients most often come to us seeking help, in one way or another, with issues of connection in relationship, and our work involves helping them discover what their obstacles may be. And from a relational therapy perspective, the therapy relationship is one of the primary means of both discovery and change.

Each therapy dyad is unique, with each person bringing his or her attachment style and core beliefs about relationships and how to be in them. It is within the intersection of what each holds as implicit that the therapeutic action takes place. One of the greatest tools in the therapy process is the therapist's ability to use his or her knowledge of self to deeply connect with and come to know the other, facilitating an understanding of that which the patient is not yet able to verbalize. And it is often within our encounters with our patients that we once again see the more vulnerable parts of ourselves. Through the lens of mother-infant research, attachment theory, and relational psychotherapy, we will explore the nature of the change process and look at ourselves as therapists to gain more clarity about how our own styles and vulnerabilities impact treatment and serve to create impasses or openings for change.

Learning Objectives:

Define the concept of intersubjective therapy.

Describe the implications of the intersection of attachment styles of the patient and the therapist.

Identify the concept of enactment and describe the concept of therapist's use of self in working through impasses.

Presenter:

Barbara L. Nama, LCSW is in private practice in Atlanta. She is a graduate of the University of Michigan School of Social Work and worked in community mental health in North Carolina before moving to Athens, Georgia, where she worked for many years at the Student Mental Health Center at UGA prior to moving to Atlanta. She has been an active member of both the Georgia Society for Clinical Social Work and the American Academy of Psychotherapists for many years. Her foundation in object relations theory and study of attachment issues have enhanced her exploration of the intersubjective process of psychotherapy and her ongoing quest to understand what makes therapy work.

8:30-9:00 Registration, coffee and pastries
9:00-12:00 Lecture and discussion
Location: Ridgeview Institute, 3995 South Cobb Drive , Smyrna, Georgia 30080
Directions: www.ridgeviewinstitute.com
Continuing Education Credits:
3 CEUs for Licensed Clinical Social Workers
CEUs have been applied for Licensed Professional Counselors

For more information and to register to go www.gscsw.org

COMMITTEE REPORTS

PROFESSIONAL EDUCATION COMMITTEE

We're off to a fantastic new year with our successful Thursday Night Workshop Series! We've already heard from some wonderful speakers on clinical topics including Trauma-Focused Yoga, Healing Body Image and Bullying through the Life Span. We're thrilled about our Thursday night line-up for 2014, which will include "Supervision: It's Not Just for Licensure" (Dan Arnold, LCSW), "Brainspotting" (Cynthia Schwartzberg, LCSW), "Impact of Family Care and Illness on Clinical Practice" (panel discussion), and "Psychopharmacology" (Jonathan Levy, MD).

This year's Diane Davis Seminar will focus on an intimately critical topic! Our speaker, *Barbara Nama, LCSW*, will present *"Moments of Meeting."* Barbara is a graduate of the Michigan School of Social Work. In addition to her private practice, Barbara is a member of both the Georgia Society of Clinical Social Work and the American Academy of Psychotherapists. In this seminar, Barbara will focus on the intersubjective experience in therapy. Barbara's presentation will assist clinicians in defining the concept of intersubjective therapy, describing the implications of the intersection of the attachment style of the client and therapist. Barbara will identify the concept of enactment and describe the concept of the therapist's use of self in working through impasses. This seminar will be held on *Friday, December 13th at Ridgeview Institute* from 8:30 am until noon. Three core CEU hours will be provided. For more information and to register for this event, please visit our website www.gscsw.org Hope to see you there!

Information on Spring Conference – TBA

Katie Alioto, LCSW and Lena Franklin, LMSW— You can contact us at professionaled@gscsw.org

ETHICS COMMITTEE

The Ethics Committee is happy to welcome two new members, Susan Vanous, LCSW, and Katherine Hall, LCSW. We continue recruiting new committee members; please email us if you are interested in joining. We have received five ethics inquiries from members since last quarter on a variety of topics. In October, we hosted our first event, "Ethics in 3-D: Dinner, Dilemmas and Desserts." Members socialized and discussed both common and uncommon hypothetical ethical situations and concerns. We were privileged to have Howard Gold, MSW, JD, a local attorney practicing family law, to provide input regarding how to consider legal implications in decision making, which occasionally intersects with ethical considerations.

We are looking forward to our future events! Since one of the functions of the Ethics Committee is to raise awareness of issues, which are important when we are providing services to clients, we invite you to suggest topics that you would like for us to address in future articles and discussions. Also, if you have any ethical concerns, please feel free to contact us for consultation.

Stephanie Cook, LMSW and Stacie Fitzgerald, LCSW—ethics@gscsw.org

MENTORSHIP COMMITTEE

Mentorship meetings continue to take place prior to the continuing education workshops at Hillside Hospital. We've been having a great turnout to meetings and look forward to planning the jobs panel in the Spring.

Danna Lipton, LCSW, Chair mentorship@gscsw.org

COMMITTEE REPORTS

LEGISLATIVE COMMITTEE

This year we welcome a new member to our Legislative Committee, Katherine Thyne, LCSW, who has been in private practice since 1999. Her specialties include working with eating disorders and trauma. She joined the legislative committee due to her interest in the law, helping to continue the push towards parity for mental health clients and practitioners, and to help build the social work profession overall.

The 2013-2014 GA Legislative Session begins Monday, January 13th, 2014 and runs through March 30th. Our legislative advocate and lobbyist, Wendi Clifton, Esq, spoke at the GSCSW FY2013-2014 Annual Town Hall Meeting in September, along with Catherine Ivy, NASW GA Chapter President. We expect to have a short legislative session, without a lot of controversial subjects, with the exception of the gun bill. We will see a cleanup of errors made in the criminal justice reform, as well as a move of Georgia's primary date from July to May 20th, due to the US Court of Appeals' vote that our voting laws are negatively affecting the ability of veterans to get their votes in on time. The main bills that we will be interested in this session are as follows:

1) Senate Bill 65 - Allows LPCs to do 1013s. Supported by the Department of Behavioral Health and Developmental Disabilities (DBHDD). There was an agreement that there were to be mobile crisis teams with clinicians to assess patients after the Dept. of Justice lawsuit and settlement. However, this also means that we need clinicians to 1013 patients to the ER for medical clearance prior to being sent to an inpatient psychiatric unit. Georgia has a shortage of clinicians in the rural areas. Therefore, with LPCs being able to write 1013s, clients will receive the care they need without requiring sheriffs to complete many 1013s. We are not opposing this bill due to the shortage of available mental health professionals to do the 1013s in rural areas.

2) LMFTs are lobbying for the right to diagnose. Background: LCSWs already HAD the ability to diagnose, an error was made years ago that took away the ability for LCSWs to diagnose for Medicaid, and this finally got corrected. Until there is parity across all three professions, we will continue to oppose this bill. LPCs and LMFTs do not have the same training and requirements for licensure as LCSWs, they do not have to take an additional exam for licensure, and there is no consistent curriculum across states for LPCs and LMFTs. The bill died in HHS last year and the Doctors from the Medical Association of GA also opposed it.

3) Senate Bill 211 – The GA Psychology Association attempting to place limits on psychological and psychometric testing. Their concern stems from examinations that are being done in the public school system. However, they may not be thinking of how this could limit their ability to delegate the testing administration tasks. In addition, social workers have been utilizing psychological assessment and rating scales for many years. With the mental health provider crisis in rural areas, why would we want to limit this scope, which would prevent testing in areas with few psychologists? Unless their definition of testing and administration changes, we are opposing this.

NASW Town Hall Meeting

There was an excellent turnout at the NASW Mental Health Town Hall Mtg. at UGA Gwinnett about the Duty to Warn/Protect panel discussion on Tuesday, 11-6-13, with the following speakers: Brenda Woodard, JD, Director of Legal Services, DBHDD; Stephanie Swann, LCSW - GSCSW; Professor, UGA School of Social Work; Anthony Stone, PhD - Forensic Psychologist; Garner vs. Stone case (1999); Senator Renee Unterman, District 45; and Moderator David Hooker, JD - Fanning Institute @ UGA.

The NASW Town Hall Meeting began with a brief overview of the states' laws. With regard to Duty to Warn/Duty to Protect, Georgia doesn't have a law, but rather case law. On the National Conference of Sate Legislatures (NCSL) website, you can read more about individual states' laws, and the legal language that other states use, either requiring or permitting mental health professionals to disclose information about patients who may become violent:

http://www.ncsl.org/issues-research/health/mental-health-professionals-duty-to-warn.aspx

History

The history of the Garner vs. Stone Case (1999) and the Tarasoff Case (1976) were reviewed, as were some myths and misconceptions about the Tarasoff Case. The concept to mandate or warn is based on what our client tells us. It was advised to have good documentation of whether there is a specific plan, details, how credible the threat is, and whether or not we can commit them involuntarily, etc. We all know that the profession is not an exact science. Having a law may seem like a good thing, but we also need to think about how well we are trained to do good risk assessments, and whether we all need to be using standardized risk assessments, as well as how this might change over time. Not having an actual law does not mean that we don't have a duty to warn. Both practice acts (for Psychologists and the Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists) require licensed professionals to act in the case of imminent risk. We also still need to practice by our ethical guidelines and principles.

Even if we introduced a bill this year, it could take several years to work on, and there is always a risk of unintended consequences.

LEGISTLATIVE COMMITTEE REPORT CONTINUED ON PAGE 17

COMMITTEE REPORTS

LMSW COMMITTEE

The LMSW committee ended last spring with a great turn-out for the Jobs Panel and our last Salon "Preparing for the LMSW exam." We had several students attend both events. It was great to have such involvement for soon to be social workers! The LMSW Committee has been busy working on new Salons for this year. Our first Salon topic will be "LCSW exam Q&A." We are still working on the logistical details but hope to have a place and time confirmed soon!

The LMSW has continued student outreach by participating in "A Social Work Career Development Panel" at Georgia State University. We met with many students in the GSU MSW program and spread the word about GSCSW. The LMSW committee has two new student representatives this year: Tara Self from GSU and Kim Brown from UGA. We are still working with the other schools and hope to have more student reps soon.

We are looking forward to another great year!

Jessica Alexander, LMSW and Allison Sweenie, LMSW lmsw@gscsw.org

LOW COST SUPERVISION COMMITTEE

The low cost supervision committee is thriving. We have 26 low cost supervisors who are willing to offer clinical supervision on a low cost basis. For those members who are interested in applying to become a low cost supervisor, the process is as follows: application, proof of liability insurance, and 2 references. Supervisees are often picking their supervisors directly from our website.

One of our supervisors, Polly Hart, has been avidly keeping up with the use of media/technology in social work supervision. The licensing board just recently shared its position on using media and technology for SUPERVISION purposes. Per the licensing board, they are reviewing this topic, however, for now, supervision should occur "in person, face to face."

Many of us recently attended a seminar offered by the UGA School of Social work, Ethics in Supervision.

Anyone having questions related to this committee, please call Jamie Bray, 404-875-4551 x241—supervision@gscsw.org

CLINICAL PAGE

The Fall edition of the Clinical Page will be coming out soon and is focused on the importance of social workers doing their own work on themselves. The current editor has resigned the position. The position is open, and a long-term editor would be ideal.

COMMITTEE REPORTS

LEGISLATIVE COMMITTEE REPORT CONTINUED

If you've missed this in previous emails, William Doverspike, PhD of the Georgia Psychological Association provides an excellent synopsis of the history of this law, case law in Georgia, their past efforts to enact legislative change (in 200, 2004, 2005, and 2006), as well as important ethical and legal considerations, some of which were discussed at this Town Hall discussion. His section, "Consideration of Ethical, Clinical, and Legal Literature," sums up how the ethical intersects with legal considerations: http://www.gapsychology.org/displaycommon.cfm?an=1&subarticlenbr=188

Practicing under ethical standards is a lot different than having to meet certain criteria, and there is also a risk of the possibility of getting sued because you didn't do what you were mandated to do. We need to consider the pros and cons of having a law. It also raises other important considerations, such as training requirements for licensure, and the use of standardized assessments (to be able to assess for homicidal intent, lethality, access, etc.). Even with these, is this enough? Someone might walk out of our offices/doors stating they don't feel like hurting/killing someone today and then do it a couple of weeks or months later. Would we get sued? It is possible if we were their treatment provider/agency. In the courts, the jurors would be asked to consider: "what would a reasonable person do?" Dr. Stone commented that he wasn't sure if having a law would have made a difference for his case. The NASW Town Hall meeting reintroduced a conversation that will likely continue in Georgia for years to come.

Finally, if you want to delve into the case law and history that is relevant to our professions, check out an excellent article about the cases that support and those cases that limit the therapists' duty to warn or protect: "Violent Fantasy, Dangerousness, and the Duty to Warn and Protect," by David M. Gellerman, MD, PhD and Robert Suddath, MD in the Journal of the American Academy of Psychiatry Law 33:4:484-495 (2005): http://jaapl.org/content/33/4/484.full

How to find your Legislators

We expect a busier legislative session this year, with more bills requiring calls to action. You may start to prepare for these calls/emails by knowing whom to contact. To find your U.S. and State elected legislators you may go to the following NASW website: http://capwiz.com/socialworkers/ga/home/

Please let us know if you have any specific questions that you would like answered about specific pieces of legislation, any comments, or an interest in joining the Legislative Committee. Thank you for your interest in legislative issues that affect our clients and our profession in Georgia.

Barbara Lewison, LMSW, Legislative Chair

Alexandra Pajak, LMSW, Legislative Committee Member

Katherine Thyne, LCSW, Legislative Committee Member

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

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