Illinois Society for Clinical Social Work

Newsletter

Development through research, advocacy, education, affiliation and action.

Save the Date:

Sunday Morning Seminar **(online)**

Register: iscsw.simpletix.com

Tara Powell, PhD, LCSW — Sept 19

Burnout and the Brain:
Evidence-Based Strategies Heal the Tired Brain during Protracted Crises

Fall Conference on Ethics and Cultural Competence **(online)**

October 15 and October 22

Learn More & Register:

see pages 10-11

Reflections

Original Clinical Article

Book Review

Announcements

President's Message

Kristy Arditti

We hope you have enjoyed the beauty of summer and the ease of spending time with family and friends outdoors. At ISCSW, we have hosted an array of stimulating speakers in our spring Jane Roiter Sunday Morning Seminar Series and are preparing for our fall conferences.

On May 16, Lynn McIntyre, PhD, LCSW, a faculty member at the Institute for Clinical Social Work, provided a timely and thought-provoking seminar entitled *"Integrating Thought and Action: Social Justice in Our Practice."* This workshop explored how psychological, sociological, and economic factors in our culture shape both our personal and professional worlds. Case illustrations along with several recommended readings were offered, including *Caste: The Origins of Our Discontents* by Isabel Wilkerson, as well as *Constructing the Self, Constructing America* by Philip Cushman.

On June 27th, we had the pleasure of hosting Terry Northcut, PhD, LCSW, a Professor of Social Work at Loyola University Chicago. Her seminar, *"Bridging Psychodynamic and Cognitive Behavioral Therapy"* explored how, by understanding the strengths and vulnerabilities of each of these major theoretical concepts, we can enhance their use in clinical environments. She provided clinical illustrations that sparked lively discussion and prompted wonderful questions.

This month, we look forward to another highly topical new Sunday Seminar presented on September 19 by Tara Powell, PhD, MSW, entitled *"Burnout and the Brain: Evidence-Based Strategies Heal the Tired Brain during Protracted Crises."* Dr. Powell is an associate professor at the University of Illinois Urbana-Champaign School of Social Work, and has extensive expertise relevant to the times we are living through on the subject of mental health impacts of collective trauma such as wars, natural disasters, and pandemics.

We are now preparing for our biennial Ethics and Cultural Competence conference, which this year will also incorporate the

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President's Message
(continued)

necessary sexual harassment training as a new, third workshop. The Fall Conference will take place online via Zoom, in half-day sections held across two consecutive Fridays.

The Ethics section of the Conference will take place on October 15 from 9AM–12PM. James Marley, PhD, an Associate Professor and Associate Dean for Academics at Loyola University Chicago School of Social Work, will be presenting. Dr. Marley frequently presents at local, national, and international conferences on social work ethics, broader professional ethical issues, and social work practice issues. He also serves as an expert witness in cases involving social work practice concerns, malpractice claims, and wrongful death allegations.

Also on October 15, Linda Freedman, PhD, LCSW, will provide a one-hour sexual harassment training from 1-2PM in fulfillment of the new Illinois licensure requirement. Linda is a faculty researcher at the Institute for Clinical Social Work, as well as a registered Licensed Social Work Continuing Education Sponsor in sexual harassment.

Our Conference's Cultural Competence section will take place on October 22nd from 9AM–12PM. Ida Roldán, PhD, LCSW, will be the presenter for this section. Dr. Roldán is the former Academic Dean and a current faculty member at the Institute for Clinical Social Work.

See pages 10-11 for more information on these presentations and how to register. We hope you will join us for these important events! I would like to extend a big thank you to Michelle Greene, our board Education Chair at ISCSW. Without her hard work, these wonderful presentations would not take place. Thank you, Michelle!

Finally, the ISCSW board is acutely aware that we are all living through a time of dramatic social change in our personal, political, and professional lives. We welcome the long overdue collective reckoning with sexual harassment, renewed awareness of boundary issues, and closer scrutiny of how unequal power dynamics can lead to abuses. In recognition of this cultural moment, we have decided that this issue of our Newsletter shall feature a re-printed Original Clinical Article entitled, *Sexual Feelings in Therapy* by Anna Lieblich, PhD, originally published by ISCSW in spring of 2010 (see page 7). We hope our readers will find value in this insightful and relevant piece, whether revisiting or discovering it for the first time.

As always, we welcome your thoughts and feedback here at ISCSW, so feel free to drop me a line at kristyarditti@gmail.com . We hope you enjoy the end of summer and hope to see you at our fall conferences and workshops.

Warmly,

Kristy Arditti

Kristy Arditti
President, ISCSW

kristyarditti@gmail.com

Reflections
on Caring for Our Clients and Ourselves during the Pandemic

Ginny Nikiforos, LCSW
Executive Director and Therapist,
Guiding Behavior Counseling, PLLC
ISCSW Board Member - Public Relations Chair

As I reflect on this last year and a half of the pandemic, the reality of the pain within this pandemic is certainly present. From increased political divisiveness, to ongoing uncertainty, to lost loved ones, this has been a year where truly all lives have felt pain and been impacted by COVID-19. This past year and a half have also brought some of the lowest lows I have personally experienced, and challenged me to provide more compassion to myself and others even in the worst of pain.

I am also surprised by what else shows up when I reflect on the year and a half of this pandemic. Tremendous connection and appreciation are more present than at other times within my life in the midst of this pain. I feel truly more connected to my clients, their pain and joy, and more connected to my loved ones as well. This has been a year and a half of appreciation of health for my family, the ability to venture to my private practice full-time and the gratitude of discovering and connecting more to clients within my practice niche. I am appreciative that mental health services are more readily available through insurance and location, and services potentially are slightly less stigmatized than before the pandemic.

A saying I keep telling myself is, "*Connection, compassion, and appreciation are values, not an endpoint*." These values certainly fluctuate daily in terms of which feel present and which feel very far removed. However, I find comfort in knowing daily fluctuations do happen, that we are all on a journey while we are alive, and each day will bring new discoveries and appreciation if I can drop my agenda of control and of struggle, and allow the presence of my values to unfold.

Jenny Philipson, LCSW
Private Practitioner

I don't have to tell anyone that this past year and a half has been like living in a *Twilight Zone* episode. Without all the interpersonal contact. Everyone has been affected by the pandemic in unique ways, and as a therapist I would like to share with my colleagues by talking about what the work has been like and how it has changed.

On March 16, 2020, work life was yanked out of a comfort zone that had taken me 20 years to achieve. I have an office that is warm and welcoming, clients—many of whom I've worked with for years—and a routine that built a nice balance between work and leisure. After March 16, everything was turned upside down. Locked up inside my home, I had to pull together a makeshift work space with my couch and coffee table. Online therapy? What? I practically never use my computer for more than writing a letter. I still use a paper date book! "I can do this for two weeks, sure!" I said to myself. Was my patience ever going to be put to the test! Would we be reimbursed? Would every client be on board with technology? Would I crawl the walls being in my own company day in and day out? My cat seemed to be the only one happy with the "new norm."

At first, I was so thrown by technical glitches. The screen freezing, my clients and I seeing but not hearing each other, instant disconnects, seeing clients only from the chin up, and clients who would only talk by phone, were some of the numerous interruptions. I was very anxious that the work would suffer. If we were consumed by technical issues, how would we be able to interact in a meaningful way? But within weeks this uncertainty began to give way to a new kind of intimacy. The sense that we were all in a crisis together brought us closer in a way that I've never experienced. This was highlighted by the loosened boundaries of space and privacy.

At times it felt more burdensome, having to hold so many people's anxiety and depression

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while having to navigate my own struggles of living in a pandemic. Clients couldn't access many of the activities that helped soothe and/or invigorate them, and neither could I. My practice grew to numbers never seen before, for which I am grateful, but which comes at a cost, both emotional and practical. I have never had to turn so many people away. This felt awful, but I hit a point where I needed to do this in order to continue to be present for those I see.

I was privileged to speak with clients in their private environments. They were in their homes with pets, spouses, children, no makeup, pajamas (as was I). And there were many times that my own cat would make an appearance flying across the screen behind me. I joked with a few clients that I would need to run a video of him behind me on my wall in the office for continuity's sake. This was so unconventional, but special. I met family members I had heard about for years, got home tours, and was also privy to meltdowns of my clients' children and how my clients addressed them. I went on virtual camping trips, walks, drive-throughs with my clients at banks and coffee shops. And I even did therapy with clients in California and Wisconsin a couple of times. We were so much more flexible, and my cancellation rate was next to nothing.

And just as soon as this became comfortable, (who needs shoes?) we got the green light to do in-office sessions. Now, this is just as disruptive as the pandemic was in the beginning. Do I have anything to wear—that fits? Will we be safe? How many feet are there between my office chair and the couch? But how wonderful to have that energy back that one only gets by being in proximity to another human being! At the same time, many mixed feelings emerged. I won't have my kitchen and bathroom within feet of my work space. I can't take a quick TV break when I need to unwind. My cat will suffer from separation anxiety. (And so will I.)

But this has to be good. I have longed to be back in my office doing what I love to do and experiencing each client who brings their own routines and quirks to the office setting. Some always bring coffee or tea; one has a million scarves she has to put on before leaving my office in the winter. One comes straight from her gym with no time to change, and another has brought in her dog periodically since the day she found him on the street (he is seven).

I am thrilled to resume life in the wild, but it won't be the same. I need to adapt and integrate the new knowledge I have of each person and yet pull the boundaries back in. I have noticed that I feel oddly out of place in my office chair. I feel instantly drawn to the couch where I had grown comfortable at home. I had gotten used to an interesting combination of much more intimacy with my clients alongside that sense of safety behind a screen in the comfort of my own home.

Initially, I found myself feeling strangely nervous about meeting in person again, like I do when I meet a new client. There is a similar mixture of intimacy and professional distance in returning to the office. My clients and I are more immediate and physically close where we can see body language and hear each other better and without interruption. However, like putting on a suit after walking around in jeans and a T-shirt, there is a kind of pulling in, sitting up straight, and distance reinstated by the confines of the neutral office setting.

I will miss the feeling of being immersed in people's lives, but I believe we'll forever be more intimately linked for having managed to maintain our relationships through a life-threatening global pandemic. We now know that there are many ways to be therapeutic, and we don't need to cling so rigidly at times to conventional ways of knowing. Here's to yet a new "new norm."

Pam Katz, LCSW • Private Practitioner
ISCSW Board Member - Membership Chair

Throughout the pandemic, I experienced a number of shifts in my practice. One of the changes that stands out the most is my increased work with individuals with Body-Focused Repetitive Behaviors. Body-Focused Repetitive Behavior (BFRB) is a general term for a group of related disorders that includes hair pulling, skin picking, and nail-biting, affecting at least 5% of the population. These behaviors are not habits or tics; rather, they are complex disorders that cause people to repeatedly touch their hair and body in ways that result in physical damage. Common BFRB's include Trichotillomania (hair pulling from the scalp, eyelashes, eyebrows, and other parts of the body resulting in noticeable bald patches); Excoriation Disorder (skin picking or when people repetitively touch, rub, scratch, pick at, or dig into their skin, resulting in skin discoloration, scarring, and even severe tissue damage and disfigurement); and Onychophagia (people biting their nails past the nail bed and chewing on cuticles until they bleed, leading to soreness and infection). Other BFRB's include nail picking, lip/cheek biting, tongue

chewing, nose picking, and bruxism (teeth grinding).

Individuals with BFRB's tend to have recurrent episodes resulting in damage to their bodies. Individuals have often made repeated attempts to stop the behavior, and the BFRB itself causes clinically significant distress or impairment in social, educational, work and other important areas of functioning. BFRB's can occur when a person experiences feelings such as anxiety, fear, excitement, or boredom. It is important to note that BFRB's are not to be confused with a nervous habit, a sign of underlying trauma, Obsessive Compulsive Disorder, non-suicidal self-injurious behavior, or Autism Spectrum Disorder.

During the pandemic, remote working environments, limited interactions with others, and greater stress increased the use of BFRB's as a coping skill. There have been a lot of barriers to treatment for individuals with BFRB's. To date, there are 307 BFRB specialists in the United States listed on the TLC Foundation for Body-Focused Repetitive Behaviors website. When 5% of the population struggles with BFRB's, having few specialists limits access to treatment for many. As a BFRB specialist, during the pandemic there has been an increase in the request for services, as telehealth has allowed more people to access services. Access to remote services has allowed people from all over the state of Illinois to contact therapists like myself to begin treatment. Additionally, I have been able to collaborate with other specialists to provide training and collaborations to support clinicians interested in working with this population. It has truly been humbling to see how the pandemic has opened doors for the BFRB population to access help.

Kevin Miller, PhD Candidate
Loyola University School of Social Work
ISCSW Boad Member - Legislative Chair

We have been surrounded by terrifying events during the past eighteen months, including the COVID-19 pandemic, continued racist police violence, and an attempted coup of the U.S. government. I have had sick family members and a sister working on the frontlines as a nurse in the intensive care unit in a hospital, who described her workplace as a "war zone." During the deadliest period of the pandemic, her hospital severely lacked basic medical equipment, like masks, having to intubate patients with nothing but a piece of paper protecting her face. I have also been frightened for the youth and their families I work with in Chicago, many of whom are also working on the frontlines. Many young people enrolled in the after-school program I direct were being forced to work, without hazard pay, hand sanitizer, or masks at grocery chains and restaurants. I am facilitating my after-school program virtually, but find myself overwhelmed trying to balance life as a social work doctoral student during a pandemic. I am reflecting on the notion of structural violence and violence through social policy, feeling infuriated that Donald Trump called COVID-19 a hoax for so long and by Democratic policymakers proposing such conservative aid packages, compared to our international neighbors.

Working as the Director of the Empowering Counseling Program (ECP) on the south and west sides of Chicago, I witness the devastating impact that inhumane social policy has on people. Our clinical work intentionally intersects with policy and politics because focusing solely on "clinical" work, without considering the political climate that we are working within, limits the effectiveness of services we provide. In addition to individual counseling services, the ECP provides free supportive after school and summer social services for marginalized youth of color, responding to structural oppressions by engaging youth and community members in participatory action programming and research to build resistance and resilience against marginalization. In response to the pandemic, the ECP re-designed programming to respond to and mitigate the disproportionately toxic impact of COVID-19 for marginalized Black and Latinx communities. During the summer of 2020, we virtually engaged forty-six youth in creating and administering a COVID-19 community needs assessment of 346 citizens' experiences and needs. The youth presented their findings in a community forum, attended by community leaders and policymakers with the aim of impacting policy.

There are social and political forces that shape how we engage clients in services and impact how our clients receive those services. But our clients are not the only ones affected by policy and politics; everyone, as human beings are living in the political arena, is whether we acknowledge it or not. I often hear practitioners, even those who are politically active, use language that reinforces a perceived separation between us and our clients. For example, I am hearing social workers encourage others to "vote for your clients' sake." I do not disagree with this, but in the U.S., being able to be alive is in itself political. The pandemic brings it home: We cannot proceed as a profession apolitically. We need to move forward in solidarity with our clients. We have much more in common with them than we do with the elite political class of policy makers who are resigned to poverty as some unfixable problem, act as though massive deaths from the pandemic were unavoidable when they could have been prevented, close our public schools for profit, and starve our nation's children.

Violence through policy, like poverty, has many causes. The pandemic spreading as it has, also has many causes. These many causes can mean we have even more pathways to make a difference. The pandemic could teach us as social workers that we only undermine our mission if we hide in a bureaucratized version of our profession that does not take structural violence and violence through social policy seriously enough to make combatting it with clients a top priority.

Calling All Writers!

The Illinois Society for Clinical Social Work is looking for contributing writers! Regardless of your level of experience with writing, we believe that if you are a clinician in the field, you have something worthwhile to say... and our Newsletter is an excellent place to say it!

If writing a full Clinical Article is not your preference, we invite you to submit a review of a book or professional journal article, or to express your opinion on cultural competence issues.

We also plan to continue our **Reflections** column as a regular part of our ISCSW Newsletters, so members of our social work community can share thoughts about their work. These brief and informal essays can be related to the hardship of the pandemic, the transition back to in-person treatment, or any other issues relevant to our work. Many of our members have shared how much they appreciate hearing about colleagues' experiences. We welcome essays varying in length from two paragraphs to two pages. Short or long, we will always find them of interest.

In addition to the satisfaction of sharing your knowledge and opinions, you will have the opportunity to work with seasoned editors to facilitate your writing process, and to see your work featured in our striking new Newsletter design.

Please get in touch at **iscswcontact@gmail.com**
for more information about submitting your writing.

Advertisement

(reprinted)

Original Clinical Article

Sexual Feelings in Therapy

by Anna Lieblich, PhD, MSW

Editor's note: A version of this article first appeared in the Spring 2010 issue of this Newsletter. See *President's Message* on page 2 of *this* issue.

We go to the waiting room to greet our new client. The client looks up from a magazine, and we are struck by how physically attractive the client is. As the session progresses, we find ourselves sneaking glances at the client's hair, body, and clothing. We tell ourselves that we are being good observers; it cannot be that we are looking because this is a sexy person. When the client schedules another appointment we are delighted. The anticipation of seeing this client causes us excitement, and we are particularly careful in how we dress that day. We notice that the client has started dressing up, and is asking us personal questions, and we are answering. We feel a bit uncomfortable about what is going on, but we tell ourselves that we are providing a warm holding environment for the client. When the client comments on how attractive we look, we blush, laugh, and change the subject.

Therapists are unlikely to talk about their own or their clients' sexual feelings with supervisors or colleagues (Pope, *et. al.*, 1993), although feelings of attraction are common across mental health disciplines (Fisher, 2004). In 23 years as a supervisor and consultant, I have found that few topics confuse therapists more—even hatred. Therapists often feel embarrassed at their ineffectual responses to clients, and ashamed of their own feelings. Women therapists report losing their professional stance and responding to clients the way they would to men who flirt with them in other settings. Therapists are shocked that they enjoy being desired by a desirable client. Being in a helping profession, therapists feel anxious about deriving gratification from therapy, other than that of helping their clients. Sexual gratification seems especially inappropriate.

Professional education emphasizes the prohibition against therapists acting on their sexual feelings, and rightly so. What we recognize as boundary violations were frequent at the beginning of psychoanalysis. Apparently therapists were not anticipating the intensity of feelings stirred up by treatment, and did not realize at first the harm having sex with patients would do. The prohibition against having sex with clients is clearly in everyone's best interests.

But the prohibition against *acting* on sexual feelings has become a prohibition against the *feelings themselves*. Therapists are taught to contain and squelch these feelings from clients, as though the feelings are too wrong or dangerous to allow in the room, and their own feelings are seen as suspect and not addressed. As we will see, this approach can have negative consequences.

What We Have Been Taught to Do When Clients Express Sexual Attraction

First, what do we mean by "expression of sexual feelings"? Sometimes clients express sexual interest directly: "I'm very attracted to you," or "I picture us in bed together." Often, clients show their sexual attraction indirectly, by dressing up, joking, looking at the therapist's body, asking personal questions, or by being withdrawn, canceling appointments, or ending therapy. Typically, we have been taught *containment* responses (American Psychological Association, 2000):

- Normalizing.
- Setting a firm boundary.
- Interpretation early in the conversation: "*You're really longing for your father's affection*," or "*It seems you're angry at me.*"
- Being 'realistic': "*You don't really know me*," or "*Therapy can't work if we have a social relationship.*"
- Redirection: "*Can you try being this affectionate with your girlfriend?*" or "*We're here to talk about your depression.*"

Why These Responses Are Inadequate

It *is* necessary for therapists to keep clients safe, so clear and unambiguous boundaries are essential, and normalizing can reduce shame. However, limiting or disconfirming the client's expression of feelings can make the client feel crazy, defective, or ashamed; this is especially true if the therapist is *participating* in roman-

tic or sexual feelings. Logical arguments against crossing boundaries do not connect with clients' underlying needs and struggles. Since sexual feelings are often connected to core issues, therapist discomfort with these feelings can injure clients where they feel most vulnerable. Feelings that are not addressed do not go away, and they can distort or end therapy. In addition, when the client reports sexual feelings about the therapist, the feelings are occurring in the context of the therapist-client relationship. Keeping the focus initially on what is happening in the room increases emotional immediacy, gives the therapist important information, and encourages the therapist to examine his or her own feelings and behavior. The therapist can then use the emergence and pattern of these feelings in the therapy to understand and treat client core issues in their lives.

Understanding Sexual Feelings in Therapy

There are many possible reasons for clients or therapists to feel or express sexual attraction. An important factor is the nature of therapy itself. Some clients and therapists will naturally be attracted to each other, and therapy can accentuate this attraction. **Individual** therapy is an intimate experience, exclusive and private. Giving and receiving care are pair bonding behaviors that stimulate affection, love, and desire. Idealizing and being idealized also stimulate sexual attraction. **Couple** clients who lack intimacy in their relationship can turn to the therapist for affirmation and love (Harris & Harriger, 2009). The triadic structure of the therapy also contributes to the emergence of sexual feelings. In heterosexual and homosexual couples, competition between the clients to be the therapist's favorite can create a sexually charged atmosphere for clients and therapist.

Sexual feelings in therapy—of therapists and clients—also connect to core issues about self. Longings for love, affirmation, dependency, or security can be expressed through sexual feelings or wishes. Sexual feelings may be a defense against vulnerability, frustration, or anger in the therapy. Clients and therapists may settle for sexual excitement when deeper needs are not being met (Maroda, 2005). Therapists who have had sexual relationships with clients most often are not classical sexual predators; they are lonely and needy and believe they and the client are in love (Gabbard & Lester, 1995).

Therapist Gratification

Therapists should not derive gratification at the expense of their clients' well being and progress in therapy. Consequently, we need to be alert to the possibility that we are using a client to manage our own emotional needs. This does not mean, however, that we should not derive and enjoy deep gratifications from doing therapy and from the relationship with a particular client. Maroda points out that mutual gratification and enlivenment are inherent in successful therapy (2005). Sexual attraction, particularly when mutual, can contribute to feelings of affirmation and connection, enhancing growth for both client and therapist.

We can see that there are many different reasons for clients or therapists to have sexual feelings in therapy. Our focus needs to be on the meaning of the feelings for each participant and how their interactions are enhancing, inhibiting, or distorting the therapy.

Case Example:

A white female supervisee was treating a 45-year-old white married man. Treatment focused on his dissatisfaction with his career advancement. After several months he hesitantly revealed that he found the therapist very attractive, but felt hopeless about her ever feeling that way about him. Exploration of these feelings revealed his deep sense of being unwanted and unappreciated as a child.

Case Example:

A white lesbian therapist began treating a lesbian couple, one of whom, Pam, was white; and one, Dorothy, was Asian. All three were in their mid-thirties. Dorothy had had a lonely childhood, and her family was shocked when she came out. Her relationship with them was civil but distant. Pam came from a large family that accepted her sexuality without drama. The couple came to treatment because Dorothy felt ignored by Pam, and Pam felt smothered by Dorothy. The therapist, Joan, had recently ended a relationship. In the sessions, she responded with empathy to Dorothy's need for more attention, and after a while gave Dorothy her cell phone number. When Dorothy called her, Joan felt good about her ability to soothe Dorothy. Joan felt increasing sexual attraction to Dorothy. Joan and Dorothy became, in effect, the couple, leaving Pam out. Pam dropped out of therapy.

Therapist Self-Awareness

What we do not know *can* hurt us, and our clients, so we need to be aware of our feelings about the client and the therapy.

Therapist's Sexual Feelings for the Client

Sometimes therapists are aware of their feelings of sexual attraction towards a client. But often shame makes therapists ignore or avoid being aware. Consequently, we need to pay attention to clues that we may be attracted to a client (Pope, 1993):

- Giving a client special privileges.
- Using the client as a confidant.
- Obsessing or dreaming about the client.
- Being exclusively supportive of the client.
- Enjoying being more gratifying to the client than his or her partner is.
- In couple therapy, seeing the "favorite" alone unplanned, or keeping a secret with one.
- Being unusually withdrawn, drowsy, forgetting appointments.
- With colleagues and supervisors, never talking about the case, or talking about it over and over without clarity.

Feelings the therapist is unaware of are the most dangerous for the therapy. Any *unusual* thoughts, feelings, or behavior need to be understood. If we are at a low point in our own lives, we need to be particularly careful about how we relate with clients we find attractive.

Emotional Tone of the Therapist-Client Relationship

The overall emotional tone of the therapist-client relationship provides important information. The following are dimensions I find useful:

- Engaged / Disengaged
- Allied / Adversarial
- Vital / Stagnant
- Gratifying / Frustrating
- Placating / Challenging

For example, a client told me how attractive he thought I was and said he pictured us in bed together. My sense of the relationship was that it was stagnant and disengaged. This was a different experience than the mutual feelings of attraction in another case where the treatment felt engaged, allied, and vital. In the first case, we addressed how his frustration with me was stimulating his sexual feelings. In the second case, the feelings were not addressed explicitly, but contributed to a positive and effective relationship. We need to be aware of whether or not we are placating the client rather than engaging in a genuine mutual relationship; when therapists give in to client demands for affection, boundary violations can occur (Gabbard & Lester, 1995). If a therapist feels gratification—sexual or otherwise—in an adversarial or frustrating treatment, the therapist needs to look at this.

Therapist's Emotional Response to Client's Expression of Sexual Feelings

How we feel in response to client sexual feelings is also important. In addition to anxiety and shame, which are very common, here are some options I think about:

- Unaffected
- Sorry for the client
- Repelled
- Teased, seduced
- Angry
- Scared, intimidated
- Affectionate
- Gratified
- Aroused

A client told me how attractive I was, but it left me unaffected emotionally, although he was handsome. In considering why, I realized that this conversation was not arousing for me because he was not aroused. He turned to sexual conversation when he was injured. If the therapist feels intimidated, repelled, seduced, or angry when a client expresses sexual attraction, there is something occurring in the therapy that needs to be understood by the therapist.

Therapy Process

To integrate sexual feelings in therapy, we need to *open up* the topic, rather than avoid it. This means helping the client put his or her feelings into words while establishing a safe boundary. One option is to say, "You can depend on me to keep this relationship safe, so we can talk openly." We can then ask the details of the client's experience, as we would with any other client feeling. As we talk about what is happening in the therapy, we can begin to develop ideas about underlying issues. Therapists must be vigilant that their own issues are not being acted out, and that their behavior is neither overly frustrating nor overly

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Illinois Society for Clinical Social Work

Fall Conference on Ethics & Cultural Competence

Location and Format: Online Webinars (Zoom)

Due to the ongoing circulation of COVID-19 and its variants, we have made the difficult but necessary decision to hold this year's Conference remotely to fully ensure the safety of our attendees. We are eager to connect in-person again when it is completely safe to do so. Fortunately, meeting online means that this will be our most accessible Conference yet! We look forward to welcoming clinicians from all over Illinois. **The CEUs for this Conference will fulfill IDFPR's Ethics, Cultural Competency, and Sexual Harassment requirements for license renewal in the 2020-21 period.**

When:

Friday, October 15 9:00AM – 12:00 PM - ETHICS
1:00PM – 2:00 PM - SEXUAL HARASSMENT

AND

Friday, October 22 9:00AM – 12:00 PM - CULTURAL COMPETENCE

Pricing:

	Ethics (3 CEUs)	Sexual Harassment (1 CEU)	Cultural Competence (3 CEUs)	*Bundle: all three!*
Members	$50	$25	$50	*$90*
Non-Members	$60	$35	$60	*$130*
Students	$20	$15	$20	*$50*

Note on **Mandated Reporter Training:** ISCSW is aware of the new Illinois requirement for Mandated Reporter Training. Rather than charge extra for a fourth workshop on this topic, we are pleased to share that the Department of Child and Family Services (DCFS) has made available a free self guided, click-through online course which fulfills this requirement. The course may be accessed at: mr.dcfstraining.org

(Please note that we offer this link as a resource and a courtesy. ISCSW is not affiliated with this training and we are not able to answer questions about it. Contact DCFS directly with any queries: (866) 250-5494 or dcfssupport@cait.org)

Register Here: iscsw.simpletix.com

email iscswcontact@gmail.com with any questions

See next page for more information >

Friday, October 15 • MORNING SESSION

Ethics and the Online World of Social Work

This interactive ethics presentation will focus on maintaining rigorous ethical standards and appropriate boundaries while providing clinical social work services utilizing technology. While restrictions due to COVID-19 are changing, it is clear the integration of technology and clinical social work services is here to stay. The presentation will look at ways to use ethical frameworks in order to address some of the complex issues raised by the use of technology. Participants will gain a deeper understanding of the ethical implications of using technology to deliver clinical social work services, as well as proactive steps they can take to mitigate risks. Participants are asked to bring issues and examples of situations from their practice to help facilitate the discussion.

Friday, October 15 • AFTERNOON SESSION

Meaningful *Sexual Harassment* Prevention Training

Until *#MeToo*, sexual harassment training served as simply another box to check off to stay employed. Now mandated by Illinois for professional re-licensure, the program Dr. Freedman will present is an iteration of several that she developed for communities, schools, hospitals, and workplaces. Not only law, but finally a feature of everyday social discourse, this presentation adds depth to what is usually cut and dried: here is what to do, and here is what not do. The goal is clear—professionals must recognize and intervene to prevent sexual harassment. Not only that, but they should be role models and change agents in their professional and private lives.

Friday, October 22

Is It Possible to Achieve *Cultural Competence* in our Clinical Work?

Dr. Roldán suggests that it is impossible to be culturally competent because this end goal of competency can never be achieved. It may be more realistic to strive for cultural humility—not competence or sensitivity. This is a life-long process that is critical to our work. Dr. Roldán will discuss the dimensions to consider when we approach our clinical work with *cultural humility*. Participants will discuss the importance of the social, political, environmental contexts within which our clients become who they are; including how as therapists we often ignore how histories of colonization, political, societal, systemic racism, oppression, and discrimination intrapsychically affects the person in our consultation room. We will examine the theories that guide us in our understanding of the complexity of our clients' internal worlds that serve to perpetuate the stereotypes racialized persons live with every day, and examine how our positions of privilege affect how we may be unconsciously complicit in ignoring how colonization, political, social, and systemic racism are at the root of our clients' suffering and part of their internal worlds.

James Marley, PhD, ACSW, LCSW

Dr. Marley is Associate Professor and Associate Dean for Academics at Loyola University Chicago. His teaching and writing focus on people with serious mental health issues, the role of family in the treatment of serious mental health issues, family interventions, and professional ethics. He presents at local, national, and international conferences on issues related to ethics and mental health. Currently, he serves on the steering committee for a grant from DHS awarded to The McCain Institute/Arizona State University focused on targeted violence, domestic terrorism prevention, and building a national practitioner network. He is on the editorial board of the Clinical Social Work Journal, the inaugural chair of the Ethics Committee for ISPS-US, a member of the Society for Terrorism Research as well as the National Organization of Forensic Social Work, and frequently serves as an expert witness in cases involving social work misconduct, malpractice, and wrongful death. He received his BSW from the University of Illinois at Urbana-Champaign and his MSW and PhD from the University of Illinois at Chicago.

Linda Freedman, PhD, LCSW

Dr. Freedman began her social work career as an individual therapist, but soon moved into a marriage and family niche. Not content with small systems and armed with a PhD from the University of Illinois, she joined the Institute for Clinical Social Work faculty in 2001, first to teach statistics, then as a researcher and long-standing member of the Institutional Review Board. Her studies of assault on campus narrowed her research to sexual harassment. In 2006 she started the process of developing workplace training and continuing education in sexual harassment prevention, ultimately piloting an intervention for medical schools, some of which she presents in this program. She is currently working on the social work definition of sexual harassment.

Ida Roldán, PhD, LCSW

Ida Roldán, PhD, LCSW, is former Academic Dean at the Institute for Clinical Social Work in Chicago. She is a graduate of the Institute for Clinical Social Work and the National Training Program for Contemporary Psychoanalysis in New York. Ida is currently on faculty at the Institute for Clinical Social Work and a consultant for BUILD, a violence prevention organization in Chicago's Austin neighborhood. Dr. Roldán is Chair of the Board of the Kedzie Center, a community mental health agency in Chicago. She is active in professional and community organizations serving disenfranchised populations. Her area of interest is on how societal and institutional racism, oppression, and discrimination intrapsychically affect racialized populations.

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stimulating. Eventually we can relate the client's experience with the therapist to client issues in their lives. If either therapist or client cannot manage their attraction to the other, therapy needs to be terminated, which is painful and complicated, but the only ethical choice (Maroda, 2004).

Case Example:

Fifteen years ago, I saw a man in therapy I will call Aaron. He came to therapy because he felt demoralized and disengaged from his work and his marriage. (He repeatedly refused to go to couple therapy.) We worked on his negative sense of himself, and consequent problematic patterns in his life.

After about a year of therapy, he began to suggest that we meet at a bar for lunch, rather than at my office. I made clear that we could not and would not do that. He argued. I explained why therapy could not work that way, and that therapy was what he needed, and so on. He left a few months later.

Our focus in therapy appeared appropriate for his issues, but we did not talk in sufficient depth about our relationship. Aaron was witty and interesting. Although he was not my "type", I felt sexual energy in our connection. I looked forward to seeing him—twice a week—and he obviously enjoyed my reactions to him. We did discuss his finding me attractive and wanting to entertain me, but did not discuss the sequence of feelings and behavior between the two of us.

Looking back, I think that he did not feel my positive feelings for him; that should have been our focus. When he was successful in making me laugh, he felt a few moments of pleasure, but that did not produce a lasting change in his sense of himself. When he wanted to meet outside of the office, I should have asked him how that experience would be better for him. My thought now is that by meeting outside of the professional setting he would have felt some confirmation of my genuinely liking him and wanting a connection with him. We could have focused in the therapy relationship on how difficult it was for him to perceive and integrate another person's positive feelings for him. Instead, my inexperience, and my discomfort with feeling gratified and aroused, stopped me from using the therapy relationship to address his deepest needs.

Erotic Transference

Erotic transference is a long lasting, obsessive, consuming passion; typically, this phrase is applied to the client's feelings for the therapist, although erotic transference is an *interactional* phenomenon. It involves both therapist and client and does not continue without the therapist's participation (Maroda, 2004). Either avoiding or encouraging sexual feelings can stimulate and maintain an erotic transference. For treatment to continue and be therapeutic, what is happening between therapist and client needs to be addressed openly. The client's experience of the therapist's feelings needs to be understood, and the therapist's part in stimulating the client's feelings needs to be acknowledged. This conversation is fraught with peril for client and therapist; it is, of course, better to be self-aware enough not to participate in the development of an erotic transference in the first place.

Sexual Fantasies

We should not be afraid to ask about fantasies, but should be thoughtful about what purpose this conversation is serving for the client and therapist. Therapists must, of course, be careful not to encourage clients to describe scenes in detail just because the therapist is deriving erotic stimulation. For clients genuinely engaged in therapy who are anxious about their sexuality, it can be relieving and enlightening to describe what they are imagining. Fantasies also contain clues about what the client is unconsciously wishing for and defending against. We need to be aware also that sex talk by the client can serve a controlling or intimidating function. Once, after viewing her videotape of a therapy session, I advised the young female trainee to confront the client, because he was using sexual conversation to derive sadistic pleasure at her discomfort. This therapy was terminated. Encouraging descriptions of sexual fantasies about the therapist in couple therapy is also unwise, although it is essential to openly address what is happening if sexual energy is flowing between therapist and client(s), and not between the clients.

Case Example:

During a couple treatment, the wife (Susan) revealed that her husband (Bob) had started using aftershave before coming to the sessions. I asked Bob why he thought Susan had brought this up. He said, with embarrassment, that Susan thought he was attracted to me. This led to a conversation among the three of us about what he was wishing for from me, and what was missing in their relationship.

Self-Disclosure

Most clients do not ask directly, "Are you attracted to me?" But clients make themselves vulnerable when they reveal genuine feelings for the therapist, and they often look for a sense that their feelings are reciprocated. This presents the therapist with a complex problem: we need to behave ethically and maintain proper

boundaries, while also responding to the client. Our response needs to be therapeutic, and not seductive, placating, or rejecting. A further complication is that even using the client's first name can be seen as a boundary violation (Gutheil & Gabbard, 1993). We must take risk management seriously, and not endanger our clients or ourselves.

There is consensus in the field that therapists should never *volunteer* to clients their sexual feelings. There is not agreement, however, about whether or not it is *ever* appropriate to reveal feelings of attraction to a client (Fisher, 2004; Maroda, 2004). The safest response is a "middle ground" response (Fisher, p. 117), in which the therapist confirms warm and positive feelings for the client without any expression of sexual attraction. Often the client is looking for a sense of being accepted and cared about, so the middle ground response is on target. It is usually possible to find something positive in the connection with the client; if the therapist has a very negative feeling about the client, it is probably a good idea to talk about why. What if the client persists in asking if the therapist is attracted to the client, even after exploration of the reason for the question? It is important not to sidestep this question, especially if the therapist is, in fact, attracted. The response needs to be, "You are attractive", not "I am attracted to you" (Hilton, 1997, p. 192). The former is about the client, and the latter is about the therapist; our response to the question needs to be about the client's need, not ours. It is painful when the client correctly perceives that the therapist does not feel sexual attraction to him or her, but I believe it is better to engage the disappointment than to avoid discussing it. Documentation is crucial in these situations, as is getting consultation. Therapists need to be particularly careful about how and what they disclose to sexual trauma survivors (Gabbard & Lester, 1995) and clients with borderline personality disorder (Phillips, 2003).

Conclusion

Sexual feelings are common in psychotherapy. Being anxious and trying to avoid or prohibit them can distort or end therapy. Instead, we can see the emergence of sexual feelings in therapy as an opportunity to help our clients with deep issues. Our willingness to accept and explore our own feelings is crucial in this process.

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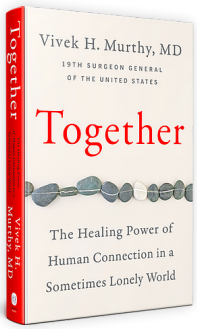
Anna Lieblich, PhD, LCSW, has been in private practice in Highland Park for 38 years. She has supervised and taught at The Family Institute at Northwestern University and the Institute for Juvenile Research. Ms. Lieblich has a PhD in Comparative Social Behavior from the University of Pennsylvania and an MSW from the University of Illinois at Chicago.

Book Review



Together: *The Healing Power of Human Connection in a Sometimes Lonely World*

by Vivek H. Murthy, MD (2020) - 289 pages

Reviewed by William Kinnaird

Selecting *Together* by Dr. Vivek Murthy, MD, for this Newsletter's book review seemed to be a good antidote to the last issue's review of *Why We're Polarized* by Ezra Klein. Not only is "the power of human connection" just fundamental in clinical social work, Murthy's book is also so timely because it comes during our era of socio-political fracture made worse by the world-wide pandemic.

So, for those who do not know of him, who is Vivek Murthy, MD? Appointed by President Obama, Dr. Murthy was the 19th Surgeon General. After serving just over two years, he was dismissed early in 2017 by President Trump. He was then reappointed as Surgeon General by President Biden. He is currently the 21st Surgeon General of the United States.

The experience of human disconnection and/or connection Dr. Murthy links to the feelings of loneliness, and the condition of loneliness is his focus. As he explains while citing current research, states of loneliness may be dangerous to one's health:

> *Loneliness is associated with greater risk of coronary heart disease, high blood pressure, stroke, dementia, depression, and anxiety. Studies were also suggesting that lonely people were more likely to have lower-quality sleep, more immune system dysfunction, more impulsive behavior, and impaired judgment.* (p.14)

Dr. Murthy notes that during his years of caring for patients, the most common condition he saw was loneliness. This observation may not be too surprising to a social work clinician.

He draws on his professional experience, wide travels, interviews with clinicians, many case examples, and a substantial body of research. His straightforward, personal writing style makes an enjoyable read. The case examples describe both people's successes and struggles, leaving the reader with the feeling that, "Hey, there are some good questions and answers here!"

Dr. Murthy begins by discussing the meaning of "loneliness." He explores intrapsychic and interpersonal conflicts people may have about their states of loneliness. A barrier to overcoming loneliness sometimes may be the stigma associated with it. He considers the role of loneliness in anxiety and depression and how these can evolve into vicious cycles.

Murthy traces how the experience of loneliness has developed in our highly social species. He considers neurological, physiological, social, and evolutionary aspects of the experience. He also describes some of the cross-cultural differences in the experience. One of these is a condition the Japanese call *takotsubo*, which names a state of such profound grief and loneliness that a person actually dies from it. Dr. Murthy considers socio-cultural conditions that help or hinder one's efforts to bond with others and feel a sense of communal belonging. These various conditions are illustrated by contrasting cultures that tend towards more individual expression with traditional collectivist cultures.

In this country, Dr. Murthy traces several trends beginning in the later third of the twentieth century that can exacerbate social isolation and the attendant experiences of loneliness. These include the rapid pace of technological change, effects of social media, virtual working, "car culture," the rich/poor social divide, the city/rural divide, racial and ethnic differences, geographic relocation, and, of course, political polarization.

The author shares examples of recovering and marginalized people who have found paths back from social disconnection to a sense of connection and belonging, and Dr. Murthy describes how some trends—social media—may be managed to facilitate connection.

Finally, Dr. Murthy explores family and developmental challenges to connect and belong across the life span, with examples of various approaches and programs developed to address these challenges. In sum, I found the book uplifting and encouraging. Dr. Murthy's broad and balanced discussion of human connection and loneliness can enrich a clinician's assessment and treatment perspective.

Meet Our Board

Treasurer

Anna Kaspark, LCSW, completed her MSW in 2014, and since then has spent most of her time working as a therapist in community-based mental health agencies and addiction treatment centers. Anna now works full-time for a private practice, and though the practice is based in Washington, DC, Anna is licensed in Illinois, Maryland, Michigan, and the District of Columbia, and provides teletherapy to patients who prefer virtual therapy due to comfort, health, or mobility issues, or who do not have access to mental health services near home. Anna specializes in depression, anxiety, addictions, trauma, low self-esteem, disordered eating, and a variety of other mental health concerns. She is new to the Chicago area as of 2020 and was excited to join the ISCSW in order to get to know the social work community in the greater Chicago area. Anna has shared that she feels honored to serve as Treasurer for the Board.

Secretary

Hillary Schoninger, LCSW, received her social work masters from Loyola University Chicago in 2010 and worked as a Crisis Therapist at Community Counseling Centers of Chicago before founding her own private psychotherapy practice, Water for Your Garden. In her practice, she incorporates yoga and mindfulness-based principles. She also has training in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy. Hillary believes in working with clients to develop and enhance healthy coping skills, recognize and redirect negative patterns, and cultivate acceptance and self-awareness in order to heal holistically. She currently serves on the ISCSW Board as Secretary.

Open Board Positions

This is a time of exciting transition for ISCSW. We are currently working on several new projects, and to that end, we are looking to add new board members who are interested in and excited about the mission and goals of our Society.

The Illinois Society for Clinical Social Work is a professional organization that advocates for the needs of social workers in direct practice settings and acts as a resource by promoting the professional development of our members through political action, advocacy, education and affiliation.

In the past, the ISCSW played a major role in the passage of the legislation that provides licensure for Clinical Social Workers in Illinois. Our organization also helped pass important amendments to mental health care laws, including third-party reimbursement, changes in the Juvenile Court Act, the Crime Victim's Compensation Act, the Mental Health and Disabilities Act, the Unified Code of Corrections, and the Adoption Act.

Participation on the board requires a social work background and academic degree, monthly attendance at our board meetings (see below) and the willingness to spend an additional 1-3 hours per month on work for our board. Benefits include networking opportunities, promotion of your own work/practice, board experience for your CV, and free attendance at our educational events.

If you would like to be a part of steering and shaping the organization through this new era of leadership and development, we are looking for new board members to fill the following positions, spanning a variety of interests and skill sets:

Student Liaison (to be filled by a social work student)

Cultural Competency

Newsletter Editor

Education

Ordinarily, the board meets on the third Tuesday of every month in the Lakeview neighborhood of Chicago (located convenient to the Belmont Red/Brown/Purple lines), from 7:30 to 9PM. During the COVID-19 outbreak, we have been conducting our meetings safely online via remote video conferencing. Either way, our meetings are both fun and productive. If you are interested in gaining board experience or have questions, please contact Kristy Arditti, ISCSW President, at **(773) 677-2180** or **kristyarditti@gmail.com**

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Illinois Society for Clinical Social Work

Board Members

A number of additional Board positions are currently vacant and open for application! See page 15 for details.

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