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NAADAC

Perspectives: Navigating Gender Differences

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>>: People are still coming in. Welcome to today's webinar. This is our first webinar in 2022. Happy new year. I hope that everyone is doing well. I hope that you are healthy and hanging in there. I hope you are good and happy to be here because I'm happy that you are here. We are starting with perspectives, navigating gender differences between counselor and client with Dr. Fred Dombrowski and Dr. Tara Matthews. Welcome. So happy to have you.

I am Jessica O'Brien, Director of Training and Professional Director here at NAADAC. In the facilitator for this training experience.

With me today, behind the scenes you see in the chat box is our training and professional development specialist, Allison White who will be addressing any issues or questions you have that are not specifically to our presenter.

You have a lot of support if you need us.

The homepage for the webinars is www.naadac.org and we have the whole lineup for 2022. Check those out and sign up for webinars and come back because we love you are here. We do have close captioning provided by caption access so you can check the chat box for the link to use closed captioning. Most of you are familiar with Zoom. This is a Zoom webinar and is a little different than a meeting.

The Q&A in the chat box, felt free to shut out with each other and ask us any comments or questions pick of you have questions for the presenters, or for us directly that you need a answer to, you can check that.

If you have a question, write it in the Q&A box and if it is for the presenters, we will get to them toward the end of the presentation when we do our Q&A. If it is for us, we will try to answer them as best we can. Lastly, there is a link to the handouts that Allison posted in the chat box as well. If you need a copy of today's slides meet can follow the link and download the PDF of that. Just a reminder that every webinar has its own webpage that has everything you need to know about that particular webinar. If you want to go take the online quiz, you will go back to the webpage and click on the

online link. That is the same website where you registered for this event.

Underneath the link isn't access to online quiz and certificate to online instruction guide. If you have not done this before, use the guide to guide you through the process to get your CE as there are screenshots and will guide you right through and be a seamless process.

So you know, if anyone is from Iowa, the Iowa Board of certification has approved this webinar for life participants only, which means that quiz must be completed within 24 hours in order for the number to appear on your certificate. If you want your certificate to say live on it and be accepted by the Iowa Board of Certification, make sure to take the quiz and download your certificate within 24 hours.

Social workers, any social workers out there? Stay with us at the end of this webinar as I will show you a two-minute video on how to enter your license number so it will show up on your certificates. More and more social work boards including mind requires a license number on the certificate and you just have to put it in so when you go to print the certificate, it will be on every single one.

Stay on at the end and I will show you that and we will give you a guide to guide you through the process.

Now, I want to introduce you to the presenters, Dr. Fred Dombrowski has worked since 1998 as a clinician in the field and has used evidence-based practices in bearing forms of treatment, CBT for gender dysphoria, personality disorders, substance use treatment and has experience as a supervisor and director for remarkable programs including inpatient and outpatient and forensic treatment because an educator, he is focused on experiential learning through perspective of cultural humility and an equitable approach. As a supervisor, he remains focused on improvement of clinical care through supervision dedicated to evidence-based practices.

Also with us, Dr. Tara Matthews is an educator, integrative health coach, clinical supervisor and therapist who works with clients who are living with co-reoccurring

disorders and seek to learn more about psychology.

She has facilitated groups and taught in higher education because she has provided supervision to undergraduate and graduate students and those seeking professional licensure and health coaching to colleagues. Her interest is group counseling, addictions, nutrition for mental health, self-care, on my supervision and making ethics fun to learn and practice. I am going to turn myself off and I will give control to Fred to take over the slides and disappear.

>>: Hello and thank you for attending today. We hope that we can have some fun together and that or a lot of people this may be some review, but we hope to enhance and support knowledge that you have and help to build bridges as many clinics, depending on the size of the clinic may not have a large clinician body and may have five women counselors or vice versa. There are ways to meet the needs of our clients when you consider special needs related.

Within that, I want to start off by thanking Dr. Tara Matthews for doing this with me. She is an absolute brilliant doctor, and we are publishing a textbook in this presentation came out of our textbook is to have our chapters. When a specifically about working with man and the other is working with women. As we are reviewing this chapters, we thought it would be fun to do a webinar, so we appreciate that, and I had an opportunity to meet Dr. Matthews with my work over at Purdue global so went to give a shout out.

Also, shout out to Patricia Chandler. We thank you for showing up today and hope that you have fun with us.

The objectives, we went to identify treatments between men and women. When I think about my best attempts to work with people from all genders, there has been times where I was doing my absolute best and I completely ruined it. I'm hoping to provide some ways to navigate that.

Also, we will identify barriers, experienced by counselors and if the preferred gender connection that the patient is requesting cannot be arranged.

We will identify strategies to overcome potential barriers and provide equitable treatment for all people that we serve.

This is our first poll, just a quick question, what percentage of substance use counselors are women? Feel free to respond to the poll.

>>: I will give about five more seconds to answer the poll and you can go ahead and click on that.

This is not just approved for social workers. Allison will put the link for all of the different bodies that approve us for CE.

>>: Absolutely. I am very happy many got the answer correctly 63%. Many clinics, there are very few men so I would have chosen 90%. In a perfect world it would be great to have 50% and 10%, some instances where within forensics where women were a lot less represented than men.

Going to our next slide, within the current demographics, there are about 68,000 substance use counselors in the US with 63% being women and 32.5% identifying as men. One thing we went to identify specifically is 21% of substance use counselors identify as LGBT, we don't know the exact number of specific trends or non-binary people that are within the profession. Some of the data that we have still not entirely complete.

Among those presenting, 66% identify as white and 14.5% or 14.5% is African-American and 11.6% is Hispanic and Latino. What I appreciate about the field of substance abuse women earned 100% of what men earn in this field. I will turn this over to Tara.

>>: What is interesting about that is that in my experience almost every clinic that I have worked at has a 50/50 split of men and women working together. Even if there was a small team, there may be two men and two women. It is a geographical issue in terms of where it is that you work or if hiring people are intentional about the gender of the people they are hiring.

When we jump in the research, we start to find there is a missing link. The idea that the gender of the client is often explored. Sexism, gender theories, the impact of gender on psychotherapy outcomes, the systems of power. When you dive into the research, you see that we are often focused on the client's gender that we seldom address the therapist gender and that is a piece of the relationship that is important, the therapeutic relationship. Avoiding the discussion of gender can also be damaging.

As Fred mentioned, there are limited research on trans counselors. I think this is a really important aspect that we need to start reflecting on when talking about cultural humility and when talking about meeting people where they are at, the self-reflection piece of I am a person in a piece of that therapeutic relationship is important to look at.

We will look at women clients. There are some unique experiences of women clients. Some of them include sexual childhood abuse, 58% of them. 90% with and him and partner violence, 29% meeting the criteria for posttraumatic stress disorder. You say men or more likely or women are more likely to seek treatment than men. What is interesting is when you Inc. about the therapist gender, which we will continue to explore throughout this presentation is depending on the intimate partner and depending on the perpetrator or the cause of the posttraumatic stress, there may be difficulty of a female client seeking treatment from a woman or seeking treatment from a man, the gender of the therapist will play a role in that.

We will look at some more statistics with women. A lot of times, women clients who seek treatment carry with them a lot of roles. These could be societal gender roles, cultural roles specific to women. They may be mothers, they may be single mothers, they may be lacking support in terms of financial or childcare. There is a huge cultural piece of how women see themselves in the world in relationship to others.

A lot of women place other people's needs before themselves whether children, spouses, family or what have you. Different societal expectations and norms. A lack of medical follow-up for those still using substances. A greater risk for intimate partner

violence. There is a lot of issues identified in research in terms of food insecurities and higher risk for HIV.

>>: Four aspects to enhance treatment, we cannot operate within a society. I get frustrated when I work with commissions who have private practice is they may not be conducting with others. The benefit of working at a clinic is he received the ongoing supervision and the ongoing support. When we think about aspects to enhance treatment, the case management aspect, when considering working with women who are mothers or trying to maintain or obtain rights and custody to their children, when we think about the difficulties with substance use and co-occurring disorders, the disconnection from services and things that are out there to enhance and support recovery, they are not connected with the individual and can set them up to fail.

Even with men as well. As we know, specific with research in regard to men and italics, men are more likely to die while on the job. We want to make sure the treatment planning is accurate. I am not going to lie as I always struggle as I was trained in the abstinence-model and having to be flexible enough to use harm reduction. Make sure we are connecting to whatever is important to the individual and get out of the way.

As they interagency progress, we don't want to work in isolation, but use all of the other sources available. Housing and transportation, to support clients in obtaining services and supporting women and children after treatment. When I was getting my certificate in substance use counseling a long time ago, it was difficult when I worked with women in the area I worked at because if they did not have access to children and they were living in a difficult environment, it was hard for them to regain their rights. Working in Connecticut, a couple people are from Connecticut and there are wonderful services that provide housing to women and their children that they are also re-unifying with.

>>: Although we identify a lot of these as issues specific to women, in my experience there were several men that I worked with that were single fathers because

their children's mother had died from an overdose, a variety of other reasons. They needed to be given the supports in terms of childcare, follow-up, transportation and all of that.

>>: I appreciate you identifying that. When we conceptualize the parenting role, many times I directly go to the mother's point of view, or I associate motherhood and children and that is the first thought and the father aspect of children is the second thought. That is something that I have to continue to assess within myself and that cultural aspect.

As we conceptualize this, we think about our own experiences have countertransference, I don't want to speak for others, but with my last name and raised traditionally Polish, and Polish families in the US, it is not an common for dads to work hard and come home and drink as much as they wanted. The responsibilities of raising children were left up to the mother.

Within that, if anyone has experience similar things to myself, I have found myself having harsh responses when working with mothers who would be struggling with substance use as it felt like we were choosing to use substances over connecting with their own kids. When we conceptualize substance use as an illness as opposed to a morality perspective, we see people struggling doing their best.

There are instances where we assess our countertransference and get out of our own way of the cultural expectations. With cultural expectations from fatherhood, father's being providers, also been defenders of families and instances where clinicians may get angry with the father if the children were victims of any violence or sexual assault. Within the power dynamic differential, in a perfect world we think about that therapeutic techniques and I love motivational interviewing and behavioral therapy because we try to have an equal and collaborative relationship.

As many clients are mandated, there is a power differential, so we have to report if the individuals adhere to treatment and be open in our reports about the analysis

findings. If there are instances where a client is ambivalent to change, we have to report that and help them within the change process.

I think about working at various clinics whether traditional outpatient, substance use and working at inpatient, there were always concerns of having to engage in urinalysis pick of the vast of clinics I had to provide urinalysis and it isn't comfortable, but it is what it is because there were few instances where some of the small clinics had one person at a time so we could not have any females be observed.

Also, within that, how do we observe urinalysis of someone who identifies as trans- and try to make an environment that is inclusive and supportable doing our job.

>>: I wanted to say one thing. I think this is a big piece because no matter your role in the vast roles with substance use treatment and whatever, outpatient and inpatient, there are so many rules and jobs out there. One of the first things we had to do was be part of that urinalysis experience. For some reason, that was the first thing that was assigned to me. You can go do they urinalysis and there was a line of people. Whether observed or unobserved, there is a line of people. It is very uncomfortable. There have been several instances where even I, as a woman, there are one or two female clients and their very uncomfortable being in this long line with all of these men and everyone's urine ends up in the same place. It is very uncomfortable. We need to be aware of how there may be different feelings by different clients about that experience and to be particularly mindful of that.

>>: Absolutely. Especially when working with individuals who experience severe trauma, by research for my doctorate was specifically about female sex offenders. When we conceptualize victims of sexual trauma, will you assume they have been victimized by men, that is not always the case.

Having to have an equitable approach where we connect with the individual with respect and compassion while still helping the individual be held accountable and be open about their substance use, even if they have assumed substance use, it is finding

that middle ground.

Other instances we may have, we will think about the instances and things the client has to lose. We will not think about this as a client. For my students, as I teach in a graduate program, there is a saying I like to say. I have worked at hospitals for so long and I use the word patient so please forgive me. I find myself saying patients are patients because they are patients as opposed to having a judgmental response to someone and doing what you can loose and caring about going to jail, as opposed to conceptualizing an individual and trying to assess that they are victim of some severe trauma. This has disconnected them from the most solid supports that they have. They are doing their best to manage life.

>>: We are not meeting people at their best.

>>: Going to the next slide, or the unique experiences of male clients, when you think about men have higher rates of suicide and completion. Women may attempt suicide and men will have higher suicide completion rates.

Cultural considerations with avoiding treatment, as my last name, for my experience working with men of Eastern European backgrounds, I try to talk with them about anxiety and they say I don't have anxiety. We have to work on the tight feeling in your chest and your palms being sweaty. In many instances, people we work with find counseling and being open as a challenge to masculinity. Differences in the conceptualization, I'm not trying to pick on anyone, but where I am from and Buffalo, New York, we have a holiday called dingoes day on Easter Monday. With the Polish tradition, there is the 40 days of Lent up until Easter and people went fast from alcohol. On that Easter Monday, that is when people drink. There is almost like the Polish version of St. Patrick's Day.

If I were to ask or do a quick survey of people who were celebrating that day, have you ever drunk more than intended or do you need more beers to get the same effect as when you started or do you continue to drink despite bad things happening? Many

people would meet the criteria for substance use disorder. Within the culture, it is not necessarily the same.

Less likely to enroll and complete higher education. Men are not engaging in education after high school at the rates that were happening, and we see more women entering and completing bachelors and graduate programs.

Men are more likely to be hurt on the job so men may take jobs such as police officers, plumbers or doing things with machinery. We see there is a loss of life as a hazard to the job.

>>: One of the resources that I love to do or use these tips. This is such a great one because we want to be reflective on the fact that we say women this and men that. There is some research to support these, but the most important piece and the biggest message we want to get through with our presentation is that you want to explore your own gender biases and be aware of your own gender and your own ideas about what gender means. You don't want to make assumptions that just because someone is telling with something, but to be curious and to be open and have those conversations.

I love the phrase lived experience because I don't know what it is like to be Fred and I cannot imagine. Not because he is male, but because he is spread. I want to know the lived experience to be Fred and to be open to that. We need to be mindful there are certain risk factors, there are certain unique issues of different genders and what they may deal with but being open to understanding what that is.

As we are given examples throughout, one of those is the idea that women struggle with childcare. In my clinical experience, the opposite was true that women had lost custody or if I was working with men, they are single fathers. Make no assumptions and be aware of how the client's own beliefs about gender and your beliefs about gender are pretty important in addressing all of those unique needs you will find in the therapeutic relationship.

Looking at countertransference, clinical supervision is a great way to do that, but

most importantly, having that conversation. We need to have that conversation. A lot of supervisors may be women and the men supervise these are seeking to gain credentials or licensure. That is a great dynamic to explore those issues that surface. The opposite could also be true. It could be a female therapist seeking clinical supervision and it is a male supervisor. Raising that issue, having the ability to re-examine and explore your own gender biases and refrain from stereotyping is really important.

>>: I appreciate we have to conceptualize the experience of the client within their gender and how they make sense. We conceptualize our own experiences. What does gender mean to us and what do gender expectations mean to us. As I have been a supervisor and director, there are instances where we identify as male, and I would work with people who identify as female and would be my supervisees working with male clients. They have instances where they fill a disconnect and worried about addressing this disconnect with me. Having to identify ways that we can find ways to connect and support the supervisee.

There was a quick question with regard to why men completed suicide at higher rates than women. Usually, you find that men use more lethal means of suicide such as guns or jumping off a buildings and women do complete suicide, but the ways in which they apply are not as lethal.

The experience of the male therapist in every place is different. What I loved about working with Tara is when we were talking about our own subjective experiences, everyplace I worked at, every clinic, there were only a few men. It drove me nuts because they would have an intercom system. I would be doing counseling with a patient and here I need a male staff for urinalysis.

I would then hear the second call and I would get a call directly of I need you to come down. When we have these instances as a counselor, I became resentful for being the only counselor. Within that, I don't think my job was not being purposeful in

the intent to hire, but there were several instances where they try to balance things out and they had a struggle of balancing it out.

We have to identify power and privilege. I think of my experiences as a male, and I haven't had instances where I am walking down the street and then cap called nor have I walked into a room and felt people were staring at me in a sexual way. Within this, within the male counselors, we don't fully conceptualize the aspects of the people we are working with. I also think about working with a woman who had a hysterectomy.

She talked about what it meant to her and was devastating to her. I had to get my own supervision. When she had her hysterectomy, she was postmenopausal, and my thought was she will not have kids without conceptualizing she lost a part of herself, and a part of her reproductive assets and it did not matter whether she would have part of her. I needed to get my own supervision to enhance my work specifically with women. When I think working with men, there is an expectation of what I think they should be doing. Trying to pull that out.

As I said before, from the male therapist perspective, I had instances where I was isolated from my coworkers and a little resentful. Transference risk. Just random times where I try to be nice to someone or I was thinking I was using the best clinical counseling skills and people would get angry with me because asking people that I notice you missed your group sessions, wondering how everything is going, the client may feel I am coming from a parenting role. Having to assess that and getting deeper to get out of my own way to take a different approach as coming off to the patient has tried to scold them or act like their father, particularly to them.

>>: That is a great point you made about the male therapist. It is true about the female therapist and that is why we need to self-reflect. We have these preconceived ideas about what men should be or what masculinity or femininity means. That is something you need to be aware of as sometimes we don't realize that. Using a simple example such as crying is one of them. This is cultural and gender related. It is one of

those things where it can carry so much shame or fear or make a person feel less than because it is happening, and they cannot control it or they resist doing it. That can be men or women clients, but as the therapist, depending on their experience, if a male is crying, they may have a very different experience than if it is a female therapist and their crying. That goes back to their own childhood experience with the men and women.

>>: When you described that, I remember being a new clinician and patients would cry and I thought am I supposed to hug them? I did not know what to do. I appreciate what you said you because from that, as a male, if I saw someone, I would fill the need to try to help.

>>: I love you share that because on the other hand, I do not feel that. In fact, I was taught when people cry, do not give them tissues. You can have tissues in the room, but you imply there shame about what it is that is happening. From early on it was a joke with my colleagues that I was the cry counselor. No matter how rough and tumble he they looked, they would cry with me because I had nothing to say about it. It was emotion leaking out.

And that is about exploring if you are a female therapist and exploring how that expectation of male or female behavior or reaction or dealing with emotions has been in your life to understand to meet the client where they are at. There are instances as a female therapist of clients becoming very possibly harassing or attracted or communicating attraction. I am sure that happens as a male therapist, I can only speak for myself.

You may be supervised by male counselors or have to supervise male counselors. Some people, due to their beliefs about gender may file female therapist would not understand them or may not be as effective simply because of their own experience with women in their lives.

This is probably one of our favorite slides, experiences from the field. We have been sharing a lot of different ones throughout all of the slides, but one of my favorite

examples was it was an intensive outpatient treatment group. I was running an all male intensive outpatient treatment for co- occurring disorders, outpatient group. We were talking about gender and talking about shame and love and have gone deep and was fantastic and therapeutic. One of the guys in the group said why aren't there any girls in this group. Why are there no women in this group?

I had to smile and think a lot about my response to this. The first thing I said was this is a male group. That is why. I am here. The truth is, as a therapist, our gender does matter, but it also matters the therapeutic relationship, the therapeutic alliance and the clinical atmosphere that we create. The fact that we did not feel and not to experience certain things because they were men and I was a woman. It is not an us against them kind of thing.

I was fortunate early in my career to have a wonderful male supervisor who was one of the most effective all-female group leaders. He shared with me the unique opportunity that we have two have all male groups and all-female groups and it is your abilities, your skills, your self-awareness that allows you to facilitate the group.

That is an experience that I like to share because there was a woman in the room, but I guess they did not notice.

>>: I appreciate you saying we conceptualize the experience because when we work with both men and women, when I was doing an intake and before I said anything, I said I really want to work with a woman counselor. I don't feel comfortable working with a man counselor and respecting where they are coming from.

Sometimes when you do the intake, they are assigned, but I would say this makes sense and you have reasons for feeling that way.

I can advocate for you to be hooked up with someone, do you mind if we complete the intake so that this part will be done before we move on to the next part? That will move us onto the next slide and what we can do to bridge that when those things do happen.

When I think about working with those with sexual trauma, especially working with female clients who have experienced sexual trauma at the hands of men and had appropriate reasons for not wanting to open up. Also, from the clinical aspect, I was the only one who had room on my caseload at that time.

With that, I know this is so rudimentary and fundamental so forgive me for saying something everyone knows, but those skills are ingrained in every aspect of how I interact with every person.

With completing an intake, as long as I use the skills and validated the person's experience, it was not a full 100%, but it was ever 99% of the people that I didn't intake with although they may have wanted to see a female, but at the end they said my interaction with you has been good and I felt comfortable connecting with you if you want to continue working together.

Within that, respecting the individual's boundaries and their experience and validating their experience, I was taking the individual as a culmination of everything that is there even if they are angry with me.

Also from the cultural humility perspective, I have a general interest in what the client is experiencing, and I want to learn more. Had instances where working with women of color who say you have no idea what it is like to be me. Your response is you are right, I don't know what it is like to be you and that is why I may ask some questions because I may never know what it is like, I may be committed to helping and I need additional information to how I can help.

When I approach the situation, the vast majority of the time it has worked out and when I was open and willing to address these discrepancies.

There are some instances when I worked with kids who have experienced sexual trauma where they would not open up no matter what. We had to eat for the next female counselor to become available and pick the individual up and do what we could.

We want to maintain boundaries. I think of a lot of people who deal with co-

occurring disorders. Boundaries are not something that are not modeled or those engaged. Within that, that boundaries can seem alien and cold and same repetitive and predictable and understandable as you know how the counselor will react.

Bridging the gap, this is extremely important. Open discussion about staff limitations. As a counselor, if you're meeting with an individual who says they prefer not to work because of the gender, it's okay to have an open discussion and to say right now we are really limited. I will advocate for your need, and I will let my supervisor know you have a preference, which you mind working with me until we get that. If the answer is no, that is fine, but we're interested in working with another agency. You can see if they have other people available. For all of the directors and supervisors out there, the agency's job is to make money. Within that, we have to look out for the patient care. If we were to say you have to work with a male client, they will leave us and go to a different clinic. We may as well help them get set up.

They informed consent and judgment free zone, how many give the informed consent as part of the packet where the client signs off and you do the intake. When we conceptualize gender and power dynamics, the informed consent is so key because we are transparent and exactly what we do.

We allow the client to hold us accountable, therefore putting them back in the driver seat. Conceptualizing the client as they run expert. It is funny because I have had people say you are a doctor. The way that I conceptualize every person I work with is that I don't know that. Talking about gender specific groups, if possible, it is great for women to have, women specific groups where they talk about their experiences and not worry about being judged. Not all women want that.

Some women want that need that. Same with men. Sometimes men get hurt from relationships and we have struggles with how to conceptualize the family.

>>: One thing we have the opportunity to offer clients is the appropriate boundaries and relationship with that other gender that sometimes they may never have

experienced before. That is something we can model as counselors and as supervisors and maybe the clients, whether male or female have not had in a healthy, appropriate boundary relationship with that person of the other gender. You have the opportunity to have that as part of the healing process.

>>: Absolutely. I love motivational interviewing as they are the foundation. We have 10 minutes left. Hopefully we can answer questions. Thank you for showing up as we sincerely appreciated.

>>: What can you do? You can self-reflect, you can have self-respect, you can have self-awareness. You can seek supervision. We talked about that. I do like the idea of approaching all clients, but I don't know you at all. We approach with curiosity, with cultural humility. We have open discussions about their concerns specific to our gender or that relationship. Refocusing on what their goals are for treatment, maintaining the evidence-based practices and going with what is reliable and that works. Continuing and coming to this session, been committed to the fact that we need the ongoing education. We need the ongoing reminder to remain open. The research that we looked at so much at the client's gender with a little written about the therapist gender if anything. Self-reflection, self-awareness, approaching with cultural humility.

We do need to look at the gender imbalances that can impact counselor and client alike. Any clinics have skewed populations. Transference and countertransference are issues that are best addressed in supervision and with clients. Focusing on the client relationship, being open and flexible, seeking ongoing supervision no matter how expert you are, I still seek supervision when I encounter a situation that I feel I could benefit from having another perspective. Approaching everything with cultural humility and competence.

>>: As we close, I want to make sure that you have an opportunity to our e-mails. If you don't get anything else out of this presentation, please make sure to take this. We have so much respect for every single counselor, clinician, substance abuse person

working specifically on the front lines, especially during the pandemic. You are valuable. You are doing the most difficult work in a field where people may never thank you. You are such a resource, and you are making a difference. It is our honor and privilege to connect with you. We hope that we have been able to help you during this time. Feel free to reach out to us if you have any questions.

We do have a few minutes to answer the question so I will turn it back over to Jessie O'Brien.

>>: Love the dog pictures. We have time for a couple of questions. The first is to please discuss the duality of male staff working with a sexually or physically traumatized female offering opportunity for a safe relationship versus being triggered or having a high risk of transference. You kind of talked about this, but this is more specific. It can also be reversed.

>>: I will make it very sustained. I think about my approach have been equitable. If we know the individual has a history of abuse, trying to put that at their speed. Especially in substance use counseling, I want them to be clean and sober after the first session. However, I have to take a human is six approach creating an environment. As the individual experiences trauma, it may take several sessions or months before they feel comfortable.

>>: Sometimes I always thought this went without saying, but maybe it does not. Sometimes even your position, your physical position and presence in your clinical atmosphere can change that dynamic. When I have always chosen, and I position myself in a way that allows the client always to access the exit. There is no physical barrier between them and the door. That gives them a sense of safety and freedom they may not have had in other clinical relationships.

It is important as was mentioned earlier that simply because a person has been sexually or physically traumatized does not mean it was by the opposite gender. Going at their pace, meeting them where they are at, it is okay to ask would you feel more

comfortable if the chair was by the door or just put the chair by the door to ask those questions.

>>: We are running out of time.

>>: I see Fred is typing. As I'm closing, if you want to type some answers, you can do that. We will send your questions to them so they can type answers and we will post that on the webpage where you find all of the information you need to find.

I am also going to go ahead and re-share my screen. As a reminder that every webinar has its own webpage and everything you need to know be found including the link to the CE quiz that is active. A reminder to use the instructional guide. There are screenshots to guide you through the process to get your certificate and if anyone from Iowa, Iowa Board of Certification has approved the webinar for light participants only meaning that you have to take the quiz in the next 24 hours and download the certificate if you need the certificate to say live to get credit. You have 24 hours.

Reminder for social workers, this is approved, sometimes you need your number to show on the certificate so I will show you how to do that.

Upcoming webinars, there are so many. The next is January 26th that is shame with Carrie Hopkins. We have five different specialty series. They are a serious consisting of six to seven webinars on a particular topic upon completion of all webinars and each training series, you can apply for the certificate of senior accomplishment of taking them in the series. We have one on advances in technology, wellness and recovery, clinical supervision and addiction treatment. In 2022 we will launch two additional series of adolescent treatment and recovery and the other on women and recovery.

Stay tuned as the women's one will kick off in March.

If you're not a member, please join us as we would love to have you in the best benefit is access to free CE through the webinar series, but there are many more so check that out if you have not joined and become a member already. Reminder that a

short survey will pop up at the end so take the time to give your feedback as we value your feedback for us on the educational programming. Everyone else, if you want to sign off, go ahead and thank you for participating and the webinar and thank you to the presenters as it was great to see you and for the valuable content.

Social workers, thank you for staying on. I will show you if you want to put your social work number on your certificates and I will play a video that is about two minutes long. This will instruct you.

Thank you for watching this quick tutorial on how to enter your social work license number into Apex CM, the association management software and home to your member account. You will only need to do this one time. After that, the system will be set up to pull the license number into your certificates of completion that you earn after attending the webinar or training.

Let's get started. The first step is to log into the member account. Once you're logged in, go to my profile here and the lower left-hand corner. Ensure you have selected account in the account tab and arrow down and ensure you have selected additional information as you can see on my screen. Next go to the right and select the license tab that is set up as you can see. You can click add new license. This is where you want to pay attention. You want to make sure under the type, select social work license in this field. This is what will tell the system to pull the license number into the certificate. Make sure to get that right. It is required to enter the state as I am doing here as well as the license number that will go on the certificate and the rest is optional, but feel free to put that in so the system has not recorded for you.

Once you have the information, you will go ahead and click save. If you have another credential or certification you want to add into the system, you can go ahead and do that, you just want to ensure that at the top under the license type, you select stage certification license or accreditation and then fill out the rest of the information. You only want to have one license type with the social work license. You are all set up

and the CE certificates will now include your license number.

>>: I will spare you the wrap up, but that is how you do it. We put a link for that in the box and there is a document that will guide you through if you need it.

If you have any questions, you can e-mail us so thank you everyone and take care.