ISCSW

SPRING 2013

President's Message

Eric Ornstein

There is a lot going on around here! I have been involved with the Board of ISCSW for many years. I cannot remember a time when there was as much energy and enthusiasm in the air, as there is right now. Just since the fall, we have updated and modernized our website. We have just completed our most successful round of the Jane Roiter Sunday Morning Seminars. Every Seminar was well attended, and each speaker made an excellent presentation. All four presentations are summarized in this issue of the newsletter in case you were unable to attend. Speaking of the newsletter, I want to publically commend and thank Ruth Sterlin for the outstanding job she has done as the editor of our newsletter. For over eight years under her editorship, the newsletter has had outstanding articles on a wide range of important, highly relevant clinical topics. In addition, for many years we have been kept on the cutting edge of developments in the field with timely reviews of journal articles – special thanks to our ISCSW member Geoffrey Magnus – as well as excellent summaries of ISCSW educational events. The current issue includes some special articles. To begin with, Nathan Dougal presents an evocative case study in his excellent original clinical article. Also, in this issue, Leslie Brefeld has written an article on the importance and usefulness of Yoga as a resource for therapist self care; and, finally, Agneiszka Grabowski has contributed an important essay on the relationship between technology and psychotherapy.

This reminds me of another important development. Agneiszka is one of three new Board members. She will be our new Cultural Competency Chair. We are also welcoming Christina James as Secretary *and* Legislation and Policy Chair, and Emily Heilman as an At-Large Board Member. We are excited about their commitment and interest in serving on the Board, and we are already benefiting from the fresh ideas and new perspectives they have brought to our meetings. Please let us know if you might be interested in serving on the Board.

Another recent happening was our successful networking event, chaired, organized and hosted by At-Large Board Member Nikki Lively. On April 12, we enjoyed great food brought by Board members, and had a stimulating discussion of Nancy McWilliams' thought provoking article "Preserving Our Humanity as Therapists". Our plan is to have a series of these networking events with each one focused on discussing a "hot topic" which will be of particular interest to our membership. We strongly encourage you will join us for future networking events!

I have saved the best for last. The entire Board has been working extremely hard on planning and organizing our Big Spring Conference. Once again, Ruth Sterlin is playing a leadership role as Chair of the Conference planning efforts. We are very proud and excited to be bringing Louis Cozolino, Ph.D., from Pepperdine University to Chicago for a day-long workshop, 9:00 am - 4:30 pm on Saturday June 8th at National – Louis University. His topic will be "*How Psychotherapy Changes the Brain: Attachment and the Therapeutic Process*". Dr. Cozolino is in the forefront of efforts to translate neuroscience research into practical, pragmatic psychotherapy interventions. This presentation is simply not to be missed. You can register for the conference using the application form in this newsletter, or on our website -- www.ilclinicalsw.com . We accept credit cards and Pay Pal payments. In association with Chicago Association for Psychoanalytic Psychology, we are also pleased to be able to offer CEU's for attendance at this conference for Social Workers, LCPC's, *and Psychologists*.

I look forward to seeing you at the Conference!

The ISCSW Networking Event Series!

Hello everyone, and Happy Spring! The Board has been hard at work over the winter thinking about ways to connect with our membership community, and to that end is launching a series of themed networking events in 2013. We have held networking events in the past but are trying a semi-structured format this year to give our community an opportunity to come together and discuss issues that are important to our work and to the field of clinical social work. Our first event on April 12 will have occurred by the time you receive this newsletter, but we are starting with the theme of "Preserving Our Humanity as Therapists" as inspired by the Nancy McWilliams article of the same name. **Our next event will be held on Sunday, August 4, 2013.** Be sure to check your email for more details on these events! Future themes we have discussed include issues surrounding the new DSM-V, as well as issues surrounding Skype and other forms of teletherapy. If you have an idea, article, or blog post that you have found intriguing and would like to discuss more, please feel free to contact me at nikkihelps@gmail.com. It is our hope that through these events we can empower ourselves and each other to find our voices, and identify ways that we can impact and improve our practices and our field. We look forward to seeing you!

Nikki Lively
ISCSW Board Member

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Excellent Services Available through ISCSW

Low-Fee Treatment Referrals

Treatment referrals are available to new professionals and the community-at-large through the Illinois Society for Clinical Social Work. Experienced therapists with a *sliding scale* comprise many of those in the Society's referral pool. A confidential consultation is the first step in obtaining a referral tailored specifically to the person interested in treatment. A call to Rebecca Osborn, New Professionals Chair, at (312) 346-6991 will initiate a discussion of how we can best serve those looking for low-fee services.

Low-Fee Clinical Supervision

Clinical supervision is also available to new professionals and the clinical social work community at a low fee. The Society prides itself in precise collaboration with the person seeking supervision in considering an appropriate referral. Supervisors have a strong background of experience in a variety of practice settings and approaches. Those interested in this service should contact Rebecca Osborn, New Professionals Chair, at (312) 346-6991.

ORIGINAL CLINICAL ARTICLE

Death within Birth:
Intrapsychic and Environmental Foci during a Four-Times-Per-Week Treatment

Nathan Dougal

Introduction

In this article, I will write about a young man I work with who struggles with issues of mood, cognition and what I sometimes think of as "varied selves" expressed through several voices. I would like to explore tensions in the treatment between exploratory/insight approaches and a supportive approach. I also plan to explore the psychoanalytic idea of regression and the amplification of the intrapsychic world of the patient; and more active approaches, such as ego-supportive psychotherapy, and the concept of management – as described by Joel Kanter – as well as collaboration with other professionals as part of a life-facilitative milieu.

In addition to Kanter, I will also apply ideas from D.W. and Clare Winnicott, and Frank Summers. Summers, in Winnicottian fashion, likens the space between the psychotherapist and the patient to the *transitional space* between a mother and an infant. The transitional space is a feature of the relationship that is to be left open for the creative use of the infant or patient. Both Summers and Winnicott use the term *spontaneous gesture* within the transitional space in reference to the beginning of a creative process both emanating from and creating the self. Summers stresses the importance of the mother, the therapist and the people who comprise the patient's environment, all seeing the authentic aspects of the patient's self, thereby helping the self consolidate. As he or she progressively consolidates the self, he or she can make even more use of the transitional space and create new ways of being and relating. I will also utilize concepts from Michael Balint on benign and malignant regression.

And, finally, I will use the above theoretical concepts to address the frequency of our sessions (four per week), as it is germane to both the exploratory, non-directive approach and the more supportive, active elements of this therapy. In particular, it is relevant because of the extreme isolation of this young man, his intense involvement in his intrapsychic world, and his physical challenges from organic factors which occurred at birth. His physical condition has created serious psychosocial gaps in his life which have needed ongoing, active support to overcome huge obstacles to the point that he is now a sophomore at a reputable university.

Stavros

As he describes it, Stavros died when he was an infant. He was then resuscitated. As a result of his birth complications, he has proceeded through his life with a medically complex matrix of problems which include a compromised immune system, joint and connective tissue problems, and some presumable combinations of neurological uniqueness and/or disorders. The vicissitudes of psychosocial problems related to that legacy are second only to Stavros' existential problems.

At 21, Stavros' medically complex history affects his readily apparent difficulties in cognition, expressive and receptive language, as well as his perception and expression of subtle social cues. His medical problems have also left him with a gait that is somewhat odd, and a very uniquely shaped head and face. He has the capacity for emotional depth and can be reflective about his subjective experience (mostly around experiencing himself as an outsider). He is also capable of abstract thought with varying degrees of sophistication and has creative ideas and a narrative about himself.

In the beginning of our treatment, I met with Stavros' parents. The fact that they were present at the initial point of engagement is typical of Stavros' way of engaging with

the world: his parents function as a stand-in for a facilitating ego. I was initially apprehensive when his mother sent me a fax about his insurance along with suggestions about how I should approach him. I felt like I was being made to "work hard" before there was even a case. In their book, *Working with Parents Makes Therapy Work*, the Novicks talk about sado-masochistic dynamics within closed family systems and how the therapist will get involved unconsciously with those features of a family's pathology. With Stavros' mother, I felt pushed to conduct myself in a certain way (at the expense of how I work) with a difficult-sounding medically complex patient. When I did not call her back very quickly and did not focus on the topics mentioned in the fax, I could see that I was resisting what felt like a potentially sadistic, or at least constrictive, set of requirements.

When I first met Stavros, he seemed barely perceptible as a person. His countenance was stiff and mechanical. His face was inanimate. He presented as nonverbal. It took quite some time for a person to emerge. During the course of a great deal of silence, I would grow indignant and enraged. Below that layer of my reaction, I was anxious that we could not do relevant work together. I privately had riddance wishes while trying to maintain some curiosity about him.

In *The Contemporary Kleinians of London*, Betty Joseph summarizes a process whereby a person unconsciously communicates to another split-off aspects of the self; and, upon receiving the communication, the second person feels strong affects related to that split-off aspect of the communicator. "It is, in any case, a very powerful and effective way of ridding the individual of contact with his own mind" (p. 102). In addition to primitive communication a la Melanie Klein (projective identification), Stavros did gradually begin talking. He would complain almost mono-syllabically. When invited to elaborate, he could produce little. When he finally began to open up, he was especially inclined to describe discomfort, upset, anger and contempt in regard to his parents. These negative feelings began to include his school, a major university with a good reputation. I was astounded when it first came out that he was a student there, given his simplistic, almost barren presentation during our initial sessions.

For a long time, I was unsure if I could continue with this silent being, who became animated only when expressing stings and strikes against apparent threats. Stavros would stare off into space. Most of what he verbalized were complaints (almost always with people and systems located outside of himself), dripping with venom and contempt. He slowly began to respond to my attempts to learn about his internal world. Stavros told me indirectly of his not really wanting to exist, or rather of feeling like he did not exist: "It's like, when I am at the store, sometimes people just... just don't even see I'm there."

Months into our treatment, Stavros began to tell the story of himself, beginning with its centerpiece: he died at birth! He seemed proud of this and reflected on its irony. Within the beginning of his story was an ending. It was at this point in our work together that I really felt "hooked".

In *Self-Creation: Psychoanalytic Theory and the Art of the Possible*, Frank Summers describes a process of creating a transitional space between mother and infant, a space that is not to be "filled in" by the mother but left open for the expression of true self by the infant. Within the transitional space lies

> "... Winnicott's concept of the spontaneous gesture that moves the child to new experience, toward the acquisition of new knowledge, mastery and exploration of the world. The mother's empathy includes appreciation for both who the child is and who the child may become. The mother is 'behind' in following the child's spontaneity by meeting it with a response of her own. If the mother's reaction fails to connect with the child's gesture, there is a danger of divorcing the child from his experience and molding him to a preformed idea. So, the maternal response both engages the child's spontaneity and adds a vision that the mother constructs from it, an addition to which the child must respond" (pp. 54-55).

Stavros had finally told something about himself that, for the first time in the treatment, had complexity and was very compelling to him and to me. It was unique to him and a telling paradox that has colored his entire life: feeling both dead and a yearning to be alive.

Reflections on Countertransference

Another point where I felt very engaged by the style and uniqueness of this young man was when he showed me his tattoo. It was done as a classic tattoo flash script banner which said, "To Be or Not to Be". In light of Stavros' "ending-beginning", this is a very poignant choice of words. I found myself having a countertransference experience of seeing him as a kind of hero, or maybe anti-hero

with a noble mission, exploring the age-old Shakespearean mega-question. At around that time, Stavros also got a 1920's retro-looking haircut to go along with his already 1950's style eyeglasses.

With him, I found myself thinking of a character played by the actor Steve Buscemi in the movie *Ghost World*. Buscemi's character was a nerd who loved playing, listening to and collecting 78 RPM records of American antiquity. In the movie, he had a retro style of dress and an apartment to match, was miserable and lonely, and seemed less than satisfied with his friends. As the movie proceeds, two teenage girls spy on this curiosity of a man selling records at his own little flea market. Together, they are intrigued with him and want to tease him sadistically as a kind of punishment for his daring to adopt a noticeable style. One of the girls, though, sees his personhood and does form a relationship with him.

Stavros reports having been egregiously teased in his childhood and adolescence for being odd and different. In high school, sometimes girls would feign interest and then recant cruelly. Understandably, this has made him quite suspicious of girls. It is possible that an already present schizoid, closed suspiciousness helped shape those interactions. Maybe the above mentioned kind of projective identification was at work in these experiences, too.

Showing a Self

As Stavros' true character has begun to emerge, I have noticed several distinct voices that he employs in his sessions: one includes grunts and guttural sounds, another is the voice of the argumentative academic, another speaks "baby talk" (with subsets of ascending and descending tones), and yet another is that of a grumpy (possibly wizened) old man. Permit me to explain further.

This young man frequently begins his sessions with a grunt or a kind of grunt-exhalation after he sits down. I think of it as an expression of the schizoid aspect of his character, partly out of my countertransference reaction of contempt, disgust and a sense that he is illegitimate. When I do not have a negative reaction to his throat sounds, I experience them as his neutral, authentic establishment of his presence in a bodily sort of way.

The argumentative academic aspect of Stavros can vehemently develop an idea, argue it and defend his position. He seems to come alive in his militance. He develops an "anti-thesis", but it is not always clear whether it is in response to an original thesis. His oppositionalism seems to fuel his thinking.

His third voice, spoken in baby talk, also has a speech impediment aspect to it. This can inspire some contempt in me, but also some curiosity. The ascending tone he employs evokes more curiosity, and the descending tone usually relates to his feelings of condescension towards someone else, or, similarly, to his feeling that someone is being condescending to him. Condescension – in both directions – is a consistent theme.

The "grumpy old man" is both a way of talking, and a view Stavros has of himself. This voice sounds a bit like a less-refined Jimmy Stewart, most memorable to me in his role in *It's a Wonderful Life*. Note the ongoing theme of the character who deals with existential questions having to do with a desire not to exist and how that informs existence. Sometimes this voice verbalizes the perspectives that Stavros has the most confidence in. It is here that he also expresses a self-concept of being more Mediterranean than American. Some of this comes from people's experience of his odd-looking face and head (especially brow) paired with his name. At a part-time job, teenaged coworkers often ask him, "Where are you from?"

The overall issue of Stavros expressing himself through different voices, and my experience of them as authentic, relates to what Summers believes is the self being visible. Invisibility is a devastatingly painful experience of non-self. Stavros' voices are his way of counteracting this, of showing his self.

Session Frequency: Analytic Regression *versus* an Additional Ego-Supportive Presence

Not long after he began treatment with me, Stavros dropped out of the university. He seemed to feel discouraged and demoralized by his university experience, but did not have enough command of language to articulate that. He had an externalized description of the failure of the environment, complaining about his absent advisor and the "ridiculous" writing requirements of professors and college. In dropping out, he acted out in a concrete way his response to academic figures and to the institution, and to his less-than-articulated feeling states of being ill-equipped for school. The thematic content of our sessions became increasingly darker and lonelier than even before. He expressed hate towards his parents, hostile ambivalence both towards and from his only friend, and the sense that he was feared and regarded suspiciously at his job. A schizoid world view and character structure was emerging prominently.

Initially in the treatment, sessions were scheduled twice a week, based on his parents' level of concern about his well-being. During my initial evaluation, they had told a story about arriving at Stavros' condominium, which they own and where Stavros lives alone, to find all of the windows and the front and rear door wide open. They called for Stavros and received no response, and then saw the legs of his prone body on the floor protruding out into a doorway. "We thought he was dead," said his mother. He was not dead, he was asleep. But the whole scene gave them an eerie feeling.

Soon, the only activity in Stavros' life seemed to be going to work and coming to therapy. This was accompanied by an intensification of his talking about needing more from his friend (which I understood as transference). I broached the subject explicitly of meeting more frequently (three times per week). After a time, when he was making good use of the sessions by talking more directly about his feeling states and new interpersonal experiences at work, we started meeting four times per week. A girl at Stavros' job approached him a few times politely and with novel interest. He described feeling suspicious of her, remembering feeling baited by girls in high school only to be rejected. He challenged her frankly and coarsely and asked what she wanted with him. She stated that she was just trying to be friendly and considers herself kind of a "weird girl" and thought that he seemed (somehow positively, wonderfully?) akin. He described softening immediately.

Transference and Regression

I have been oft named "Doc" by Stavros. He has had quite a few doctors in his life. He gestures (slightly boastfully) toward scores of them throughout his life and alludes to having had some of the best in their field.

Quite a few of his professors at the university are addressed by the title of *doctor*. Early in the treatment, he voiced rage at "the negligent Dr. Gustafsen", who never answered emails or called back. Stavros "kept him" as his advisor for two semesters. Was it a repetition of some kind of neglect? Was this reminiscent of the impossibility of a full attachment given his disabilities and communication problems? There was also Dr. Howard, who was exacting but ultimately had Stavros' best interests in mind regarding teaching him how to write at the level he was able (remedial for most college students' abilities). Stavros sought him out for a second course because of the relationship between them and Dr. Howard's willingness to work on remedial writing. I asked Stavros if I was doing something akin to Dr. Howard in making myself available to him so that he could speak in the way that he is able, and whether our adding a fourth session per week was like "the second course with Dr. Howard". Later, I told him about an experience in my life where I chose to stay in the same partner dancing class repeatedly rather than advancing prematurely and becoming lost. Was the theory of transference informing an ego-supportive style on my part? Might I have left it alone at interpreting the transference, or can we understand my insertion of my story as "relational"?

Stavros has a paucity of friendships. He experiences himself as an outsider. His closest friend, Arthur, is also an outsider with readily apparent self-loathing: he is a Latino who espouses a hatred of Latinos, and a self-described conservative who is gay in sexual orientation and has no money. Arthur, and the therapeutic material generated about him, is extremely important.

I often struggle with how to understand the stories of Stavros' interactions with Arthur. I waver between the following ways of listening to and thinking about them: are they 1) a psychological identification he has with this friend (therefore a way of talking about himself), 2) a repetition of an early object relations template, 3) a sharing of the actual relationship with this essential person, or 4) a way of talking about his transference to me.

During the deepening of the therapy, through meeting more frequently, Stavros had Arthur move in with him as a roommate. Initially, he was pleased to have someone around. They would cook together and hang out. Over time, though, he found Arthur's aloofness (a quality he already knew about) to be annoying. Arthur, who did not pay rent, was also provocative with Stavros and with Stavros' parents, as well. They were insulted. At one point, Stavros and Arthur had a supreme fight where Stavros seriously thought about what kind of violent action he could take. At times, I felt sorry for Stavros, as this only friend was so precious to him. Their own personal histories conspired for them to have only a partial connection that was getting volatile. I struggled with whether to focus on the relationship outside the room or the one in the room. I found myself sometimes wanting to be assertive on Stavros' behalf because of a growing affection and concern for him. At other times, I felt aloof, piteous and even disgusted with Stavros. Clearly, there is an inherent tension between my thinking intra-psychically about the object-relations configurations of Stavros, and my focusing on the interpersonal, external world of Stavros.

Features of a Regression

Michael Balint has cited the following features of a regression:

Benign

1. Not much difficulty in establishing a mutually trusting unsuspecting relationship
2. A regression, leading to a true new beginning, and ending in a real discovery
3. A regression for the sake of recognition; in particular, that of the patient's internal problems
4. One which expresses only a moderately high intensity of demands, expectations, or "needs"
5. One with an absence of signs of severe hysteria in the clinical symptomatology and of genital-orgastic elements in the regressed transference

Malignant

1. Since the mutually trusting relationship is highly precariously balanced, the atmosphere breaks down repeatedly, and frequently symptoms of desperate clinging develop
2. There are several unsuccessful attempts at a new beginning, a constant and unending spiral of demands, and an addiction-like state
3. The regression is aimed at external action
4. There is a suspiciously high intensity of demands and the presence of severe signs of hysteria

With the above in mind, how can Stavros' regression be understood? Perhaps as a benign, adaptive regression in service of the ego – a regression to Stavros' "dead" voice in the presence of the "expert doctor"? Or as a malignant regression, with resultant negative countertransference: what happens in the consulting room later contributes to a potentially violent night outside of the consulting room.

Actually, I believe there is an intensification of the therapy in meeting more frequently, which has been for the sake of recognizing the patient's experience (termed by Balint as an aspect of benign regression) of loneliness, pain of being different and feelings of rage and resentment. I do not think all of the earmarks are present for either kind of regression. Can a schizoid personality structure regress *with* the psychotherapist?

Stavros punctuates his points of objection with pounding or slapping the leather couch. While this might not sound like much of an occurrence, for some reason it has an impact on me; I find it really unnerving. I feel deeply irritated somehow. Perhaps, I should challenge him to put that action into words in order to help him communicate his intense wants. The explicit location of his high intensity of demands, expectations and needs are mostly outside of the therapeutic relationship. The most hysterical versions of his demands are contained in his relationship with his parents, who he seems to hold to an unspoken standard of "making it all better" and then hates for not being able to.

Stavros' dropping out of the university could be thought of as a malignant regression in that it was a reaction to the absence of a gratifying external action by the university environment. I suppose his eventual return to attending the university, while talking a great deal with me about his struggles and worries, could be seen as allowing himself a benign regression, since he feels powerless at school. The whole withdrawal, and eventual return to school with renewed choice and purpose, could be thought of as a spontaneous gesture (of authentic self) in relation to the transitional space of our treatment.

In terms of the ease or un-ease of mutuality and trust as indicators of a benign or malignant regression, Stavros' attendance of our sessions could be interpreted as a sign of trust in a mutual purpose. Additionally, I suppose the frequency of his suspicion and contempt for people outside of the room could be understood as a subtext for how he feels about me. Often though, he seems to regard me as a kind of entity that may be available to provide a function, but there is little evidence of the quality of interpersonal involvement described in either of the above kinds of regression. Stavros is much more schizoid than that, and our relationship does not feel really interpersonal. Alluding to Stavros' early history, we may have more of a dead baby on our hands here. Or, in regards to the concept of regression, I am the mother holding the newly resuscitated baby, a baby who needs help to orient himself to the very basics of life, but who is also allowed to find the orientation himself.

Ego-Supportive Work: Management *a la* Clare and Donald Winnicott

I met Joel Kanter (a psychotherapist who identifies the unique perspective of psychoanalytically informed clinical social work) at an American Association for Psychoanalysis in Clinical Social Work (AAPCSW) conference several years ago. Kanter has a practice in the Washington, D.C. area and moderates the AAPCSW listserv. In our discussion, he was very passionate about the unsung contribution

of Clare Winnicott to sophisticated developmental theory in social work and psychoanalysis. Our conversation led to his discussion of a case where he was treating a deeply disturbed young adult and saw that a great deal of session frequency was indicated. The young adult had moved to the city where Kanter had his practice in order to attend college. In a very creative way, Kanter and the client's parents facilitated the young adult patient's moving into housing near Kanter's office so that there could be daily sessions. In my work with Stavros, I began to grasp the enormous importance of his having a transitional space. There were strong indications for a treatment plan with a high frequency of sessions. This was informed greatly by Kanter's case.

Kanter writes about the concept of *management*, of regressed patients, the process of regression and of the environmental needs of those who have profound psychic (including object relations) impairment. He draws from Masud Khan's application of Winnicott's thinking about management, which includes the following:

1. The quality of the analytic setting, its quiet and freedom from impingement on the patient
2. The provision by the analyst of what is required by the patient, be it abstention from intrusion through interpretation, or a sensitive body-presence in his person
3. The analyst facilitating what can only be provided by the social and familial environment; here the range is from hospitalization to care by family and friends

In my work with Stavros, I would add (to number three above) management regarding the educational environment. I recently made a referral for Stavros to have a neuropsychological assessment, particularly in the areas of cognitive ability and learning issues, for the purpose of academic planning. He struggles mightily with writing, and his executive functioning is poor or lacking in planning for study and completion of assignments. His experience of the social milieu in class and his own self-esteem profoundly affect his ability to stay with the challenging process of school. However, he has amassed two-thirds of his credits for a B.A. I believe an assessment and a written report to the school commenting on his learning capacities as related to organic and psychosocial factors and on possible educational accommodations would benefit Stavros and provide direction to his university and his professors. Needless to say, such a report and its perspectives would also help me understand more about his capacities and challenges.

According to Kanter,

> Foreshadowing Kohut's work, Winnicott suggests that the 'individual introjects the ego-supportive mother' as de-adaptation occurs in graduated doses as part of the gradual change toward independence. Later, the family unit as a whole continues this process, providing both opportunities for regression to dependence of a high order (p. 29).

I had an ego-supportive-mother countertransference ambition for Stavros when I increased the frequency of our meetings to four times per week. While his difficulties with school necessitated expanding the therapeutic frame, on some level, my thought was, "I'm going to get this kid through college." And, perhaps, proposing the neuropsychological evaluation to Stavros and his parents was a continuation of that. My thinking, which I made explicit to Stavros and his parents, was, "You have a unique configuration to your brain and therefore a unique style of learning. There may even be diagnosable learning disabilities. The same can be said for expressive and receptive language: a unique or diagnosable communication disorder. The value – although you may have feelings about the word 'disorder' – of establishing this kind of perspective is that the school can make realistic accommodations to help you learn and get credit for learning. This testing and the report from it are essential to getting through college and understanding more about how your mind works." This certainly changed the therapeutic frame and took my stance more into a management mode. I even began introducing the psychological jargon utilized in education that I did know about, my thinking being that Stavros and his parents would need to become familiar with these terms in order to participate in academic planning.

There is a whole fantasy scenario that plays out in my countertransference, where I use the neuropsychological report to talk with Dr. Shapiro, the literature professor who displayed an interest in and aptitude for comprehending how Stavros' mind works. In this scenario, she and I go to his academic advisor, and the two of them implement educational accommodations according to the report. In terms of Stavros' history, this fantasy seems related to orienting the newly resuscitated baby to its environment for survival. I ask myself, how can the fantasy inform my in-depth analytic stance, and how much of the fantasy should become part of a plan for management of the case in conjunction with other

professionals? Should my focus on Dr. Shapiro's effectiveness in understanding how Stavros' mind works be understood on an intrapsychic level, as evidence of Stavros developing observing ego? Or, should my focus be on her as an actual person in the environment to collaborate with around the neuropsychological report?

Conclusion

Stavros' symptomatology, character structure, developmental lacunae, disabilities, talents, creativity, uniquely prominent aspect of an inchoate intrapsychic experience, and needs from the environment, all beg for mobilizing both a psychoanalytically informed intensive treatment *and* a more active management means of participating in improving the meaning and quality of this young man's life. Utilizing the Winnicotts' work, as seen by Frank Summers and Joel Kanter, along with Michael Balint's elaboration on the aspects of regression, has helped provide my psychotherapy with Stavros with a developmental framework that includes both an intrapsychic and a management focus. Understanding the theory has also been helpful by encouraging the increase in the number of sessions in our work. I hope that my experience in treating Stavros and the above explanations will prove helpful to readers in understanding the numerous possibilities we as therapists need to utilize in our in-depth work with patients, especially those with intense psychic challenges.

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About the Author

Nathan Dougal, L.C.S.W., B.C.D., *is a psychoanalytic psychotherapist in private practice on the north side of Chicago. He is a member of The Lakeview Center for Psychotherapy cooperative. Nathan is also a Visiting Lecturer within the Masters in Clinical Counseling and Psychotherapy training program of The Institute for Clinical Social Work in Chicago.*

Permission for the inclusion of case material, which was highly disguised, was obtained from the patient discussed in this article.

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The Cutting Edge...

Reviews of Recent Literature

Neural correlates of moral sensitivity and obsessive-compulsive disorder. Ben Harrison *et.al*. (2012). *Archives of General Psychiatry,* 69(7), 741 – 749.

Guilt – selective functional disconnection of anterior temporal and cingulate cortices in major depressive disorder. Sophie Green *et.al.* (2012) *Archives of General Psychiatry,* 69(10), 1014 – 1021.

These two articles were published at a fortunate time for me. I was treating several patients with OCD, who were very obsessed with guilt. The clinical literature on OCD seems to focus on compulsions or anxiety, and very little of it deals with obsessions or guilt.

In Harrison's study, both the group with OCD and the normal control group were asked to look at pictures with stories depicting either a difficult moral dilemma or a simple choice between two alternative choices. The difficult ethical dilemma might be, "You are hiding from the enemy with several other people. Just outside of your hiding place, the enemy soldiers are killing everyone they find. Your baby starts to cry, and you know that if the enemy soldiers hear the baby, they will find you and kill all the people hiding

with you. Would you suffocate the baby to save yourself and the others?" In contrast, a simple choice might be, "Should you take your vacation at the seashore or in the mountains?"

After learning all of the situations, the subjects were then placed in the functional magnetic resonance imaging machine (FMRI). The FMRI measured the blood flow to different parts of the brain. The blood flow is greatest in the areas of the brain that are most active at the time. What the investigators observed was that patients with OCD displayed *much greater activation of the orbital frontal cortex* when making the ethical decision. The orbital frontal cortex is involved in emotional ethical regulation. It is important to know that if the orbital frontal cortex is injured, the person becomes less responsible and less concerned about how his behavior will affect others. Also, stimulating the orbital frontal cortex can induce feelings of guilt and shame.

The patients with OCD also showed a strong activation of the *left lateral posterior temporal cortex.* This is an area of the cortex which is involved in understanding speech, speaking and pre-verbal thinking; and this area is also active when people cognitively evaluate their emotions. Another area where participants with OCD showed more activation was the *left posterior dorsolateral prefrontal cortex,* an area which is involved in the late stages of decision-making. Thus, some people with OCD showed *greater activation of the regions of the brain involved with feelings of guilt and shame*, as well as those areas involved in speech and cognitive evaluations of their emotions.

Some of my OCD patients do not feel anxiety. Instead, they feel guilt and shame and then try to think their way out of it verbally. Unfortunately, the verbal thinking does not work for them, because verbal thinking does not touch the feelings of shame. One patient told me that his anxiety was caused by not being able to stop the cycle between feelings of guilt and the verbal thinking. I have found that when a patient can break this cycle, he can get some relief. This patient is now able to concentrate on the feeling of shame and how he expresses it with his posture, and ignore the verbal thinking. Over time, with a lot of persuasion and pressure from me, this patient was able to open up his posture when he felt shame, thereby breaking the cycle and no longer feeling obsessed with guilt.

Another patient was unable to focus on his feelings; the verbal and logical thinking was too compelling. During one of our sessions, I asked him to repeat his obsessive arguments until he could not do it anymore. After forty-five minutes of trying to convince me of the reality of his obsessions, he drifted off the topic without realizing it. When I pointed out that he was no longer focusing on his obsessions, he was amazed. He asked me, "Why didn't you do this ten years ago?" After that, this patient's symptoms were greatly reduced for months. He even reduced his dose of SSRI's by about 75%. In another case, a patient and I could not find a way to break the obsessive cycle until he began to have unrelated physical symptoms that his physicians could not diagnose. His worry about his medical condition then stopped the cycle of obsessive guilt. This patient and I have not yet found a way for him to use this as a tool to reduce his obsessive guilt.

Harrison's article, plus my experience with patients with OCD, convinced me that OCD is not really an anxiety disorder. I was very proud of this original insight, until I found out that the DSM-5 will no longer classify OCD as an anxiety disorder.

Green's article suggests a number of things about guilt, including the neurobiological difference between obsessive guilt and depressive guilt. Depressed people often feel guilty. Their guilt has a different character than that of someone with OCD: they do not have the compulsive verbal rumination, and their guilt tends to be rather diffuse and is not focused on one particular thing. As stated above, in obsessive guilt there is strong activation of the left lateral temporal cortex which is associated with verbal rumination. *In depressive guilt the excess activation is in the right superior temporal lobe* which is associated with recognizing social meaning.

The compulsive person shows activation in the medial prefrontal cortex and the left dorsolateral prefrontal cortex, the brain areas responsible for the omission of socially inappropriate behavior and for directing attention, respectively. The left hemisphere, in contrast to the right hemisphere, processes well-learned information. The left hemisphere activation in the obsessive-compulsive guilt may reflect the fixity of these obsessions. Depressed people, on the other hand, tend to have more right hemisphere activity – remember, the right hemisphere processes negative information – than left hemisphere activity.

Green hypothesized that the right superior temporal lobe, which processes social meaning, is strongly connected with the subgenual cingulate cortex – which specifically processes guilt. In people who are not depressed, processing social meaning helps to ameliorate guilt. Thinking through a social interaction allows us to think through our guilt. In contrast,

people who are depressed always assume that they are "wrong" in social conflict. They have trouble shifting their point of view. For example, a depressed teenage patient told me that a girl who sits across from him in class was staring at him as if she thought that there was something wrong with him. In a therapy session, I helped him understand the social meaning of a girl looking into the eyes of a young man. "It's a kind of a flirtation." This simple understanding relieved his feelings of guilt.

Green measured the connectivity between the social meaning area and the guilt area of the brain by measuring the blood flow to both regions using a computer program. She compared people who had never been depressed with people who have recovered from major depression. She also looked at what happened in the brains of people when they heard the sentence, "You treated your best friend, Ann, poorly." This was compared with what happened when the same people heard, "Your best friend, Ann, treated you very poorly." Both depressed people and people who had never been depressed had more activity in the cortical areas reflecting guilt when they heard the first sentence, as compared with the second sentence. What Green found, however, was that the areas processing social meaning were *less correlated* with the areas processing guilt in depressed people. This means that depressed people can process social meaning, but *they do not use it to analyze their feelings of guilt*. Talking to a depressed person about a situation in which he or she felt guilt helps that person make the connection between social meaning and feelings of guilt. Thus, either cognitive therapy *or* mentalizing psychotherapy can be very useful in dealing with *depressive* guilt. With obsessive guilt, on the other hand, examining social meaning cognitively is not useful. With an obsessive person, a therapist's warm smile when talking to the patient about his or her guilt may temporarily relieve the pain, but the therapist's *words only reinforce the left hemisphere verbal ruminations* which in very short order make the pain worse.

Before I read these two articles I did not recognize the difference between obsessive and depressive guilt. Reading these two articles confirmed and clarified my clinical experience of both types of guilt. Looking back on my experience with patients, I realize that I have always responded differently to each type of guilt, but understanding the neurobiology helps me make sense of my clinical experience. I hope this understanding will make my future clinical work more focused and effective.

Geoffrey Magnus

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.*

Three Students Reflect on Issues Important to Their Future as Clinicians

Mindfulness

Christopher Novak

Recently, the term *mindfulness* has found its way into the American vernacular, but what does it actually mean to be mindful? How does one "do" mindfulness, and what are the benefits of doing it? This essay will explore these questions and explain how the practice of mindfulness can contribute to less suffering in the human mind.

First, according to the Zen Monk Thich Nhat Hanh (2007), "The practice of mindfulness requires only that whatever you do, you do with your whole being" (p. 42). This may sound easy, but the challenge of staying with what one is doing is very challenging. For instance, when one is washing the dishes or brushing one's teeth, is one's mind fully with these activities or is one's mind somewhere else in the past or future?

To illustrate this point, there is a mindfulness meditation where the practitioner tries to count the in-breaths from one to ten, and whenever the mind wanders he or she starts

again at one. Most beginning practitioners cannot make it past *three* before starting over. Yet, over time and with consistent practice, a practitioner's mindfulness will strengthen, his mind will wander less, and it will carry over into everyday activities.

Furthermore, "Recent research has highlighted the fact that we have many blind spots when it comes to understanding our patterns of thinking, feeling and behaving" (Association for Psychological Science 2013). In other words, people tend to be on autopilot without any understanding of what is happening in and around them. As a result of practicing mindfulness, one becomes aware of what thoughts are occurring in the moment, and how the body feels when emotions arise in the moment. This gives the practitioner enough awareness to have a choice in how he or she behaves. This allows us to change behavior patterns and to lessen suffering .

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Legal and Ethical Implications

Kelsey Exner

To be an effective social worker, I need to be aware of the legal and ethical implications of refusing to work with a client whose sexual orientation and/or religious beliefs are not congruent with my own. An example of a legal implication was stated in an article by Hermann and Herlihy discussing that the refusal to work with homosexual clients "may result in job termination" (2006, p. 418).

I believe that, in addition to it being illegal, it is also unethical to refuse to work with a client as a result of ones own sexual and/or religious beliefs. Herman and Herlihy (2006) stated, "Refusing to counsel homosexual clients on relationship issues constitutes illegal discrimination" (p. 416). For example, I interned at a faith-based homeless shelter as a case manager. I encountered a gay, male client who was seeking assistance to find transitional housing. My supervisor refused to work with the client due to his sexual orientation, which the supervisor's religion did not support. Herman and Herlihy (2006) wrote that by accommodating employees' religious beliefs, the company might "prevent clients from getting the assistance to which they were entitled" (p. 415). I believe my supervisor's behavior was not only illegal but unethical, and her actions appeared to lead the client not to return for services, as evidenced by him stating, "I won't come back to an agency that won't support my lifestyle." For the duration of my internship, I did not see the client return to the agency for future services.

I hope through self-reflection and field work I will be able to gain the proper knowledge and skills needed to work effectively with a variety of clients. As a social worker, it is important to remember that my clients are entitled to services for which they qualify, regardless of my own personal beliefs.

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Colorblindness

Deborah Gaughan

Racism and the lack of acknowledging it is relevant in today's society. Scruggs defined *colorblindness* as believing that "the idea that ignoring or overlooking racial and ethnic differences promotes racial harmony" (2009, p. 45). According to Scruggs, there is an implication that one may believe he or she is promoting racial harmony by ignoring people's skin color. In the past I have been encouraged not to address one's skin color and the correlated nice word choice characteristics, but Scruggs has shown me how my avoidance of race has prevented me from learning who and what makes up the complete person. Although he discusses colorblindness in an educational setting, one can apply colorblindness to any setting, including social work.

In my past, I have prided myself on not noticing a person's race. I have said that race does not matter to me. I believed that race did not affect how I think about people. However, after reading Scruggs' article, I was taken back with how naïve I have been. I have hurt myself and others

by ignoring the opportunities to learn about a person's history as related to his or her color.

Not acknowledging race does not mean there is racial harmony. I used to think that I promoted racial harmony as I was not noticing or judging others based on skin color. But, in fact, I was judging those who did acknowledge other people's races and regarding them as racist. I now know that I need to learn about other people's races, as I was not becoming fully informed about people's lives or experiences related to their race.

By reading the article on colorblindness, I have realized how important race is to learning about the whole person. Not acknowledging and learning about race can be detrimental to my life and to my role as a social worker. I need to take risks and challenge myself to ask and learn more about people's race. Learning about the makeup of the whole person will assist me in gaining further understanding of the person and his or her history.

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Christopher Novak, Kelsey Exner, and Deborah Gaughan *are first-year social work students at Aurora University School of Social Work.*

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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.

Reviews of Our 2012-2013 Jane Roiter Sunday Morning Seminar Series

"Dynamics and Treatment of Extra-Marital Affairs"
Presented by Philip Elbaum, L.C.S.W.
Case presentation by Margaret Grau, L.C.S.W.
November 18, 2012

Philip Elbaum's presentation on this topic was really compelling, with a beginning statement that 75% of marriages sustaining an extra-marital affair are able to remain intact. There are many reasons for affairs, but an affair that is both sexual and emotional is truly the most devastating to all parties involved. The presenter posed the question of whether or not our culture, down to the shows we watch on television, actually promotes having affairs. And when we look at the range of emotional problems of those participating in affairs, personality disorder clusters – in particular those with Narcissistic Personality Disorders – appear most prominently.

According to Philip, the warning signs of problematic relationships which may then lead to affairs include a lack of intimacy, a lack of transparency between partners, boredom with the marriage, and a disinterest in the marital relationship. When an affair does come out into the open, it can be extremely difficult and must be monitored closely. Either spouse can become depressed and anxious and find it hard to cope. Sometimes, the offending spouse can become so remorseful that he or she becomes suicidal.

People generally enter treatment after the affair has come out in the open. At this point, it is important to explore with the couple the context, or reason that the affair began in the first place. Then, if both parties are willing, the long journey of re-establishing trust begins.

Re-establishing trust occurs through various stages of apology: the expression of regret, taking responsibility, finding a remedy in order to do things differently in the future, and, finally, forgiveness. These stages can overlap, and all of these elements are not just one-sided. Both partners must look at their part in the marriage breakdown.

In order to remedy the situation, treatment must help the couple by examining active coping strategies, looking into social support, encouraging physical exercise, exploring the couple's moral compass, and challenging negativity in the relationship. All of these factors and more can help the beginning of a new trust.

Margaret Grau presented a very complex case of a couple she has been seeing where the husband had two affairs with the same woman, a person he has felt an ongoing attachment to. The couple in question is in their mid 30's with one child. While the husband is very remorseful about his affairs, there continues to be uncertainty about his ability to truly stay away from the woman he has so frequently been drawn to, since they continue to share the same workplace.

Margaret described that the marriage has had a faulty dynamic, whereby the wife has been too dominating and the husband too passive aggressive. Thus, when the husband had negative reactions to his wife's behavior, he coped by running to someone outside of the marriage both for comfort and to act out his anger towards his wife. The treatment with Margaret has been long and complex, with the result that the couple is now talking directly to each other about the real issues between them. With careful work, Margaret has helped this couple to a better place where the crisis of the affairs has now passed. And, of course, the treatment is ongoing.

At the end, seminar attendees were eager to ask questions, and most felt that these issues figure prominently in all of our clinical work.

Ruth Sterlin

"Exploring Boundaries: The Case for Maintaining and Examining Boundary Issues in Group Psychotherapy" Presented by Hylene Dublin, L.C.S.W. December 16, 2012

Hylene Dublin made an excellent presentation and is clearly an experienced and sophisticated clinician who is passionate about the importance and usefulness of group therapy. In sharing her clinical wisdom, she gave us invaluable, specific guidelines and tips for leading effective therapy groups.

Hylene strongly emphasized the importance of having at least two individual preparatory sessions with clients prior to the start of the group. These sessions should be with the leader of the group, rather than with an intake worker not directly involved in the group. During these preparatory sessions, the importance of regular client attendance and making a commitment to stay in the group until their problems are resolved should be emphasized. Clients should be prepared for the reality that there will be difficult and challenging moments in the group, especially in the beginning, but that they will also have the opportunity to learn who they are and to improve how they handle interpersonal situations.

Another aspect which Hylene stressed was the tremendous therapeutic value of having a clear contract with the group members in terms of attendance, fees, and confidentiality. She also emphasized the importance of members being willing to discuss openly anything and everything that happens in the group with the group; otherwise there is a danger of a "conspiracy of silence" which can undermine the effectiveness of the group. A clear contract gives the leader significant leverage to insist that clients look at how their violations of the contract reflect their characterological issues and interpersonal difficulties; and, therefore, how they must be "grist for the mill" in terms of the therapeutic process.

She also made a distinction between boundary *crossings* – which deviate from usual behavior but do not cause harm – and boundary *violations* – which are harmful or exploitive in their impact on the group and its members. She stressed that both of these occurrences need to be openly examined, reflected upon and processed in the group.

Another aspect of group therapy is co-therapy. Hylene described the advantages and disadvantages of co - therapy and stressed the importance of regular communication and processing between the co-leaders. Also discussed were the issues involved when a group member's individual therapist is also the group therapist *versus* when the individual therapist is different from the group therapist.

Finally, Hylene shared her ideas about the stages of group development. She described the *forming stage* in which issues of dependency and inclusion are prominent in the group process. Next is the *storming stage* in which the group focuses on issues of power, status, differences and conflict including fight or flight reactions. The third stage is the *norming stage* in which there is often a resolution of group conflicts and a new level of trust emerges in the group. The fourth stage is the *performing stage*, the stage characterized by a mature and productive group process that creates room for each member's individuality to emerge and to be explored. The last stage is the *termination stage* during which the group explores members' readiness to leave the

group.

By the end of the presentation many of the seminar attendees were seriously considering the possibility that their individual clients' treatment experiences could be significantly improved by adding group therapy to the mix.

Eric Ornstein

"A Cognitive Integrative Perspective on the Therapeutic Relationship: Exploring the Boundaries of Theoretical Integration" Presented by Noriko Martinez, Ph.D. February 10, 2013

Noriko Martinez gave us a lively presentation, beginning with the key features of her approach. The *cognitive* aspect of her approach utilizes many of the concepts written about by Sharon Berlin. This aspect includes all of the things your brain does, whether conscious or unconscious, and places importance on basic social work values such as regarding the person in the environment.

The *integrative* aspect of her approach is self-explanatory, in that Noriko had the underlying theme of relating all of the concepts of her approach to each other. Her use of the word *perspective* relates to the important meanings we assign to the things in our life, and how these meanings are not just word-based. They are also based on the memory schemas we rely on. This last factor makes it clear that Noriko's cognitive integrative approach is not the traditional cognitive-based therapy. Her approach also takes into account the effects of the social values of the person in therapy, as well as the emotional schemas and attachment style one has. These also refer to both the client and the therapist.

Noriko laid out a description of many different interacting cognitive subsystems which process in our brain in parallel fashion, as opposed to the brain processing things in a linear way. The result is that, in our brains, many things are happening at once. As a therapist, we must pay attention to all of the various levels of processing, information and schemata impacting the client and the relationship between the therapist and client. For example, in the therapy relationship, there are layers of meaning in each moment. One layer is the *manifest content* (what is known). Another layer is the *axiomatic content* (automatic, unconscious assumptions of both client and therapist). And, finally, the third layer is *relational content* (how each different moment/event in the therapy impacts the co-created relationship).

Noriko sees the self as a *memory system:* there is the self as knower, the self as known, the self as motivated by one's memory system, and the self as influenced by the emotion/memory system. We have multiple selves; and, when things are functioning well, we can move from one self to another in a coherent, prioritized, procedurally appropriate way. We have access to all of our different selves when we need them, and they do not become obstacles to us.

When things are not functioning well, there is a need for change. Noriko explained how change happens. The easiest level of change is when a sense of coherence can be established by a change in the fairly straightforward information one has about one's situation. The more difficult kind of change, which also takes longer, is when one must change one's procedural knowledge; that is, there is a journey that must take place in order for one to access the new, usable information that will lead to a sense of coherence in all of one's selves.

While this is just a short description of the myriad of concepts Noriko shared with us, she alluded to mindfulness (being in the moment), mentalization (takes one out of the moment), shifting a schema that already exists (somewhat less complicated), and creating a new schema (a much more complex and difficult undertaking).

Noriko's comfortable style of presenting opened the door to many questions which were discussed both during and after the seminar.

Ruth Sterlin

"Intimacy and Autonomy in the Therapeutic Relationship: Exploring the Boundary between Care Giving and Self Care Taking" Presented by Nora Ishibashi, Ph.D. March 10, 2013

Nora Ishibashi began her presentation by talking about the self. There are many ways of thinking about this. The *arenas* of self are physical, psychological, emotional, social and spiritual. The *processes* of self are emotional, cognitive and meaning making. The *ecological* aspects of self are person-in-environment, systems-based, and family-systems-based.

As she spoke, Nora shared her experience of how she developed her current beliefs and approach to psychothera-

py. By focusing on the "the rest of her life" – which she is doing in her own current life stage – and adding to that her studies in anthropology and what she learned during the several years she lived in Japan, she has arrived at an approach which focuses on whether or not "what the client does makes sense". She believes in the unconscious and is psychodynamic. For many years subscribed to Intrapsychic Humanism, but over time she has changed her thinking and stresses the value of "just sitting and talking". She feels that there is a tremendous loss of opportunities in our society for just sitting and talking, and people are starved for this.

Nora shared that about ¼ of the impressions we give to one another come about through our expressions; and, when we sit together, there is a process of interplay between our mind and the mind of the person we are sitting with. She has found that so many people believe that everything that happens in their life occurs because they evoked it. She also believes that, as therapists, one of the ways we cope with our clients' pain is by telling ourselves that, "our client is just limited." This speaks to how hard it is for us to sit with that pain.

As clinicians, it is extremely important for us to be aware of our relationship to ourselves. In care giving, which she feels is what we do in our work, it is a two-way street. Both sides are participating in the care giving, even though the roles are different for each of the two people involved.

We must also pay attention to our own self care as we are doing the care giving. In our culture, being "other directed" is considered unselfish and a positive value. In fact, it is considered better than being "self-directed". Nonetheless, being too other-directed can actually come from a place of being out of touch with our own needs, of being unable to have self-knowledge and intimacy with ourselves. Nora pointed out how the balance between the two ways of being – other-directed and self-directed – must be examined by each of us as therapists, both frequently and mindfully.

Another concept Nora addressed was "talking". As clinicians, we have a bias towards talking in the therapy relationship. She discussed the importance of non-verbal intimacy. Talking generally comes from a cognitive and conscious place, which is only a small part of the therapy relationship. Verbalizing things in therapy is not always the best route to take, and verbal interpretations of clients' behaviors, thoughts and feelings can be very distancing. When working with children, sometimes the most important thing we do is to give them an oasis in which they can practice explaining who they are.

Nora sees her approach as an "ideals-focused psychotherapy". What takes place in the treatment is the process of a client identifying the core ideas of what matters to him or her. Simply defining them is the work. She also sees this kind of work as in-depth therapy which can help someone pursue their ideals and let go of "skewed ideals". This is very different from focusing on outcomes and trying to "fix" problems: one can achieve a sense of happiness from simply pursuing what one has finally identified as meaningful. It was evident that attendees appreciated Nora's ideas and wanted to know more about them, since her presentation was followed by a rich discussion.

Ruth Sterlin

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Original Essay…

"I'm So Lucky to Have a Therapist Who Texts!" Reflections on the Marriage of Technology and Psychotherapy

Agnieszka Grabowski

In a psychotherapy group, a client launches into an emotional description of her distress and its sources. Encouraged to reflect on how she can actively cope, she asserts that she is blessed to have a therapist who immediately responds to her distraught text messages with words of advice and encouragement. That is how she copes, she explains to the group.

A client's phone rings in an individual therapy session just as she is tearfully describing the pain she felt when her mother harshly criticized her parenting skills. She excuses herself, quickly wipes the tears away, and answers the phone with surprisingly cheerful voice: "Hi hon, I can't talk right now, but let's go for lunch. We're set. See you soon." She explains that this was her friend from work; she then returns to the original topic, her voice again shaken and upset.

A client e-mails her therapist, who has a clear email-for-attendance-purposes-only policy, and states that her depres-

sion has worsened. She proceeds to describe just how badly she feels. The therapist reads the e-mail eight hours later and does not respond.

As therapists, we increasingly encounter similar situations on a daily basis. The smartphone, with its staggering capacity for instant, ubiquitous communication via email, text, or voice, has in many ways transformed human relationships. To varying degrees, the therapy relationship – that most venerated of 'tools' for promoting change that we clinicians have at our disposal – has become machine-mediated. As mental health professionals, we need to accept this reality. What I propose, however, is neither a passive, resigned acceptance nor enthusiastic, mindless consecration of the marriage between technology and psychotherapy. Instead, I argue that we need to question and critique the inroads these technologies make into the daily practice of our profession. This kind of open inquiry will allow us to harness their positive potential while protecting our clients and the therapeutic relationship from their more destructive implications. Psychologist Nancy McWilliams reminds us in her brilliant article on "Preserving Our Humanity as Therapists" that the therapeutic endeavor is a subversive one, in the sense that we often challenge mainstream cultural assumptions in an effort to help our clients find their own authentic voice amidst the many frequently unhealthy pressures our society exerts on its members. This is based in a dialectical worldview that emphasizes both acceptance and change. To foster growth, it is imperative that we *examine* and *question* assumptions, beliefs, values, and actions espoused by us, our clients, and the larger society.

Current Attitudes

It is interesting that the above-described stance – one so foundational to our profession – does not figure prominently in the debate on the use of e-mail and/or text messaging between therapists and clients. Indeed, at times I cannot even find traces of the debate itself! A clinical social worker who recently joined a group practice shared with me that when she received her new business cards, she was puzzled to discover that her e-mail was included on it. She learned that she could have asked to not have the e-mail address included, but since it did not occur to her to do so (she thought it would not be), it was assumed she had nothing against having it there. Some professionals simply do not examine the implications of this mode of communication with clients. I term this the **non-issue view.**

Some therapists who embrace this view make themselves available to clients without considering whether their behavior fosters growth and change or helplessness and unhealthy dependence in a client. Boundaries can become compromised. Other therapists give in to the illusion that internet communication is private, and fail to take steps to protect their clients' confidentiality. Ethics are not taken into consideration.

The second stance holds that since internet technologies are here to stay, their foray into clinical practice is inevitable and therefore must be regulated in a practical manner. Psychologist Ofer Zur, who writes and teaches extensively on digital ethics, espouses this view. On the website of his Zur Institute, he offers useful advice on how to protect confidentiality and privacy of clients, become HIPAA compliant, establish and enforce written rules about e-mail or text message communication, and elicit informed consent. Zur acknowledges that technology "can be constructive and helpful or can be misused and be destructive" (2011) and teaches us how to rein in its destructive potential while maximizing the benefits (such as the beloved by many therapists efficiency of rescheduling or cancelling sessions via email rather than having to play endless 'phone tag' with a client). I term this **the pragmatic view**.

The pragmatic view further holds that therapists can be divided into two camps. "Digital immigrants" (Zur 2012) are presumed to be those of us who were born and socialized prior to the advent of the Digital Age. This group tends not to feel entirely at home in the technology-driven world. Many digital immigrants may resist integrating internet technologies into the clinical milieu. The other camp is made up of "digital natives" (Zur 2012) – children of the Digital Age who are presumably comfortable with and transformed by technology. Zur explains that in order to "inhabit the 21st century", "digital immigrants have to find a way to learn about and respect this unfamiliar territory, just as if we were going to do therapy with the people from the steppes of Outer Mongolia or the jungles of Brazil, even if we don't necessarily want to go native ourselves" (2012).

The pragmatic view is an improvement over the non-issue view. Like the non-issue view, it understands that technology is not an enemy to traditional values espoused by psychotherapists. It adds a caveat: technology is a tool that needs to be harnessed so as not to be harmful to clients. This being said, the problem with this view is that it puts forward a deceptively uncomplicated notion of the impact of technology on human relationships and psyche, and admonishes therapists to resign themselves to and prepare to face these new realities.

We are changed by technology, but there is nothing uncomplicated about the implications this has for one's psychological well being. If we ignore this fact, we defy the central precept of good psychotherapy – to examine each intervention we undertake with the potential it carries for benefit *or* harm in mind.

The Alternative

No matter what kind of theoretical framework guides our clinical practice, most of us agree that the therapeutic relationship has a strong transformative potential. As such, it must be protected. In using technologies such as texting or e-mail with our clients, we need to pay close attention to whether the relationship is strengthened or its healing potential diluted by such use. Psychologist Sherry Turkle (2011), who writes extensively on the impact of technology on relationships in general, points out that texting and emailing allows users to censor emotion and its expression, and craft an online persona that may be shielded from vulnerability and whose authenticity may be questionable. It may be the case that this does not occur when clients communicate matters of clinical importance to therapists via email. However, it is our duty to examine such a possibility so as to provide our clients with a therapy experience that is most conducive to healing.

Turkle finds that even young people, whom Zur would term "digital natives", express a paradoxical nostalgia for life untethered to electronic devices. She describes a yearning to be fully seen and heard. Indeed, most people find their way to therapy because they are feeling disconnected and alone in the world – the same world that offers instant connectivity on a previously unheard of scale. We see manifestations of this disconnection on a daily basis. I am often astounded at the silence on the bus I take from work as all eyes of fellow passengers are typically glued to smartphones. Turkle talks about a novel social experience of being "alone together" (p. 14). This is a powerful shift in relating that needs to be considered when technology begins to figure prominently in the therapeutic relationship we have with a client.

Therapy is a "social microcosm": (Yalom 2002, p. 47) much of what occurs in the session reflects relational and/or intrapsychic issues that a client experiences outside of it. When technology begins to be part of what occurs in the session, we need to consider it as a matter of clinical importance. Not judge it or resent it; such a stance would make open inquiry impossible. Not take it for granted either; again, this would stifle curiosity. Instead, we need to talk about it and talk *a lot* – with each other and our clients.

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Agnieszka Grabowski, LSW, *is a Program Coordinator and Staff Therapist for Women's Reproductive Mental Health Program at Insight Behavioral Health Centers in downtown Chicago. She is also the Cultural Competence Chair of the Illinois Society for Clinical Social Work Board.*

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Our Next Networking Event!

ISCSW will be having its next Networking Event on Sunday, August 4, 2013. Please watch your mailboxes for information on the time and place.

Resources for Social Workers…

Simple Yoga Techniques to Help Ease and Prevent Pain

By Leslie Brefeld

Yoga is based on an appreciation for the interconnectedness of all aspects of our being and seeks to unify and integrate the wide variety of factors that affect our health.

---*Carol Krucoff,* Healing Yoga for Neck and Shoulder Pain, (p. 15).

In this article are several yogic techniques that can help to bring health to the body and mind. Yoga brings awareness, so one possibility is that you can find the source of your pain. Another possibility is that yoga does the healing in and of itself. These exercises can be used by health-care practitioners and patients alike.

According to *Yoga for Pain Relief: Simple Practices to Calm Your Mind and Heal Your Chronic Pain* by Stanford University psychologist Kelly McGonigal, "One of the best things you can do for your everyday well-being is learn to breathe with less effort and tension. Tension in the breath can reinforce pain and stress, but a relaxed breath sends a continuous message to your mind and body that you are safe and well" (p. 30).

Yogic Tool*:* Deep Breathing

Sit up straight, move away from the back of your chair so you are sitting on the edge of your seat. Have your feet flat under your knees and imagine that a string is pulling up from the crown of your head to the ceiling. If a light were to be projected from your chest, it would shine straight ahead.

Now, place one hand on your belly. Take a deep breath in through your nose, and as you exhale push all the air out. Then, let the air come back in without any effort, automatically. Correct breathing for optimal health is like this; the belly rises a little with the inhale and falls with the exhale. Continue for five deep breaths. Now relax the breath and the hand, but continue to breathe in and out the belly as you do yoga. Try to make this type of breath a habit.

Yogic Tool*:* Alternate Nostril Breathing for Balance and Perspective

Use the thumb of your right hand to block your right nostril. Take a deep breath in through your left nostril. Now use the pinky of your right hand to block off the left nostril and exhale deeply through your right nostril. Repeat this cycle. Continue for five deep breaths. This opens you to new ways of thinking, and also calms down the constant working of the mind. This can be used before bed to help you fall asleep.

Consider this. "Yoga turns the mind into an ally." According to the book *Yoga as Medicine* by Timothy McCall, M.D., "Yoga is a technique that teaches you to stop your mind from working against you. Yoga turns the mind into an ally" (p. 51).

Yogic Tool: Observe Your Thoughts

Thoughts, like prayers, are powerful. By simply becoming aware of them, you initiate a process of change. It follows the law of science that everything that is observed changes. Therefore, you have the ability to change your thoughts and patterns of thinking that cause you suffering.

To begin, it is enough just to observe the workings of the mind. Notice thoughts without acting on them immediately. When this becomes second nature, a sense of control emerges. The choice is yours; when you notice a thought you can take the next moment to decide whether you want to act on it, or reflect on if it is actually true. There is also the option of consciously adding thoughts that you know make you feel healthy and happy. With the latter, you create new, healthy habits of the mind.

Take one minute now to close your eyes and just notice the thoughts in your mind. Do not judge yourself, and also do not engage in the stories. Just try to let them pass. Every time your mind wanders, bring it back to noticing your breath, or the stillness beyond the thoughts.

Yogic Tool: Movement

A profound yogic truth is that simple movement heals. According to Krucoff, "The ancient yogis realized a truth that modern medicine now confirms: Simple movement offers profound healing benefits" (p. 14).

Try some that are easy to repeat at home, at the office, or with someone who is experiencing pain. With yoga,

each person is different, so if something does not feel right for you, whether it is just today or always, do not do it, or if you can modify it in some way, do so. Yoga is about healing. Do not be aggressive or competitive. You want to be comfortably challenged. Also keep in mind that there are as many ways to do yoga as there are people, so if at first you do not find what works for you, keep looking.

If possible, it is ideal to close your eyes to lessen distractions and to breathe in and out through your nostrils. Try to keep all of your awareness or attention on the sensations of your body. All of the following exercises can be done in a chair or seated in a cross-legged position.

Head and Neck Warm-up: Neck Turns – Sit up straight. Turn the head to look over the left shoulder as you take a deep breath in. Exhale and turn the head to look over the right shoulder. Continue for ten breaths.

Ear to Shoulder – Inhale and tilt the head so the left ear comes toward the left shoulder. Exhale and tilt the head so the right ear comes toward the right shoulder. Continue for ten breaths.

Shoulder Rolls – Imagine your shoulders are moving with a clock. Bring them up to 12, back to 9, down to 6, and forward to 3. Continue using your inhale to come up and exhale on the second half, as you make big, smooth circles. Do ten in one direction. Then reverse and do ten in the other direction.

Spinal Flex – Place your hands on your thighs or, if done on the floor, sit in a cross-legged position and grasp your shins right above your ankles. Use the breath to coordinate the movement. As you inhale, tilt your pelvis forward and lift your chest, bringing it forward and the shoulders back a bit. Keep your head at a level position, so that it does not flip-flop. As you exhale, go the opposite way – tilt your pelvis back and collapse the chest and shoulders. Close your eyes and focus them at the root of your nose, *a.k.a.* the third eye center. Find a rhythm and pace that is right for you. Feel every sensation of your body. Continue this for three minutes. To end, take a deep breath in, straighten up the spine and hold the breath. Exhale slowly and take a few moments to notice how you feel with normal breath. This is for the health and flexibility of the spine. Master of Kundalini yoga – and my teacher – Yogi Bhajan said that if your body is flexible, then your mind will be flexible too. (This exercise is also featured in McGonigal's book, along with most books on Kundalini yoga.)

Standing Sun Salutations – Come to a standing position. Make the spine straight. Have the crown of the head reaching up toward the ceiling. Have the shoulders relaxed and down. As you take a deep breath in, bring your arms up with the palms facing up, first reaching out, then all the way up over your head, until the palms come together. Look up and fill up the chest, but do not let the head drop back. As you exhale, slowly bring the hands down into prayer pose (palms together), until they are in front of your heart touching your chest. Repeat. As you inhale, imagine you are connecting to the infinite energy and light all around you; and, as you exhale, bring that energy and light into your own being and heart. Continue for five deep breaths.

Yogic Tool: Meditation

Meditation is, in essence, an antidote to stress. Stress is in the mind, and yet it has a detrimental effect on the body. According to medical Dr. Dharma Singh Khalsa in his book *Meditation as Medicine*, "The central common element that all of these forms of meditations share is relaxation, with a suspension of thought, which causes the opposite physiological effect as the stress response" (p. 40).

Walking Meditation – The Buddhist scholar Thich Nhat Hanh offers a simple meditation for anyone, at nearly any time. It is called walking meditation. As you walk, whether it is going somewhere, or it is for the sake of the walk, simply bring all of your awareness to each step that you take. Notice each stamp that your foot makes on the earth. As your mind wanders away, simply bring it back to noticing how one foot moves, then the other. If you like, you can add the mantra "Sa Ta Na Ma". Think *Sa* with one step, *Ta* with the next, *Na* with the next and *Ma* with the next, and then begin again.

Meditation with Mantra – Using a mantra can be very helpful for some people attempting to meditate. As you sit on the floor or in a chair with your spine straight, close your eyes and rest your hands on your knees, or rest your hands on each other in your lap, or in *Gyan Mudra* position with the thumbs and index fingers touching. Silently repeat in your mind your mantra. Try one that reverberates with

you, that you actually feel good while saying or that brings you into a peaceful state. Following are a few examples:

- May I be well. May I be happy. May I be peaceful. (This is a loving-kindness meditation)
- Every day, in every way, I am better and better.
- I am, I am.

Or you can try counting. Inhale and think one, exhale and think two, inhale, three, exhale, four, and continue until you get to ten. Then start over with one.

If you are looking for inspiration, there are many mantras to choose from. Ask a yoga or meditation teacher, or go online and look around, or find a book, or come up with it yourself. Also, there are many places that offer group meditation practices to join in. Find a Buddhist temple or group, or yoga studio, or private group to enhance and support your practice.

Continue for ten minutes to start. Work your way up to longer periods if desired. You can also practice mantra work when you are doing mundane tasks like laundry or dishes or something similar.

Meditation into Being, or I am, I am Meditation – Use this mantra to increase your intuition by connecting your finite self to the infinite self. Simply sit in a meditative posture, on the floor in cross-legged position, or in a chair, with the right hand resting on the knee or thigh in *Gyan Mudra* (thumb and index finger touching). Place the left hand in front of your heart, palm facing you, about six inches out. Chant, "I am," then take a small inhale through the nose as you move your hand closer to you, then chant, "I am" again on the exhale. Move the hand back out and say, "I am," then bring it back in with the inhale and chant "I am" on the exhale again. Eyes can be closed or 1/10 open. Continue this for 3-11 minutes. When the mind hears "I am," it automatically begins to try and answer with all the identifications you have for yourself; but you can avoid this automatic response when you immediately say, "I am" in response. When you do the latter, the mind finds acceptance.

Do something every day – Yoga is meant to be done every day. Repetition forms connections which create and then support healthy habits of mind and body. Try and take one or more of these yogic tools offered above and implement them every day! It is also useful to note that yoga is slow medicine. It accumulates over time, and therefore patience is necessary to get the full benefits. Yoga is a form of self-care. It is free medicine without side effects.

What I have offered you in this article is the tip of the yogic iceberg. If this resonates with you, please use the tools offered. As you progress, you may find yourself wanting more. I have listed several books below to start you on your path, or you can find a weekly group class at a yoga studio or gym, or arrange for a yoga class to be given where you work or with a group of friends. There are also many videos. Check out *spiritvoyage.com* or *pranayama.com* to name a few.

Resources

Khalsa, D.S. & Stauth, C. (2001). *Meditation as medicine: Activate the power of your natural healing force.* New York: Simon &Schuster, Inc. (This book, along with *Yoga as Medicine* and *Yoga for Pain Relie*f, shows how new research with modern scientific methods is verifying the effects of yoga, which the ancient masters discovered through experience.)

Krucoff, C. (2010). *Healing yoga for neck and shoulder pain*. California: New Harbinger Publications, Inc. (Stress is commonly held in the neck and shoulders and this book targets that kind of pain.)

McCall, T. (2007). *Yoga as medicine: The yogic prescription for health and healing.* New York: Bantam Dell.

McGonigal, K. (2009) *Yoga for pain relief: Simple practices to calm your mind and heal your chronic pain.* California: New Harbinger Publications, Inc. (This book includes restorative yoga which is mostly a resting type of yoga. I would also recommend the series called *Freeing the Breath* as a basic, powerful set.)

About the Author

Leslie Brefeld *is a certified Kundalini yoga instructor who has been teaching since 2010. She can be found teaching weekly, drop-in classes at Integral Therapy Center in Roscoe, IL, where she also publishes a monthly newsletter. Find the current class schedule at* integraltherapyonline.com*. If you would like to arrange for a private or group yoga class at your office, home or at the Roscoe studio, schedule an appointment by contacting Leslie at* bluecircleyoga@yahoo.com *or at* facebook.com/bluecircle.yoga.

3322 N. Ashland Ave.
Chicago, IL 60657
773. 525. 3322

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