ISCSW

NEWSLETTER
FALL 2013

President's Message

Eric Ornstein

We had a great Spring Conference! On June 8, over 140 people were enlightened, entertained and charmed by Louis Cozolino, Ph.D., during his day-long presentation entitled "How Psychotherapy Changes the Brain: Attachment and the Therapeutic Process". I want to acknowledge and thank Ruth Sterlin, our conference Chair, and the conference committee who all worked tirelessly to make the conference such a success.

Dr. Cozolino's presentation was extremely interesting and informative. What I found to be most compelling was his statement that there is convincing neuroscientific evidence that when therapists work collaboratively with their clients to help them develop a more cohesive narrative, many higher centers of the brain are stimulated and changed in a positive and lasting way. This provides strong empirical support for and confirmation of the psychodynamic, attachment-based way of working with clients that many of our members practice. I also see it as an implicit endorsement of the phrase, "Preserving the relationship in clinical social work", which the board recently added to the home page of our website (*http://www.ilclinicalsw.com*.), in order to highlight the critical importance of this aspect of our work. If you are interested in learning more about Dr. Cozolino's sophisticated integration of neuroscience and psychotherapy, I encourage you to check out his recent book *The Neuroscience of Psychotherapy: Healing the Social Brain* which is available for a very reasonable price on Amazon.

We recently had our second successful Networking Event, hosted by Rebecca Osborn, our New Professionals Chair, at her lovely Evanston home. The focus of this event was on the new DSM-5. Participants enjoyed great food and fellowship while having a lively discussion of how to understand and use the new diagnostic manual. We hope you will consider joining us for future Networking Events!

As you are probably aware, there is a lot of controversy in the field about the new DSM-5. Some clinicians are excited about the way the latest research on mental disorders has been incorporated into this diagnostic system and appreciate the beginning movement from a categorical approach to diagnosis to a more nuanced, dimensional approach. Others have been highly critical of the new DSM. They feel that its broadened diagnostic categories will pathologize normal behavior, and that its validity and reliability are questionable. These are complicated issues, to which there are no simple answers. If you are interested in exploring this controversy further, I would recommend Allen Frances' very recent book, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life (*also available on Amazon*)*. Frances provides a powerful and penetrating critique. His views are especially interesting and important; because, as many of you know, he is one of the most prominent psychiatrists in the country, and he was the editor of the previous edition, the DSM-IV.

If you are like me and have procrastinated about getting your three ethics CEU's in time to renew your license by November 30th, ISCSW will be coming to the rescue! We are hard at work planning a three-hour ethics conference and are proud to announce that the speaker will be *Joseph Monahan, M.S.W., J.D.* The conference will be held on Friday, November 15, 2013 from 9:00 a.m. -12:00 noon. Among his many accomplishments, Monahan is an adjunct law professor at Loyola Law School, and he is widely acknowledged as one of the leading authorities in Illinois on the intersection of legal and ethical issues in social work practice. Please save the date! ISCSW will also be sending out email announcements and will post a brochure on our website where you can register for the conference. We are especially pleased that two of our new board members, Emily Heilman and Christina James, are Co-Chairs for our conference committee. Thank you Emily and Christina!

Finally, I want to briefly mention that the Jane Roiter Sunday Morning Seminar committee is hard at work planning the next round of Sunday Morning Seminars which should start in late October of this year. The theme of the Seminar Series will be "Relational Derailment and Repair". Specific topics will include post-partum mental illness; dealing with hopelessness in therapy; pedophilia: issues and actions; and neuropsychiatry for clinicians. Please check your email and your mail for more information. And don't forget to look on our website.

I hope you all had a restful, relaxing and enjoyable summer and that you are energized and enthusiastic as we enter the fall. I look forward to seeing many of you at our upcoming and exciting ISCSW events.

Save the Date for Our Ethics Conference!

ISCSW Proudly Announces

Who

Joseph Monahan, M.S.W., J.D., will present at our three-hour conference. He has a background primarily related to child welfare, guardianship, and mental health law, particularly complicated discharges from hospitals. His areas of special interest include the following: NASW code of ethics, ethical issues related to children, boundaries, record keeping, consent, risk management (*i.e.,* how to avoid lawsuits), role of the GAL, and working with unmarried parents and blended families. He lectures regularly on ethical issues and teaches two courses at Loyola Law School as an adjunct professor. For more information about him, you can go to his website:
http://www.monahanlawllc.com/joseph_monahan_bio .

When

The conference will take place on Friday, November 15 from 9:00am – 12:00 noon.

Where

UIC Student Center East

Details

Fees: To be announced.
3 C.E.U.'s

Watch for more information on our website, www.ilclinicalsw.com, and look for a brochure in the mail.

ORIGINAL CLINICAL ARTICLE

Boundaries and Other Complex Issues in Conducting Psychotherapy Groups

Hylene S. Dublin

Introduction

Conducting psychotherapy groups presents the clinical social worker with many complex issues affecting the success of this undertaking. In an era when insurance dilemmas permeate, time-limited and technique focused therapies are emphasized, and little training for group therapists is available, it is difficult to deal with the many factors which make conducting an interactional, interpersonally focused group especially challenging. In particular, the boundary issues involved must be comprehended before attempting to provide this especially valuable form of therapy, and they can be quite difficult at times. As a group psychotherapist, one must begin with a clear understanding of the complex boundary issues which operate in psychotherapeutic group situations. Unfortunately, the inaccurate notion of groups being only valuable in in-patient settings or with regressed populations has prevented expanded use of therapy groups, but this perspective appears to be changing. And the boundary issues are even more complex in in-patient settings.

Preparation of Group Members

Preparing a potential member for a psychotherapy group and addressing the boundary issues necessary for creating a safe group envelope are ideally addressed in individual pre-group sessions. Thus, the individual is boundaried from the group until a mutual decision is made about potential entry. This protects the individual from unnecessary pre-group exposure and the group from involvement with an individual who might not commit or terminate prematurely.

During these individual sessions, an assessment is made of the individual and his/her problems and how they might be best addressed in group sessions. Additionally, a beginning therapeutic alliance is established with the potential member, a formulation regarding the individual's needs and dynamics is made, and the potential member "contracts" to utilize the group in ways agreed to during the preparatory sessions. Such a contract involves (1) regularity and timeliness of attendance; (2) the need to work on problems actively; (3) putting feelings into words not actions; (4) staying in the group until problems are resolved; (5) using group contacts therapeutically and not socially (a significant boundary issue); (6) responsibility for fees; and (7) protecting the identities of fellow group members (Rutan, Stone, & Shay 110). Actually, in Illinois, the members' obligation to maintain confidentiality is written into law. Regarding confidentiality, most group therapists set up a boundary that allows personal experience and learning to be shared outside of the group system by individual patients while, at the same time, protecting the identities of individual members.

It is important to note that the group contract is not a legally binding document but an understanding of how the group needs to operate effectively. Obviously, the individual screening/preparatory sessions must also involve gaining diagnostic perspective and a historical picture of the client which is more available over time in individual psychotherapy. Also addressed are the nature of the on-going relationship between the therapist and client and the importance of the client's responsibility to share significant information with the group.

Group and Individual Therapy

One of the most significant boundary issues regarding group treatment is the effective and ethical collaboration with an individual therapist who refers the patient to group (called *conjoint treatment*). What needs to be clarified with the patient as well as the referring therapist (with the

patient's permission) is the importance of mutual communication. The therapeutic work must be coordinated so that two therapists are not working at cross purposes. Sometimes, a group referral is made when there is a negative countertransferential issue in the individual treatment, which makes the patient's choice about how to relate to the new therapist and join the group a complex one. It also provides a dilemma with which the group therapist must deal—does the patient experience the referral as a rejection and/or a recommendation of an inferior treatment resource?

These are obviously not concerns when the individual work is being done with the group psychotherapist (called *combined treatment*). However, even in combined treatment, clarity must be established about whether the therapist assumes the therapeutic authority to bring individual material into the group sessions. Therapists differ on this issue, but most often the patient, with the therapist's guidance, reserves the right to decide about what is shared and when. Despite these concerns, it is important to note that the addition of group psychotherapy often provides an opportunity to work on relationship issues that have been addressed individually but require a peer arena for further examination and an opportunity to experience more autonomy and less dependence.

External Boundary Issues

One significant way of considering boundary issues is to divide them into external *vs.* internal boundary concerns. External issues have to do with what is the boundary of the group itself (*i.e.,* a commitment to the group membership that it will not be altered without giving group members advance warning and an opportunity to react to the potential of a new member being added). Members need to recognize membership as a relationship commitment as opposed to a drop-in situation and that consistent attendance and being on time matter.

Additionally, locale, session length (an important issue regarding beginning and ending sessions), fee payment issues, preparatory sessions (as discussed previously), the dilemmas regarding outside contact between members and the need to discuss such in group, and the implications of combined or conjoint treatment are all important external boundary considerations. These need to be explored and an understanding reached before a potential new member can join the group. Noteworthy, however, is the fact that boundaries will inevitably be crossed by both patients and therapists, but it is important that these boundary crossings be identified and discussed within the group. There is, also, a difference between boundary *crossings* and boundary *violations*, which are potentially harmful to group members, and which will be discussed later.

Internal Boundary Issues

Internal boundary issues become the main concern when group membership is established (however, whenever group members leave or join the group, the external boundary issues come into focus once again). Attention must be paid to evolving norms, roles, clarity about the task, subgrouping and its positive and negative impact, phases of group development and the necessary relevant techniques of the group therapist. Often, in a beginning group, the therapist is seduced by the disclosures of one group member and begins prematurely to work with this "identified patient." This bodes badly for the individual as well as the group in that this person can be scapegoated and feel inappropriately vulnerable, and, most importantly, it avoids the opportunity for all group members to deal with the necessary examination of connection issues—*i.e.,* how to make the group a safe arena for everyone—without premature sharing of intimate secrets. A significant boundary, therefore, exists between the various phases of the group's development which the therapist must keep in focus and help the group to understand.

Phases of Group Psychotherapy

Tuckman (1965) is credited with formulating the phases of a team's development, and his perspective has tended to inform the view of phases in an evolving therapy group: *forming*, *storming*, *norming*, and *performing*. Forming has to do with creating a safe environment which involves all members exploring their anxiety about connection and the sharing of significant personal material. The second phase, storming, is often accompanied by some feelings of dissatisfaction when, having established safety, unrealistic expectations regarding progress have not been met. This allows for the examination of negative feelings regarding the members and the leader. As this phase is traversed, the group comes to recognize that positive and negative feelings can be expressed productively, and that it is normal to consider all of these within the group (called norming). Subsequently, the group moves into a phase that involves the most therapeutic work (performing). As individual patients make progress, the issue of termination is most effectively contemplated when group members are able to provide feedback and deal with the feelings involved in ending the relationships. It is important for the group therapist to keep in mind the notion of phases so that expectations of the group's process are realistic and so that the

group therapist utilizes phase-appropriate interventions.

Contact outside of the Group

One of the complex boundary issues with which groups struggle is the issue of contact outside the group. Obviously, in certain settings, it is impossible for individuals to avoid seeing each other outside of the group session. Even in a private practice setting, there are opportunities for contact outside—walking to a parking area, meeting in the waiting room, etc. "Subgrouping," making connections with like-minded or supportive members can be a form of "secondary gratification." In the preparatory process, members need to recognize the significance of their contact with others and to understand that anything that happens between group members is part of the here-and-now of the group. It, therefore, needs to be examined as an element of the group process. Groups have floundered when two members have evolved close outside contact which has affected their ability to be open in the group and to be confrontive when necessary. The therapist's role is to help the individuals discuss these occurrences and to explore their feelings without maintaining a critical, punitive stance. Additionally, the formation of subgroups presents those excluded with a difficult dilemma and feelings which reinforce non-participant behaviors—often a replay of exclusion experiences earlier in their lives which warrant exploration.

The Utilization of Co-Therapists

Another highly significant boundary issue is the utilization of co-therapists. In many training settings, individuals are paired as co-therapists to meet training requirements and often seasoned therapists are paired with inexperienced ones. This can result in an effective collaboration if the individuals doing the co-therapy are able to deal with the potential power and experience differences effectively. There is an opportunity to recapitulate the primary family group with two co-leaders, but consultation should be available to enable the partnership to evolve effectively. When the two therapists have not explored and resolved competitive issues and dealt with their differences during meetings outside of the group, this destructively affects the functioning of the group and is a replay of unhealthy parental relationships for many group members. It must be possible for group members to provide feedback to co-leaders about their similarities and differences regarding their competitive *vs.* collaborative behaviors. The importance of regular pre- and post-meeting dialogues between co-leaders cannot be over emphasized. The issues of fee splitting and responsibilities for recording and other administrative tasks must be discussed as well. All of the issues involved in creating a "good marriage" must be considered.

Boundary violations are a significant concern in group as well as individual therapy. These can include inappropriate therapist behaviors such as romantic, sexual, business, or other problematic personal involvements with group members. On occasion, there can be sexual and/or romantic involvements among members. When these remain secret, they very much affect the members' abilities to be open and confrontive with each other in group—and tend to make the process ineffective for the involved members as well as for others in the group. As Yalom states, "members of a therapy group who become involved in a love/sexual relationship will almost inevitably come to award their dyadic relationship higher priority than their relationship to the group" (Yalom 330). This is particularly destructive since what is enacted is often a repeat of past destructive relationships—and the issues are not shared with the group. The couple ignores their primary goals in treatment, often acting out destructive past histories. As Yalom reminds us, “anything that happens between group members is part of the here-and-now of the group" (Yalom 330)—there is no boundary here.

Individuation

Perhaps, lastly, the most significant group boundary issue has to do with an individuation phase, which individuals need to address after having dealt with the earlier group development issues. During this effective working phase of the group, individual members must recognize and accept differences between themselves and other members. They must also recognize boundaries within themselves; *e.g.,* between their potential for conflict, hostility, and aggression in opposition to their passivity, dependency, and the need for connection and closeness.

Conclusion

One must note that there are a plethora of boundary issues affecting psychotherapy groups. These must be addressed in the diagnostic/preparatory individual sessions which, in themselves, must be boundaried from group participation. One does not join a psychotherapy group in a casual, drop-in fashion but rather only after “contracting” to respect the internal and external boundaries of the group. This does not mean, however, that boundary crossings do not occur. They occur frequently. Since there has been an earlier agreement, these crossings are examined as the acting out of the psychological issues they represent for the individuals as well as the group-as-a-whole.

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About the Author

Hylene S. Dublin, L.C.S.W., A.C.S.W., B.C.D., Certified Group Psychotherapist, and Life Fellow of the American Group Psychotherapy Association*, is currently in private practice in Evanston working with individuals, couples, and groups. She also provides consultation to other clinicians. Ms. Dublin has recently completed a four-year assignment as Institute Co-chair for AGPA with responsibility for planning and maintaining the two-day Institute Program at AGPA's annual conferences. Formerly on the faculties of Evanston Hospital, Northwestern University Department of Psychiatry, the University of Illinois Neuropsychiatric Institute, the University of Chicago Department of Psychiatry, and the University of Chicago School of Social Service Administration Summer Programs, Ms. Dublin has published numerous book chapters and articles on issues in psychodynamic group psychotherapy. Currently, she is a Visiting Professor at the Institute for Clinical Social Work in Chicago.*

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The Cutting Edge...

Reviews of Recent Literature

Restoring Mentalizing and Attachment Relationships: Treating, with Plain Old Therapy. Allen, J.G. (2013). Washington, D.C.: American Psychiatric Publishing.

I have often thought that John Allen is overly modest. At first, I thought that was the reason he called mentalizing, "plain old therapy". However, near the beginning of this book, I discovered that the term "plain old therapy" is far from modest. Rather, it is a modest man's way of making the claim that he can explicate the main mechanisms of all psychotherapies, as well as how they work. His explanation is simple, self evident and commonsensical. After reading this book, I believe that many therapists will share my wonder and feel with me, "So that's what I've been doing all these years!"

Mentalizing was devised as a manualized treatment for borderline personality disorder based on the current research on attachment, affect regulation and cognition. Evaluation research has shown it to be a highly effective treatment; however, shortly after the method was developed, Allen recognized that it was nothing new. Mentalizing therapy was a succinct way to conceptualize the central process in all psychotherapies. The other developers of

mentalizing therapy, Anthony Bateman and Peter Fonagy, readily agreed with this.

Mentalizing is the unique human ability to know one's own mind and to know the minds of others, as well as to understand how others see us. It is sometimes also called the *self-reflective capacity.* This ability has had so much attention in the past few decades from the psychotherapy community, that it has been given several names: mind sight, metacognition mindfulness, and theory of mind. It is central to the unique human abilities to have affect regulation, feel interpersonal connection, and even conceive of and feel a connection with a personal God. Allen contends that it is the basis of hope, faith and the human ability to find meaning in life.

Mentalizing is a deeply interpersonal process. It is not an intellectual process that can be developed in isolation. An infant's first understanding of the world is not that of space and time, but of her intersubjective connection with her mother. For example, an early understanding of the mind's relationship to the world and of our own internal states comes from experiences such as when we as children awake crying from a nightmare. A parent sits next to us on the bed and tells us, "It will be okay. I am here. It was only a bad dream."

Thus, Allen believes that all psychotherapy is relationship-based. He points out how even therapies that claim to be cognitive behavioral are deeply dependent on the patient -therapist relationship. He quotes Marsha Linehan as saying, "My emphasis on the therapeutic relationship as crucial to progress in DBT comes from my work in intervention with suicidal individuals. At times, this relationship is the only thing that keeps them alive." Teaching skills and giving patients intellectual structures for their chaotic minds is very helpful, but these things can only take place in the context of the safe, holding therapeutic relationship.

Allen views psychopathologies in terms of various types of failures to develop mentalizing. With patients who have borderline personality disorder, for example, the world will be viewed as hostile and rejecting, and patients are unable to question their particular own view of the world. To this patient, his feelings and perceptions are reality. He cannot distinguish them from the outside world. For someone with PTSD who is having a flashback, it feels as if the trauma is happening *now*. It does not feel as if it is happening in his mind, and it becomes in the moment this patient's reality.

Allen introduces the concept of *attachment trauma.* By this he means a failure in the parent-child relationship which results in an insecure attachment. He focuses, in particular, on the disorganized attachment. He sees *complex PTSD* as PTSD in a person with severe attachment trauma. He believes that PTSD is much more painful if the trauma is suffered alone and cannot be shared. Allen told one of his patients, "The mind can be a scary place." She replied, "And you wouldn't want to be there alone!"

In practice, the one difference between plain old therapy and mentalizing therapy is that in mentalizing therapy, the process of *mentalizing* is made explicit to the patient. Mentalizing is set out as the goal of psychotherapy; *i.e.*, "Together we will understand ourselves and each other and our relationship in the present moment."

Allen believes therapists should follow a set of simple guidelines. Among these are 1) maintaining an attitude that is both attentive and curious, 2) taking a not-knowing stance, 3) promoting a level of engagement that is neither too hot nor too cold, 4) providing a secure base that facilitates the patient's exploration of the emotional states of both herself and the therapist, 5) validating the patient's experience before offering alternative perspectives, and 6) engaging the patient in viewing her interactions and self experiences from multiple perspectives.

As a counterpoint, Allen believes that, as a therapist, 1) you should not strive to be brilliant and clever, 2) you should not present your ideas about patients with a sense of certainty, 3) you should not engage in psychobabble, and 4) you should not react to the patient with intense, reactive, "non-mentalizing" emotion.

Overall, this is an excellent book. I believe it should be the basic text in any introductory psychotherapy course. For me, it is like the *Little Red Book* of the Cultural Revolution, one to keep close by and consult to make sure I stay on track!

Geoffrey Magnus

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The Josselyn Center Opens a Living Room for Crisis Intervention

In 2011, The Josselyn Center, a community behavioral health agency located in Northfield, was chosen to receive new funding from the Illinois Department of Human Services (IDHS) for a pilot innovative crisis respite care pro-

gram called the *Living Room*. This service has resulted in decreased hospital emergency department visits, lower costs associated with outpatient and preventative care, and a promotion of paraprofessionals acting as peer counselors and advocates.

The Living Room, located in Deerfield, is a comfortable, non-clinical space that provides an alternative to hospital emergency department visits for adults, age 18 and over, who are experiencing a psychiatric emergency. This intermediary approach creates an opportunity for guests to decompress and problem solve with a licensed clinician and peer counselors in a safe and non-medical environment. Guests work with the staff to evaluate their level of need and to develop a coping strategy to reduce stress level and anxiety. The Living Room setting includes a separate area for triage where new guests can be assessed; and, in addition, there are soft seating, quiet spaces to rest and healthy food. The setting is intended to provide a restful and calm environment to allow guests to feel comfortable and safe so they can resolve issues without more intensive intervention.

The services offered by this non-clinical setting include the following:

- Brief assessment completed by a licensed clinician
- Crisis intervention
- Support from peer counselors
- A safe space in which to rest or relax
- Assistance with problem solving
- Linkage with referrals for housing, healthcare, food and mental health services

Each guest is paired with a peer counselor who orients the guest to the Living Room and who provides support to the guest throughout the time the guest remains in the Living Room. The peer counselor also assists the guest to make use of the resources that will help the guest to resolve his or her crisis. A licensed clinician then re-evaluates the guest before he or she leaves the Living Room.

The target population is adults who are experiencing a mental health crisis and who hopefully will be helped in such a way as to prevent the need for an unnecessary hospital emergency department evaluation. Since opening in October 2011, the Living Room has had over 400 visits. None of these individuals required transfer or referral to a hospital emergency department. Using the evaluative scores established by the Living Room, the average level of mental health distress at the time of arrival to the Living Room has been 7.03, but then generally drops to an average of 5.48 at the time of departure from the Living Room. This is a significant drop of 1.55 in the guest's distress level. The ability of the Living Room to prevent unnecessary hospital emergency department visits results in significant dollar savings. In addition to the dollar savings, the benefits to the consumers of services are greatly enhanced; since, for most mental health consumers, a visit to a hospital emergency department is chaotic, disorganizing and unnecessarily expensive.

The Josselyn Center's Living Room is located at 130 Waukegan Road in Deerfield. The hours of operation are Monday, Tuesday and Saturday from 3:00 P.M. to 8:00 P.M. Appointments are not necessary. All of the Living Room's crisis intervention services are free, and there are no geographic limitations for the guests.

If you would like to obtain more information about the Living Room, please contact Suzan Eckstein, L.C.S.W., Program Director of Clinical Services for The Josselyn Center at 847-441-5600, ext. 146.

Suzan Eckstein, L.C.S.W.
Program Director of Clinical Services
The Josselyn Center

Calling All Writers!

The Illinois Society for Clinical Social Work is looking for writers! Regardless of your experience with writing – whether a lot or very little – we believe that, if you are a clinician in the field, you have something to say. And our *Newsletter* is an excellent place to say it! If writing a full article is not your preference, we invite you to write a review of a book or professional journal article in the ***Cutting Edge*** column, or to express your opinion in our new ***Cultural Competence Platform*** column.

In addition to the satisfaction of sharing your knowledge and opinions, you will have the opportunity to work with a seasoned editor to facilitate your writing process. Please contact us at ISCSW@ilclinicalsw.com for more information about submitting your work.

ISCSW Hosts another Successful Networking Event

On August 4th, our New Professionals Chair, Rebecca Osborn, welcomed 30 people into her Evanston home for a successful, fun and intellectually stimulating ISCSW Networking Event. The people who came were both members and nonmembers, since all are welcome to these events. While eating from an outstanding brunch buffet, attendees chatted with each other informally, and then eventually filtered into the living room to participate in a discussion of the DSM-5.

Eric Ornstein, our President, led a discussion of the pros and cons of the new DSM-5, including many of its political implications. This evolved into a general discussion of how as social work clinicians we often find ourselves at the mercy of systems that make us feel helpless. Participants came to an agreement that we need to ally with other organizations and advocate for ourselves for everything from higher insurance reimbursement to having a voice in how we diagnose our clients.

We strongly encourage all of you to come to our Networking Events. They are really good!

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ISCSW Welcomes Four New Board Members!

An organization is only as vital as its board of directors. As you will see below, following many requests from individuals in our professional community to serve on our board, we continue to have a board of outstanding social workers. ISCSW is proud to introduce you to our four new board members.

Agnieszka Grabowski
Cultural Competence Chair

Agnieszka currently specializes in psychotherapy with pregnant and postpartum women. Her general experience includes treatment of individuals and couples, and group psychotherapy. Most of her treatment experience has focused on various aspects of women's reproductive mental health which includes perinatal mood and anxiety disorders, childbirth trauma, grief over pregnancy and neonatal loss, as well as the psychological sequelae of gynecologic cancers, and infertility. Agnieszka did her specialty training at the Women's Mental Health Program of the Department of Psychiatry, UIC Medical Center.

Agnieszka is also actively involved with the Perinatal Depression Program at NorthShore University Health Systems which operates the only 24/7 hotline for perinatal women in distress in the Chicago land area. Her other clinical interests include therapy with culturally diverse populations and mindfulness-based approaches to therapy.

She brings a broad background of women's issues to her work and will have a lot to offer in focusing on important subgroups that need a culturally competent sensitivity from those of us who work with them. Welcome, Agnieszka!

Christina James
Secretary and *Legislative Chair*

Christina received a Dual Masters from the University of Chicago in Social Work and Public Policy in 2007 and currently works as a Licensed Clinical Social Worker at the University of Illinois Chicago Medical Center in the Department of Psychiatry. The majority of Christina's clinical experience has been with adults facing various issues, including depression, anxiety, psychotic disorders, and trauma. She has experience providing individual therapy, and facilitating psychotherapy and psycho educational groups which include Group Therapy, Mindfulness, Cognitive Behavioral Therapy (CBT), Anger Management, and Communication Skills.

Christina's clinical work is informed by different types of therapy and theoretical perspectives, including Dialectical Behavioral Therapy (DBT), CBT, Psychodynamic Theory, and Mindfulness-based treatment. While the majority of her clinical work has been with adults, she also has experience working with children through her social work internships: her first internship was with Children's Home and Aid, and her second was with The Children's Bureau of New Orleans. Additionally, Christina has an interest in issues related to Alzheimer's disease, having worked part-time for the Alzheimer's Association 24/7 Helpline. She is very excited to have joined the ISCSW Board, and we are happy to have her!

Emily Heilman
Public Relations Chair

Emily Heilman received her Master of Social Work & Women's Studies from Loyola University Chicago. Throughout her career she has worked with several populations, including clients with issues around foster care and adoption, HIV and AIDS, homelessness, women's health and children's mental health.

In her current work in her private practice, she provides individual, couples, and group psychotherapy, with a special focus on perinatal mood disorders, infertility, and perinatal loss. She also offers reduced-fee psychotherapy for

students, and clinical supervision towards an L.C.S.W. Emily's treatment approach is psychodynamic and relational, and she is currently working towards her Ph.D. at the Institute for Clinical Social Work. Welcome, Emily!

Michael Kittelton

Treasurer

Michael has worked in the social service field since 1980, beginning as an undergraduate at the University of Maryland where he was a psychiatric counselor at a local private hospital. In his work doing psychosocial assessments, conducting various groups and pulling friends and families into the treatment of the patients, he realized his wish to further his education. This culminated in his receiving his M.S.W. from the University of Maryland.

After relocating to Chicago, Michael worked for the Department of Children and Family Services as a child protection investigator. This was followed by a position with the Chicago Read Mental Health Center, and then by one with the Maine Center for Mental Health in Park Ridge.

Currently, Michael has a full-time position as a parole officer within the Illinois Department of Corrections. His experience there focuses on police apprehensions, family treatment and case management. He hopes to find an employment situation that will allow him to focus more intensively on clinical social work.

Michael says, "He is excited and honored to be a member of the Illinois Society for Clinical Social Work and to have the opportunity to serve as its treasurer." He believes that his interactions with other ISCSW members are important for his personal and professional growth, and that they will enhance his skills so that he will continue to learn. Welcome, Michael!

Jeff Pyritz

Student Representative

Jeff is an M.S.W. student at Loyola University Chicago, pursuing a specialization in Children and Families. He is especially interested in treating adolescents; members of the lesbian, gay, bisexual, transgendered community; couples; and families. His first internship was at Gads Hill Center in Pilsen, assisting Latino high school students with their adaptation to high school and helping them transition to college. This fall, he will begin an internship at Cristo Rey High School in Pilsen doing psychosocial therapy with the students in the school's counseling department.

After receiving his M.S.W., Jeff hopes to do agency-based therapy with individuals, couples, and groups. He also wants to play an active role in the local LGBTQ rights movement, as well as to help future professionals develop skills through their field placements.

Jeff is excited to join the Illinois Society for Clinical Social Work board, in particular so he can help foster a partnership between professionals in the field and students in the classroom. He believes ISCSW provides important networking opportunities and seminars. In addition, he is interested in becoming more acquainted with the workings of a professional organization such as the ISCSW, and in using his strengths to support and create successful ISCSW events. He is especially eager to learn from other "veterans" in the field of clinical social work. Jeff states, "The knowledge I might gain from working alongside other long-time professionals will help me help my clients in the future. I feel that professional organizations are incredibly important, and I would like to help the ISCSW grow further in the future." Welcome, Jeff!

Soon, the above information about our new board members will be available on our website. And, although our board is almost full, there are still two positions left if you would like to join us. For information, email Ruth Sterlin or Eric Ornstein in care of ISCSW@ilclinicalsw.com.

Office Space Available in Libertyville

Furnished therapy office with waiting room available for sublet. Office is part of a two-office suite in a professional building on Milwaukee Avenue in Libertyville. The office has a floor-to-ceiling window overlooking a beautifully landscaped pond, with vertical blinds providing privacy while preserving the view. The office is available Mon., Wed., Thurs., Sat., and Sun. and is located north of Route 60 and south of Route 176. Great access to restaurants and a variety of retail shopping! Rent is based on the number of days per week the tenant needs. Please contact Barbara Racioppo, Ph.D. at 847-247-0816 for further details.

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We integrate three major approaches: psychodynamic, cognitive/behavioral and experiential. Our therapists foster supportive, mutually respectful relationships with their clients. We believe that change happens through a combination of insight and action.

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