NEWSLETTER
WINTER 2015

Illinois Society for Clinical Social Work

President's Message

Eric Ornstein

The arrival of the New Year put me in a reflective, reminiscing mood. I realized that I am beginning my 10th year as a member of the Board of ISCSW. It has certainly been a satisfying and rewarding decade. Planning and facilitating major conferences with national speakers such as Allan Schore, Louis Cozolino, Jon Allen, and Laura Brown; making my own presentations at an Ethics conference, a Sunday Morning Seminar and a Supervision Series; writing an article on relational supervision for our *ISCSW Newsletter,* and leading the Jane Roiter Sunday Morning Seminar Committee are just a few of the experiences that have contributed tremendously to my personal and professional growth.

I find it impossible to quantify how much I have learned attending every single Sunday Morning Seminar since 2006. It has been incredibly meaningful and valuable to learn from my psychodynamic clinical heroes such as Irwin Hoffman, Frank Summers, Joseph Palombo, Barbara Berger and Jill Gardner, in such an intimate setting. Other giants in social work who have greatly influenced my clinical work through their presentations at the Seminars include Froma Walsh, Mathew Selekman, Anna Lieblich and Hylene Dublin.

I have thoroughly enjoyed attending more than a dozen Society Networking Events over the years. It has been especially exciting when I have had an opportunity to reconnect with old friends and colleagues at these ISCSW events, some of whom I had not seen in years. In recent years, the discussions at the networking events have included topics such as dealing with managed care, deciphering DSM-5, and understanding the Affordable Care Act; and they have been stimulating and moving for me, as members passionately shared their personal clinical experiences and feelings regarding these important topics.

Clearly, I have saved the best for last. Above all, I cherish the close relationships I have developed over the years with fellow Board members and Sunday Morning Seminar Committee members. These connections have nourished and sustained me on so many different levels.

In this regard, I want to single out my relationship with Ruth Sterlin, my predecessor as President, current Interim Vice President and long time editor of the *ISCSW Newsletter.* Ruth has been an inspirational figure, a wonderful mentor and a close personal friend to me. Her contribution to our Society as editor of our *Newsletter* for more than 10 years has been immeasurable. It has always struck me as an incredible accomplishment that a small organization such as ours could produce such a high quality publication with "cutting edge" articles and reviews for such a sustained period of time. Thank you, Ruth, for everything!

Turning my attention from the past decade to the present and future of our Society, there are a number of important developments that need to be highlighted. We have just completed a total re-imagining and redesign of our website, adding color and content to make it a truly inviting, engaging, and relevant Internet experience for our members. I want to acknowledge and sincerely thank Nikki Lively, Board Chair of Public Relations, for her creativity, hard work and tireless efforts, which made our new website a reality. Please visit the new website, and tell us what you think of it. "Like" us on Facebook if you have a chance!

We are over halfway through this year's round of the Jane Roiter Sunday Morning Seminar Series. We have already had three outstanding Seminars, two by top clinical social workers in Chicago: Georgia Jones presented on Mindfulness, and Anna Lieblich presented on Intimacy in the Therapeutic Relationship. In addition, a wonderful presentation was given by Frank Summers, a national figure, on "To Live in a Dream." All three seminars were fascinating and informative and had record attendance.

But wait, there's more! On March 8th, Irwin Hoffman, a world-renowned psychoanalyst, will present on "Sixteen Principles of Dialectical Constructivism Revisited". I hope that you will make every effort to attend this last Seminar. For more information see the seminar brochure on our website. You can still register for the last one online and pay with PayPal.

I hope that all of our members had a happy and enjoyable Holiday Season, which will lead to a productive and rewarding year ahead. I look forward to seeing you at ISCSW events throughout the year.

Chicago's Minimum Wage Ordinance and the Impact on Mental Health

Carolyn Morales

Poverty and mental health:
Many studies have documented the negative effects of poverty on the mental health of children[1] and adults[2]. Recent research focusing on the impact of a higher wage on a variety of health outcomes predicted that instances of depression and other mental health issues would greatly decrease following an increase of the minimum wage.[3]

What clinicians should know about Chicago's minimum wage ordinance:
For the first time, domestic workers, which include nannies, home healthcare workers, and cleaners, are entitled to receive the minimum wage.[4] *Every* adult working in the city of Chicago for at least two hours over a 2-week period at a workplace with at least 4 employees is entitled to the following minimum wage:[5]

Effective Date	Non-Tipped Employees	Tipped Employees
Current minimum wage	$8.25	$4.95
July 1, 2015	$10.00	$5.45
July 1, 2016	$10.50	$5.95
July 1, 2017	$11.00	Increase pegged to inflation
July 1, 2018	$12.00	Increase pegged to inflation
July 1, 2019	$13.00	Increase pegged to inflation
July 1, 2020	Increase pegged to inflation	Increase pegged to inflation

Who will benefit from the increased minimum wage?
Approximately 410,000 Chicagoans would benefit from the passage of the Chicago Minimum Wage Ordinance.[6] Nearly 31% of Chicago's workforce makes less than $13 per hour: two-thirds are over 25, two-thirds are African-American or Hispanic, and half are women.[7]

What if a worker is not paid the minimum wage?
If someone you know is not earning the proper minimum wage, contact the Illinois Department of Labor or a local worker center for further assistance.

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[2] Krieger, N., Kaddour, A., Koenen, K., Kosheleva, A., Chen, J. T., Waterman, P. D., & Barbeau, E. M. (2011). Occupational, social, and relationship hazards and psychological distress among low-income workers: Implications of the 'inverse hazard law'. *Journal of Epidemiology and Community Health*, *65*(3), 260-272.
[3] Bhatia, R. (2014, May 1). Health Impacts of Raising California's Minimum Wage. Retrieved January 10, 2015, from file:///Users/andrewwidmer/Downloads/SB935_HealthAnalysis.pdf.
[4] Marcotte, A. (2014, December 4). Chicago will raise its minimum wage to $13, and no longer exempt nannies. *Slate*. Retrieved January 10, 2015, from http://www.slate.com/blogs/xx_factor/2014/12/04/chicago_minimum_wage_vote_13_by_2019_including_for_domestic_workers.html.
[5] Chicago Minimum Wage Ordinance (2014, December 2). Retrieved January 10, 2015 from file:///Users/andrewwidmer/Downloads/O2014-9680%20(1).pdf.
[6] Chappell, B. (2014, December 2). Chicago Council Strongly Approves $13 Minimum Wage. *National Public Radio*. Retrieved January 10, 2015.
[7] Pawar, A. (2014, December 5). 47 *Ward Newsletter*. Retrieved January 8, 2015, from http://archive.constantcontact.com/fs115/1105372825263/archive/1119390148649.html.

ORIGINAL CLINICAL ARTICLE

Attunement in Adult Psychotherapy for New Clinicians and Beyond

Christina James

Introduction

I was asked by a colleague to present on the topic of "engagement of clients" to a class of first-year social work students in 2013. I thought back to when I was a new clinician and wanted to be told what to *say* or how to format a session with new clients, in order for them to trust me and to feel comfortable with me. And yet, as I've gained experience and become less nervous when meeting new clients, I've developed an understanding of engagement. When I'm attempting to be attuned to clients – being actively present in session, curious about clients, and demonstrating both verbally and non-verbally that I want to understand them – this is when I feel that I have engaged a client. Therefore, I decided to focus my presentation to the social work students on attunement. It was this presentation that led me to write this article. Although this article will focus on new clinicians' experiences of being attuned to their clients in psychotherapy, more experienced clinicians may find it helpful as well.

What is Attunement?

Attunement is rooted in attachment theory and is based on theories developed by John Bowlby, who studied children in orphanages as well as wild primate behavior; and Donald Winnicott, who observed mother-infant interactions in a clinical setting (Cozolino 2010). Attunement between caregiver and infant is crucial to healthy development. It's predictive of toddlers' ability to engage in self-control and later ability to put feelings into words (Cozolino 2010). Spiegel, Severino, & Morrison (2000, 26) note, "The self developing within mutual empathic attunement and the experience of repaired misattunement will develop with integrity and a reliable capacity to accurately read the interpersonal environment."

Stern (1985), a psychoanalytic theorist who observed interactions between mothers and their children, describes affect attunement as: 1) The "parent being able to 'read' the feeling-state from an infant's overt behavior, 2) That the parent's behavior in some way corresponds to the infant's behavior and 3) The infant is able to recognize that the parent's behavior is a response to the infant's own original feeling experience and is not just mimicry" (McCluskey, Roger, & Nash 1997, 1262-63). Further, per McCluskey, Roger, and Nash (1263), Stern summarizes attunement as involving "some form of matching, where what is being matched is the other person's emotional state and where the matching is cross-modal (*i.e.,* is not dependent upon using the same mode of verbal or non-verbal communication by both interactants)." I will be using Stern's descriptions of attunement as the foundation to describe the importance of attunement in adult psychotherapy.

Importance of Attunement in Adult Psychotherapy

Although attunement is most often discussed in terms of the relationship between an infant and mother, there is also research about the importance of attunement in psychotherapy with adults. A therapeutic

relationship in which the therapist is attuned to the client can be a corrective experience for a client who did not have an attuned caregiver during infancy/ childhood (Spiegel, Severino, & Morrison 2000). Recent attention has focused on how psychotherapy can have positive changes on the brain (Schore, Ogden, Siegel). In his book, *The Neuroscience of Psychotherapy: Healing the Social Brain,* (2010, 46), Louis Cozolino argues that, "*Empathic attunement* with the therapist provides the context of nurturance in which growth and development occur. By activating processes involved in secure attachment, empathic attunement likely creates an optimal biochemical environment for neural plasticity."

I have chosen to focus this article on the importance of attunement in psychotherapy with adults – as opposed to infants, children, or adolescents – because my own clinical experience currently focuses on psychotherapy with adults, and I think this topic is underexplored in clinical supervision. This article will describe three different aspects of attunement in adult psychotherapy: non-verbal, verbal, and "process" attunement (a new term I use in my practice); I will use research and case examples from my own clinical experience to illustrate these concepts.

I want first to make it very clear that while this article will present examples of non-verbal, verbal, and "process" attunement, the examples are not intended to be prescriptive or to imply that there is one "right" way to be attuned. Instead, the goal of the article is to explore specific categories of attunement in psychotherapy and to open up a discussion. Each therapist is different and no single behavior or strategy, such as voice intonation, exploratory questions, a comfortable and safe office-setting, etc., constitutes an attuned therapist. Equally if not more important is a continued desire to be an attuned therapist, demonstrating a spirit of curiosity and openness to discussing the client's experienced level of attunement in therapy. Further, because we are all human and have moments when we fail to attune to our clients, it is important to remember that a willingness and ability to notice attunement failures and repair them is just as important as being a "perfectly attuned therapist," which, of course, is an impossibility to begin with. In fact, if attunement ruptures occur and are discussed openly between therapist and client, it can strengthen the therapeutic relationship (Bruce, Manber, Shapiro, & Constantino 2010).

Please note that while the attunement process is an interaction between two people, I will be discussing the attunement process more from the perspective of the therapist's effort to attune to the client.

Non-Verbal Attunement

It may seem obvious to state, but in order for therapists to demonstrate attunement through both non-verbal and verbal communications, we must first be able to "'read' [our client's] feeling-state" (McCluskey, Roger, & Nash 1997, 1262). As a new clinician, it can be difficult to be fully present, aware, and curious about our clients' in-the-moment experience when we're wracked with self-doubt and anxiety about how the session "should" go. In my own experience, mindfulness has been hugely helpful with this, though it took me a long time and a lot of practice to be open to how mindfulness could be helpful to me. Here, I'm defining mindfulness as an intentional and focused awareness of the present moment; taking a non-judgmental stance; and accepting and acknowledging what is happening in the present moment. Mindfulness has been helpful to me in sessions in the following ways: being aware of my own internal state – emotions of anxiety, worry, etc. – while not being "overtaken" by these emotions, which then means I can be more aware of the present moment of the session; attempting to take a non-judgmental stance about how the session is "going;" when thoughts about the future or past come up – which, for me, often come up in the form of worrying about what to say next; and noticing this, and bringing my focus back to the present moment of the session. In this vein, I recommend the two following articles: 1) "Introducing Mindfulness as a Self-Care and Clinical Training Strategy for Beginning Social Work Stu-

dents," Gockle, Burton, James and Bryer (2012) and 2) "Psychotherapist Mindfulness and the Psychotherapy Process," Bruce, Manber, Shapiro, and Constantino (2010).

Non-verbal cues may include body posture; facial expressions; tone, volume and intonation of voice; hand gestures; physical proximity to clients; sounds (*e.g.*, sighs, throat-clearing), etc. Research has shown that non-verbal attunement can have positive effects on clients. For example, Håvås, Svartberg, and Ulvenes (2014, 1) found that therapists' "nonverbal matching of affect as well as nonverbal openness and regard for the patient's experiences predicted a decrease in ambivalent attachment style." Further, in "A Preliminary Study of the Role of Attunement in Adult Psychotherapy," McCluskey, Roger, and Nash (1997) found that experienced clinicians observing other therapists rated them as attuned when they matched clients' feeling states through tone of voice, facial expressions, and waiting to speak when clients appeared to be thinking, among other non-verbal behaviors. Conversely, experienced clinicians rated therapists as non-attuned if they appeared anxious, (*e.g.*, through fidgeting and appearing physically irritated), moved physically away from clients, used a tone of voice that closed off exploration, etc.

Clinical Example

A social worker I supervise, "Jessica," reports that her client "Mary" spends the majority of each session with her head down, making infrequent eye contact. However, in the moments when Mary does look up, her gaze is direct and fixed. In supervision we've discussed how it seems important to Mary to be observed, and for her "feeling state to be read" (Stern 1985), while not being asked to make eye contact herself. And when Mary is ready to make eye contact, Jessica is waiting and ready to meet Mary's gaze with a caring facial expression.

This example is in line with the attachment function of mutual gaze, which can increase positive affect in infants (Spiegel, Severino, & Morrison 2000). It is also in line with Stern's attunement definition of an infant wanting to know if the parent can read their feeling state and respond in a way that's a reflection of that feeling state; Jessica's ability to keep eye contact and give a caring facial expression likely indicates to Mary that what she [Mary] is feeling is important and valued.

Verbal attunement

As a supervisor of new clinicians – and from my own experience – I've noticed that new clinicians' anxiety often centers on what they should say in session or how to problem-solve with the client. I remember asking my own supervisor, "But if the client says [this] in session, what should I say back??" and then asking her to wait so I could write down what she said. This anxiety is understandable given how much weight we often give to verbal expression. However, as noted above, non-verbal cues are equally, if not more, important in the attunement process, as is "process" attunement, which I will discuss later. That said, it is clear that what we say in session matters and is an opportunity to show attunement to clients' feeling states. Moreover, it is important to be aware of what we choose to say *first* and how this can affect a client's experience of attunement in the moment, especially when the client is flooded with emotion. For example, how many of us have had the experience of venting to a loved one about being stressed or anxious, and the loved one's first response is to suggest a problem-solving strategy. This can leave us feeling even more frustrated and as if our loved one doesn't "get it." What we often need and want *first* in those moments is for our feeling state to be noticed – for the loved one to say in a caring manner, "That sounds stressful." *Then* we may be in a place to be able to problem-solve. Our clients' experiences of what we choose to say first are likely the same.

Again from McCluskey, Roger, and Nash's study

on attunement in psychotherapy, it was found that experienced clinicians rated therapists as attuned if they made statements "in the form of an idea or a feeling in the same general area [as the client] … which the client seems to be able to take up, build on or pursue" (1997, 1269). Conversely, experienced clinicians rated therapists as verbally non-attuned if they changed the subject, interrupted clients, or made comments that closed off exploration; *i.e.,* "[It's] all right, then?" (1997, 1269). Other ways to demonstrate verbal attunement may be to ask open-ended questions which demonstrate curiosity about clients' experiences, to encourage clients to clarify if it seems that we haven't "gotten" their feeling-state or intended meaning, and to be willing to bring up therapeutic ruptures. As noted above, in order for therapists to choose *what* to say to demonstrate that we've understood a client's feeling state, we need first to be attuned to what that feeling state is. The case example below illustrates my initial misreading of a client's feeling state, and my attempt to re-attune.

Clinical Example

"Marsha" recently had an unsuccessful dental procedure which altered her speech, though not to the point where her speech was unclear. Therefore, every time that Marsha appeared frustrated (*e.g.*, sighed, looked away, became teary) after having difficulty saying a particular word, both staff and clients in our program would respond by saying, "You're doing fine! We can understand you." Yet when we said this, Marsha continued to appear frustrated. Once I became conscious of the fact that our comments – which were an attempt to build her confidence – didn't seem to reduce her frustration, I tried to picture what it would be like if my speech had been altered as the client's was, and realized I would be terrified to hear my own voice in its altered state. Therefore, the next time Marsha appeared frustrated when speaking, I said to her, "I wonder if it's scary and confusing for you that your speech is different than it used to be." While Marsha did not answer either way, she held my eye contact instead of looking away, and did not appear as frustrated as with my previous attempts to assuage her.

The case example above, and other attuned verbal statements therapists make, serves to build clients' capacities to verbalize their feeling-states independently. As Cozolino explains, "A mother's ability to resonate with her infant's internal states and translate her feelings into words will eventually lead to the child's ability to associate feelings with words… This safe emotional background created by proper attunement, reciprocity, and loving kindness parallels an optimal educational and psychotherapeutic relationship" (Cozolino 2010, 181).

"Process" Attunement

The final type of attunement is something I've termed "process" attunement, and is more subtle than verbal or non-verbal attunement. Here, "process" is meant to describe the parts of psychotherapy that don't necessarily fit into the verbal or non-verbal categories, and are more of a reflection of the environmental aspects – or process – of therapy itself, which may or may not take place in-session. Examples may include the environment of the therapy setting (*e.g.*, office building, client's home, school, etc.); the more specific location (*e.g.*, therapist's office, group room, client's living room, etc.); client-therapist expectations about therapy appointments (*e.g.*, frequency of sessions, times, dates, cancellations, etc.); billing policies; client-therapist interactions between sessions (*e.g.*, phone calls, letters, etc.); and the therapist's supervision process in which the client is discussed, etc.

For example, the expectation that the therapist will

be available to meet each week may reflect that the therapist is attuned to the client's need for a consistent attachment figure; this may also be true when a therapist calls to check in with their client when they fail to show for their therapy appointment. Making sure that the therapy office feels safe, warm, and nurturing may demonstrate an understanding of a client's need to feel safe, cared for and respected. The therapist being willing to bring up billing issues in an open, caring way with a client who has reported anxiety about financial issues may reflect that the therapist is attuned to the client's state of anxiety. To connect these ideas back to Stern's definition of attunement, "process" attunement may reflect a caregiver's (therapist's) behavior corresponding to the infant's (client's) behavior and demonstrating that this is in response to the infant's (client's) original feeling experience. Below is a case example of "process mis-attunement," which my client and I were able to work through.

Clinical Example

> I was working with a client named "Kimberly" who had had multiple medical issues since childhood. She didn't come to one of our scheduled appointments because of an emergency medical appointment and had forgotten to call me to cancel. This event coincided with a recently-adopted departmental policy of charging a "no-show" fee if clients didn't call to cancel their appointment within 24 hours. In my anxiety about this new policy, I called and left Kimberly a message "warning" her that this bill would be coming. Soon after Kimberly got my message, she left me a message saying, in an irritated tone, that she would no longer be able to see me for therapy. I was hurt and confused, especially since we'd been seeing each other for therapy for years. Kimberly eventually agreed to come in to discuss this in person. She noted that when she got my message about the bill, she felt like I didn't care about her or the fact that she has medical issues, which had been a theme in her life. I encouraged her to share more about this experience and validated her reactions. I also shared my own perspective of wanting to "save" her from the shock of getting the bill. Clearly, both our department policy and my phone call did not validate Kimberly and were mis-attuned to her feeling states at the time, including vulnerability, helplessness, and sadness about her medical issues. Fortunately, we were able to work through this in-session and repair the mis-attunement.

These are more "hidden" examples of attunement or non-attunement. If therapists are aware of "process" attunement and make efforts to repair "process" mis-attunements, this can serve to build an empathic therapeutic relationship. The recognition of "process" attunement may be especially helpful for new clinicians, given their focus on wanting to know the "right" thing to say or do in a session in order to make clients feel comfortable and cared for. Because of this anxiety, new clinicians may be overlooking more subtle examples of how they've already demonstrated attunement towards their clients, or it may help them be aware of and explore "process" mis-attunements in supervision.

Conclusion

This article has sought to illustrate the importance of attunement in adult psychotherapy, based on research on attunement between caregivers and infants. Specifically, it outlined three different aspects of attunement in adult psychotherapy, namely, non-verbal, verbal, and "process" attunement, and how an attempt to create an attuned environment can have a corrective experience for individuals whose caregiving relationships in infancy may have been marked by mis-

attunement. The spirit in which a therapist treats their client with curiosity, empathy, and respect for their individuality is similar to the holding environment that Winnicott described (Cozolino 2010, 189) and one which can have lasting, positive impacts on clients.

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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 ***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.

The Cutting Edge...

Reviews of Recent Literature

Modifying resilience mechanisms in at -risk individuals: A controlled study of mindfulness training in marines preparing for deployment. Douglas C. Johnson *et.al*. (August 2014) *American Journal of Psychiatry,* 171(8), 844 – 853.

I am always looking for ways to convince my patients that meditation is as mainstream as any adjunctive technique for psychotherapy. This study should help me accomplish that. The control group consisted of 134 men who received the standard stress inoculation training. The other group of U.S. Marines went through mindfulness training as an addition to the usual marine program in stress inoculation. The course consisted of 20 hours a week for eight weeks. One of the hours was individual practice in meditation. The material was presented as a model of a way to increase resilience and deal with high stress situations. The marines were then asked (ordered?) to practice meditation for at least 30 minutes every day.

The marines were tested during and after exposure in the infantry immersion training facility. This facility is constructed to look exactly like a Middle Eastern village. The marines are exposed to close-quarter combat scenarios with the aid of foreign national role players, sensory stimuli (the realistic sounds and smells of combat) and military pyrotechnics. They experience three scenarios: a passive village patrol, a meeting with village leadership, and finally responding to a complex ambush.

This study has two advantages over civilian studies. First, I am certain that the compliance in a group of marines ordered to meditate as part of their training must have been very high; and, secondly, no civilian study could provide such a realistic stress inducing situation.

The investigators measured how quickly the heart rate and respiration of each marine responded to stress and how quickly they recovered from stress. They also looked at the changes in plasma levels of norepinephrine, an indicator of stress, and at the levels of neuropeptide Y, a neuromodulator that has several roles in the regulation of the stress response. They also gave a psychological test which measured the marine's subjective response to the experience of stress. Finally, they looked at the use of oxygen in the brain's anterior cingulate and in the right insula.

They found that both heart rates and breathing responded more quickly and recovered more quickly in the marines who had practiced meditation than in the marines in the control group. There were no significant changes in the plasma level of norepinephrine in either group; but the meditation group showed far less increase in plasma levels of neuropeptide Y in response to this stressful situation.

The meditation group also showed less activation of the right insula and the anterior cingulate in response to stress when they were performing a task of recognizing facial expressions. This suggests that the brains of the meditators did not have to work as hard to deal with the stress as the controls. The investigators also found that those who meditated showed less activation of the right insula and anterior cingulate and reported that they experienced less stress in the situation.

This study clearly shows us that eight weeks of meditation training helped the marines, allowing them to deal with stress in a healthier manner.

Geoffrey Magnus, Former ISCSW Board Member

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.*

Reflections on Sexual Orientation*

Introduction

I am a forty-six year old white woman. I am well dressed, have a 1.5 karat diamond ring on my left index finger, and live in a four-bedroom home in the wealthy, conservative Christian town of Wheaton, Illinois. According to Lum (2011), the descriptions I have provided are *external intersections* or characteristics of a person that we can observe. A person does not have to know me well in order to identify a few of my external intersections. Lum also explains that an individual has *internal intersections* which must be "shared, discovered, and appreciated" (155). By getting to know me, one may discover that I am a heterosexual woman who is happily married for the second time, with a daughter and two stepsons. In addition, I am an only child who was raised by a single mom on the north side of Chicago. How I identity myself and how others perceive me is determined by the complex mix of external and internal intersections. Through reflection on my various intersections, I am becoming more aware of what they mean to me. I will share some of my reflections on the internal intersection of sexual orientation, and then expound on what this means to me as a social worker for my clients.

My Sexual Orientation

I am a heterosexual woman, and society assumes this because I have an engagement ring and a wedding band on my left index finger; however, not every woman who wears a wedding ring on her left index finger is heterosexual. The assumption that I am a heterosexual woman is made by society because heterosexuality is celebrated and accepted in our society, while being gay or lesbian often carries a sense of shame. Even though homosexuality is becoming more accepted in our society, it continues to be stigmatized (Coleman 1982). Furthermore, because I am heterosexual, I have never been rejected or discriminated against because of my sexual orientation. As a heterosexual, my development and experiences may be different than someone who is lesbian or gay, and I have privileges that someone in the sexual minority may not have. Reflecting on my development and experiences as a heterosexual adolescent and adult has helped me become more sensitive to and concerned about the experiences of the LGBTQ community.

Adulthood. There are numerous policies in place in the United States that adversely affect the LGBTQ community when it comes to the right of marrying someone of the same sex. My heterosexual marriage is recognized as a legal contract in every state of the United States; therefore, I can move with my husband to any state we choose, and our marriage will be rec-

ognized as legal. This is not true for same-sex couples. The Defense of Marriage Act (DOMA) was passed by Congress in 1996 and signed into law by President Bill Clinton (Government Track 2013), and as a result, individual states are not required to recognize the legality of same-sex marriages that were performed legally in another state (Barusch 2013).

If I were a lesbian who was legally married to another woman in the state of Illinois and dreamed of retiring to Texas with my wife, our marriage would not be protected under Texas law. By fulfilling our retirement dream of moving to Texas, we would no longer be legally married, as the state of Texas currently prohibits same-sex marriage, and DOMA does not require Texas to recognize our legal marriage from the state of Illinois. As a same-sex couple, we would have to contemplate what this would mean for us in the state of Texas. Some disadvantages of not being married that we would have to consider include dependent benefits such as health insurance and life insurance, decision making rights when a partner becomes seriously ill, and the possibility of losing a partner's assets to a family member due to the death of a partner (Zastrow & Kirst-Ashman 2013).

My husband and I do not have to worry about any of these matters now or during our retirement. I am eligible to receive healthcare benefits on his employer sponsored plan. I can legally make decisions for him if he were incapacitated due to injury or illness; and if he were to die, I would legally receive his assets. I have taken these heterosexual privileges for granted. I do not worry about them, nor do I think about these legalities as factors when considering my retirement. The only thing I am thinking about when it comes to retirement is being in warm weather with my husband whom I love dearly. I am not worried about any legal issues related to our marriage because we have privileges that same-sex couples do not.

Adolescence. Throughout grammar school and high school I was attracted to boys, kissed a boy for the first time when I was 14 years old, and dated boys in high school. Discovering my attraction to boys was straightforward and uncomplicated because my behavior and sexual orientation were accepted by my family, peers, teachers, coaches, and community. LGBTQ youth may go through the process of discovering their sexual identity differently. The realization of being attracted to the same sex may cause LGBTQ youth to develop unfavorable perceptions of themselves because of the disapproving views toward homosexuality they are receiving from society (Coleman 1982). They may feel rejected and have difficulty accepting their same-sex orientation and may become depressed (Coleman 1982). The struggle and conflict an LGBTQ youth could experience during this discovery process is the complete opposite of my heterosexual discovery process, because LGBTQ youth may not be accepted by family, peers, teachers, and their community.

Adolescence is also a time of identity formation. During my adolescence, my identities included being an athlete, an honor student, and a daughter. Zastrow and Kirst-Ashman (2013) explain that LGBTQ youth not only have to deal with their identity development in general, but also their identity of being gay or lesbian in a world where being heterosexual is the dominant culture. As an adolescent, I strived to fit in and be accepted by my peers. I was constantly evaluating myself in terms of what style of clothes I wore, what I said, who I was friends with and who I was dating. An LGBTQ youth who feels disconnected from the dominant heterosexual culture may suffer from minority stress, which is conflict that occurs "between one's internal self and his or her expectations of society" (Craig, Austin, & Alessi 2012, 259). Society is expecting them to date people of the opposite sex which contradicts their feelings of being attracted to the same sex. As a result, youth who identify as gay or lesbian may experience anxiety and depression and have feelings of low self-worth (Craig *et al*. 2012). The complete opposite experience and feelings occurred for me. Dating during adolescence as a heterosexual teenage girl produced feelings of reassurance and happiness which improved my self-esteem. I was

not looked at with disdain by my peers. I was admired by my friends, because I had a boyfriend.

What does sexual orientation mean to me? According to the Human Rights Campaign, 92% of lesbian, gay, bisexual, and transgender (LGBT) youth hear derogatory messages about being LGBT (Growing up LGBT 2014). I cannot imagine how sad and isolated LGBTQ youth might feel if they are hearing insulting messages from their peers and friends. They may feel rejected and think of themselves as different from their typical peers (Coleman 1982).

I sensed being different growing up as I was a child whose parents were divorced and my father was not part of my life. I did not know anyone whose parents were divorced. I was made fun of by a few of my peers for not having a father. I felt empty and ashamed when I heard these unkind comments about not having a father, and wished I had a father so I could be like everyone else. Thankfully, my mother "showered" me with love and affection, which helped combat the hateful comments of my peers; however, LGBTQ youth may not have the support they need from their parents when they are experiencing being different from their peers, as they may also be experiencing rejection from their parents.

When I read a book, watch a movie, or read scholarly articles about LGBTQ youth being rejected, I think about how devastating this must be for them, especially when they are rejected by their mother and/or father. Reflecting on this sense of rejection, I think about my daughter, who is now 17 years old, who has been rejected by her father (my ex-husband). Her father remarried when she was 10 years old and has had three children with his second wife. My daughter began expressing that she believed her father did not love her as much as his other children, because there were many pictures of his other children in his home and only one of her. Furthermore, she felt as if he was not interested or supportive of her in school or in sports, as he never attended any school functions or any sporting events.

My daughter had a bedroom at her father's house which he gave to his other children. He then made her sleeping quarters in the storage room in the basement. This made her extremely angry, sad, isolated and unloved. He then explained that he no longer had room for her to have a bed in the basement storage room because he needed the space for storage. My daughter found the courage to tell her father that she did not feel like part of his family, that she did not want him to get rid of her bed in the storage room, and that if he took the bed away that she did not want to come to his house anymore. Even though she communicated her feelings and wishes, her father called her selfish and spoiled, and got rid of her bed in the basement storage room. As a result, she stopped visiting him. This led to her father's request of me to legally relinquish his parental rights of our daughter.

Watching her endure the pain of being rejected by her father was "heart wrenching". There were many emotions she experienced during this process. At times, she was so angry she could not speak about how she was feeling. She suppressed her emotions and as a result, my present husband and I were the recipients of my daughter's displaced anger. I also held her often while she cried about her father, and I cried with her and for her. She was able to get through this rejection because she had my support and the support of my husband, who adopted her when she was 15 years old. My daughter's experience has taught me how desperately she just wanted to be loved and accepted by her father, and about the capacity for resilience and strength a teenager can possess when faced with adversity.

What does this mean to me as a social worker? Understanding what it feels like to be different and having a daughter who has been rejected by a parent, I can empathize with my LGBTQ clients who are being rejected, and who may feel lonely or isolated. Being the mother of a child who has been rejected by a parent, and understanding the pain a child can experience due to the rejection, I must also be aware of the fact that transference and countertransference may

occur if I am counseling an LGBTQ youth who is being rejected by his parents.

Transference is a displaced reaction, such as unresolved feelings, wishes, or fears, which may be projected on to a counselor by a client (Hepworth, Rooney, Rooney, & Strom-Gottfried 2013). It is possible that as a social worker counseling an LGBTQ youth, I may remind my client of his mother who has rejected him because of his sexual orientation, and as a result, my client may become fearful of me disapproving of his sexual orientation. He may refrain from sharing his true self with me. It will be important to be aware of this so I can work on trust with my client, and getting him past these feelings of fear of disapproval in our treatment.

On the other hand, countertransference is the reaction of the counselor to the client, which can produce feelings, wishes, or anxieties (Hepworth *et al.* 2013). For example, if my client begins crying about being rejected by his father because of his sexual orientation, I may subconsciously begin thinking about my daughter being rejected by her father. These reactions may then interfere with my objectivity toward my client, and may cause me to become over-involved with the client because of countertransference. If this were to occur, it will be important that I reflect on this situation in order to react to my client thoughtfully instead of emotionally.

I must also educate myself on the culture of the LGBTQ community and how to work with LGBTQ youth and their parents who are non-accepting of their same-sex orientation in order to be an effective social worker. According to the Human Rights Campaign, 26% of LGBT youth identified that the number one stressor in their lives is not being accepted by their families (Growing up LGBT 2014). I must be aware that I may become angry with parents who are not accepting of their lesbian or gay child, and to reflect on these feelings as I may be subconsciously thinking of my daughter being rejected by her father.

Summary and Conclusion

Reflecting deeply has allowed me to become more self-aware of what various parts of my identity, such as sexual orientation, mean to me and apply these meanings to my profession as a social worker. It is important that I continue to reflect in order to achieve greater self-awareness, which in turn will help me grow as a person, and as a social worker. Reflecting on my sexual orientation has made me aware of privileges I have because I am heterosexual. My clients who identify as LGBTQ do not have the same freedoms as I do. Understanding this will help me empathize with my LGBTQ clients if they have been fired from their job because of their sexual orientation, or who are unable to adopt a child because of the policies that may be in place for same-sex couples. Furthermore, I will understand my LGBTQ clients' sense of rejection by a parent because my daughter has been rejected by her father. Learning through reflection has helped me understand the origin of my ideas, feelings, and meanings of sexual orientation. Continuous reflection on sexual orientation, along with other areas, such as race, religion and social class will lead to personal and professional growth. By understanding more about myself, I can be more thoughtful as a social worker with my clients.

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• Although the *ISCSW Newsletter* doesn't regularly publish anonymous articles, we have chosen to respect this author's request that we not include her name. She is a second year student at Aurora University School of Social Work.

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ISCSW Launches a New and Improved Website!

As some of you know, at our last networking event we provided a sneak peek of our new logo and newly designed website. The website was just in the infancy of its development at that point, but after rounds of design with the help of designer Steven Shay – Creative Director at ICrossing – web developer Tony Kim at Tony Kim Design(http://www.tonykimdesign.com/), and numerous contributions from Nikki Lively's husband, and from the ISCSW Board, we are finally ready to go public!

Our main goal for the new website is to have a place for members to interact with the Society and with each other. The website features a new "members only" section where members are invited to post topics on our discussion board, to post job opportunities, and to get materials from past conferences and Sunday Morning Seminars. We have also started a blog! Our first blog entry was contributed by Geoff Magnus, former Board member and regular contributor to our ISCSW *Newsletter,* in which he outlines what he believes are "must-reads" for all clinical social workers, whether students or seasoned professionals. **Please be sure to read Geoff's post and let us know what books you might add!**

We welcome other members to contribute blog posts on topics related to issues in our field. If you are interested in contributing a blog post, please contact Nikki Lively at nlively@family-institute.org). We also invite members to interact with blog authors by offering their comments online.

Elsewhere on the website are support resources featured to help professionals with their own self-care, as well as a variety of other resources for students and new professionals. We are in the process of creating a list of clinical social workers who specialize in providing psychotherapy to therapists. We all know that therapists need therapy too, and we hope compiling this list and having it available on our website will ease the burden of the search! If you would like to add your name to this list, or if you would like to recommend someone for this list, you can use our new website forms to contact us.

Our URL will remain the same, so you can still find us at: http://www.ilclinicalsw.com/

We hope the website will enhance your membership experience, and that you love the new site as much as we do!

Nikki Lively, Public Relations Chair

Two More Members Join Our Board

Cheryl Neuman Meltzer, Member-at-Large

Cheryl Neuman Meltzer is a licensed clinical social worker who has been practicing for 19 years. She received her M.S.W. from Loyola University School of Social Work in 1995 and has been working for the past 14 years at The Village of Niles Family Services Department doing therapy with children, adolescents, adults and families. In addition, she collaborates with police, fire, and other village departments to provide solid clinical social work services to the community through crisis evaluations and interventions, as well as mental health training to non-mental health professionals. Cheryl is the coordinator of the Student Internship Program at Niles Family Services and loves being a mentor to new professionals in the field. For many years she organized the professional development and training at Niles Family Services.

Cheryl's past work experience also includes working at Turning Point Behavioral Healthcare Center in Skokie, and at Pillars in Summit, Illinois. She has a particular interest in psychodynamic practice and has received a Certificate in Advanced Psychodynamic Practice from the University of Chicago's School of Social Service Administration. She is currently in the trauma consultation group at Womencare Counseling Center.

As a Member-at-Large, Cheryl looks forward to educating and reaching out to members through networking. She also has a particular interest in helping to plan conferences and educational events. Welcome, Cheryl!

Carolyn Morales, Membership Chair

Carolyn earned her M.S.W. from the University of Chicago's School of Social Service Administration with an emphasis on group therapy and community organizing. Currently, Carolyn works as the Workplace Justice Campaigns Organizer at Arise Chicago where she helps low-wage workers across Chicagoland to recover stolen wages and address workplace concerns.

Prior to starting at Arise Chicago, Carolyn worked in social service agencies that supported immigrant survivors of interpersonal violence, human trafficking, and torture. Carolyn's professional interests include narrative therapy, anti-oppressive social work, and community organizing. She holds a dual B.A. in art history and sociology/anthropology from Carleton College and is fluent in both Spanish and English. Welcome, Carolyn!

Save the Date!

Jane Roiter Sunday Morning Seminars

On March 8, 2015
"Sixteen Principles of Dialectical Constructivism Revisited:
From 2000 to 2014: The Impact of Raised Political Consciousness"
Presented by Irwin Hoffman, Ph.D.

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