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INSIDE THIS ISSUE:

FROM THE PRESIDENT 3

THE ETHICS OF WORKING WITH COMPLEX CLIENTS 5

HELLO. I'LL BE YOUR THERAPIST AND CEO 8

DO YOU SEE THE EMPEROR'S NEW CLOTHES? 9

COMMITTEE REPORTS 12

CALENDER

December 11, 2015—Diane Davis Lecture. See page 11 for more details and how to register.

"The Effects of Reintegration on Spouses/Partners and Children of Mentally Ill Veterans of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF)"

BY: ALEXANDRA PAJAK, LMSW

Within the last fifteen years, about 3.6 million military personnel have been deployed to Iraq and Afghanistan in Operations Iraqi Freedom and Operation Enduring Freedom. Over half of these veterans are married, and the OIF/OEF military conflicts have resulted in the separation of about 2 million children from a military parent. We as social workers are likely to encounter OIF/OEF veterans and their families in our clinical settings. Veterans and their families may seek support from a variety of resources including clinicians in private practice, school social workers, and therapists at community treatment centers. As more and more OIF/OEF veterans return to their communities, the frequency with which we work with OIF/OEF veterans and their families may increase with time.

Compared to veterans of other service eras such as Desert Storm or Vietnam, OIF/OEF veterans are presenting with higher levels of mental illness, especially depression and post-traumatic stress disorder. OIF/OEF veterans are also entering treatment with concerns about reconnecting with family and adjusting to life at home. Recent research suggests that a veteran's mental health problems correlate with relationship strain with spouses/partners and increased mental health problems among family members. This article outlines the most up-to-date information available at this time regarding the needs of OIF/OEF veterans and their families whom we may encounter in our clinical social work settings.

Mental Health, Family Reconnection, and Reintegration Challenges among OIF/OEF Veterans

Compared to other conflicts, OEF/OIF were unique due to the conflicts' length, the frequency of deployments, and short periods of non-combat between deployments. This form of deployment has been linked to increased mental health problems in veterans. Diagnoses common among veterans returning from Iraq and Afghanistan include depression and Post Traumatic Stress Disorder (PTSD). OEF/OIF veterans are three times more likely than veterans of other service eras to have PTSD diagnoses. OIF/OEF veterans with PTSD are more likely to have difficulty maintaining employment and more likely to report martial strain with their spouse/partner.

Veterans with children tend to have similar characteristics including being older, married, report feelings of anger and more symptoms of depression, endorse interpersonal violence, lower satisfaction with relationship compared to veterans without children. Common challenges specific to reintegrating into family life include regret at missing key moments in child's life, difficulty reconnecting with child, self-identified need for help in anger management and emotional expression, and adjusting to co-parenting. Additionally, veterans who report their children have problems themselves tend to have higher rates of depression, anxiety, and other mental health symptoms and lower satisfaction with social relationships and with family.

Common Effects of OIF/OEF Deployment on Spouses

Spouses/partners of OIF/OEF veterans often present with depression and anxiety symptoms. Spouses/partners often report these symptoms result from adjusting back to co-parenting upon the deployed spouse/partner's return, fear for the spouse/partner's safety, and adjusting to a new organization of family decisions, tasks, and roles. Some research suggests spouses/partners may experience increased levels of anxiety and depression with the veteran spouse has a physical injury.

Continued on page 7

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PRESIDENT'S MESSAGE

Dear GSCSW Members,

Attending CSWA's National Summit in Washington DC this fall, allowed me to begin my new term as President with great energy. Surrounded by knowledgeable, experienced, and passionate clinical leaders from across our nation, I was able to reflect on GSCSW's accomplishments of the past few years, as well as the growth and advances yet to come. Our team of board and committee members are truly committed to leading and meeting the needs of our record setting membership this upcoming year.

The current GSCSW board, with our new additions of Jean Rowe as Low-Cost Supervision chair, and Britni Brown as co-chair for Membership, started off the year with a fabulous retreat at Lake Lanier. A huge thank you to Polly and Will Hart, both LCSW's, who opened their property to us with open arms. We were able to spend time developing our team and engaging in strategic planning for the upcoming year. I was so impressed with the energy and dedication expressed by all towards serving our membership! We used our time at the lake to focus our efforts this year on 3 main areas: **Education, Connections and Networking, and Legislative Advocacy.**

Our use of technology is at the forefront of our education and connection efforts. We will be launching an updated website that will feature a member's only area for viewing our CEU events. Online viewing of these presentations will allow us to reach current members as well as new members outside of the metro Atlanta area. The potential is huge! Along the same lines, our active and ever growing Facebook page keeps our members informed and connected, and recent advancements in training in Telemental Health are opening doors for serving those who may not otherwise have access to support.

GSCSW will also further our membership connections through our low-cost supervision and mentorship meetings, as well as our upcoming salons and job panels. These events are excellent member benefits, especially for our new clinicians. And for our more seasoned members, we hope to continue to connect through fun and engaging events such as our "Ethics in 3-D" (Dinner, Dilemmas and Dessert), where we are able to explore perspectives on challenging cases. We are also building bridges and planning to forge stronger relationships with our local MSW Colleges and Universities. What a full year we have!

Finally, I am thrilled about our recent work in the legislative realm. The outstanding work completed by last years' board has enabled us to continue to be involved with legislative issues from a ground level. With our highest turn out ever at our Town Hall meeting this fall, we know that there will be great energy leading into this legislative session. We encourage our membership to prepare for the upcoming session, which begins in January, by keeping track of our legislative updates and contacting your legislators and representatives. Let your voice be heard.

With so many exciting opportunities, I hope you all will add your skills and talents to our dynamic group by getting involved - there are many opportunities available! I am humbled to be working with such a gifted team and would love to engage more of our membership in volunteering. Please do not hesitate to contact me if you have any questions, needs, or ideas to share. I look forward to seeing everyone at our upcoming Diane Davis workshop in December.

Stacie Fitzgerald, LCSW

GSCSW President

president@gscsw.org

FROM THE EDITOR

Dear fellow GSCSW members,

Children, parents, and teachers all have a direct connection to the rhythm of the school year – they live out the cadence of beginning a year anew, periodic breaks, and ending a year for the summer. Despite the distance there may be between us and our school days, perhaps this rhythm never leaves us. Do any of us in the workplace not miss a long summer or winter vacation, or realize we suddenly want a nap or a snack mid-afternoon? Once again, I find myself ingrained in the rhythm of the school year, especially now as I have transitioned from work a group practice to work in a school. Fall once again brings back-to-school time, the weeks leading up to Thanksgiving bring exams and celebrations, and the long-awaited winter break looms ahead.

I believe that we social workers are deeply connected to the rhythms and the seasons life brings. The articles in this issue highlight this connection, through Liza Gellerstedt's reflections on opening a new private practice, Alyce Wellons' exploration of the ethics of working with complex clients, Alexandra Pajak's consideration of the effects of the reintegration of recent veterans with their families, and Pam Chubbuck's look into the efficacy of psychiatric medication and the need for psychotherapy. Additionally, the Letter from our President, Stacie Fitzgerald, as well as GSCSW's committee reports, highlight the new initiatives and issues we seek to address this season.

This upcoming season brings changes to the *Clinical Page* as well. I will be taking a maternity leave for next spring's edition, and the *Clinical Page* seeks an additional committee member to assist in editing and preparing articles for print. The *Clinical Page* is also exploring new formatting ideas, and would love to work with a committee member who has expertise in online publishing, editing, or software. If you would like to be considered for this position or would like to share about your experience, please contact me. Thank you!

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 that benefit our membership, and I look forward to our continued work together. Please do not hesitate to contact me with any questions, concerns, or ideas about the *Clinical Page*.

Warmly,

Elizabeth Eiland Figueroa, LMSW
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LETTERS TO THE EDITOR

Let's be in conversation about the articles we publish!

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 this new feature. We look forward to this way of being in dialogue!*

The Ethics of Working with Complex Clients

BY: ALYCE E. WELLONS, LCSW

In March, I applied to present "The Ethics of Working with Complex Clients" at the Georgia NASW Annual Conference in October. After I submitted all my materials, I began pondering, "What is a complex client? What makes a client complex? What are the best ways to handle complex clients?" I quizzed a few of my colleagues on these questions and got some very interesting answers. My two favorite responses were: "This person needs help--wait, I AM the help!" and "I try to stay away from them!"

I think these answers reflect the complexity therapists face in working with complex clients. They can be challenging and difficult, requiring expertise in assessment, diagnosis, and treatment planning. There can be intense experiences, transference, counter-transference, and projective identification. Solid treatment team communication, professional support, continued training, and lots of hard work are core. Sophisticated boundaries are a must. Patience is essential.

Complex clients and the work involved often cause clinicians to feel helpless, inadequate, frustrated, impatient, and angry (at the client, at ourselves, at the system, at the family, at the world). The work can be long, hard, tedious, isolative, and painful for everyone involved.

Clients often enter treatment with a presentation of stress, depression, or anxiety. Upon further assessment, we discover a much deeper and more complex history. These issues can include, but are certainly not limited to: addiction, complex PTSD, complex family histories, dissociative spectrum issues, domestic abuse, dual disorders, a myriad of medical problems, and other psychological/medical/psychiatric issues. We can quickly discover there is much more to the story than initially presented. And we can even more quickly feel we are in over our heads.

The NASW Code of Ethics can be a guideline for clinicians who need direction for difficult situations. The NASW Code of Ethics speaks to clinician competence, consultation, referral for services, misrepresentation, and integrity of the profession – areas we are called to uphold as ethical clinicians.

The NASW speaks to the following specifically:

- Social Workers should promote the integrity of the profession through high standards of practice (5.01)
- Practicing outside area of competence (1.04)
- Using derogatory language about clients (1.12)
- Ensure adequate supervision and working environment that encourages ethical practice (3.07)
- Provide ongoing continuing education and staff development (3.08)
- Maintain policies and procedures that do not interfere with the ethical practice (3.09)

The Code of Ethics give us the framework, guidelines, and boundaries to explore our scope of practice, know when to get supervision, training and support, and know whether we should continue work with a client or make appropriate referrals. It is nice to know we are supported, even required to actively review assessment, diagnoses, and treatment plans as we work with clients.

As we learn in ethics trainings, many, if not most, ethical violations begin as a result of boundary violations. These can begin in small ways such as not starting and ending on time, and communication between sessions that is not structured and bounded. And there are bigger violations such as "helping clients" financially and emotionally in ways that are outside of our role, as well as dual and sexual relationships with clients. These violations are especially apt to occur with clients who are complex because our feelings of wanting to help and feeling hopeless when the work is difficult. We don't like feeling helpless and uncomfortable, and we may begin doing things to alleviate those feelings. Our difficulty and resistance in sitting with helpless and overwhelmed feelings can trigger a slippery slope of boundary violations. This is where awareness and self-care become real and central issues in working with complex clients.

The NASW Code of Ethics does not explicitly address self-care as an ethical requirement. However, it does address self-care in relation to its impact on client care:

- Social Workers must not allow personal problems to interfere with client care (4.5)
- Social Workers who are impaired should seek help (4.5)
- Social Workers should promote the integrity of the profession through high standards of practice (5.01)

Continued on Page 6

The Ethics of Working with Complex Clients

Continued from Page 5

However, many violations of ethical responsibilities to clients may be the result of inadequate self-care:

- Practicing outside area of competence (1.04)
- Conflicting interests; dual or multiple relationships (1.06)
- Having inappropriate physical contact; sexual relationships (1.05)
- Using derogatory language about clients (1.12)
- Disrespecting colleagues (2.01)

Supervisors and agencies have ethical responsibilities to support self-care:

- Provide appropriate field supervision for students (3.02)
- Ensure adequate supervision and working environment that encourages ethical practice (3.07)
- Provide ongoing continuing education and staff development (3.08)
- Maintain policies and procedures that do not interfere with the ethical practice (3.09)

This brings up the critical need of self-care for clinicians. Self-care is the awareness of what we as clinicians need to do in order to feel healthy personally and professionally. Insight and awareness of our own process is crucial as we work in a field that believes we are our own best tool. Bowen/Satir put it best: "use of self is the tool in which a therapist's professional work is based on" (Bowen, 1978; Satir, 1983). Therefore, it is also important for us to know the signs of when we are not practicing good self-care. Warning signs of burnout might include:

- Ineffective handling of crisis, poor performance of professional duties or increased negativity and cynicism. Increased absenteeism, social isolation, misinterpreting those in crisis, defensive demeanor and inappropriate justification of their actions are additional indicators of professional impairment. It is clear that burnout equals impairment.
- Missing or cancelling appointments, feeling fatigued, loss of enjoyment, low motivation, impaired sleep, self medicating, blurring boundaries.
- Professional warning signs: boredom, anger, daydreaming, wishing you were somewhere else, hoping for missed appointments, ending sessions early, arriving late

What to do?

- Know your warning signs
- Honest self reflection
- Increased training
- Professional support team, formal and informal
- Your own supervision, professional and/or peer
- Begin/Continue your own individual psychotherapy
- Accept you are human and in need of assistance
- Don't try to be perfect, have it all or know it all. Know your limits and be realistic
- Strive for balance and remember it is a moving target!

Working with complex clients requires assessment, diagnosis and treatment planning. Supervision, education, and professional support are essential. Awareness of our own self-care needs and burnout signs are helpful in order to be present and healthy as we work. We are fortunate to work in a field that calls us to be our best selves and gives us the opportunity to do our own work professionally and personally. When we allow ourselves to become vulnerable to our own thoughts, feelings, and needs, we immediately allow the work we do with clients to deepen. Education, ongoing, post-licensure supervision, and ongoing personal psychotherapy are, in my opinion, gifts and requirements the profession bestows upon us.

"As we let our own light shine, we unconsciously give others the permission to do the same." (Nelson Mandela)

Alyce E. Wellons, LCSW, is a psychotherapist in private practice in Virginia Highlands. She has been in practice over 15 years and sees individuals and couples as well as offers consultation and supervision for therapists pre and post licensure. While she has experience and expertise in practicing short and long term psychotherapy, she specializes in addiction, recovery, couples, psychotherapy for therapists, and use of mindfulness as a treatment modality. She can be reached at 404.664.3110, alycewellons@hushmail.com or check out her website: www.alycewellons.com for further information.

"The Effects of Reintegration on Spouses/Partners and Children of Mentally Ill Veterans of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF)"

Continued from page 1

PTSD diagnosis in the returned veteran can increase the level of mental health problems in the spouse/partner. Spouses/partners of OIF/OEF veterans with PTSD often report stress related to financial hardship, gambling, problems requesting leave to care for spouses with PTSD from employers, and time spent talking to the veteran's medical professionals, taking him to appointments. When compared to veterans without PTSD, veterans and spouses/partners of OIF/OEF veterans report higher levels of interpersonal violence in the home. Some research suggests that marital satisfaction between military couples is not different than non-military families with the exception of when the deployed spouse has PTSD, in which case both military members and their spouses report lower marital satisfaction, with such aspects as poor parenting alliance and negative communication.

Common Effects of OIF/OEF/OND Parent Deployment on Children's Behavior

Children with a deployed OEF/OIF parent often present in clinical settings with the following diagnoses: depressive disorders, acute stress reaction and behavioral difficulties. PTSD diagnosis in the veteran parent often leads to increased emotional and behavioral difficulties among the child.

Behavioral and psychological effects of parental deployment and reunification vary based on the child's age. Children ages 0-48 months display behavioral problems, attachment issues (difficulty separating from parent, ignoring the parent) as reported by veteran and their non-deployed spouses. This disruption due to deployment resulting in separation can be stressful for both the child and parent during the parent-child attachment relationship is formed during early childhood. Children ages 3-12 often present with higher levels of anxiety compared to children without a deployed parent. Children who take on parenting roles during a parent's deployment may miss out on age appropriate activities including spending time with peers, which in turn can interfere with age appropriate development. Teenagers with a deployed parent, especially if raised by a nonparent during the deployment, exhibit higher rates of substance abuse compared to teenagers without a deployed parent.

Family communication stands as a protective factor regarding children's psychological and behavioral response to parental deployment. Other protective factors include children participation in school and after-school activities, support from the Army community, and a family's positive opinion about the war.

Suggestions for Behavioral Healthcare Professionals

We as clinical social workers can improve our services for military families by educating ourselves on military culture and the unique challenges faced by veterans and their families. Asking about military service during our intake process may help build rapport with clients and improve diagnoses, treatment plans and outcomes. Educating the veterans on what responses to separation and reunion are age typical and incorporating interpersonal violence between returned veterans and their spouses/partners particularly if the veteran has a PTSD diagnoses may be also helpful. Finally, building professional relationships with the Department of Veterans Affairs and the Department of Defense can also aid social workers in effectively connecting military families with these agencies.

Resources

Department of Veterans Affairs toolkit for community providers to learn about military culture:

http://www.mentalhealth.va.gov/communityproviders/index.asp

Department of Defense online course about effects of deployment on children and families:

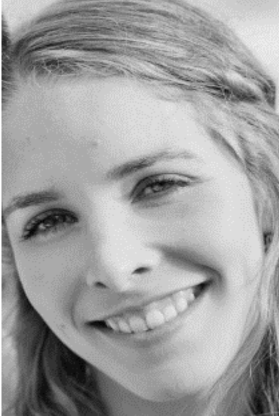
http://www.deploymentpsych.org

Contact

Alexandra Pajak, apajak@uga.edu

"Hello. I'll be your therapist and CEO."

By: Liza Gellerstedt, LCSW



Becoming a therapist is not for the faint of heart. You go to graduate school, take out loans, and after graduation, start with jobs where you often work with disenfranchised populations. In these jobs we are the holding environment for some of the most gut-wrenching stories of abuse and neglect. While you are busy helping your clients, you also have to do the hard but necessary task of working on yourself. As often cited in social work textbooks, you are the tool in the therapeutic relationship, and you must care for yourself the way a surgeon ensures he has the proper scalpels. All of this, and be sure to get your CEUs in the evenings and on the weekends.

Starting a business is also not for the faint of heart. We may be on the other side of the worst economic crisis since the Great Depression, but only slightly, with constant reminders of the potential for further financial strife. And taking on the financial risk of starting a business is only one piece of the puzzle. You must also be sure that you have the skill set to create something from nothing. With the most recent NASW Workforce Assessment stating that 12% of social workers work in independent private practice and hundreds in the Metro-Atlanta area alone, there are many of us who are finding ways to integrate these two skill sets.

I have known for many years that private practice was in my future, but I always had a lingering sense that I needed to be really *ready* before taking the plunge. I had assumed that I would work at an agency and ease my way into the private practice world, maybe never even doing it full-time. But after my son was born, I knew that I was ready to be my own boss and set my own hours. Now that my LLC has been registered with the Secretary of State for six weeks, I knew that my initial instincts were correct — opening a practice is really empowering and also a *lot of work.*

In the last month and a half, I have launched a website, designed a logo, binged on private practice podcasts, created legal forms, sent out a newsletter, ordered business cards, selected an online practice management system, started a Facebook page, a Twitter account, and a blog, and I've even learned some basic website coding. This is a small and neat summary of some of my activities, and, as many of you know, each of these tasks was wrought with details I could not have imagined and my attempts were fraught with errors. Starting a private practice is like nominating yourself to be CEO, CMO, and CTO, and meanwhile being a therapist too.

As the world goes, my son has been sick six times in the six weeks since I started the practice and our babysitter has been in the hospital for half of that time, leaving the "set your own hours" dream looking pretty different than I anticipated. I have found it more challenging to get to sleep at night and find that I am employing many of my sleep hygiene and mindfulness techniques more regularly with myself. But, as exhausted as I am, I am my own boss and knowing that everything I do goes back into something that I care so much about is a powerful feeling.

And in the classic social work way, I have been helped so much already by those who are farther down the private practice road. Thank you so much to so many clinicians who are helping me along. Just as with raising a baby, starting a practice takes a village and I am so grateful to count the GSCSW as part of my village. And while I am at it, go ahead and check out that website I was talking about: www.skylinecounselingatl.com. Just don't look too closely yet…

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Do You See *The Emperor's New Clothes*?: Emerging Truths in Psychiatry Create the Need for Psychotherapy to Take Back Its Rightful Place as Healing Modality

By: Pam Chubbuck, PhD, LICSW, LPC

[Author's Note: I do ***not*** *oppose responsible medical treatment. This is a call to fully educate ourselves so we can better assist clients to heal. We need access to accurate and complete information in order to make our best and independent decisions.]*

Our profession is needed now more than ever! Remember the kid who said, "The king isn't wearing anything at all" while the whole country went along with the tailors' deception? An explosion of information is telling us "the king" we call mental health care (currently, drug-based treatment with psychotropic medications) is only wearing underwear.

Every day more information is emerging that affects us personally and professionally. Scholarly books, journal articles, websites with proficient contributions by mental health professionals as well as descriptions of the lived experiences of "psychiatric survivors," are reporting that the medical pharmacologic model of mental health treatment just isn't working; in fact, it is causing more harm than good. Shocking? Perhaps, but statistics show that for the last 50 years people in the US are getting sicker, not better, as drug companies have attested.

Scholars are publishing revelations of once buried drug trial data and research studies which increasingly suggest that much of the "*more sick*" is *caused by* psychotropic medications. Countries that do not use psychotropic medications as liberally as the US have healthier citizens – sadly, the countries who have adopted our biopsychiatric model have seen their health measures slide.

Globally, numerous physician researchers, scientists, journalists and dedicated psychiatrists are stepping up for the public good, documenting corruption and deception by the pharmaceutical industry including burying of negative data, as well as supposed watchdog agencies such as the FDA failing to require rigorous honesty and correction of deeply flawed drug trials (1).

"Psychiatry… has a long history of ignoring the adverse effects of drugs, or attributing them to the underlying disease, of essentially blaming the patient rather than blaming the drug…. For example, in the history of tardive dyskinesia, and the history of the obesity caused by the new atypical antipsychotics, in both cases there was an attempt to say 'No, it's the disease' and in both cases it has eventually been shown conclusively that 'No, it was the drug.'"
Joanna Moncrieff, MD, psychiatrist and senior lecturer, University College London

Pre-Freud psychiatrists traditionally ran "insane asylums," while post-Freud created psychiatrist-psychoanalysts. After World War II, returning soldiers found counselors, social workers, and ministers who helped as well or better than physicians. By 1980, psychiatrists began to buy into the idea that mental illness was a brain-based disease that could be cured by giving drugs. Although this theory has *never been proven* (2), most psychiatrists started to almost exclusively prescribe psychotropic medications. According to industry data, one in five adults in the US are taking psychotropic medications (http://www.apa.org/monitor/2012/06/prescribing.aspx) which are demonstrated to not do what the drug companies claim they do, but instead often cause harm.

Oft-repeated myths: "You have a chemical imbalance and will need this lifelong - just as diabetics need insulin"; "There's no harm in giving this medication a try"; "This new drug does not have side effects as the old ones did." These myths continue to harm us. Negative effects ("side", withdrawal, and long-term) are not typically discussed prior to prescriptions being written even with FDA "black box" warnings. Samples of dangerous medications are freely available even by mail. To our disgrace, children and now *even infants* are given psychoactive drugs.

History clearly shows us that before lobotomies, Sigmund Freud, ECT, or psychotropic medications – "methods" including friendship, ministry, ensuring healthy nutrition, and the "gift of time" were available to assist troubled minds and souls, and they worked remarkably well much of the time for many life struggles now being too quickly medicated. Similar methods are currently working in other countries, such as Sweden.

What do we need to do? It's not really so hard or frightening – just be independent, informed, reasoning thinkers, and don't swallow the *Emperor's New Clothes* deception. Think and find your ethical truth. Demand that psychiatric drugs are researched by autonomous scientists not paid by drug companies. Do not allow companies naturally wanting to protect product image, to research their own merchandise. To truly help people in crisis we must come together and share authority with philosophers, child development experts, educators, mental health "patients", biologists, physicians, ministers, social workers, and psychologists. None of whom may be funded by drug companies.

We need to give voice! Therapists have long been discouraged to voice opinions or participate in medication decision-making. As social

CONTINUED ON PAGE 10

Do You See *The Emperor's New Clothes*?: Emerging Truths in Psychiatry Create the Need for Psychotherapy to Take Back Its Rightful Place as Healing Modality

Continued from page 9

workers we are on the front lines. We care. We know our empathic methods work. It is our ethical responsibility to inform ourselves about what is *not* working. We must be ready to assist in giving accurate and complete "informed consent" to clients who may ask for drugs, for themselves or a family member.

["Do not attempt to discontinue psych drugs without first very carefully educating yourself on the risks involved in both getting off and staying on these medications."] (3)

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Pamela L Chubbuck, PhD, LICSW, LPC, with over 35 years of experience as a psychotherapist, is a Certified International Core Energetics Trainer, with a serious interest in ethics. *Email us:* Info@VitallyAlive.com *for more resources and information. Call Pam: 770-388-0086. Visit* VitallyAlive.com.

DIANE DAVIS LECTURE

Insight-Oriented Psychotherapy in the Treatment of Psychotic Disorders

Presenter: Dr. Belinda McIntosh

FRIDAY, December 11, 2015 - 9:00 am - 12:15 pm

Ridgeview Institute, **3995 South Cobb Drive , Smyrna, Georgia 30080**

Dr. Belinda McIntosh is an Adjunct Assistant Professor in the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine. She is currently in private practice in Atlanta. After obtaining her bachelor's degree in Biology at Harvard University, she attended medical school at Duke University and Emory University. She completed her residency in General Adult Psychiatry at Emory, where she served as Chief Resident at Emory University Hospital. Dr. McIntosh worked as a Student Health Psychiatrist at the Georgia Institute of Technology as well as at Emory University, where she served as the Interim Associate Director for Psychiatric Services. Dr. McIntosh has also worked in the Trauma Recovery Program at the Atlanta VA Medical Center and served as the Associate Medical Director at Skyland Trail. Dr. McIntosh is engaged in a variety of clinical and teaching endeavors. She is a member of the American Psychiatric Association and serves on the Board of Directors of the Metro-Atlanta Chapter of the American Foundation for Suicide Prevention.

OVERVIEW:

Advances in psychopharmacological treatments that alleviate positive symptoms of psychosis greatly influenced the evolution of prognostic considerations in psychotic disorders. Over time, there has been variable consensus on the relevance and appropriateness of psychotherapy in the treatment of persons with psychotic disorders. Contemporary guidelines for employing psychosocial treatments in psychotic disorders emphasize the utility of psychoeducational and cognitive-behavioral approaches. At the individual level, a therapist's perception of an individual's capacity for recovery influences the therapist's selection of treatment modality, with significant potential impact on actual treatment outcome.

This presentation will describe the utility of insight-oriented psychotherapy in the treatment of patients with psychosis. The clinical course of schizophrenia and psychotic disorders will be reviewed in detail. Integration of psychopharmacological treatment with psychotherapy will be addressed. Through case presentations and discussion, the speaker will demonstrate how insight-oriented psychotherapy can be used to move patients beyond maintenance and relapse prevention to a deeper understanding of the conflicts that contribute to the onset and maintenance of psychotic symptoms.

EDUCATIONAL OBJECTIVES:.

- Describe historical perspectives on diagnosis and prognosis in psychotic disorders.
- Describe the clinical course of schizophrenia and related psychotic disorders.
- List and describe various psychotherapy modalities that are used in the treatment of psychotic disorders.
- Describe risk and prognostic factors in psychotic disorders that predict effectiveness of specific psychotherapy modalities.

3 Hours of Core CEU's

FOR MORE INFO AND TO REGISTER ON LINE - (Early Bird Rate good through November 20th) Click here

COMMITTEE REPORTS

LEGISLATIVE COMMITTEE

Greetings, GSCSW Members! This year, would like to welcome two new members to the Legislative Committee: Mr. Patrick Bryant, LCSW, and Mr. John Tatum. Mr. Bryant is a Licensed Clinical Social Worker and Certified Clinical Hypnotherapist, specializing in helping adolescents and adult men gain and/or restore healthy connection with themselves, their families, and the world around them. Much of his work has been grounded in redefining the relationship between masculinity, emotional vulnerability, and resilience. He is owner and psychotherapist at The Peaceful Place, LLC in Decatur, GA, is a contributing writer for Psych Central, and is currently collaborating with Divorce Mediation Centers to create a program designed to strengthen the family system during transitions of divorce and separation. Patrick has a longstanding interest in legislation as it relates to the support of our profession and the advocacy of the populations we serve.

Mr. Tatum was drafted into the military in 1968, spent two tours in Vietnam, several deployments in Iraq, and time in several combat zones. He is now retired from the U.S. Army after 32 years. Mr. Tatum received a Bachelor's degree in Psychology and Sociology from the University of Arkansas, a Master's degree in Theology from Southwestern Theological Seminary, and a Master's degree in Psychology from Texas Christian University. Presently an MSW student at Clark Atlanta University and pursuing an LCSW, Mr. Tatum has a primary goal to help people who are in need by addressing their social problems and challenging social injustice wherever it may be found.

On September 9th, 2015, GSCSW had our Annual Town Hall Meeting at Java Vino. A huge thank you to Wendi Clifton, Esq., our speaker, lobbyist and legislative advocate, and to all who came out to make this year's GSCSW Annual Town Hall meeting a big success. Wendi Clifton, Esq., discussed her training as a lawyer and her role as our lobbyist, which is to be an expert in the legislative process and to keep us informed - it is not to be a social worker or to speak on our behalf, as this is *our* job. Wendi also discussed how a bill becomes a law, and how our GA General Assembly is a citizen's legislature - this means our legislators do an incredible public service, working part-time for 40 legislative days, and working at a job in their district the rest of the year when they are not in session. Out of 236 members total (180 House Representatives and 56 Senators), we have only *2* social workers in the GA General Assembly. This means that there are very few people creating law that know what social workers know and know what social workers do, and they all get an equal vote. About 2,000 bills go through each term and terms are 2-years. The *only* constitutional obligation is for them to pass a budget, and there is not much in social work that isn't affected by the budget. Our 2016 Legislative Predictions are as follows:

- Despite 16-months of improvement in the economy, Governor Deal said that budgets would be staying flat. Full budget is $21 billion: >50% - K-12 Education, 25-27% - Medicaid, and ~23% (of the $21 billion) goes to everyone else (DBHDD, Dept. of Human Services, Transportation, Adult Education, and ~25 other state agencies).
- Expenditures that social workers will care about: DFCS - Gov. Deal proposed increase of 500 caseworkers for DFCS after a number of tragic deaths of children. 175 have been added for FY16 and Wendi predicts 175 for FY17. DFCS Director, Bobby Cagle, has made a number of suggestions regarding improvements.

How do we get involved? The Legislative Committee will be sending out updates about how to track the various bills we will be watching closer to the beginning of the session. Most importantly, VOTE and find out who your representatives are. Go to meet them in person if you can. Please contact them if an issue is important to you, and thank them for supporting relevant issues. If they get a call, an email, a letter, or a visit from *anyone*, they remember. Here are links to find out who your legislators are: http://capwiz.com/socialworkers/ga/home/ -or- http://www.openstates.org

Here is the process of how a bill is passed in the Georgia General Assembly:

http://georgiainfo.galileo.usg.edu/topics/government/article/general-assembly/how-a-law-is-passed-in-the-georgia-general-assembly

To find examples of bills and resolutions, go to the GA General Assembly's website: http://www.legis.ga.gov

1) Enter in the type of bill at the top left (i.e., "HB, for House Bill," "SB," for Senate Bill."

2) Enter the number of the bill in the blank space, and

3) Click "search" to obtain the full text.

You may read the text for a few of the bills from last session by searching the following House Bills: HB 72, HB 131, HB 177, and HB268.

As your Legislative Committee, we look forward to presenting the latest legislative topics of interest to our profession and clients in Georgia. We will continue to establish, strengthen, and maintain relationships with NASW-GA, to inform our membership about legislative issues that directly affect our work, and to keep you posted if there is a call to action. Finally, we welcome any information, suggestions, or questions and encourage our memberships' involvement in the legislative process and/or in joining the Legislative Committee.

Barbara Lewison, LMSW - Legislative Chair, Antwan Aiken, MPA, LMSW, Legislative Committee Member, Patrick Bryant, LCSW, Legislative Committee Member, John Tatum, MSW Student - Legislative Committee Member legislative@gscsw.org http://www.gscsw.org/legislative/

In the GSCSW website's Legislative section, you will find information on how to get involved in the legislative process, the areas that GSCSW focuses on for advocacy, links to finding your legislator, and voting/election information.

COMMITTEE REPORTS

PROFESSIONAL EDUCATION COMMITTEE

We have had a successful fall season for our Thursday night workshop series. Thanks to all who came out this fall! Upcoming events are:

Annual Diane Davis Workshop: *see page 11 for more information and how to register.*

Don't miss our first Thursday night workshop of 2016! On Thursday January 7th, 2016, from 7-9pm, Chantea Williams, PhD will present on "*Addressing Microaggressions in Everyday Life, Strengthening Our Work and Service to Others.*" This will kick-off our 2016/2017 Workshop Series.

We invite you to contact our committee at professionaled@gscsw.org with any questions you might have. With Gratitude, Katie & Lena

ETHICS

Our ethics committee members have much experience in the field, and are poised to ponder ethics consultations. Do not hesitate to contact us if you would like an ethics consultation, or are considering an ethics question. We are here to serve you!

Most recently, our committee handled an ethics consultation involving a confidentiality, client information, and the use of cell phones to store information. We offered several ideas to maintain and protect client confidentiality with the use of cell phones.

We are currently looking forward to our next ethics event: "Ethics in 3D - Dinner, Dessert and Dilemmas." Stay tuned for more details to come! Please contact us with any questions or input at ethics@gscsw.org

Ethics co-chairs, Carol Finkelstein, LCSW, and Sherri Rawsthorn, LCSW

PUBLIC RELATIONS

Since last spring, the social committee has been growing. Emily Giattina, LMSW, and Robin Kirkpatrick, LCSW, joined the committee, and have already begun video recording of the fall lectures to be able to later add to our updated website. They have also helped with event photography for both the website and the Facebook page. Our committee has been collaborating with other committees to assist them in the creation of more effective event marketing, to include new copyrighting, video announcements, and social media posting, all of which has been very successful in terms of engagement and the increasing number of people attending the events. The social media committee has also been working closely with Trisha Clymore, the GSCSW administrator, and Southern Web, our web designers for GSCSW, to revamp the website to include easier accessibility for membership renewals, and to make the lectures available to membership directly through the website rather than through an additional website. The Facebook page continues to grow and has stayed very active, with several daily post by membership, including articles, referral searchers, and other community discussions. Facebook page has proven very helpful in terms of introducing GSCSW to a larger audience of clinical social workers throughout the state of Georgia. As social media has become a part of everyday life, the committee's role continues to expand in facilitating the dissemination of current news, updates, upcoming events, etc. If you have an interest in social media and would like to know more about this committee, please contact socialmedia@gscsw.org

LMSW COMMITTEE

We are excited about the new season, which commenced with an inspiring GSCSW retreat in August, and we have several events in development. Please mark your calendars for January 23, 2016, the planned date of our first salon, which will focus on issues related to clinical practice in the digital age (details TBD, please visit gscsw.org for updates). As we continue to receive inquiries about LMSW/LCSW licensure, we plan to host a salon dedicated to this topic in March 2016 with details to follow. We are pleased to continue our partnership with GSCSW Mentorship Committee for the 2016 Jobs Panel, which will take place in April 2016. The LMSW Committee welcomed two new committee members this season who bring much enthusiasm and experience. We had the privilege of visiting a UGA MSW class in October and continue to look for opportunities to connect with MSW students. If you are interested in joining the LMSW Committee, please contact me at lmsw@gscsw.org.

Allison Sweenie, LCSW, Chair

"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

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