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INSIDE THIS ISSUE:

FROM THE PRESIDENT 3

MINDFULNESS AS A TREATMENT MODALITY FOR ADDICTION 5

MY EXPERIENCE AS AN AUTUSIM MOM:HOW BEING A SOCIAL WORKER WAS MY SALVATION 7

PSYCHOTHERAPY: FROM THE COUCH TO THE YOGA MAT 8

DIANE DAVIS LECTURE 12

COMMITTEE REPORTS 13

CALENDAR:

December 12—Diane Davis Lecture

January 8, 2015: Holistic Health: The Reciprocal Relationship Between Mind & Body Wellness *Meghan Toups, LPC and BJ Toups, BS*

February 5, 2015: Hypnotherapy: What It Is, What It Isn't & How It Heals - *Pat Wells, LPC, ACHT*

March 5, 2015: The Inner Life of the Therapist: Impact of Suicide on the Therapist ** *Panel Discussion*

April 2, 2015: The Neurobiology of Mindfulness *Stephanie Swann, Ph.D., LCSW*

*May 2015: Spring Conference TBA

BRAINSPOTTING:A DUAL ATTUNEMENT PROCESS

BY: CYNTHIA SCHWARTZBERG, LCSW

Brainspotting is a revolutionary therapy model for rapid and effective change. It was discovered in 2003 by David Grand, an EMDR and Somatic Experiencing practitioner who was working with a figure skater blocked on her triple loop, when the unexpected happened during eye movements. Grand's ability to openly follow his client and go beyond prescribed protocols opened the door to the discovery of Brainspotting.

While Grand's client tracked his finger moving across her visual field of vision, he noticed a profound wobble followed by an eye freeze. Instead of continuing the back and forth eye movements, he stopped his finger directly in front of her frozen eyes. He attentively witnessed her deepened and accelerated processing in the ten minutes that followed. A torrent of material that had not come out previously after a year and a half of EMDR was released. The client left and called the next day reporting she was able to do

her triple loop flawlessly. She no longer has the problem. This focused attuned presence to the client and her process, along with his willingness to sit with the client in the unknown, became a primary foundation for Brainspotting. This harkens back to the words of Socrates: *I know one thing is, I know nothing.*

Brainspotting has since grown to over 8,000 therapists trained in 23 countries. Brainspotting's rapid growth is enhanced because it is designed to support and enhance the model the clinician is already using with their clients. The relationship is central to Brainspotting as it recognizes that the core of healing is the mature, nurturing therapeutic presence the clinician offers. Research has shown that over the years the primary aspect of therapy is the relationship, as stated in NREPP, SAMHSA's National Registry of Evidence-Based Therapies: *"... the relationship between the client and the clinician is a crucial, fundamental determinant of success. Both parties bring themselves into the human endeavor known as psychotherapy."*

I bring this to our discussion to emphasize that no matter how powerful the tool is, our presence is the key to healing emotional wounds. Much of the Brainspotting training is on focused, attuned presence and a willingness to sit in a state of uncertainly while following the client wherever they go. The more we can allow for the space of the unknown to exist and to trust the process the more we are able to help. This is a process where less is more. This shift has allowed me to listen more deeply, speak less and trust more the innate wisdom of the client's capacity to heal.

"Brainspotting is a dual attunement model making use of the combination of relational and neurobiological attunement simultaneously," states Dr. David Grand. As the clinician is attuned to the client, the client is attuned to their internal body felt sense.

Robert Scaer, MD, states, "The attunement activates the mirror neurons between the cingulate and the OFC (Orbital Frontal Cortex), creating an empathic environment that inhibits activation of the amygdala. This sacred face-to-face empathic attunement is a critical environment for trauma therapy to work, just as it is in maternal-infant bonding and this state of presence is essential for healing." He further adds, specific to Brainspotting, "It should be noted that intense attunement is required by the therapist to attain the brainspot, a potential important element for its efficacy."

"Brainspotting works by identifying, processing and releasing core neurophysiological sources of emotional/body pain, trauma, dissociation and a variety of other challenging symptoms," writes Dr.

Continued on page 7

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PRESIDENT'S MESSAGE

Fall Greetings GSCSW Members!!!

This is one of my favorite times of year. I love the beautiful colors of the leaves and the crispness in the air. It has always represented new beginnings and it is reflective of what is happening with GSCSW.

I am sending a big hello to our new President-Elect Stacie Fitzgerald as well as our new Secretary, Liza Gellerstedt, and Susan Vanous, who moved from stand-in to officially elected Treasurer. They have been hard at work. Stacie pinch-hit hostess duties for our monthly workshops – hard to believe we've had three already!!! I am thrilled we have gathered such a fun and enthusiastic group to serve as our new Membership Committee. They did a wonderful job at our last meeting, despite some unexpected improvisation!! A very warm welcome to you all!!!

Our membership continues to grow in record numbers. It is so satisfying to participate in an organization specifically designed to meet the needs of clinical social workers, a profession I love so much. As I enter into my last year as President, I think about what I would like to accomplish. I am continuing my commitment to offering Webinars to our members; it is vitally important that everyone has an opportunity to partake in our Thursday events. It is also important that GSCSW stays relevant with our times and embrace technology and all the convenience and connection it offers. We are a presence on social media via our Facebook page. This is a place to find useful knowledge, lively discussions, and on-line collegial support. I also strongly support the involvement of our members in the legislative process. In the coming weeks, you will see more information regarding crucial bills that could forever alter how we practice. Because of the severity of scope, we have joined forces with NASW to form a unified collaborative. I realize it can be daunting, but it's important to understand that advocacy is a core principle of our profession and the time is now to do this for ourselves! I am looking forward to exploring this together throughout the winter.

Overall, I am filled with gratitude for our clinical social work community, our membership, and the dedication of our wonderful Board of Directors and committees. There is strength in the basic tenets of GSCSW: education, mentorship, promotion and support. We have an organization of which we can all take some pride.

As always, please do not hesitate to contact me if you have any questions, a desire to become involved in committee work or just to make acquaintance! I am so looking forward to seeing everyone at our upcoming Diane Davis workshop December 12.

It is with great honor that I continue to serve,

Annie M. Garry, LCSW

President

president@gscsw.org

Annie Garry maintains a private practice in Smyrna and Sandy Springs. She works with both adolescents and adults, providing individual, couples and family therapy specializing in addiction and eating disorder recovery, mood disorders and relationship issues. She can be reached at 770-598-0496 or anniegarry@comcast.net

FROM THE EDITOR

Like many of us, I look forward to the coming of autumn. Of course, the pumpkin spice lattes, cozy sweaters, and beautiful foliage are a few (predictable) reasons for this happy anticipation. However, what I look forward to the most is the *change itself* – the transition of summer into fall, the first glimpse of something new as the heat finally relents or the first leaf falls, and the steady knowing that one season will surely transform into another after what seemed like months of the same.

There is no doubt that we clinical social workers are keenly aware of this process of change. Indeed, our profession works for change in our communities, our legislatures, and our world. We notice and witness the smallest signs of change in our clients, oftentimes difficult to see. And it is critical for our work that we notice our own internal movements and shifting, as we ever seeking to become even more effective and attuned clinicians. As clinical social workers, we know that change is central.

Likewise, this issue of the *Clinical Page* reflects our field's stance towards exciting change, with integrative and innovative ways of practicing clinical social work. This issue includes articles about incorporating yoga and body-focused work into psychotherapy, applying research about mindfulness as a treatment modality for addiction, and using Brainspotting as an effective neurobiological and relational attunement model. We also have an article about navigating changes in one's family. As our field learns more and more about brain science, our therapeutic modalities shift and change to reflect new research, new insights, and new applications for our work.

It is my hope that the *Clinical Page* continues to publish thoughtful articles and diverse opinions with intentionality and rigor. Thank you for your contributions to benefit our membership, and I look forward to our work together! Please don't hesitate to contact me with any questions, concerns, or ideas about the *Clinical Page*.

Elizabeth Eiland Figueroa, LMSW, clinicalpage@gscsw.org

LETTERS TO THE EDITOR

Letters to the Editor is a new section of the Clinical Page*. With this feature, the GSCSW membership will be able to continue the many conversations that authors begin with our* Clinical Page *articles. If you have any feedback, questions, follow-up commentary, or additional notes from a previous edition's article, email Elizabeth at* clinicalpage@gscsw.org *for your letter to be considered for publication in this new feature. We look forward to this new way of being in dialogue!*

I really enjoyed the article on technology in the Spring 2014 issue! I also believe it is imperative for us to stay abreast of technological advances and how they can enhance our work with clients. The use of technology is already a form of best practices for us as social workers; therefore, we must keep the conversation going and support one another on how we can most effectively utilize it to aid our clients.

Hannah Kimbrough, LMSW

Intown Family Therapy

MEET OUR PRESIDENT-ELECT— STACIE FITZGERALD, LCSW

Stacie Fitzgerald, LCSW, has been practicing social work for 20 years. After obtaining her BSW from Cornell University, and her MSW from UNC Chapel Hill, Stacie came to Atlanta where she began her clinical work. As a native of New York state, she returned mid-career to New York with her husband and 3 children, where she opened a private practice as well as maintained work at a psychiatric emergency room and hospital setting. Stacie returned to Atlanta a few years ago, and has been actively engaged with GSCSW since, most recently as the Ethics Committee co-chair, and now the President-Elect.

Stacie has practiced clinical social work in a variety of settings, including residential, outpatient mental health counseling centers, psychiatric hospitals, mobile crisis, health care, and private practice locations. She has a passion for work with adolescents and families. With experience in both supervisory and clinical roles, Stacie has enjoyed offering supervision to both master's level clinicians and students throughout her career.

After recently leaving a clinical supervisory/management position, Stacie is now the Behavioral Medicine Specialist/Clinical Social Worker for a multidisciplinary medical team in Atlanta, as well as the lead clinician for a Mobile Crisis Response team.

Stacie brings energy, creativity, and passion to the Society and to the profession. She is committed to elevating awareness about clinical social work practice, and envisions supporting and strengthening our profession through future emphasis on training, certifications, clinical supervision and collaboration within the rich resource of our Georgia Social Workers.

Mindfulness As A Treatment Modality For Addiction

BY: Alyce E. Wellons, LCSW

In recent years, there has been much research and writing about mindfulness and the disease of addiction. Since both areas of study have roots in neurobiology, it seems fitting that one would complement the other. But what are these links, and how do addiction and mindfulness fit together? We will target these questions in this article.

First, it is important to understand the current leading definition of addiction. According to the American Society for Addiction Medicine, addiction is "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to maintain abstinence, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

A short neurobiology of addiction of goes like this: from an evolutionary perspective, when the earliest humans came across food or water sources, it was imperative for survival to lay down this memory as "good." Similarly, when early humans encountered dangerous situations, it was crucial to remember that as "dangerous." This is how we as a species have survived: trigger, behavior, and reward, or, reward-based learning. Fast-forward through many centuries of evolution, and now we have substances that have hijacked the reward-based learning system. In fact, "every substance of abuse from tobacco to crack cocaine affects the same brain pathway--the mesolimbic pathway which mainly acts through the neurotransmitter dopamine" (http://www.rehabs.com/pro-talk-articles/is-mindfulness-an-emerging-treatment-for-addictions/). In the modern day, we do not need to stay vigilant to survival sources such as food, water, and safety to the same extent as our predecessors. But for many of us, our brains have not caught up. Our amygdala continues to scan the environment for safety and danger, even though it doesn't need to do so anymore. This hyper-aroused amygdala is one of the leading causes of anxiety.

Enter mindfulness. Currently a hot topic in popular culture, mindfulness appeals to many types for many different reasons, ranging from

CONTINUED ON PAGE 6

Mindfulness As A Treatment Modality For Addiction

Continued from Page 5

a high-powered CEO in hopes of better productivity and creative energy, to people in recovery wanting an effective tool to treat addiction. We are catching up to what eastern medicine has believed for hundreds of years; mindful meditation works.

One of the best definitions of mindfulness belongs to Jon Kabat-Zinn: "Mindfulness means paying attention in a particular way–on purpose, in the present moment, and nonjudgmentally." Here is how mindfulness as a treatment for addiction works.

Mindfulness as a treatment for addiction is rooted in the modality of Mindfulness Based Stress Reduction (MBSR), the work of Jon Kabat-Zinn and his colleagues at the University of Massachusetts Medical Center. Begun at the as a way to treat patients for pain and other medical conditions using a combination of mindfulness, body awareness, and yoga, it has since grown in scope. The module we use for addiction is Mindfulness Based Relapse Prevention (MBRP). The primary tool is to use mindfulness as a way to pay careful attention to cravings as they arise, then stay with them and ride them out instead of acting on them by using. MBRP encourages people to pay close attention to cravings, see what they are made up of, use observing thoughts and body awareness to notice cravings, observe how they can shift moment to moment, and realize they do not last forever.

The primary goals of MBRP are:

1. Develop awareness of personal triggers and habitual reactions, then learn ways to create a pause in this seemingly automatic process.

2. Change our relationship to discomfort, learning to recognize challenging emotional and physical experiences and respond to them in skillful ways.

3. Foster a nonjudgmental, compassionate approach toward ourselves and our experiences.

4. Build a lifestyle that supports both mindfulness practice and recovery.

Why does MBRP work? MBRP targets the core addictive loop. By giving people a tool to observe their cravings and not act on them, it decouples the link between craving and use, weakening the link and eventually dismantling it altogether. One of the meditations MBRP uses is called Urge Surfing. It is a guided meditation which takes clients into a craving, guides them through the process of observing the dimensions of the craving, and then thru the craving process without using. It is a very powerful tool with empowering results.

How can you use this in your practice and work with clients? First, I would recommend you complete the 8-week Mindfulness Based Stress Reduction course. This is based on the work of Jon Kabat-Zinn and is the foundation all subsequent work. After that initial course, there are many more specialized trainings, workbooks, and education on use of mindfulness in a clinical setting, including the workbook *Mindfulness Based Relapse Prevention* by Sarah Bowen, Neha Chawla, and G. Alan, Marlatt, PhD. The website http://www.mindfulrp.com has information on resources, trainings and MP3's to download for clinicians and clients alike.

And the best part of adding mindfulness based work to your practice is that you are very likely to begin your own mindfulness practice!

Resources and References:

American Society for Addiction Medicine: http://www.asam.org

Mindfulness Based Stress Reduction: http://www.mindfullivingprograms.com

Mindfulness Based Relapse Prevention: http://www.mindfulrp.com

Article: http://www.rehabs.com/pro-talk-articles/is-mindfulness-an-emerging-treatment-for-addictions/

Alyce E. Wellons, LCSW is a psychotherapist in private practice in Virginia Highlands. She has been in practice for over 15 years and works with individuals, couples and families. While she has a general scope of practice, she has specialized training in addiction and recovery, couples, and use of mindfulness as a treatment modality. She can be reached at 404.664.3110 or alycewellons@hushmail.com

BRAINSPOTTING:A DUAL ATTUNEMENT PROCESS

CONTINUED FROM PAGE 1

David Grand. Brainspotting makes use of the natural phenomenon of "where you look affects how you feel" through its use of relevant eye positions. Together the therapist and client pair a fixed eye and body awareness to an unresolved issue. As the client stays focused on the eye position and their body felt sense around a specific concern, the therapist tracks the client's internal process. The client shares and reports as much or as little information as they feel necessary. The therapist focuses more on the body processing rather then on the content of their experience. Dr. Grand describes the stance of the therapist much like the tail of the comet which follows the client's lead, assuming nothing, and supporting the unexpected.

Clinical Example:

Sara, who was a mother of three teenagers, came in for trauma work. She experienced extreme anxiety, many negative beliefs, suffered from ADD and wanted to get off her medication. She had a very negative image of herself and not much support to view her self differently. Sara is the youngest of four in her birth family and had been very attached to her analytical story of what happened to her. She wanted a way out and was told Brainspotting could help. Although she found that EMDR was helpful, she still reported being overwhelmed and anxious. For her, the strong container of both the therapeutic relationship and the invitation to go into her body felt sense made it possible to feel more present as she processed things she had not thought of or witnessed about herself before. The release supported her to be able to reduce her anxiety and get off her medication. She developed a stronger sense of self and left therapy having reached many of her goals.

These results are common in Brainspotting because this dual attunement addresses both stabilization, and tolerance to process and release of distressing emotions. It also increases the client's ability to connect more positively towards the self and enhance relationships with others.

Experience Brainspotting and Its Grounding Effects

I invite you to think about something that gives you positive feelings. Next notice what you feel in your body. Where do you feel most grounded, calm, and connected? Now shift your awareness to that part of your body. I'll guide you now in finding your positive Brainspot (eye position). First look at an object straight ahead and determine on a scale of 0 to 10 how grounded do you feel (10 being the most grounded, one being the least). Next look at something to your right and assess on a scale of 0-10 how grounded do you feel now? Finally shift your view to an object to your left and see how grounded do you feel now? Once you determine the Brainspot (eye position) where you feel the most grounded, simply take a few minutes with your gaze focused on the positive Brainspot and mindfully follow your internal process wherever it goes. Notice where your processing goes with out any judgment or expectation. After a few minutes return to the positive issue you started with and recheck on a scale of 0-10 how grounded do you feel? This exercise is developed to give you an experience of enhancing a body experience connected to a location in your visual field and how the process works.

For further information on Brainspotting sessions Consultations, lectures, workshops and trainings in the South and metro Atlanta area, contact Cynthia Schwartzberg, LCSW, at www.cynthasis.com

My Experience as an Autism Mom: How Being a Social Worker Was My Salvation

By: Annie M. Garry, LCSW

I thought about this article for weeks before I ever put words to paper. It began as a passing comment to a colleague that my 9-year-old son has autism, and her genuine surprise at this fact gave me pause. It made me aware of how guarded I have been. The growing numbers of this disorder are considered by many to be epidemic and despite my reservations, it became a gnawing compulsion to write on the topic. There is admittedly ambivalence between the desire to impart what I believe is useful information, and the hesitation to be vulnerable of my often-private self, but the universality of the experience compels me to share. My story is a personal one about my experience of having a child on the spectrum, but the fact is that autism affects an estimated 3 million people in the US and ten of millions worldwide.

The current CDC statistics are that 1 in 68 children – and 1 in 42 boys – have been diagnosed with autism, a 30% increase from just two years ago. This incidence rate is only partly explained by increased diagnosis and awareness. It is because of these facts that I believe that our personal and professional paths will cross with a person touched by autism at one time or another, and it is critical to recognize symptoms in both children and adults. I believe it is important to understand from a bio-psycho-social, integrative, humanistic and psychodynamic perspective what it means to love and accept the ongoing challenges of a person with disabilities, and the multiple stressors a parent may face. It is a process that takes much time and adjustment, and requires a great deal of help and support.

CONTINUED ON PAGE 9

Psychotherapy: From the Couch To The Yoga Mat

By: Lena Franklin, LCSW, LLC

Practicing psychotherapy looks different today than it did in years past. Although the traditional practice of insight-oriented, psychodynamic therapy continues to exist as the underpinning of many of the therapies we see today, the spectrum of practice is expanding and evolving.

Through talk therapy, we can help our clients develop insight about the origins of emotional experience, such as anxiety and depression, and help create an understanding by linking past and present. However, a deepened cognitive understanding of the symptom origins doesn't necessarily lead to easing the symptoms themselves. Reinforcing the inner narrative (stories) surrounding the anxiety and depression through talk therapy can, at times, intensify the symptoms. So, as clinicians, where do we turn next?

Shifting Into the Body

I believe the key to effective psychotherapy exists within the experience of *embodying* stillness and silence – shifting away from cognitive processing and *into* the deep recesses of the body. Through body-centered practices, such as yoga, we can help clients clear emotional blocks, tolerate waves of emotionality and connect to their core selves – assisting them to move towards a greater sense of inner balance.

For centuries, yogis used breathing, mudras, and meditations to balance the body and mind. The goals of psychotherapy parallel ancient yogic intentions of self-awareness, self-acceptance, and self-regulation thus assisting the client toward the maintenance of positive mood states. The benefits of yoga for the mind and body are now well documented by empirical research. Studies show that yoga can help strengthen social attachments, reduce stress, and relieve anxiety, depression, and insomnia (to name a few).

As a Mindfulness-Based Psychotherapist, I often integrate yogic practices into my sessions with clients. For example, I might begin a session with an anxious client by guiding him or her to practice a calming mudra (e.g., hands cradled in lap) with slow breathing, guiding them through extending the exhale.

Breathing, meditation and body postures (asanas) can help clients focus, allowing them to access their emotional state and better prepare for therapy work. How many times have you experienced a client arriving in your office all "revved up" with anxiety? Yogic practices can help ground your clients, energetically shifting them into a space where they are more present for therapeutic work to take place. Additionally, yogic practices exist as a beautiful way to contain the sacred space of healing for our clients – providing a grounding ritual for beginning and ending a session.

Mind/Body Over Mood: Yoga In Session

As psychotherapists, yoga can be an effective way to help clients with mood management. It's fundamentally important for the therapist to have one's own yoga practice in order to embody the essence of yogic healing – this is what gives the therapeutic work meaning. There's also a misconception that yoga must be done in a studio, with yoga mats and Lululemon gear. This simply isn't true. Most of the yogic practices I teach clients can be done sitting on the ground, without mats. Okay, now back to the body.

Let's look at our body's stress response to anxiety: anxiety is mediated through the autonomic nervous system, which involves sympathetic (fight or flight) and parasympathetic (rest and relaxation) responses. There are integrative ways to work with the body to help shift our clients into parasympathetic dominance. For example, I'll have my clients extend the exhalation relative to the inhalation – shifting the body from sympathetic to parasympathetic dominance. Working with *prana* in session can be very useful in countering the hyperarousal that typically accompanies anxiety.

First of all, what is *prana*? Literally, *prana* is the Sanskrit word for "Life Force." *Prana* is the energy of the universe that we're all connected to through breath. The way in which you breathe is a powerful metaphor for the way in which you walk through the world. In times of anxiety or stress, are you restricting your breath as if you don't deserve the fullness of each breath cycle? When we restrict the breath, we dim our inner spirit. Inviting and embodying the fullness of breath enlarges the spirit, helping us reconnect with the light of our heartspace (this center of emotional experience within the chest). Yogic methods enrich our *prana* and can be used with clients to help them reconnect to their natural state.

Various body postures, or asanas, can help clients cultivate an awareness of their present moment experiences, easing symptoms of anxiety or depression. Asanas can also be used to work with the heart in ways that enhance our capacity for empathy, compassion and kindness. For example, if you're working with a client who has difficultly giving or receiving love and their heart feels closed and tight, you might want to consider a heart-opening pose. Camel pose is where you're sitting on your knees in a backbend (head back) while holding onto your heels or ankles. With gentle, intentional guidance, this can be a powerful tool to open the heartspace. A word of caution: Camel pose can be an intensely vulnerable position for a client who has endured trauma. It's possible to trigger an emotional space where the

Continued on Page 9

Psychotherapy: From the Couch To The Yoga Mat

Continued from page 8

client who has endured trauma. It's possible to trigger an emotional space where the client re-experiences the trauma and, as the clinician, this is why a thorough assessment and strong therapeutic relationship continue to be the foundations for treatment.

If you're thinking about integrating yoga into your psychotherapy practice, it's important to get formal Yoga Therapy training. For example, Amy Weintraub, MFA, E-RYT 500, founding director of the Lifeforce Yoga Healing Institute (http://yogafordepression.com/) offers practitioner training certifications for psychotherapists. Through yoga practitioner training, you'll gain a holistic understanding of the various ways asanas and pranayamas access the emotional body and the neurobiology behind their effectiveness.

As a clinical social worker, I feel energized by the expansion of our scope of practice. Yoga has proved to be a transformative practice for both myself and for clients I've been privileged enough to work with. As therapists, we emphasize bringing our "whole selves" into the therapy room and I believe this encompasses working with the *whole* body to affect client change.

Lena Franklin, LCSW, LLC, Mindfulness-Based Psychotherapy: www.lenafranklin.com ~ 181 14th Street NE, Suite 450, Atlanta, GA, 30309 ~ 404.550.8422 ~ Lena@LenaFranklin.com

My Experience as an Autism Mom: How Being a Social Worker Was My Salvation

Continued from Page 7

However, the dizzying statistics and the knowledge that others share this condition offered me no comfort in the midst of my struggles; for none of them were in the room with me. I became a member of a club I had never wanted to join and it changed my life as I knew it. It is my hope that my recall of how I experienced this process will be helpful and enlightening to others.

The feelings I experienced are universal – disbelief, terror, pain, grief, shock, anger, outrage – and words can only begin to describe the depth of emotion. It goes so far beyond surprise, frustration, sadness, or fear. This emotion started with the nagging sense that something was very wrong with my infant, and this sense was waging war with my desire to deny and bask in the glow of his arrival. Our family joy was proudly displayed on the "I'm a big brother" t-shirt worn by my then 6-year-old first born. Having been an only child, I delighted in witnessing their instantaneous and poignant sibling bond. Upon the sight of big brother, it was unbridled hero worship from the start, still unwavering today; the response from older brother was protective and responsible with surprisingly mature observational humor.

Along with our joy, the first 9 months were also hellish; this baby would not sleep and was absolutely inconsolable. He would finally fall asleep around 4 am. My husband would take big brother to school, and then I would get up, take the baby to daycare and go to work after no more than 4 hours of sleep. I lived in a state of perpetual exhaustion. I didn't understand then that these were early signs of sensory issues and it was a glimpse of what was to come. When he was a year old, we began noticing that some developmental milestones were happening more slowly than expected. Fast forward several months, when the missed milestones became more concerning and also the cause of marital dissention. I began doing the very thing that many fear the most: I Google'd. The validation reached through the computer screen, and the dread gripped me by the entrails. He was 15 months, and was not walking, barely talking, not maintaining eye contact, and not responding to his name. A trip to the pediatrician, a referral to Babies Can't Wait, a screening questionnaire, a full-scale evaluation by several specialists including a Pediatric Neurologist, all led to the inevitable diagnosis at 17 months. I died a little bit that day.

In an attempt to find the cause of his diagnosis, I perseverated over every detail of my pregnancy and childbirth, which had been complicated at the end by toxemia and high blood pressure. I believed it was my fault, my carryover from childhood. I took responsibility for any situation that was chaotic or out of control, because in childish magical thinking "if I created it, I could undo it." But I couldn't control this diagnosis. I was wracked with guilt. I recalled working in foster care and marveling at the patience and fortitude of many of the foster parents who dealt with special needs kids and thinking "I do not have that in me, I could not handle that." Now, I was being called upon to live this very task, and to say I felt ill-equipped and inadequate was an understatement. If only my love itself was transformative – another magical childhood wish.

This disorder is characterized by difficulties in social interaction, communication challenges, and the tendency to engage in repetitive behaviors. Delayed motor skills and sensory issues are common. These symptoms are referred to as "classic autism," and here is where my son falls. The symptoms and severity vary widely across the spectrum. Sometimes, there can be accompanying medical conditions, gastrointestinal and immune system deficiencies, and seizures. In more severe cases, there are self-injurious behaviors, aggression, tantrums, and wandering. The spectrum ranges from mild social awkwardness to profound mental retardation. The saying goes: "If you've met one child with autism, you've met one child with autism," as no two children are exactly alike.

I discovered the origins of autism are not in vaccinations (the result of a flawed research study that has long since been debunked), but in-utero by a series of still unexplained genetic mutations in varying forms in combination with some environmental factors. It was NOT my

CONTINUED ON PAGE 10

My Experience as an Autism Mom: How Being a Social Worker Was My Salvation

Continued from Page 9

fault, but it was my responsibility to do everything in my power to help my child by becoming his most devout advocate.

Mercifully, the Babies Can't Wait program offered specialists (speech, OT, PT) and the help of a very astute case manager. Her social work skills helped me understand my own grief, normalize it, and allow me to stop punishing myself for feeling it. She used a strengths perspective to help me begin the process of mobilizing myself to combat the disorder as well as the overwhelming maze of services. My son made measurable advances and stayed with the program until age 3, the age of discontinuation. After the program's discontinuation, I privately paid the OT to come to our home each week. To date, insurance mandates to cover treatments vary state by state, and Georgia has no such mandates. All expenses are paid out of pocket, and Autism Speaks estimates the expense to be $60,000 per year.

To continue his care, I enrolled him in a Special Needs Pre-K program through the public school system, where he would receive PT, OT, speech therapy, and small group instruction. I wanted him to get these services, but the fact that he still needed them was in and of itself gut-wrenching. This very dichotomy becomes part of the existence: sometimes I grieved what I didn't have (a typical kid), but at the same time I felt gratitude for the opportunity to assist him.

One of the most profound experiences of this process happened at my son's first Individualized Education Plan (IEP) meeting. This meeting involves all professionals and teachers who interact with your Special Needs child, setting goals and objectives for the school year. There were two boxes of tissues in the middle of the table, a sign that indeed I was not the only parent to sob through it. One of the county Occupational Therapists offered up a perspective that has never left me: "If you think about it, half of Georgia Tech students are autistic and they navigate their way through the world. He's going to be fine." Well, I did think about it, a lot, and it was the contextualization I needed to hear. It has gotten me through many moments of worry and discouragement.

Fortunately, my social work experience taught me how to get the help he needed. My son received several interventions that were helpful: Floortime, an RDI (Relationship Development Intervention) education specialist, medication management, and music therapy. Today he is in the 4th grade and he continues to receive Special Needs services from his school, though the types of services have changed as he's grown and developed. I recently added in a social skills group that uses improvisation and acting as the medium. Developing his peer relationships is what he needs the most help with now, as the other autism symptoms have greatly reduced.

As I write this, I am aware that I make reference to myself only, not a *we*. I wish I could tell the story of a couple that grieves together, shares the responsibility and the emotion, and feels closer than before. That is a triumphant tale, but it is not mine. Autism did not in any way cause the chasm between us, nor prevent the attempted mends from working, yet it did amplify a sense of insurmountability. It is not uncommon for partners to differ regarding acceptance of the diagnosis, how to proceed with treatments, or the allotment of funds. There are differences in the reported rates of divorce, but overall, it is believed that there is a higher than average divorce rate among autism parents.

There were many ways being a LCSW helped me come to terms with my son's autism. I use this expression purposefully, as there are different terms you arrive at over time as the process is always evolving and changing. From a psychodynamic perspective, we work with our clients everyday to accept painful truths about their loved ones, to see things as they truly are versus how we want them to be. We help them tolerate the seemingly intolerable. The true work of therapy – sitting with feelings, strengthening, instilling a sense of mastery – happened for me, over time. The grief, loss, and fear, while not a space I live in every day, still remain a presence to be acknowledged.

I credit so much of my child's success on the special relationship he has with his brother. I have encouraged it, but they have grown it to a melding of their overtly loving and caring personalities. We have a very busy household, with lots of verbal and physical affection demonstrated every day. I know how privileged I am, for there are many parents of non-verbal autistic children who do not hear "I love you"s. I hear those words daily and most unusually for a child with autism, with sincerity and spontaneity.

I strive to find balance as much as possible between meeting my sons' differing needs and growing my practice, caring for our household, and my work-related responsibilities, and caring for myself. The self-care gives me the energy I need to give to others. I have moved closer than I ever have been toward acceptance of the autism. It is no longer the enemy. My son fits into some of the described categories and defies many of the others. He is not a stereotype, a classification or a statistic. He reminds me every day there is so much more to him than I ever dreamed, and thus I realize, there is so much more to me.

SOCIAL MEDIA and GSCSW

Are you on Facebook yet? If so, please consider joining the GSCSW Facebook page! You can request to join us here:

https://www.facebook.com/groups/144040415624274/

This Facebook page group is a way for all social workers with a clinical focus in Georgia (MSWs, LMSWs, and LCSWs) to connect, exchange information, network, and learn more about the Georgia Society for Clinical Social Work (GSCSW)! Here we post events that GSCSW hosts specifically for new social workers like you! These include networking events, meetings on various relevant clinical topics (i.e. Substance Abuse or Eating Disorder treatment, Community Resources, Starting a Private Practice, and more). The only requirement is that you are a social worker in Georgia, or a social work student with a clinical focus. Please enjoy participating in this group, and tell your fellow social workers about GSCSW!

Have questions about the confusing licensure process? Not sure where to get clinical resources for clients? Looking to network with other clinical social workers? Interested in low cost supervision? Georgia Society of Clinical Social Work is here for you!!

Questions about Licensure? Have a look here:**http://www.gscsw.org/membership/licensing/**

Low-Cost Supervision? Browse LCSWs here:**http://www.gscsw.org/supervision/**

Need support from experienced clinicians to help you navigate the field as a new social worker? Check out the Mentorship page:**http://www.gscsw.org/mentorship/**

Learn more about the Georgia Society for Clinical Social Work and how we can help you at **http://www.gscsw.org/**

Disclaimer: This group is not intended for case consultation or supervisory substitution, but merely a way to connect new social workers in Georgia to opportunities for professional development through various means. Because this group is public, please do not provide information on this page that you would not want public.

Stephanie Cook, LCSW, Social Media and PR Chair

Clinical Social Work Journal

Springer Publishing has notified GSCSW of a significant price increase for the *Clinical Social Work Journal* for 2015. The pricing is as follows: (this includes sales tax):

Electronic Access $50.00

Print $85.00

Print and Electronic $110.00

These prices are still significant lower than if you ordered outside of your GSCSW membership which would be more than doubled. The Journal is published 4 times a year.

You can go to the GSCSW website and find out more information - http://www.gscsw.org/journal-order-form/

We will submit the order to Springer on your behalf (the only way to get the discount).

Please let Trisha Clymore know if you have any questions—you can reach her at **admin@gscsw.org**

DIANE DAVIS LECTURE

"YOU CAN'T ALWAYS GET WHAT YOU WANT"

SELF-DESTRUCTION, MASCHOHISM AND PATHWAYS TO CURE

Robert E. Hooberman, Ph.D

Our society is rife with stories of those who kill and maim, both others and themselves. Although the headlines concentrate on particularly dramatic occurrences, those of us who work day to day with disturbed individuals confront these destructive and self-destructive compulsions on a smaller scale, but with still devastating consequences to those involved. In this presentation I will discuss the origins of self-defeating behaviors by identifying the underlying conflicts implicit in them. I believe that three unconscious aspects: guilt, masochism and destructive internalizations (the 'inner saboteurs' as Fairbairn says) and their inter-digitations impel much self-destructive repetitive behavior. I will further describe how patients often "choose" self-destructive and masochistic behaviors as the best options available, favoring these over even more frightening alternatives. Guilt and shame are powerful motivators of unhealthy actions and it is my belief that the origins for these feelings are from early childhood experiences, real and imagined, that are typically unremembered. Forgiving oneself and moving beyond such self-destructive needs requires understanding of the origins of these needs, and mourning of both one's perceived inadequacies and lost opportunities.

BIOGRAPHY

Robert E. Hooberman, Ph.D. practices psychoanalysis and psychotherapy in Ann Arbor, Michigan where he works with adolescents, adults and couples. He also supervises a number of graduate and post-graduate clinicians. He is the former President and former Training Director of The Michigan Psychoanalytic Council. Dr. Hooberman is the author of four books, the most recent being "Forgiving, Forgetting and Moving On: Living a Less Conflict Life". He has presented papers locally and nationally. Dr. Hooberman enjoys working with a variety of clinical problems and has a special interest in working with those who are often considered challenging.

LEARNING OBJECTIVES

From this presentation, the participant will be able to demonstrate an understanding of the conflicts that create self-destructive behavior. The participant will understand how guilt and shame create symptomatic behaviors. The participant will be able to describe how patients improve once they can both understand the underpinnings of their propensity to self-destruct and mourn lost opportunities

REGISTRATION

To find out more information and how to register go to: **http://tinyurl.com/q4tnhov**

E. Diane Davis
1940 – 1986

E. Diane Davis' professional contributions are far reaching. As a therapist, supervisor, administrator, consultant, teacher, advocate, mentor and friends, she touched not only the professional lives but the personal lives of many. Still the teacher, Diane generously has given a bequest for a yearly memorial lecture to be sponsored by the Georgia Society for Clinical Social Work.

Ms. Davis, a native of Florida and a graduate of Columbia University School for Social Work, moved to Atlanta in 1965 and rapidly established her style, substance, and potential with accomplishments as a major contributor to the heart of social work. A founding member of the Georgia Society for Clinical Social Work, she was Georgia's first representative to the National Federation of Societies for Clinical Social Work board meeting.

Ms. Davis was appreciated in the community for her knowledge and ability to convey the excitement of learning as evidenced by long standing connections to the University of Georgia School of Social Work, Atlanta University School of Social Work, and Roger Williams. In addition, for more than a decade, Ms. Davis taught several courses at Smith College School for Social Work's Continuing Education program, including the Innovative course she developed, "Developmental Origins of Psychopathology". The connection with Smith College underlined her commitment to a psychoanalytic framework for understanding human **behavior.**

Ms. Davis epitomized the Renaissance woman with interests as varied as the ballet, symphony, opera, and regional county fairs. A world traveler, she was equally at home in Ireland as in Unicoi. Her presence is deeply missed.

COMMITTEE REPORTS

LOW COST SUPERVISION COMMITTEE

The **Low-Cost Supervision** committee added some supervisors over the last few months both on the north side and the south side of Atlanta. We are trying to expand our pool of professionals willing to provide low-cost supervision outside of the perimeter, per the request of some of our membership seeking supervision. Many of you have asked about the credentialing process for providing supervision, and other professions on our licensing board are moving toward this. We think a credentialing process is a good idea, and are exploring such a change for LCSWs. As a reminder, for those seeking supervision through the low-cost supervision committee members, membership is not necessary. For those wanting to provide supervision, one must be a member of GSCSW. For questions, contact Jamie Bray, LCSW.

ETHICS COMMITTEE

Carol Finkelstein, LCSW and Sherri Rawsthorn, LCSW have accepted positions as Co-chairs to the **Ethics** committee. Thank you to their predecessors, Stephanie Cook, LCSW, and Stacie Fitzgerald, LCSW, for their dedicated and professional service during the past two years. Since Spring, the Committee provided ethical consultation and guidance for two members and responded to two additional inquiries from members in the community. The next "Ethics in 3D" (Dilemmas, Dinner, & Desert) event is scheduled for Thursday, December 4th, 7:00-9:00 PM at Manuel's Tavern located at 602 North Highland Avenue, NE, Atlanta. Please come and share in stimulating and informative discussion about ethical decision making models with your fellow GSCSW members. Space is limited, so please RSVP to ethics@gscsw.org as early as possible. Please welcome members Shirley MacLeod, LCSW and Jacey Yunker, LCSW as the newest members of the Ethics Committee. Along with existing members - Susan Vanous, LCSW, Stacie Fitzgerald, LCSW, Stephanie Cook, LCSW, Katherine Hall, LCSW, Carol Finklestein, LCSW (co-chair), and Sherri Rawsthorn, LCSW (co-chair), your Ethics Committee has over 100 years of vast professional clinical experience available to serve and support GSCSW members. Please contact us at ethics@gscsw.org if you would like consultation regarding any ethical concerns you may have.

SOCIAL MEDIA AND PR COMMITTEE

The **Social Media** committee continues to encompass all things related to public relations, marketing and social media. The Social Media Committee has the main task of promoting and increasing the professional and public awareness of our organization. Stephanie Cook, LCSW, who serves as the new committee chair, will begin taking photos of the upcoming events to add new content to the webpage. Future lectures will be videotaped in order to make it available to members online once the board is in agreement about its launch, and the legal requirements are confirmed. The Social Media Committee continues to oversee the Facebook page, which is being actively used by its members. The Social Media committee is currently open to new members, so please email Stephanie Cook, LCSW, at socialmedia@gscsw.org if you are interested in joining her on the committee.

PROFESSIONAL EDUCATION

The **Professional Education** committee has had a successful fall season for our Thursday night workshop series. We ended with Margo Geller's presentation on "The Business Side of Building a Fulfilling Private Practice" on November 6th, which was well attended. Thanks to all who came out!

Annual Diane Davis Workshop: *Robert E. Hooberman, Ph.D, who will be presenting on, "You Can't Always Get What You Want: Self-Destruction, Masochism and Pathways to Cure."*

The workshop will take place on ***Friday December 12th, 2014 from 8:30 am – noon.*** Visit our website to register: http://www.gscsw.org/events/ **GSCSW Members:** $40 / **Non-GSCSW Members:** $60

Don't miss our first Thursday night workshop of 2015! On Thursday January 8th, from 7 - 9 pm, Meghan Toups, LPC & BJ Toups, BS (owners of MERGE into Health: http://www.mergeintohealth.com/) will be presenting on *Holistic Health: The Reciprocal Relationship Between Mind & Body Wellness.* This will kick-off our 2015/2016 Workshop Series. Please visit http://www.gscsw.org/events/ for a full list of upcoming events.

We invite you to contact our committee at professionaled@gscsw.org with any questions you might have.

With Gratitude, Katie Alioto, LCSW, and Lena Franklin, LCSW

COMMITTEE REPORTS

LMSW

Fall 2014 has been off to a productive start for the LMSW Committee. We are pleased to have hosted the first salon of the season on October, 5, "Supervision: A Professional Journey," in which several seasoned members shared their experiences with supervision throughout their professional journeys. Much gratitude is owed to our panelists, Phyllis Glass, LCSW and Barbara Nama, LCSW, as well as to Alyce E. Wellons, LCSW and Sharon Burford, LCSW who served as panelists in addition to graciously hosting the event.

LMSW Committee Chairs had the pleasure of visiting a MSW class at UGA Gwinnett last month to share about GSCSW and our experiences with LMSW licensure and employment. Jessica Alexander, LCSW participated in a Professional Social Work Panel at UGA Gwinnett on 10/21/14, in which she shared about her profession, provided feedback on licensing questions and discussed the benefits of GSCSW.

The LMSW Committee continues student outreach projects with local universities with the goal of inspiring and encouraging involvement of the next generation of professional social workers. If you are affiliated with a GA social work program and wish to inquire about bringing one of our committee members to speak at your location, please contact us at LMSW@GSCSW.org. We are also seeking student representatives to help us connect with MSW students.

Jessica Alexander, LMSW and Allison Sweenie, LCSW email: LMSW@GSCSW.org

LEGISLATIVE COMMITTEE

In September's Annual Town Hall Meeting, we met and welcomed the new NASW-GA Executive Director, Cheryl Bonneau-Harris, MSW, JD, and were informed by Wendi Clifton, Esq., that the Psychological testing bill will most likely be re-introduced this year, which can negatively impact the scope of social work practice in GA. The primary concerns about SB211 are as follows:

- The broad definition of psychological testing to include "the use of assessment instruments" limits, and potentially prohibits, the use of screening and other assessment tools used by social workers to identify the presence and/or frequency of behavior(s).

- The definition limits the use of such tools to determine the probability of a mental health disorder, a cognitive or memory impairment that warrants additional medical evaluation, or a possible developmental disorder requiring further testing.

- While social workers agree that intelligence tests, neuropsychological tests and other sophisticated assessments fall within the scope of psychology practice rather than that of other mental health practitioners, the definition of "psychological testing" in the proposed practice act is sufficiently vague as to question the authority of clinical social workers to use screening tools and similar instruments.

- If social workers are prohibited from using assessment instruments to guide and inform practice, the scope authorized within the social work practice act is potentially compromised.

In light of the current workforce shortage in behavioral health, it seems counterproductive to propose language that restricts existing practice.

Another big issue will be that the Department of Children and Family Services will be evaluated and reorganized, moved from under the Department of Human Services to being directly reportable to the Governor's Office. Finally, we discussed the possibility of Georgia's LCSW supervision to be done via video, in addition to face-to-face supervision, as is the rule now. This would be done as an appeal to the GA Composite Board, as this is not a legislative issue, and we plan to meet with professionals from the other disciplines to discuss bringing this possibility to the Georgia Composite Board. We will keep you informed of any updates and calls to action.

Thank you for your interest and please feel free to email us if you have any questions, or if you would like to become a member of the Legislative Committee: legislative@gscsw.org

Barbara Lewison, LMSW - Legislative Committee Co-Chair

MEMBERSHIP

The **Membership** committee has recently grown – thank you to our newest committee members. They are already doing a great job serving the needs of our members!

ADVERTISEMENT

OUR ADDRESS HAS CHANGED:

GSCSW

P.O. Box 33338

Decatur, GA 30033-0338

www.gscsw.org

404-237-9225

PLEASE MAKE A NOTE OF THE NEW ADDRESS. THANKS

"The views and opinions expressed in the Clinical Page are those of the individual authors alone, and do not necessarily reflect the position, practices, or policies of the Georgia Society for Clinical Social Work membership or Board as a whole."

JOIN THE GSCSW LISTSERV

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

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

ADVERTISEMENT RATES

LISTSERV: $25 Members $35 Non-Members

QUARTER PAGE	HALF PAGE	FULL PAGE
$15 Members	$40 Members	$90 Members
$25 Non-Members	$50 Non-Members	$100 Non-Members

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