ISCSW

NEWSLETTER
WINTER 2014

President's Message

Eric Ornstein

The ISCSW is certainly firing on all cylinders! In the last 12 months we have had two major conferences, two successful Networking Events and five Jane Roiter Sunday Morning Seminar presentations. It takes a tremendous amount of work to put on successful, high quality events such as these, and I want to commend and thank the Board and committee members whose hard work made these events possible.

Ruth Sterlin chaired our Louis Cozolino conference this past June, our largest conference in the last seven years. It was incredibly exciting and a little scary to bring such a nationally renowned expert on neuropsychiatry to Chicago to enlighten and entertain over 140 participants.

More recently, this past November, we held an outstanding ethics conference featuring Joseph Monahan, a lawyer and social worker, who dazzled us with his cutting edge knowledge and pragmatic guidance about contemporary ethical and legal issues. (See Nikki Lively's article about the ethics conference in this issue of the newsletter.) I am both pleased and proud that this conference was co-chaired by Emily Heilman and Christina James, both of whom joined our board within the past year. At each step of the way, they made great decisions that ensured the success of the conference, which was attended by over 100 participants.

Earlier in the year, spear-headed by Nikki Lively, our Board put a lot of thought and effort into revamping the format and approach to our networking events. The result was two of the best attended networking events the Society has ever had. The new format involves having specific discussion topics and relevant articles for each event, generally held in Board members' homes.

Our first networking event this past April focused on a discussion of Nancy McWilliams article "Preserving Our Humanity", which encouraged us to stick to our values and convictions in the face of the challenges of managed care. Board member Nikki Lively graciously hosted the event, and other Board members brought a wonderful variety of delicious food.

Similarly, the focus of the second networking event, in August was on a discussion of the new DSM 5 and was hosted by Board member Rebecca Osborn. Once again, the food was great and the discussion was quite lively and even passionate at times, as participants shared their perceptions, experiences and strategies for dealing with insurance companies, who determine which DSM diagnoses will be reimbursed and at what rates.

The Board will be planning future networking events for the coming year. We strongly encourage you to join us, and please let us know if you have any suggestions for future discussion topics.

Finally, the Jane Roiter Sunday Morning Seminars, the Society's longest running program, had its most successful round of Seminars during the past year and is off to a great start this year. The overall theme of this year's seminars is "Relational Derailment and Repair". In October, Vivian Skolnick, Ph.D., made a fascinating presentation about the issues and challenges surrounding pedophilia, emphasizing her unique experience in dealing with this problem in the Orthodox Jewish Community. In December, one of the most well-known and highly regarded social workers in the Chicago area, Joseph Palombo, LCSW, made a wonderful case focused presentation on "Empathy Failures in the Treatment of Patients with Neurocognitive Deficits". Both of these presentations were well attended and included lively and informative exchanges between the presenters and participants.

We are very excited about the two remaining Sunday Seminars. On January 26, 2014, Anna Lieblich will be presenting on the topic of "Hopelessness in Therapy, Yours, Mine and Ours"; and, on March 2, 2014, our own Board member, Nikki Lively, will be presenting on "Mindfulness and Attachment in the Relational Treatment of Perinatal Women." Both of these presentations promise to be evocative and clinically compelling, and we look forward to seeing you there!

Special recognition goes to the Sunday Seminar Committee, which I have the privilege of Chairing, and whose members include Karuna Bahadur, Carol Crane, Margaret Grau, Mary Ann Jung and Jane Pinsoff. Our excellent Sunday Morning Seminars would not be possible without the considerable efforts of each and every committee member.

I hope you will join us at our continuing, outstanding programs and events throughout 2014, and I wish you all a wonderful Holiday Season and a Happy New Year!

ISCSW 2013 Ethics Conference a Success!

On November 15, 2013, the Society held an ethics conference entitled *Legal, Ethical, and Technological Considerations for Clinical Social Workers in a Changing Landscape* featuring Joseph T. Monahan, M.S.W., A.C.S.W., J.D., of Monahan Law Group, LLC. Over 100 attendees came to the conference, which was held at the UIC Student Center, to hear a full and exciting morning of helpful discussion and information about social media and the impact of technology on clinical practice, as well as recent changes to the Mental Health and Developmental Disabilities Confidentiality Act, and points to consider with court-ordered outpatient commitment and medication.

Mr. Monahan's no-nonsense style and sense of humor helped make what can be anxiety provoking topics for clinicians both funny and engaging. He modeled that we should know the law, while accepting that there will always be unpredictable situations that we find ourselves in clinically (as demonstrated by the numerous "What if..?" questions from the audience), and that we should use our knowledge and experience to weigh the risks and benefits of clinical decisions we make.

One of the most animated topics during the morning was about distance therapy and how to think about the increase in client requests that we provide psychotherapy *via* phone or Skype when the client may be outside of Illinois. Another topic that brought up many questions and concerns is treating a minor when the parents are divorced, and how we should think about obtaining consent from both parents. Though there is always a tension with ethical and legal topics to get an "answer" to every situation, Mr. Monahan managed this tension well and was able to encourage us to think about the law as an important – though increasingly outdated – guide in managing the complexities of our clinical work. Mr. Monahan generously stayed after his talk to answer more questions, and provided a full packet of information for participants to take home and have as a resource.

We are honored to be able to provide these conferences to our members and our local community of therapists, and we welcome your ideas for topics for future ethics conferences. ISCSW is also interested in looking for ways to invite more involvement from our membership. If you are someone who enjoys event planning, and would like volunteer your talents as we plan future conferences please stay tuned for more details!

Nikki Lively

Public Relations Chair

ORIGINAL CLINICAL ARTICLE

Clinical Issues: Conflicts between Young and Middle Adult Development

Barbara Berger

Slipping through my fingers all the time
I try to capture every moment
The feeling in it
Slipping through my fingers all the time
Mama Mia
By Abba

Introduction

To feel loss at the same time one feels joy is a passion filled moment in time. This paper examines the intersecting developmental stages of young (20-40 years) and middle adulthood (40-60 years) when just such poignant experiences are occurring, albeit with unexpected ambivalence. The early struggle for separation - individuation seems rekindled for each, often creating conflicts as developmental processes seem incompatible. These struggles will be examined in the context of the lifelong striving for individuation and autonomy.

Poignant conflicts occur at exciting points in young adult development, while parents in middle adulthood are caught unaware and are shocked by the sense of loss and change of priorities in their adult children. The important achievements of young adulthood include the formation of deeper relationships, marriage, accepting a new family, having children and creating one's own family. All are milestones that parents look forward to with pleasure and excitement. Cheerfully many parents say things like, "we are not losing a son, we are gaining a daughter" (or the reverse). They express joy at the developmental achievements of their young adult children, signs boding the promise of more good things to come.

Particularly as middle adulthood progresses in a healthy manner, careers are established, relationships solidify, children enter young adulthood and the view of one's self in the world changes. Healthy productivity to this point engenders a sense of generativity and personal satisfaction that avoids a feeling of stagnation (Erikson 1963).

The Beginning of Conflict

The challenges of each new stage may catch most parents and young adults by surprise. Unlike all prior developmental stages, this is a time of strikingly unexpected conflicts requiring life-altering redefinition. When toddlers learn to walk and become mobile, parents may resolve the loss and embrace the child's achievements by having another baby, continuing the growth of family. When children enter school, parents can become involved in the school community, enhancing their own development while remaining intimately involved in the new challenge of the child's life. And, during adolescence, there is a great focus on keeping a balance between maintaining parental protectiveness and providing a child the room to develop beginning autonomy and independence. Normal parental attention to each maturational step evokes a sense of safety and security in children, a context in which more growth is welcome.

Young adulthood, though, is the first time that the normal, exciting developmental achievements of a child confront parents in middle adulthood as they are struggling with the entrance into their own new developmental stage, facing extraordinary new challenges. Not only will they be deposed from the special position they have always known in relation to their children, but they will be replaced! Al-

ice Rossi (1968) reminds us that when a child is born it "… is not followed by any gradual taking on of responsibility….It is as if (one) shifted from a graduate student to a full professor with little intervening apprenticeship of slowly increasing responsibility. The new (parent) starts out immediately on a 24-hour duty, with responsibility for a fragile and mysterious infant, totally dependent on (her/his) care" (Shectman 1980, p. 74). With this realization comes the understanding that, successively, this infant, toddler, child and beginning young adult is a center of the parent's life. And, then, almost as suddenly, as a young adult matures, middle adults are decentered!

With little or no preparation, that child, around whom a parent has built life, is launched. Departure from the family base, charting the course of a new life adventure, is the challenge of young adulthood. The parent, or middle adult, watches with pride, but from the sidelines, no longer the center of their child's life, leaving a space in the center of their universe.

Case Examples and Exploration

Mr. and Mrs. Jones come for their first appointment with a great deal of anxiety. They explain that their son, a graduate of an Ivy League medical school and winner of a highly esteemed and competitive fellowship, is engaged to be married. They tell me of his brilliance, of what a great son he has been, how many wonderful friends he has, and that they have always had a close relationship with him. Why, they sigh, is he planning to marry a crazy woman? "We think she has a borderline personality disorder!" they exclaim in despair. "She keeps him away from us and will not let us participate in wedding plans. She has locked us out of his life, and he is completely controlled by her!"

The Jones's perception of being excluded is not an unusual experience. Their son and daughter-in-law to be are trying to define themselves as a newly emerging couple, which requires realigning relationship priorities. New partners must become each other's main concern, while parents are expected to understand and step back, becoming second in priority. The research of Dr. Mkucki-Enyart at the University of Wisconsin (2013) indicates that mothers of sons worry the most about their sons marrying. They tend to be concerned for the continuity and well-being of a son's relationship with his nuclear family, whether his wife will interfere or if his interests will change. Correspondingly, daughters-in-law tend to worry about mothers-in-law meddling, and so the expectation of trouble becomes a self-fulfilling prophecy.

While in the throes of these familial role changes and adjustments, there are profound physical and psychological changes occurring for middle adults. Women are entering menopause and the end of reproductive years, as sons and daughters may be entering a time of potential generativity. Men, too, in middle adulthood are entering the climacteric, another time of physical and psychological adjustment (Spira & Berger 1999). It is complex to understand the experience of watching sons and daughters embark on the building of their lives, while parents are looking back on their achievements, consolidating them and looking for ways to create new meaning. As new significant others enter the young adults' lives, their parents want to continue close participation, but are held at a distance that may be experienced with the unexpected impact of disappointment.

Katy and her husband are about to celebrate their first anniversary, and she is planning a romantic weekend. Suddenly, her upset mother-in-law makes Katy aware that she has hurt feelings, because she is not included in the plans. Katy exclaims, "I thought it was my celebration, but she thinks it's a family event!"

Experiences like this are reported in clinical treatment frequently and therapists must listen, explore and help understand the changing landscape. Adaptation is the goal as challenges are presented requiring new expressions of autonomy.

Lisa and Mark come for treatment after 40 years of marriage, their plans for the future devastated. Their children are grown, finishing college and entering the work world. One is in a serious relationship; the other is recently married. In conversation, the young adults are blunt with their parents. They do not want to have children, nor are they interested in taking over the care of a lakeside home that has been in the family for generations. Lisa sighs, "Why can't they understand that their parents are people with feelings too? They just don't seem to get it!"

In this case, much of the beginning of therapy was concerned with helping these parents deal with grieving the loss of their dreams for retirement with adult children and grandchildren visiting at the lake, boating, gardening, and continuing beloved family traditions. The couple worked to realize their success at parenting children who have be-

come achieving young adults with their own aspirations and plans. After finding pride in the independent efforts and new accomplishments of their children, Lisa and Mark are moving toward a new understanding of themselves, redefining their marriage, and relating to independent adult children.

Checking Back

Interestingly, as they begin to think about "downsizing" and paring back, Mark is surprised when his oldest daughter balks. She resists as he speaks of selling things they need to let go of, although she is not interested in taking them. As a young adult, she aggressively moves toward independence, but expects her parents to remain in the "holding" position.

Psychologically, this is analogous to the "checking back" behavior of early childhood. It is a time when the young child is venturing out into the world, but wants to be sure that their parents stay in the same place. The child's comfort and security is in knowing that they are still "there". In this different time, the individuation of the young adult is met either by resistance or by a corresponding adaptation of the maturing parent.

It is apparent that developmental tasks are complicated by the reactions of both parents and young adults to the necessary shifts in roles and relationships. Not only are they each driven by normal developmental urges, but also by the necessity of negotiations and compromises with the needs and worlds of each other. New struggles continue between a young adult and his/her own parents, but also in the confrontation with the family of a significant other. In the tearful words of a 35-year-old newly engaged, dynamic, professional woman in my practice, "I can't believe I will have to deal with this for the rest of my life!" No longer is the only stress between a young adult and his/her own parents the struggle for identity and independence, but now there are multiple and competing entities. The challenge is a formidable one, as the loving connections to lifelong central figures conflict with tensions that arise as young adults experience the compelling need to generate new and abiding relationships. The discord is escalated as middle adults resist internal developmental demands, clinging to earlier meaningful roles, while external forces simultaneously urge them into a new phase of life.

Alice, age 28, bemoans her mother's behavior whenever she and her fiancé come to visit. "It's like she wants to break us up! She always puts me in these crazy positions where I have to choose between them. Now he hates her, and she thinks he's selfish and mean." She confides, "When we go there next time, we will stay at a hotel for a day before she knows we are in town, just so we can have a little time peacefully together."

Alice's mother always felt herself as the protector and mentor for her daughter. In college and beyond, Mom helped with financial support and acted the confidante, supporter and advisor. But, when the new couple visits she complains they do not spend enough time with her, and they do not help out enough. She cries, becomes frustrated and angry with the couple who, in turn, become frustrated and angry with her. Mother's resistance pushes Alice away, just when she is hoping to hold her closer.

Clinical Implications

The realization of conflicting needs of young and middle adults creates a powerful awareness of the need to understand clinical issues concerning the adult maturational process. Colarusso and Nemiroff hypothesize, "that development is continuous from birth, through childhood and adulthood, to death. The reasoning behind this hypothesis is simple enough; the body, mind, and external environment are always present and interacting." (1992, p. 113). Settlage (1993) proposes that development in adults be seen as a process, rather than in stages; that is, he sees developmental interactions creating changes in the formation of psychic structure and leading to higher levels of organization. Developmental tasks of adulthood proceed from the need for work achievement, marriage, parenthood and grandparenthood, through confrontation with retirement and the death of loved ones. Adults, from young to old, are always dealing with these issues in some form. As clinicians, we are often presented with these hurdles as patients grapple not only with their own developmental challenges, but with the complications of parallel developmental processes in significant others.

The ongoing, dynamic process of development continues throughout life. While in childhood there is a formation of psychic structure, for adults there is an evolution of these structures as they are applied to life experience. The child sees himself as special; the adult experiences the self as special but not unique. Colarusso and Nemiroff believe the healthy adult sees herself as "…part of the mosaic of humanity" (1980, p. 114). Additionally, the adult

has the critical challenge of recognition and acceptance of finite time and mortality, which shatters any remaining sense of omnipotence, increasing narcissistic vulnerability.

The struggle to deal with these complexities is unique for each individual, because the developmental process includes a summation of the past from childhood to the adult's present. The issues of childhood continue as central, although in altered form. As is shown in the work of Beebe *et al.* (Seligman 2012, p. 500), early interactive patterns are reflected in later patterns of self and object relating. Anna Freud defines the achievement of object constancy as enabling "a positive inner image of the object to be maintained, irrespective of either satisfaction or dissatisfaction" (1965, p. 65). When this occurs in the child around the age of 3, there is a sense that relationships can survive the expression of angry or negative feelings and separation can be endured without great anxiety. One can love or be loved despite anger; and, therefore, tolerance of ambivalence becomes the consequence of this integration. Failure to accomplish this developmental milestone leads to an excessive reliance on external objects for self-regulation, and aggressive feelings can evoke fear of destruction of the object.

Since conflicting experiences with different love objects can create disruptions in object constancy, it becomes clear that separation-individuation itself must be seen as a lifelong process. This is reflected in the adult's focus on marital relationships—seeking, creating and maintaining them over time. The fantasies and idealizations of adolescence must be replaced with real others. A constant realignment of object ties seems always to be in process as experiences with children and parents unfold. The presence of ambivalence is exquisitely apparent as the healthy adult is gratified by the adolescent's push for independence, though simultaneously and undeniably affected by aggressive feelings toward and envy of youth. Such rivalry is continuous throughout life as old narcissistic issues carry forward, and new ones arise.

These challenges are central to the development of the adult self, which Colarusso calls a *third individuation*. He defines this as, "that continuous process of elaboration of the self and differentiation from objects which occurs in the developmental phases of early and middle adulthood….Adult developmental theory postulates growing complexities in object ties…" (1990, p. 180). This is illustrated by young adults like Lisa and Mark's daughter. The need is to contend with libidinal attachments and longings that are confounding as the experience of normal urges to move forward, forming new mature relationships and financial autonomy become increasingly pressing.

At this point the young adult's physical maturity intersects with a growing capacity for intimacy and the establishment of life partnerships. Nonetheless, longings and old attachments, in addition to pressure from parents to hold on to old roles, evoke fears and threats to the survival of a new relationship. Uncertainty and lack of knowledge between in-laws and new spouses generate feelings of jealousy, anger, and sadness. The normal response is an urge to withdraw so that the couple presents a united front and defines themselves as a new and separate entity. The achievement of this milestone makes way for the realization of desires to create new lives, as couples become parents, building families, careers, and creating their own traditions.

Once again the couple is confronted with much confusion and pressure. The birth of a child creates multiple pulls from external objects who desire inclusion, and issues internal to each parenting individual as well as the couple itself. Le Masters states, "…married couples find the transition to parenthood painful because the arrival of the first child destroys the two-person…interaction and forces a rapid reorganization of their life into a three-person or triangle group system." (1980, p. 273). As the new family invents itself, the parents of new parents, now grandparents, watch from outside deeply impacted by the need to once again change, accommodate and adjust themselves to new roles in relation to their children, the couple, and the new grandchild.

Adults becoming grandparents signal the entrance into another new phase, as the need to face issues of narcissism and omnipotence are re-evoked. Every new independent achievement of the younger couple contains a fear of object loss and, simultaneously, a sense of pride. In midlife all separations have constructive and destructive potential as the impact of every event is experienced. Middle adults resist more changes in an attempt to address their own need to hold closely the young adults who withdraw in order to achieve separation. Once again, the adult in midlife is confronted with the right of the object to exist without reference to the self (Colarusso 1990). The grandparent's

self and the object, the new family, are independent of each other. Their mutuality and interdependence need to evolve over time, as each becomes more secure in their own existence and feels safe with the other.

Sandy complains her mother-in-law is intrusive since they have a new baby. She worries that her husband's mother wants to see the baby often, more often than her own parents. This grandmother wants to hold the baby and take care of her, despite Sandy's insistence that they need bonding time as a nuclear family and should be given more privacy and alone time.

Molly is filled with anxiety because her mother-in-law is wonderful with her children when she is at work, but she fears they will love grandmother more than they will love her.

A Gradual Redefinition of Roles

Grandparents in middle adulthood are redefining themselves in relation to the generations as new internal mental representations of their adult children are evolving. As new object relationships develop with children, additional ones also emerge in relationships with grandchildren. Healthy grandparents will come to embrace their roles in the continuity of multigenerational object ties (Nemiroff & Colarusso 1980).

Sandy's mother-in-law responds to Sandy's patient tolerance and subtle cues about when it is okay to hold the baby. As Sandy has understood grandmother's excitement and urgent desire to be present in their lives, she no longer feels aggressively challenged. Sandy and her husband work on communication with compassion as they define boundaries for extended family.

As Molly realizes the importance of her mother-in-law's contribution to the family, she can allow herself to feel appreciative and less competitive. Simultaneously, she recognizes the importance to her of her professional life. In treatment we work to understand that the heart is a big place and children can love many people. Molly can grow and be her own person, have a warm and loving relationship with her children, and enjoy her mother-in-law's presence.

Conclusion

The clinical experience of listening to people as they work through these complex family dynamics may seem relatively simple at the most manifest level. The reports of young adults wrestling with new in-laws or their own parents who they perceive as obstacles to the growth of new relationships are provocative. Likewise, the reports of middle adults trying to maintain their parental relationships and relate to new persons entering the changing family circle are challenging. The understanding that these experiences are most often normal developmental struggles must be part of therapeutic awareness and woven into the clinical response.

Adults naturally anticipate, and have the means to cope with, maturation in earlier development as it proceeds in a linear stage by stage progression. The quandary presented by the clash between development in young and middle adulthood is less anticipated. New dynamics create stress on the former expectations of intimate relationships between parents and children. Young adult children take on partners who themselves have families, and members of all are jockeying for position with the new couple. The complicated creation of a larger family system has its own challenges but is underscored by the internal demand for continued development.

Throughout life there is a continuing process of internally motivated maturation and development. A corresponding evolution of a series of interdependent relationships urges this process along externally. The result is a marked emphasis on an ever-present need for the reworking of issues of separation-individuation and a redefining of oneself as an autonomous individual with meaningful connections and purpose.

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The Cutting Edge...

Reviews of Recent Literature

Topics in the Neurobiology of Borderline Personality Disorder

Borderline Personality Disorder and Emotional Regulation: Insights from Polyvagal Theory. Austin, M. *et al.* (2007) *Brain and Cognition,* 65, 69-76.

Developmental Differences in Diffusion Tensor Imagery in Borderline Personality Disorder. New, A. *et al.* (2013). *Journal of Psychiatric Research*, 1-9.

Response to Psychotherapy in Borderline Personality Disorder and Methylation of the BDNF Gene. Peroud, L. (2013). (Transl.) *Psychiatry,* 3, 2-8.

The Neurobiology of Empathy in Borderline Personality Disorder. Ripoll, L. *et al*. (2013). *Current Psychological Perspectives,* 15(34), 342-354.

Earlier this year, while preparing a brief presentation on the neurobiology of borderline personality disorder as part of a workshop on Dialectic Behavioral Therapy at the College of Medicine in Rockford, I very quickly realized that this was an extraordinarily ambitious project. The literature on the neurobiology of borderline personality disorder is contradictory and incomplete. The neurobiological basis of borderline personality disorder is very difficult to study. Patients with borderline personality disorder often have been abused, undergo continual social stress, are frequently depressed or anxious and have been treated with many different psychiatric medications. All of these things have profound effects on the brain. Thus, it is very difficult to separate out the neurobiological changes in the brain due to the sequelae of borderline personality disorder from the essential neurobiological aspects of this disorder. Thus, I selected a few articles in the professional literature from which I could make a coherent story. This review is not complete and is, therefore, an oversimplification. Nonetheless, I felt it would be useful, because it sketches a plausible neurobiological basis for borderline personality disorder.

I will first present some evidence that the brain does not control the body's response to social distress in borderlines in the same way as it does in normal controls. Then, I will present a model that suggests the borderline brain processes social information in a unique way. Next, I will present several studies that support this model. Finally, I will review a study that demonstrates that six weeks of Dialectic Behavioral Therapy can turn on or off the genes for the production of the brain-derived neurotrophic factor. Patients who benefit from these six weeks of treatment turn on the genes. Those who do not benefit turn off the genes.

Stephen Porges, formerly of the University of Illinois College of Medicine in Chicago, has discovered a way that we can look very deeply into the brain simply by placing a pulse oximeter on someone's finger. The following is a summary of his findings.

Heart rate is controlled by several systems. The heart has at least two different intrinsic pacemakers. There is a complex system of sympathetic innervation to the heart. Heart rate is also controlled by adrenaline in the bloodstream. There are two components of the vagus nerve which slow the heart. The most recently evolved among these systems is the myelinated component of the vagus. This system occurs only in mammals. It provides a brake on the intrinsically high mammalian heart rate. One of the reasons for this is that mammals need to be calm around each other in order to mate, nurse, and socialize.

Porges has described a human engagement response which allows us to calm down too many anti-human speech and facial expressions, in order to look and sound approachable. This system allows us to calm down quickly when we have minor conflicts with other people. The myelinated vagus has its origin in the nucleus ambiguus which is directly connected with the orbital frontal cortex, the seat of our social conscience.

Given that borderlines have problems with affective regulation and human social relationships, we might expect that borderlines have some dysfunction in the system. This system has a feature that makes it very easy to study. The vagus controls a rhythmic variation in heart rate called the *atrial sinus arythmia*. Every time we breathe out, the vagus fires at a higher rate and slows the heart. The more the vagus is active, the greater and more coherent is the heart rate. We can measure these variations very simply with a pulse oximeter and a computer. These variations allow us to see how actively the vagus and thus the brain control heart rate.

Porges showed a group of borderlines and a group healthy controls three films. The first and third film were neutral. The second film had some very upsetting emotional material about people and relationships. In the group of healthy controls, he noticed an increase in the respiratory sinus arrhythmia when they were shown a disturbing film. On the other hand, patients with borderline personality disorder did not show this increase. This means that the orbital frontal cortex and the nucleus ambiguus started to calm the normal control group (who had increased respiratory sinus arrhythmia) while they were watching the disturbing film. This did not happen in the borderline patients. In fact, the atrial sinus arrhythmia became weaker in the borderline patients.

Porges also looked at the correlation between vagal activity in the heart rate. He has shown that in normal control groups, participants' vagal activity correlates strongly with slowing of the heart. In those with borderline personality disorder, it does not. The brain of normal people automatically engages to calm them down when they are seeing a distressing film. This does not happen in people with borderline personality disorder.

Ripoll *et al*. have proposed a coherent model of the central neurobiological dysfunction in borderline patients. There are two systems in the brain that let us understand and react to other people. The first is the immediate gut level response to other people which is called the *shared representational system.* When we observe emotion in other people, our mirror neurons fire in such a way that the muscles in our body and our face move in the way that we have pre-consciously observed in the other person. This gives us an immediate gut feeling of what is going on in the other person.

The second system is the *mental state attribution network* which gives us a cognitive understanding of what is going on in other people and between other people and ourselves. The mental state attribution network uses information which is first processed by the shared representational network. The shared representational system involves both limbic and cortical brain structures, whereas the mental state attribution network is mostly cortical.

There is reason to believe that the shared representational system is hyper-responsive in borderlines and that the mental state attribution network is impaired in borderlines. Note, that in people on the autistic spectrum, the shared representational system is likely to be impaired. It has also been shown that people with borderline personality disorder are better at reading emotions from looking at others' eyes than are those without this disorder; however, they often misinterpret neutral expressions as disdainful. It also appears that those with borderline personality disorder show more activity in the amygdala – part of the shared representational system – than others when asked to observe emotion in other people and not react to it. The anterior cingulate which is also part of this system is underreactive to physical pain in borderlines and overreactive to emotional pain. The shared representational system's overactivity in borderlines may be due to genetic or epigenetic factors.

Insensitive or neglectful parenting, for example, may further activate the system. This leads to neurobiological and epigenetic changes in the brain, which render the person more susceptible to interpersonal stress. Stress further deactivates the mental state attribution network; in particular, it shrinks the hippocampus. This results in a cycle which makes the borderline ever more sensitive to social pain and less able to accurately interpret interpersonal interactions.

There is a group of medial brain structures that are active when distinguishing self from others. These structures have to work harder in borderlines when they are trying to socially distance themselves from a situation. The superior temporal sulcus – involved in processing social meaning – is less active in deliberate empathetic processing while it is more active when the person is trying to dampen their reaction to an emotional stimulus. Since borderlines show difficulty in inhibiting responses, their brain function is often examined when they perform simple no go tasks. For example, they can be asked to push a button every time a letter appears on the screen, except when the letter is "X". Their brain has to work harder at this task if they have seen disturbing words between presentations. In one study, investigators looked at the activity in the medial prefrontal cortex, part of the mental state attribution network, while borderlines were performing this task. They found a very strong correlation between activity in the medial prefrontal cortex and the amount of control over emotional reaction that these patients experienced in their everyday lives. Similarly they found that the more active the left amygdala was during this task, the more anger the patient showed in everyday life.

It is speculated that part of the reason for emotional liability in those with borderline personality disorder, may be due to a dysfunctional connection between the orbital frontal cortex – which dampens anger and impulsivity to the amygdala – and the amygdala, which has been activated when people are expressing strong emotions. One study showed that, in control groups, when blood flow to the orbital frontal cortex is increased, blood flow to the amygdala is reduced. This correlation is weaker in borderlines than in those without this disorder. With a technique called *fractional anisotropy* we can directly observe how well myelinated and how straight the fiber bundles between different areas are. It has been shown that the fiber bundles connect-

ing the hippocampus and orbital frontal cortex with the amygdala are not as well structured in adolescents with borderline personality disorder as they are in controls. These connections are weaker on the left side of the brain, which contains well learned responses and pleasant affect, while the right side of the brain contains poorly learned responses and unpleasant affect. Thus, adolescents with borderline personality disorder have learned less about emotional regulation, and experience more negative emotion.

In the past, several studies have demonstrated changes in brain structure and function due to psychotherapy or meditation. Now Perroud *et al*. have shown that a psychotherapy (DBT) can carry off and on genes in the brain. Brain-derived *neurotrophic factor* is responsible for growth of new cells in the hippocampus. Stress, on the other hand, reduces the amount of brain-derived neurotrophic factor in the hippocampus. The gene for it is turned off through a process called *methylation*. Methyl groups attach to the DNA for the gene, and zip it up and make it impossible to transcribe the gene. It is possible to measure how many genes for a particular protein have been methylated. Perroud *et al.* showed that the greater the number of traumas a borderline disordered individual has experienced, the more methylation they showed for this gene. This correlation was strikingly high.

A group of individuals with Borderline Personality Disorder was treated with DBT for six weeks. The patients who responded positively to DBT showed a decrease in methylation. That is, the psychotherapy turned on more of the genes that make the hippocampus grow. However, patients who did not respond to DBT showed an increase in methylation of the gene. Successful psychotherapy turned on more of the gene, while unsuccessful psychotherapy turned the gene off. The good news is that psychotherapy results in real epigenetic changes in the brain. However, the bad news is that unsuccessful psychotherapy made things in the brain worse. It is well-established that about one-third of patients do not respond to a particular psychotherapy, and approximately 12% of patients get worse in the course of treatment. I have always been worried about the 12% of my patients who get worse during the course of treatment. I was not particularly concerned about the 18% who did not get better or worse during the course of treatment. This study, however, suggests that we need to look more carefully at our patients who do not respond to treatment. Even though they appear to be no worse at the end of treatment than they were at the beginning, unsuccessful treatment may do real harm to the brain.

Geoff Magnus

Book Review

Rape is Rape: How Denial, Distortion and Victim Blaming are Fueling a Hidden Acquaintance Rape Crisis. Jody Raphael, (2013). New York: Lawrence Hill Books.

In the powerful new book, *Rape Is Rape: How Denial, Distortion and Victim Blaming Are Fueling a Hidden Acquaintance Rape Crisis*, Jody Raphael takes a balanced but unflinching look at the media, the public, rape deniers, and how they support the behavior of rapist, impact victims, and judicial outcomes. She also makes room for the voice of the survivor as they try to make meaning of the unthinkable. Their changed lives after the assaults include: giving voice to their confusion and shame, the impact of others as they disclose the rape, reactions from friends, family, and the hospital, rape evidence collection, the media, police intervention (if they are able to have charges filed), and the court system.

The understanding of rape in our society is colored by how we understand sexual violence, its prevalence, and who rapes**.** Is it rape if you were drunk or high, if you were asleep, if you didn't fight hard enough to leave bruises or physical evidence of trauma? Is it rape if you went willingly into a room, car, or a party dressed in a way that can be deemed sexually provocative? In 80% of reported rape cases the victim knows the perpetrator. Raphael's book examines the arguments of what is "real" rape versus what is bad sex or alcohol-fueled miscommunication. The answer should be that rape is rape.

"If you think about rape, it is the taking away of an ability to express love. It shatters the way you connect to everyone. It involves where your core intimacy lies and your love, and when that is involved, it shatters the way you connect to every human being," said one of the rape survivors in the book on the way the experience affected her.

The latest study from the Centers for Disease Control and Prevention finds that 12.3% of American women over 18*—more than 14 million women – state that they have been forcibly penetrated within their lifetime.* There have been 620,000 women raped within the last twelve months. This number does not include men and children under the age of 18, but think of what the number would be if it did. This book looks at how entrenched beliefs from both sides of the argument impact how we as a society deal with far-reaching effects of sexual violence. The collusion to minimize acquaintance rape from feminist and conservatives voices distorts the cultural understanding of what is rape. Is it really a price of women's sexual freedom or a result of women's promiscuity?

In her book Raphael explores rape deniers perpetuating the dangerous indifference that can deeply affect institutions: police, church, and educators. Looking closely at the rape statistics collected, examining their methodology and distortions of statistics, she reveals how by using incorrect or incomplete data, supporters of survivors of sexual violence can do damage to the very cause they are trying to support. Data has been misconstrued and twisted by those who want to minimize or flat-out reject the findings, using outdated information or studies that are just plain wrong. Raphael effectively give us current context by looking at high-profile examples of rape cases to understand how strong and pervasive the distortions are—from Julian Assange, Todd Akin, Dominique Strauss-Kahn, Kobe Bryant, and the armed forces. What gets lost in the debate is that rape is not about sex; it is about power, violence, control, and the utter humiliation of the victim.

In her book, Raphael states, *"Rape is probably the only offense in which a suspect can successfully defend himself by claiming that the victim consented to the crime, which causes the police to intensely scrutinize the believability of the injured party's description of events."*

She ends her well-written book with hope and a guide to steps that we as a community and country can do to create a world without rape denial. This is a powerful, moving, extremely well-researched work that brings a focused light to a complex issue. She ends with, "There is only truth. And we all must tell the truth. Denying rape makes society unsafe for women and allows predators to go free. Rape is rape."

Judith Ierulli

Note: ***This book review was initially published in the*** **NASW Networker Magazine,** ***July 2013****.*

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Cultural Competence Platform...

This column was originally created by Henry W. Kronner, Ph.D., a current member of ISCSW and the former Cultural Competence Chair of its Board. As an Associate Professor at Aurora University School of Social Work, he continues to contribute to our Society by encouraging present and former social work students from his courses on Cultural Diversity to submit their writing and opinions here. As part of an effort to further our cultural competence and understanding, we hope that all ISCSW members will consider contributing articles, essays and opinions to this Cultural Competence Platform *column.*

Attempted Self-Medication in Dual-Diagnosis Clients: Present Implications in Social Work and Counseling Practice

Trover Gray Wilson

Introduction

Recently, researchers have begun to investigate substance abuse as it relates to human actions and behavior. Several correlations and breakthroughs have been discovered and identified linking substance abuse to mood, thought, and developmental disorders in myriad ways. Even more recently, researchers have begun to posit a link between these disorders and the use and abuse of substances as a method of self-medication. Our society is plagued by substance use and abuse, including everything from alcohol and tobacco to illicit drugs such as opiates and cocaine. One might posit that those patients afflicted with disorders causing them any sort of mental anguish would eventully discover the perceived beneficial effects of substance use and abuse treatment.

The issue of self-medication using alcohol, tobacco, and illicit drugs for all demographics is a shadow problem in our current society. The United States is already in the midst of fighting a war on substances (specifically illicit drugs), and light has yet to be shed on the microcosmic problem at hand. Because of the positive correlations between mood, thought, and developmental disorders and alcohol and other drug (AOD) use and abuse, we as a collective profession should attempt to combat this growing social concern by focusing on one of the populations most in-need: dual-diagnosis patients.

Definitions

Self-Medication: Self-medication is commonly defined as the use of a substance, usually an over-the-counter medication, in an attempt to treat some form of illness, legitimate or otherwise (Ksir, Hart, & Ray 2006). For the purposes of this paper, self-medication deals specifically with substance use and abuse. The *Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR]* serves as an excellent reference for all queries related to mental illness.

Substance Dependence: The American Psychiatric Association (APA) defines substance dependence in the *DSM -IV-TR* as, "A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same twelve-month period…" (APA 2000, p. 197). Included in the criteria are a rise in tolerance to the substances, exhibition of withdrawal symptoms when the substance is absent, and a rise in the amount of the substance used to achieve the same effect (APA 2000).

Substance Abuse: Substance abuse is somewhat different. The *DSM-IV-TR* states that substance abuse is, "A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve-month period…" (APA 2000, p. 199). Included in the criteria are putting oneself in physically hazardous situations to obtain the substance, failure to fulfill duties at work and/or home, and the inability to stop using the substance after multiple issues and problems have surfaced because of it (APA 2000).

Therefore, the specific definition of self-medication with regard to this paper would be the use of a substance such as alcohol, nicotine, or an illicit drug in order to at-

tempt to alleviate the mental and/or physical pain associated with a mood, thought, or developmental disorder. These disorders have specific medical, psychiatric, and psychological treatments, pharmacological and otherwise, that are commonly accepted and used; however, treatment success rates for these illnesses are extremely low and recidivism rates remain high, making self-medication with substances an extreme concern. Further heightening this concern is the fact that the aforementioned treatments are expensive and difficult to procure, especially for patients on any sort of public entitlements, *e.g.*, Medicare and Medicaid.

Forms of Self-Medication

Alcohol – According to Bizzarri *et al.*, alcohol is the most abused substance in individuals diagnosed with a mental illness (2007). Deas and Thomas state that seventy-three percent of adolescents who have used alcohol met the *DSM-IV-TR* criteria for a Major Depressive Disorder (2002). Moreover, Deas and Thomas also state that Post-traumatic Stress Disorder and Chemical Dependency (CD) may cause an increase in the risk of substance abuse among adolescents and the subsequent development of a Substance Abuse Disorder (2002). It is possible that these individuals are attempting to self-medicate with alcohol.

Of all psychiatric patients, those diagnosed with Bipolar Disorder are the most likely to have trouble with substances and attempt to self-medicate, with a percentage that fluctuates anywhere from seventeen to sixty-one percent (Bizzarri *et at.* 2007). It is unclear as to whether those with a Bipolar diagnosis use substances because they also have a substance abuse disorder such as alcoholism, or because they are attempting to self-medicate. Bizzarri *et al.* state that, when asked about the perceived positive effects of self-medicating with substances, subjects mentioned an improvement in their mood, more energy, and relief of tension (2007).

McCarthy's article contains a relevant theory, appropriately dubbed the Self-Medication Hypothesis (McCarthy *et al.* 2005). It contends that individuals use substances to try and alleviate symptoms or feelings they perceive as unpleasant. McCarthy *et al.* state that adolescents diagnosed with a comorbid psychiatric disorder have markedly worse treatment outcomes than their counterparts. While other substances may be used to treat other issues, alcohol is mainly used to combat symptoms associated with Generalized Anxiety Disorder and Schizophrenia (2005). Consequently, McCarthy's Self-Medication Hypothesis broaches the idea of a discrepancy between self-reported data and actual data regarding substance abuse.

Tobacco – The question remains, why do people diagnosed with a mental disorder attempt to self-medicate with substances, illicit or otherwise? One of the most thoroughly documented and accepted forms of self-medication in individuals with mental illnesses happens to be tobacco use. Ait-Daoud states that fifty to ninety percent of individuals diagnosed with a mental illness are dependent upon some form of nicotine. Also, the mentally ill have decidedly higher rates of mortality and adverse physical effects from smoking (2006). Additionally, the use of substances and mental illness are associated not only with increased mortality rates, but also with increased physical illness, lower productivity in the workplace, and emotional damage (Saffer & Dave 2005).

More work and research are needed to develop an effective method of treatment for individuals who are afflicted with a mental illness and use tobacco in an attempt to self-medicate. Ait-Daoud's article states that subjects who present with a Major Depressive Disorder and a problem with substance abuse do not fare as well in treatment (2006). It also states that we should focus further on treating the mental illness and the substance abuse together, not as two separate conditions, but as co-occurring conditions (2006).

Opiates – Though opiates have one of the most far-reaching and complex histories of all the substances mentioned, the research suggests that they are not as desirable as a method of self-medication in people diagnosed with a mood, thought, or developmental disorder. Bizzarri *et al.* rank opiates as the sixth most-desirable drug to consume in an attempt to self-medicate at a mere eight percent of the representative sample, higher than only hallucinogens and inhalants (2007). Though countless reports of addiction to opiates are apparent throughout the ages, the vast majority of addictions began because an opiate was used in an attempt to combat physical pain, leading to morphine addiction's nineteenth-century nickname, *The Soldier's Disease* (Ksir *et al.* 2006). One might surmise that because of the lack of availability and social stigmas attached to intravenous drug users in our current society, persons afflicted with a mental illness choose to use other substances that are either legal, easier to acquire, or both.

Cocaine – Cocaine presents yet another opportunity for people diagnosed with a mental illness to self-medicate, in part because of its widespread use and abuse and subsequent availability to the general public. Bizzarri *et al.* found that of all substances individuals attempted to self-medicate with, cocaine ranked fourth at seventeen percent of the representative sample (2007). Obviously, the euphoric effects and temporary respite from the unpleasant feelings and emotions that come with these disorders combine to make cocaine a very appealing choice. Horner *et al.* state that cocaine usage by individuals with an Attention Deficit Hyperactivity Disorder (ADHD) diagnosis could very well be an attempt to self-medicate in order to rid oneself of the unpleasant symptoms of ADHD (1996). Horner *et al.* go on to say that some people who abuse cocaine and present with ADHD-like symptoms obtain what appears to be a therapeutic response when primarily under the influence of the drug, though an unfavorable response presents with continued use. Additionally, the article affirms that people with low self-esteem have been known to use cocaine in an attempt to improve it (1996). In conclusion, Horner asserts that if ADHD-like symptoms persist past young adulthood, then the individual is at a higher risk of cocaine use in an attempt to self-medicate (1996).

Clinical Implications

With regard to alcohol and other drug use concerns and present social work and clinical practice, it would prove beneficial for practitioners in both fields – addictions and social work – to have a working knowledge of addictions treatment. Because substance use and abuse are such pressing issues among dual-diagnosis populations served by social workers and counselors today, one would posit that it be necessary for all mental health professionals to have at least a partial idea of AOD treatment methods. The State of Illinois' Certified Alcohol and Other Drug Counselor (CADC) qualifications serve as an excellent resource for practitioners to become more knowledgeable about AOD issues and subsequently provide more specialized and effective services. However, many states lack this certification, or any certification for that matter, with regard to AOD treatment.

While current common practice in the field is to refer addictions issues to a CADC or other addictions professional, referrals are not always a constructive choice. Because of the repeated budget cuts through the Illinois state legislature, the funds for public mental health services have been drastically reduced, thus further curtailing the subsequent effectiveness and follow-through of the referral practice. With wait-lists, layoffs, and the financial crises that have occurred in agencies throughout the state, it could take months for an individual to receive an appointment with a specialized AOD practitioner. Such delays among dual-diagnosis patients, particularly patients in crisis or newly in recovery, could prove disastrous. Only if Illinois is able to regain control of the budget crisis and restore funding to public mental health services, will referrals again become an effective common practice for AOD treatment.

Conclusion

This reporter chose to focus this document on dual-diagnosis patients and self-medication for a variety of reasons. He has always felt drawn to clinical work, particularly addictions and mental health. During the last year of his undergraduate education, he began to apply to Doctor of Psychology (PsyD) programs. At the urging of his sociology advisor, this reporter chose to apply to Masters of Social Work (MSW) programs as well. At this point, he has received a Bachelor of Arts in Psychology and Sociology with a focus on addictions and mental health, and chose to attend the Aurora University School of Social Work graduate program. Upon completion of his MSW, this reporter aspires to work with dual-diagnosis adolescents, particularly with mood, thought, and developmental disorders. The adage, "know what you do and do what you know" seems applicable, for this reporter believes that many clinicians feel some sort of calling to work with a specific group.

In summation, with the current state of the economy still perilous and the Illinois state funding for public mental health uncertain, it would prove advantageous for all practitioners to continue to broaden their horizons in addictions and clinical work in order to provide a consistently higher level of patient-focused care. Regardless of how unfortunate this may be and how offensive it may seem, it is what it is. Thus, we as practitioners are now responsible for determining better courses of treatment and care for our patients, much more so than before the budget cuts. Though it will take time to effectively remedy all of the problems created over the past few years, we must continue to function as best we can in order to provide the highest possible level of patient-focused care.

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Another Perspective on Cultural Competence

Janell McNulty

Introduction

As a graduate student working to achieve a Masters in Social Work, this writer has realized through countless experiences, both in the field of social work as well as in the classroom setting that references to cultural competence tend to focus on race or ethnicity. While it is true that the world is composed of people of various ethnicities and races, and that the experiences of these people need not be minimized, this writer believes that race and ethnicity are not the only traits that need to be observed in social work practice.

A key aspect of a person's identity that is regularly forgotten in daily interactions, both professional and personal, is one's sexual orientation. Fredriksen-Goldsen *et al.* state that "social workers in the United States and Canada have an ethical obligation to be competent in interventions and to promote social justice and empowerment among marginalized and oppressed groups, including lesbian, gay, bisexual, and transgender (LGBT) individuals" (2011, p. 19). Although the concept of sexual orientation encompasses a variety of orientations, this writer will focus specifically on the lesbian experience in the field of social work.

Sexual Orientation as a Continuum

Before sexual orientation in regards to social work is further explored, the concept of sexual orientation itself needs to be discussed to ensure understanding. At times, it can be difficult to define or describe as people have different opinions on the topic. First and foremost, sexual orientation refers to whom a person is attracted romantically and sexually (Fredriksen-Goldsen *et al*. 2011). Today's society tends to be very "black-and-white" in its description of many concepts, sexual orientation included. Certain people believe that a person is either gay or straight and that no middle ground exists. Although everyone is entitled to his or her own opinion, this writer believes that this narrow view is an overgeneralization and oversimplification of the concept of sexual orientation.

This writer believes that instead of limiting sexual orientation to a rigid set of restricting labels, it really exists on a continuum. Sexual orientation is a range from gay to straight, and people can fall anywhere on the spectrum between the two ends. A person may be strictly attracted to members of the opposite sex, and therefore may identify as straight. Another person may be strictly attracted to members of the same sex, and may identify as gay or lesbian. A third person may have a greater attraction toward men, but may be attracted to women in some instances.

Sexual orientation is not a limited concept meant to constrict people into metaphorical boxes. At times, society can be quick to assign labels to people; however, it is a great disservice to "pigeonhole" people into the boxes of gay or straight. As previously stated, this writer believes that sexual orientation is on a continuum, and each individual falls at a different point on that continuum. This is a concept that can be difficult to understand and synthesize into one's social work practice.

Lesbians in Professional Social Work

On the continuum of sexual orientation, one end of the spectrum is comprised of people who identify as lesbians. The struggles that lesbians face against discrimination and homophobia do not need to be discussed in depth, as it is widely known and easily observed. However, people may not register the extent of the adversity that lesbians face. It is indisputable that women have been an oppressed population in this country throughout history as men are seen as the power-holding gender. Not only do lesbians face discrimination based on their sexual orientation, but they also face discrimination based on their gender (Sperling 2010). In general, lesbians face a combination of discriminations that differ from gay men or straight women. To take it a step further, racial minority lesbians face all of the above-mentioned modes of discrimination, in addition to discrimination based on race.

When all of these factors are considered, it is not shocking to find out that lesbians are extremely underrepresented in the field of social work; though this does not mean that lesbian social workers are nonexistent (Sperling 2010). The decision to "come out" and reveal one's sexuality can be freeing in many ways, but it is simultaneously terrifying, especially in one's employment setting. At any moment in time, a person or a group of people may have a destructive reaction to a person who decides to reveal his or her sexual orientation as not being heterosexual. At times this risk may be too big to take. Quite often, many lesbians choose not to reveal their sexual orientation for fear of facing backlash in the employment arena.

Clients and Sexual Orientation

As this article has focused mostly on the sexual orientation of fellow social workers, one must not forget that our clients are people deserving of the same respect we show our co-workers and peers. Unfortunately, "homophobia and heterosexism are well documented among health and human service practitioners" (Fredriksen-Goldsen *et al*. 2011, p. 19). It is a common practice in our society to assume that every person one meets is heterosexual; however, this may not be the case, and competent social workers need to avoid making this assumption about their clients.

According to *the National Association of Social Workers' Code of Ethics*, "social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of… sexual orientation" (para. 4). It explicitly states that social workers have a duty to practice cultural competence in regards to the sexual orientation of clients as well as peers (National Association of Social Workers 2008). Further, being respectful of another person's sexual orientation includes avoiding making assumptions and colluding with heteronormativity.

On a Personal Note

The idea of demonstrating cultural competence and sensitivity when working with LGBT people is a very personal mission in this writer's life and social work practice. Specifically, this writer identifies as a lesbian, and therefore has a great deal of personal experience in this arena. As a member of the LGBT community, this writer has experienced a great deal of harmful encounters relating to sexual orientation. For example, on many occasions this writer has chosen to remain "in the closet" while engaging in professional interactions or employment situations for fear of facing discrimination or negative reactions.

Conversely, this writer has encountered innumerable experiences with accepting and encouraging people, both in the field of social work as well as in other areas of life. It is indisputable that times are changing as our society begins to shift toward a more accepting view of same-sex relationships, especially emphasized by the recent legalization of same-sex marriage in Illinois. This writer believes that this period is an incredibly important time in our na-

tion's history in regards to acceptance. It is the duty of professional social workers to maintain a respectful attitude towards people of varying sexual orientations, as social workers are responsible for remaining culturally competent regardless of their personal beliefs.

Conclusion

The purpose in writing this article has been to remind social workers to remain sensitive to others, and most importantly to avoid making assumptions about another person's sexual orientation. Just as a social worker avoids making assumptions and discriminating based on the ethnicity, religion, or physical ability of a client, one should never assume to know another person's sexual orientation until engaging in a dialogue about the topic. It must be kept in mind that all assumptions of sexual orientation are rooted in stereotypes. For example, the belief that a woman with short, spiky hair is a lesbian is rooted in stereotypes that are not always accurate. Assuming that a man with a feminine quality to his voice is simply that—an assumption.

Although society is quick to assign labels to people, such as gay, straight, or bisexual, the only person who can truly make a determination about sexual orientation is the individual person him or herself. It is not for an outside party to guess another person's sexual orientation, as it would be simply an uneducated guess. It all boils down to maintaining respect and courtesy for all people and treating others as one would like to be treated.

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Introducing Two New Board Members

Emily Heilman – Membership Chair

Emily Heilman received her Masters 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!

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Nikki Lively – Public Relations Chair

Nikki Lively is a Licensed Clinical Social Worker with over ten years of experience in providing individual, couples, and family therapy, and specializes in the treatment of perinatal mood disorders, and the impact of these disorders on family relationships. Ms. Lively most recently served as a consultant and trainer for the Illinois Perinatal Mental Health Project at UIC, a statewide initiative to train providers in the screening and assessment of depression during and after pregnancy. Ms. Lively has training in Dialectical Behavioral Therapy (DBT) which integrates the philosophy of Zen Buddhism into the treatment of emotional difficulties, and this training launched her personal and professional interest in the practice of mindfulness meditation. Ms. Lively will join the staff of The Family Institute this fall where she will continue to maintain a clinical practice working with women and families, as well as provide clinical supervision, training and consultation. Ms. Lively received her graduate training at the University of Chicago's School of Social Service Administration from which she holds a Masters in Social Work, and the Erikson Institute from which she completed the certificate program in Infant Mental Health. Welcome, Nikki!

(Note: This is a correction of the error in our last Newsletter about the Chair titles of each of these two board members.)

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