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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

Undoing Our Psychotherapy License

By Marsha Wineburgh, DSW, Society Legislative Committee Chair

Way back in 2001, all of the major social work professional associations, city and state agencies were in support of social work licensing and licensing the field of psychotherapy. The final legislation, which included scopes of practice for the LMSW as well as the LCSW, was the result of a very long process which required determining which of the various disciplines and specialties outside of social work were qualified to deliver mental health services to the public. New York State was among the last states to regulate psychotherapy and when all was finished, there were six licensed mental health professionals including the Licensed Clinical Social Worker, the Licensed Psychologist, the Licensed Marriage and Family Therapist,

the Licensed Mental Health Counselor, the Licensed Creative Arts Therapists and the Licensed Psychoanalyst. Keep in mind that there was a ground swell of support for this legislation, essential for passage.

The LCSW emerged with an autonomous, comprehensive scope of practice which made clinical social workers very competitive with the other mental health professions and essentially equivalent to the scope of practice for clinical psychologists. Recently, we have been made aware of efforts to weaken the LCSW behind the scenes, to dilute the strength of the license by reducing the required hours of supervised psychotherapy experience (currently about 3,000 hours) and adding non-clinical experiences (i.e. case management,

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counseling and discharge planning) which are currently LMSW functions, as relevant areas of clinical experience. As it stands now, the LCSW is specifically for the practice of diagnosis, treatment planning and treatment of mental illness. The current experience standards have been in existence since 1978 when the "P" legislation was enacted.

What rationales are offered for lowering standards?

Claim: Shortage of clinical social workers

Response: The mental health field has been increased by five additional licensed professions who are competing for LCSW jobs. Their licenses require more hours of clinical education and supervised experience than the LCSW. Why would we lower our standards now? A shortage in the field? ...if there were a shortage, managed behavioral health care would be increasing our fees to attract LCSWs to panels. We have not seen an increase in two decades. If agencies can't locate LCSWs, perhaps they should look to their salary scales and work loads.

Claim: Budget crunch – there is no money for LMSW salaries so agencies wish to offer experience credit toward the LCSW in trade for salary increments. If the



Photo: Sandra Indig

At the 40th Annual Education Conference in May (Left to Right) Keynote Speakers Carol Tosone, Ph.D. and Jerome C. Wakefield, Ph.D., DSW, with Education Committee Chair Susan A. Klett, LCSW-R. Story Begins Page 8.

President's Letter

Jonathan Morgenstern, MSW, LCSW, Society President



Jonathan Morgenstern,
MSW, LCSW,
Society President

At the last State Board meeting, I initiated a discussion about membership development and the central importance of professional and Society identity to this effort.

The very next day, I found myself at a social event struggling to explain what I do professionally. I made a deliberate point to start out by stating that I am a social worker. When this was greeted with a fairly blank

stare, I proceeded to describe what I do through my professional roles in both agency and private practices. And it occurred to me that I often struggle to produce a good "elevator speech," a focused message to a stranger that captures the essence of my work and expertise and its importance. It would be a "pitch" of about 30 seconds, the length of an elevator ride, delivered in plain, memorable language.

I recall how my students often sum up the profession. They say that they are entering the field of social work "to help people." What does that mean? And is that what we as

social workers do? The image that comes to mind is of the old proverb: I am standing on the banks of a river with a man, and I decide not to give him a fish, but to teach him to fish. That is, my job is to cultivate independence.

Is that what we do? Do we ensure that our work does, in fact, lead to better functioning through independence? And how do we capture that idea with a brief description, given the multitude of ways in which we provide services, even in our circumscribed role as clinicians?

"...we must begin with honest and direct discourse about our professional self perception, whether we are satisfied with it, and if not, what to do about it."

This line of thinking stimulated a lot of self-reflection. Now, I am hereby opening it up to you, as a Society member. I am asking for your thoughts and feelings, and beyond that, for actual elevator speeches you compose. Please send them by e-mail to me.

We should be proud to be social workers and clinicians. Yet the way we present ourselves often does not reflect pride, but defensiveness. This can be the result of many factors, not the least of which is a concern about the shortcomings and reputation of the graduate social work schools in New York State.

However, if we are to clearly define our professional identity, then perhaps we must begin with honest and direct discourse about our professional self perception, whether we are satisfied with it, and if not, what to do about it. The power to define ourselves can strengthen our identity and our practice and improve our working conditions, especially in the area of financial compensation.

I invite you to contribute to the discourse.

Jonathan Morgenstern LCSW-R, mjonathanm@aol.com ■

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Legislative Committee

Authorized Settings for Professional Practice

by Marsha Wineburgh, DSW, Chair

As often happens with landmark legislation, unintended consequences arise as the new laws begin to be implemented. This is the third article intended to provide an understanding of the basic problem areas and report on progress in resolving them. The stakeholders are the Office of the Professions of the State Education Department, the professions involved, legislators and their staff, and the Governor's office. Two of the three key problem areas have been addressed. Issues around authorized settings for professional practice remain and we need your assistance (see box on page 4 for how you can help).

The Society Board with the help of our lobbying firm continues to be actively involved in the resolution process.

1. We have supported successfully a new policy for LMSWs who have had a supervised private practice prior to February 2, 2009. They will be permitted to use that experience to fulfill their supervised clinical experience

providing it meets all other criteria. (For specifics: www.op.nysed.gov/swprivatepractice.htm)

2. The 2002 Social Work licensing laws exempted programs regulated, funded, operated or approved by OMH, OMRDD, OASAS, OCFS, local social service or mental hygiene districts until 1-1-2010 to allow any person to provide services without being licensed. We supported a 6 month extension of the exemption clause, which was passed in the 2009-2010 Executive Budget.

3. Authorized settings: When the State licensed those clinicians who provide psychotherapy services, it also triggered New York State's corporate practice laws which require that the setting where the services are provided must be also authorized by the State. Now that the practice of clinical social work and the other mental health professions is restricted, for-profit and not-for-profit businesses which provide psychotherapy services are now also restricted. The definition

CONTINUED ON NEXT PAGE

Reflections on Leadership and the Nomination Process

Beth Pagano LCSW, Nomination Chair 2009, Member-At-Large

The Society governs itself by a specific process detailed in the Society by-laws. Inherent in this process is the dynamic of succession which involves the delicate balance between continuity and change. We require both in order to execute the charge of our mission statement which is to preserve and protect the practice of clinical social work.

As a volunteer organization we have dedicated professionals in our membership who practice clinical social work in a variety of settings, teach in schools of social work as well as at institutes, administer mental health agencies and organizations and do research. Representation on the State Board does not reflect this diversity and should.

The Nomination Committee is comprised of the chapter presidents. Their contact with the membership puts them in a position to identify and cultivate new leadership on the chapter and state level. The challenge of utilizing the wisdom and expertise of long standing leaders while promoting new leadership on the State Board is interesting. Some chapters have positions on their boards for a chapter historian or advisor. Perhaps this could be considered for the state level.

What became clear during the nominations process this year is that newer potential leaders preferred not running against long standing leaders. This reaction may be related to professional self esteem and seeing ourselves as successful leaders, an issue that seems to plague clinical social work in general.

But I think it is something we can creatively overcome.

Next year, the office of President Elect must be filled. This person sits on the State Board for one year before assuming leadership of the State Society. It is a system that has been effective since we began in 1968. It affords new leadership the opportunity to observe and learn established system. Changes can then be incorporated in a wise systematic way that preserves our solid foundation while simultaneously moves forward.

I encourage our leaders and members to take some time to reflect on the importance of succession. Grooming and preparing for leadership is what will sustain our society and our profession. ■

of an authorized setting for mental health services is under discussion and will include a process to register entities that are not currently approved by the Office of Mental Health or another government agency. This directly impacts on the settings and supervision requirements for acceptable clinical experience for LMSWs seeking clinical licensure as well as ensuring that patients receive quality services.

Dear Speaker Silver:

I am (writing/calling/emailing) you on a matter of great urgency. I am a (student/LMSW/LCSW/constituent) and I am looking to you for leadership in managing a potential crisis in the provision of critical mental health services.

[Insert brief description of who you are/where you work]

As you may be aware, in 2002 and again in 2004, the State's laws governing the social work profession were dramatically changed. Two licenses — licensed master social worker (LMSW) and licensed clinical social worker (LCSW) — were created from what had been only a certification. For a number of reasons, these changes have not been implemented smoothly and have created many barriers for the acceptance of required professional experience and the provision of mental health services.

Among other difficulties, the new laws created conditions in which many corporate and community-based organizations which have provided vital mental health services for decades, often to New York's most vulnerable populations, are now considered to be operating illegally.

The State Education Department has worked with all interested parties to craft an effective solution which is set out in **A.8897**. This bill would allow entities to continue to provide services by registering with the State Education Department (SED), which would assume responsibility for assuring that the integrity of the practice of the professions is protected as provided by New York's corporate practice laws. It would also allow the SED to accept experience for the LCSW that was acquired by many LMSW professionals in good faith at the affected entities.

I am asking that you urge the enactment of **A.8897** as soon as possible when the Legislature returns this Fall. Without this solution **immediately** in place, significant workforce and service delivery consequences will likely threaten the mental health service system across NY state.

Thank you for your consideration of this important matter.

Legislation (A.8897) has been drafted to address this issue. The purpose of this bill is to prevent the disruption of services to the public in the professions of licensed master social work, licensed clinical social work, licensed mental health counseling, licensed marriage and family therapy, licensed creative arts therapy, licensed psychoanalysis, and licensed psychology by creating an exemption from corporate practice prohibitions for not-for-profit corporations, education corporations, firms, business corporations, and other business entities that provide professional services in these professions.

This legislation would require that such entities register with the State Education Department by July 1, 2011. Upon registration, the bill would permit these entities to employ licensed professionals or contract with professional business entities to provide such professional services. Importantly, this legislation would recognize work experience gained by individuals employed by such entities and would permit such individuals to apply this experience towards the experience qualifications for **professional licensure**.

(The bill can be found at Google: www.NewYorkStateAssembly.gov. Use bill number A. 8897.)

The NYSSCSW Board and the State Legislative Committee request that you:

Immediately write to your Assemblyperson and the Speaker of the Assembly to ask them to support A.8897.

- Your Assemblyperson can be found using your zip code at the New York State Assembly site. Or call the League of Women Voters in your area.
- Speaker Sheldon Silver, 932 Legislative Office Bldg., Albany, NY 12248

See the box on the left for suggested content. Please send copies to your chapter legislative chair or to mwineburgh@aol.com. ■

Strategic Planning Committee

by Judith Crosley, LCSW, Chair

The members of the Strategic Planning Committee are pleased to announce that all of the Society Policy and Procedure manuals we set out to produce have been completed. This has been a huge job and would not have been possible without the help of our consultant, Marian Sroge.

The manuals fall into three categories: policy and procedure manuals which delineate the role of the Society, the State Board and the chapters; manuals for specific jobs, such as for the treasurer and for nominations and elections; and "how-to" manuals that provide guidance and helpful hints for running a committee or organizing an event. We also have written policies that are required by the IRS and the government, such as a whistle blower's policy, nondiscrimination policy, and a conflict of interest disclosure form. At the end of this article is a list of the manuals.

These manuals document the administrative and management infrastructure of the Society and, in particular, the relationship between the State Board and the chapters. They will enhance that relationship and provide for more open communication. They will be invaluable in recruiting new leadership, as members will have at their fingertips the information they need to do their jobs.

It is important to note that except for the policies, all of which have been voted on by the State Board, the manuals are guidelines to assist members who have taken on specific roles in the Society. As such, they provide helpful information to get you started on a project and allow and encourage you to use your initiative in developing the project. Therefore, if a member has taken on the job of putting

on a conference in a chapter, he/she can go to the Event Management Manual and find sample contracts for speakers, how to get appropriate insurance, and check lists to be sure that all contingencies have been met. In other words, it will not be necessary to reinvent the wheel every time a chapter has an event or a new person takes over a role in a chapter or on the State Board. It is important to note that the manuals can be amended at any time. Issues may be raised at a State Board meeting and modifications can be made and will be incorporated into the manuals.

In addition, the Strategic Planning Committee has been working on developing a strategic plan for the 2009-2010 year, as well as a five year plan. A primary goal for this year is to review the Society by-laws and make revisions that will reflect the new licensing law as well as other changes that will increase the clarity of the by-laws. The President of the Society, Jonathan Morgenstern, is currently appointing this committee.

Other aspects of the strategic plan will encompass leadership development and succession and most importantly, the retention of members and recruitment of new members.

You may contact the president of your chapter if you wish to use any of the manuals.

The manuals available are: State Society Policy Manual, State Nominating and Election Manual, State Society Operating Procedures, State Treasurer's Manual, Board Policies and Procedures, Event Management Manual, State Board Orientation Manual, State Society Committee Manual, Chapter Policies and Procedures, Transitioning Manual and Chapter Leadership Orientation Manual. ■

Undoing Our Psychotherapy License Message

CONTINUED FROM COVER

definition of clinical services is generalized to ANY direct service to a client, they claim that LMSWs might be attracted to low paying, unpopular kinds of agency work because it counts as LCSW supervised experience.

Response: The legislature, when it enacted the LCSW and other five mental health licenses, meant to regulate medically necessary psychotherapy services, not the general field of human services.

Claim: New York's LCSW license is limited to only psychotherapy. This is too narrow. Other states have a broader definitions for clinical social work.

Response: Other states have not regulated psychotherapy, nor have they licensed six new professional groups to provide mental health services. ■

What you can do: Protect our consumers from inadequately trained LCSWs. Call/e-mail the executive directors of other social work associations you are a member of and ask if they are advocating diluting the LCSW law by requiring fewer hours of supervised experience or the types of experience required for the license. Let them know how you feel about it.

Why haven't the issues appeared in their newsletters or on-line so you are informed about their positions? Let your NYSSCSW chapter legislative person know what response you receive or e-mail mwineburgh@aol.com – "Protect our LCSW."

Vendorship and Managed Care Committee

by Helen T. Hoffman, LCSW, Chair

Managed Care Companies Continue to Target Out-Of-Network Providers

Recent e-mails from members reveal that out-of-network providers are still being pummeled by faxes and calls from MultiPlan asking them to accept a discounted reimbursement rate.

What is this about?

Corporate profits, pure and simple. At root is the fierce competition among insurance companies to lower their costs. We have confirmation of this in MultiPlan's own pitch to insurers: "Millions of dollars are spent annually in *uncontrolled costs* resulting from *non-contracted* healthcare services."

(See http://www.multiplan.com/solutions/fee_negotiation.cfm).

MultiPlan offers the primary insurer (UBH, Cigna, HIP) a chance to manage these out-of-network costs. It can "reprice" each claim with the click of a mouse. Recently, a MultiPlan lookalike, A&G Healthcare Services, came on the scene advertising to insurers, "Repricing your medical claims can't be any easier and faster!"

MultiPlan makes the claim that it "helps *providers* to more effectively control reimbursements." But the true gain is to the employer, the primary insurer, the stockholder (and possibly to you, if you own mutual funds). However benevolent they try to sound, managed care companies are attempting to provide the best service at the lowest price to satisfy investors.

What has the Society done?

This committee wrote to MultiPlan on May 12, 2008 expressing our concerns, but a subsequent discussion with the State Board discouraged pursuing this legally with New York State Department of Insurance. Essentially, the problem appears to be "a perfectly legal nuisance."

This should not deter individual members from writing MultiPlan, the New York State Department of Insurance, the FCC, or the New York State Attorney General (see addresses below).

What steps can members can take?

- Ignore faxes and calls. Many members say that this will make them stop—at least for a while.
- Fax back the request. Draw a line through the fax and write "REFUSED. FINAL DECISION." One member wrote

"DECLINED" in black marker and faxed it back. She was promptly paid.

- Contact the MultiPlan Service Advisor at Service@Multi-Plan.com, 1-800-546-3887, Option 3, and ask to be removed from the database. One member reports that he was told he was removed from all Multiplan databases.
- Write to MultiPlan and cc the Attorney General or NYS Department of Insurance: Provider Services, MultiPlan, 1100 Winter Street, Waltham, MA 02451-1440
- Write to the State Attorney General. This must be a consumer-oriented complaint: Office of the New York State Attorney General, Health Care Bureau, The Capitol, Albany, NY 12223-0341; Healthcare Hotline is 1(800)428-9071. A form provided by the Office of the Attorney General Health Care Bureau is available at: http://www.oag.state.ny.us/bureaus/health_care/about.html.
- File a complaint with the FCC at <http://www.fcc.gov/cgb.complaints.html>. See "Telemarketing, Prerecorded Messages and Do-Not-Call." Telephone 1(888)CALLFCC
- Write to the New York State Department of Insurance. New York State Department of Insurance, 25 Beaver Street, New York, NY 10004-2319 Or go to "How to File a Complaint" at <http://www.ins.state.ny.us/complhow.htm>.

At Stake: Autonomy and Confidentiality

Calls from MultiPlan are maddening but the greater issue is the coercion of out-of-network providers to conform to in-network protocols. UBH and Magellan are now demanding OTRs from out-of-network providers. One out-of-network provider for UBH was asked for medical records on his patient after four visits.

Patients who have chosen to go out of network to preserve confidentiality are now told that the therapist must send an OTR to the insurer to continue reimbursement. This may be legal but from a clinical point of view it represents a violation of privacy. Letters to the New York State Insurance Department should stress this issue of confidentiality.

We cannot have an impact unless we make ourselves heard. ■

Call for Proposals

For Workshops and Panels for the 41st Annual Conference of the
New York State Society for Clinical Social Work

LIVES DISRUPTED:

Contemporary Approaches for the Treatment of Trauma

Date of Conference: May 8, 2010

Traumatic experiences profoundly compromise development and have serious ramifications on one's capacity to form and maintain intimate relationships. Wars, natural disasters, terrorist attacks, a sudden death or unexpected illness, as well as, the discovery of an extramarital affair and getting fired from a job shatters one's sense of self and sense of safety in the world. This conference will address the importance of identifying, differentiating and understanding various degrees of trauma. Clinicians will learn effective approaches to healing trauma and significant ways to care for themselves in the process. We are looking for proposals for workshops and panels from all **theoretical orientations** as well as **all modalities** reflecting this theme.

Suggested Topics:

- PTSD: Treating returning veterans and their families
- Medical conditions, the aftermath of a medical emergency on patients and their families
- The impact of suicide on a spouse
- The relationship between attachment, trauma and neuroscience
- Exploring the assets and liabilities of working with groups: such as victims of natural disaster, war veterans, terrorists attacks, domestic violence/physical and emotional abuse
- Understanding and healing intergenerational passage of trauma, children of Holocaust survivors, Post Traumatic Slavery Syndrome (PTSS)
- Birth Trauma/ maternal loss
- Addictions as affective regulators: alcohol, drugs, food, gambling, shopping, sex, excessive work, compulsive exercise, eating disorders, self mutilation
- The relationship between trauma, particularly childhood sexual and physical abuse and depression/anxiety/social phobia
- Working with the traumatized couple
- Compassion fatigue/ burn out/vicarious trauma
- Using EMDR, hypnosis, EFT, neuro-feedback, biofeedback in the treatment of trauma
- Enmeshment and shared psychosis
- Dissociative Disorders/DID/Multiple Personalities
- Supervising the traumatized supervisee
- Dreams as a pathway to facing and working with severe trauma
- Understanding sadomasochism and self injury as a form of traumatic bonding

Proposals should be from *three to five* typewritten pages, double spaced, and should include the following:

1. Description: purpose, function, and teaching objectives. Include **clinical illustrations**.
2. A workshop or panel outline describing original concepts to be developed.
3. A bibliography.
4. **Nine copies** of the proposal, **one copy** of your C. V. (and all other identifying information) on a separate page. Underline one affiliation that you would like listed in the brochure. Private practice is not considered an affiliation.
5. **On a separate page:** A brief paragraph of @ five lines stating purpose of workshop and listing 5 to 6 aims and objectives.

Deadline for Submission of Proposal: November 23, 2009

Mail to: **Susan Klett, 157 East 57th Street, Apt. 6D, New York, NY 10022**

OUT OF SORTS:

A very large, vibrant group of clinicians gathered for the 40th Annual Education Conference at the Nightingale-Bamford School in Manhattan. Two renowned keynote speakers, Dr. Jerome C. Wakefield and Dr. Carol Tosone, presented cutting edge research and clinical examples of working effectively with depression versus sadness and panic disorders. Afternoon workshops covered a wide range of topics addressing the needs of clinical social workers from various settings, working with a broad spectrum of disorders and challenging situations faced by children, parents, individuals and couples.

The conference was dedicated to the memory of Eddie Mirkin, a long time contributor to the Society who was the husband of Mitzi Mirkin, our Executive Secretary for the past 32 years. His recent passing was a great loss to us all.

The Education Committee, chaired by Susan A. Klett, LCSW-R, is planning next year's conference, to be held on May 8, 2010 at the same venue as this year's event. A "Call for Proposals" has been mailed out and included in this issue as well. We welcome your feedback and invite you to submit suggestions of topics and speakers by e-mailing suzanneklett@aol.com.

Comparative Treatment Models for Panic Disorder: A Case Illustration

Keynote Presentation by Carol Tosone, Ph.D. / Review by Gil Consolini, Ph.D., LCSW

We were delighted this year that Dr. Carol Tosone, Associate Professor of Social Work at New York University Silver School of Social Work, was one of our keynote speakers at our conference.

Tosone is the recipient of the NYU Distinguished Teaching Award and a National Academies of Practice Distinguished Scholar in Social Work; she was recently selected for a Fulbright Senior Specialist Award for teaching and research at the Hanoi University of Education in Vietnam. Tosone is *Journal of Clinical Social Work* Editor-in-Chief and serves on the editorial boards of *Social Work in Mental Health*, *Social Work in Health Care*, *Psychoanalytic Social Work*, *Psychoanalytic Perspectives*, and the *Social Work* online journal, *Beyond the Couch*. The author of numerous professional articles and book chapters, Tosone has delivered over 100 professional papers and presentations in academic, medical, and mental health settings throughout the United States as well as in Asia, Europe, and South America.

And, somehow, she has managed throughout the time she has devoted to her many other professional pursuits to continue to find time to treat patients.



Carol Tosone, Ph.D.

In keeping with the theme of this year's conference, Tosone discussed comparative treatment approaches to panic disorder and used a compelling case illustration from her own practice to do so. The benefits of a carefully planned and rigorously implemented short-term psychodynamic treatment approach were highlighted in the case — one that she presented originally in the

chapter on short-term treatment she wrote for the book she co-edited with Barbara Dane and Alice Wolson, *Using Long-Term Skills in Short-Term Psychotherapy*.

She began by citing some pertinent statistics that indicated quite clearly how anxious we are in the United States.

- 40 million Americans are affected annually by an anxiety disorder.
- The cost in the United States alone is \$42 billion dollars a year — one third of our \$148 billion health bill.
- Anxiety disorders and panic attacks are more common than bipolar disorder, schizophrenia, alcohol abuse, or depression.

GIL CONSOLINI, PH.D., LCSW, who is Director of Behavioral Health for Personal-Touch Home Care in Brooklyn and maintains a private practice in Manhattan treating individuals and couples.

Meeting the Challenge of Working with Anxiety and Mood Disorders

- Those suffering are three to five times more likely to seek medical treatment.
- These disorders are twice as common in women as in men.

She proceeded to list the numerous applicable DSM-IV diagnostic categories familiar to most seasoned clinicians, including panic disorder with agoraphobia (300.21), social anxiety disorder (300.23), obsessive-compulsive disorder (300.3), post-traumatic stress disorder (309.81), and generalized anxiety disorder (300.02).

She then distinguished normal anxiety from pathological anxiety, considered the role of signal anxiety in relation to the mobilization of defense mechanisms, and used cognitive behavioral and anatomical explanatory models to differentiate fearful reactions from anxious reactions. Throughout her presentation, she used cartoons which helped bring her conceptualizations to life in ways that only cartoons can.

In the case that she was able to go into in some depth, she utilized a short-term psychodynamic approach developed by Lester Lubovsky, well-known for establishing the *Global Assessment of Functioning* scale used by many practitioners to evaluate the effectiveness of their work with psychotherapy patients. She began by outlining the four phases of Core Conflictual Relationship Therapy (CCRT).

- **Early Phase (1-5 sessions):** The clinician establishes a therapeutic alliance in relation to the Axis I presenting problem by sensitively eliciting the patient's descriptions of interactions with others that are problematic.
- **Middle Phase (6-11 sessions):** The interpretive work links CCRT to anxiety, worry, panic, and self-monitoring of countertransference related to CCRT.
- **Termination Phase (12-16 sessions):** CCRT is discussed in relation to termination and the internalization of the analytic function (enhanced capacity for self-awareness and self-healing).
- **Booster Phase (one session per month for three months):** The clinician reinforces the CCRT-related interpretive work.

She was then able to offer vignettes from each of the phases to show how her patient — a middle-aged woman coping with tragic loss — progressed and benefited from this approach. What struck this listener was the rapidity with which Tosone clarified the nature of this patient's

internalized object relations and therapeutically addressed this with her patient, someone who had had great difficulty benefiting from past treatment efforts. This culminated in a very emotionally powerful session in which her patient re-enacted her son's sudden, unexpected, and violent death while being symbolically held by her therapist.

Although it was not a simple matter in any respect to shift gears, Tosone was able to next talk about other approaches one might usefully employ in such cases, including the use of various key cognitive behavioral techniques such as systematic desensitization. This listener was further impressed by Tosone's evenhanded presentation of these other approaches — she was able to highlight the benefits of other ways of addressing anxiety disorders even after offering a very compelling illustration of the approach she herself had chosen to take. She could have easily used her case to criticize other ways of working but did not do so, something which seemed to leave the audience in the right frame of mind to think about the relative value of the many different ways one might look at the suffering of an anxious person and what one might decide to do about this suffering.

Following her presentation, the engagement and enthusiasm of the audience was apparent as Tosone responded to the questions and comments of conference attendees together with Dr. Jerome Wakefield, who had earlier talked about the mislabeling of normal sadness as a depressive disorder in his keynote presentation. ■



Photo this page and opposite: Sandra Indig

Education Committee:

(Left to Right) Meryl G. Alster, Susan A. Klett, Tripp Evans, Gail Grace, Ashanda S. Tarry, and Gildo Consolini

OUT OF SORTS:

***The Loss of Sadness:* Is Normal Sadness Being Mislabeled as Depressive Disorder?**

Keynote Presentation by Jerome Wakefield, Ph.D. / Review by Gail Grace LCSW-R

Dr. Jerome Wakefield Ph.D., DSW, discussed his work focused on the conceptual foundations of the mental health professions, especially the concept of mental disorder and the validity of DSM diagnostic criteria. Wakefield is a University Professor, Professor of Social Work, and Professor of Psychiatry, as well as an affiliate Faculty in Bioethics at the Center for Ancient Studies, at New York University; and Lecturer in Psychiatry at Columbia University College of Physicians and Surgeons. He is the co-author with Allan Horowitz of *The Loss of Sadness: How Psychiatry Transformed Normal Sadness into Depressive Disorder*, which was named the outstanding psychology book of 2007 by the Association of Professional and Scholarly Journals.

The book's central thesis is summarized nicely in the forward of the text: "[C]ontemporary psychiatry confuses normal sadness with depressive mental disorder because it ignores the relationship of symptoms to the context in which they occur." Artfully integrating stories, literature, humor and statistics, Wakefield explored the consequences of this shift in thinking and how it relates to the social work field and society in general.

He explained that social work professionals are at risk of being squeezed out of the market due to other views and ideologies. Historically there has not been a social work representative present at the discussions for DSM IV. The DSM V task force does not contain a social work representative. DSM V is looking at diagnostic criteria which may possibly be changed. Wakefield stressed that social work should keep its eye on this and make a commitment to voicing its concerns, and being actively engaged in this process for DSM V and diagnosis in general.

He believes there are some conceptual problems distinguishing normal sadness from depressive disorder, arguing that making this distinction helps us better understand our patients and what they are going through. How a patient gets

classified impacts the treatment they receive. The presentation highlighted the skyrocketing diagnosis of depression and how it has become by far the most common diagnosis today in both psychotherapy and psychiatry. Statistics from the CDC were presented that showed 11% of women and 4% of men are on antidepressant medication. Advertisements for depression stress that, if you are "out of sorts," depression is the cause and medication is the answer. The ads tell people to call their general practitioner, not their psychologist or social worker, and the pharmaceutical companies use ads that list symptoms almost anyone can identify with. Distinctions between what is intense normal sadness versus depressive disorder have not been made clear in diagnosis. There is a cultural tidal wave with depression replacing anxiety as the "diagnosis du jour." This is big business! As psychotherapy rates go down, psychopharmacology rates go up.

How do you know when it is depression versus intense normal sadness? The *nuances* in how people respond to sadness are the key. Wakefield cited some of the thinking historically about melancholia versus depression. Freud distinguished grief from melancholia; melancholia was seen as more pathological. This type of categorizing goes back to Aristotle, Hippocrates, Kreapelin and Freud. Wakefield went into some of the historical views on depression and compared these to the current diagnostic criteria. It is only recently that diagnostic criteria do not make distinctions for cause and effect relationships.

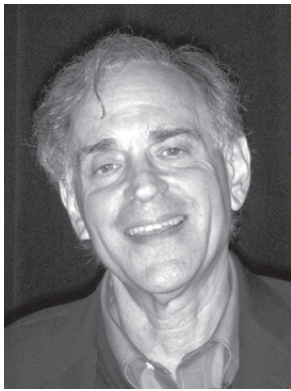
Wakefield then pointed out that DSM IV said complicated grief involved mourning that lingered beyond two months following the loss of a loved one (no distinctions are made for other types of losses); any sadness prior to that two months was uncomplicated or normal grief. But what about people who lose a valued job, significant relationship, loss of status, loss of financial security, and physical illness — can't all of these cause people to feel sad? Could these people be

GAIL GRACE, LCSW-R, Certified Psychoanalyst, NYSSCSW Education Committee, Part-Time Social Worker Maternal and Child Health North Shore University Hospital, Private Practice, Manhasset, New York.

Meeting the Challenge of Working with Anxiety and Mood Disorders

labeled as “depressed?” It was pointed out that often, over time, these situations eventually resolve and the depression lifts. Most depression can be connected to life events and resolves over time, but these distinctions are not currently made when diagnosing for depression. Clinicians making these distinctions can help determine what kind of approach would be most appropriate.

Wakefield weaved in some stories that helped further illustrate his theme. One such story he was from 150 A.D., when Aretaeus of Cappadocia made the distinction between normal versus “without cause” depression. The story was about a young prince who became depressed. The king called in a great physician from another land to evaluate the prince. The physician “talked” to the young prince and discovered that he was in love with a woman from the court, a consort of his father (Wakefield joked, “all Oedipal issues aside”). The young prince had made an overture that was not responded to and following this rejection he had become depressed.



Jerome C. Wakefield, Ph.D.

The physician made a distinction — this was not depression but unrequited love — and counseled the prince on how to speak to the young lady. The prince was able to talk through his problems with the physician, eventually speaking to the young woman, expressing himself and gaining her affections. The talking and the behavioral changes he made helped resolve his depression.

Historically, depression has always been evaluated by looking at the emotional response and whether it was in proportion to what was going on in the person’s life. If it was not, it was seen as pathological. Look at the environment and see if there has been some major loss. If so, then assume it will eventually right itself. In depressive disorder, there is often not an environmental trigger, or the depressive response is not in proportion to the loss.

In all cultures, certain situations contribute to sadness. For example, subordination, inferior status in your group, a sense of being trapped (in a job, marriage, country), or loss of a valued project, all of these can impact mood. But, Wakefield cautioned, if we create a society of people seeking to get rid of the feelings these situations generate, what do we lose? Do we distance ourselves from these very important feelings? What are the implications? How will this affect the relationships in our lives? Is this creating a culture of people who cannot tolerate negative emotions? The presentation cited research after 9/11 pointing to rates of depression rising, but eventually normalizing over time without a spike in patients seeking more mental health services.

Wakefield said that all of this impacts how we think about our clients, and how we think about clients’ needs to be more specified. He cautioned that some people respond more intensely to loss than others, but he stressed this can at times be seen as an evolutionary response to what is going on in the environment. The relationship to the environment is “cause and effect” and DSM does not make these distinctions. The DSM has no clause for the symmetry or asymmetry of the symptom to the environment. Psychiatry has asked us not to make these distinctions.

Wakefield asked, “Can you deal with these symptoms in other ways than medication?” Think of the prince who simply needed to talk. The DSM has an enormous impact on how we see our patients. Many adolescents could meet criteria for MDD, but would we want to put all of them on medication? What are the implications of diagnosing depression as a “syndrome?” He stressed the importance of psychotherapeutic interventions such as CBT, dynamic therapy, behavioral therapy, looking at people’s relationships, and he said he feels that the DSM should list other circumstances/stressors and treatments other than medication that can help when diagnosing depression. These are the types of services we provide as social workers.

In conclusion, Wakefield highlighted the need to make distinctions between biological versus “meaning-based” depression. What are normal responses versus abnormal responses? How is the person coping with the loss? Clinicians need to make room for all possibilities when thinking about their patients. ■

Chapter Reports

BROOKLYN ▶ MID-HUDSON ▶ QUEENS ▶ STATEN ISLAND ▶ WESTCHESTER

Brooklyn Chapter

Carol Kamine-Brown, President

On March 22, 2009, the Brooklyn Chapter held a special educational/networking event (including a sumptuous brunch) on *The Fee: a Clinical Tool in Therapy*, resolving conflicting feelings about therapy practice being a business.

The speaker, Shoshana Ben-Noam, Psy.D., CGP, FAGPA, is a national presenter in the areas of group therapy, trauma and money matters. She is on the faculty of Pace University, the Eastern Group Psychotherapy Society and the Training Institute for Mental Health in New York City. She is also a guest editor of the *Group Journal on Trauma and Group Therapy*, and the recipient of the American Group Psychotherapy Association 2007 Affiliate Societies Assembly Award. Ben-Noam is a psychoanalytic psychotherapist in private practice in New York City.

She presented the following issues. Money is transactional, interpersonal and symbolic. It is a taboo topic in many cultures, often evoking powerful feelings. Its symbolic meanings are shaped by cultural, religious and familial beliefs and attitudes. In therapy, setting and collecting fees may trigger feelings such as anger, jealousy and greed, both in patients and therapists. To gain insight into these feelings, the money taboo has to be lifted, and money matters have to be openly discussed. A clear fee and billing policy has to be presented to patients, and policy violations have to be therapeutically explored. To effectively do so, therapists need to work through any discomfort about discussing money matters, and resolve conflicting feelings about a therapy practice being a business.

The presentation was well received by the group, and a lively discussion ensued.

Mid-Hudson Chapter

Rosemary Cohen, President

The Mid-Hudson Chapter is pleased to announce the addition to its chapter interactive listserv of Society members from the Albany, Capital District Area; and the northern and western areas of New York State, among them from cities such as Ithaca, Fayetteville, Saratoga, Syracuse, and many other towns and cities in the state. The new listserv name is

Hudson Valley and Upstate. Our new listserv e-mail address: nysscsw-hudsonvalley-and-upstate@yahoo.com

At our chapter workshop this past winter and in July in San Francisco, at the ICAPP-CSW (International Conference for the Advanced Professional Practice of Clinical Social Work, Carolyn Bersak, DSW, a former Mid-Hudson Chapter president and current chapter board member, presented her workshop on her innovative clinical treatment for couples, "The 'Fatal' Counter-Transference or, The Therapist and the Triangle."

The all-chapter Clinical Study Group read *The Center Cannot Hold*, by Elyn Saks for discussion following the September chapter board meeting in Milton. On October 3, Ron Robbins, Ph.D. will present his workshop, "Fear and Panic: Rapid Treatment Methods for Change." He will introduce the Rhythmic Integration (RI) developmental change model and the results of the Rhythmic Integration Panic Research Project, which he has directed since 1999. On January 9, 2010, Shelley Tatelbaum will present her workshop on "Bereavement and Grief."

Queens Chapter

Fred Sacklow, President

The Queens Chapter held monthly Board meetings and monthly educational presentations from September 2008 to June 2009. We are ready again to follow up on a busy and meaningful past season with meetings and presentations this season. We meet monthly at Holliswood Hospital, which is centrally located and easily accessible. Refreshments are provided.

We will be meeting on the following dates 9/13, 10/18, 11/22, 12/13, 1/24/09, 2/28, 3/21, 4/18, 5/16, 6/13.

After the Board Meeting, we have a networking break from 11:00 to 11:30 am. We then have an educational presentation from 11:30 am to 1:00 pm. Our attendance is good and the experience is lively and involving. Our board members are involved in State committees and we actively support State initiatives to promote clinical social work.

Questions and comments can be referred to Fred Sacklow, LCSW at Freds99@aol.com or 917-747-3316.

Staten Island Chapter

Mary Fitzpatrick, President

We have had an interesting, educational and social year. We had eight Chapter meetings hosted by members where we welcomed old and new members, and benefited from presentations about treatment modalities and treatment-related topics.

Among the presentations: "A Group Therapy Approach to Mid-life Issues," Michael DeSimone Ph.D.; "Saying Goodbye to an Eating Disorder," Louise Parente, Ph.D.; "Coping with Hopelessness and Helplessness in Patients," Dennis Guttsman, LCSW; "Individual and Group Treatment Modalities with Suboxone Patients," Karel Angell, Ph.D.; and, "Introduction to Advanced Integrative Therapy," Glenn Soberman, Ph.D. Our meetings also keep members informed about legislative and vendorship issues, as well as provide networking with colleagues.

We had a large and spirited turnout for our Holiday Dinner at EsCa. Members and guests socialized and mixed the personal with the professional.

In April, we hosted our Annual Educational Conference at the Staaten. Laura Arenss Fuerstein, Ph.D., spoke about her latest book, *My Mother, My Mirror*, over brunch. Her presentation was a thoughtful and engaging perspective on the mother/daughter relationship. She examined self esteem and body image and how messages about them are transmitted through generations. She offered insights and ideas on breaking the cycle in your relationships and in your own parenting. Her case material was moving and elicited many questions and comments.

Our chapter will begin its cycle of Sunday meetings on September 27th. For information, you may contact our President, Mary Fitzpatrick, LCSW, at 917-882-9118 or fitzrodal@aol.com.

Westchester Chapter

Martin J. Lowery, President

The Westchester Chapter's Annual Conference continues to be the highlight of the year's activities. Last April it attracted mental health professionals from

CONTINUED ON PAGE 17

ARTS AND CREATIVITY IN CLINICAL PRACTICE COMMITTEE

Tolerating and Containing through Creative Application of Learned and Intuitive Skills: A Dialectical Behavioral Therapy (DBT) Approach

Presentation by Susan A. Klett, LCSW / Review by Sandra Indig, LCSW, ATR-BC, Committee Chair

In a very lively, theoretically and clinically rich workshop on November 23, 2008, Susan A. Klett, LCSW, demonstrated the creative use of her psychoanalytic self to deepen and enrich a dialectical behavioral therapy (DBT) approach in treating a patient suffering from a severe borderline personality disorder. Klett is the chair of the Society's Education Committee. She is certified in adult psychoanalysis/psychoanalytic psychotherapy and dialectical behavioral therapy (DBT). She is faculty, supervisor and training analyst at Washington Square Psychoanalytic Institute, and faculty of The Psychoanalytic Institute, Postgraduate Center for Mental Health. She has a private practice in Manhattan.

Throughout her presentation Klett adeptly integrated different schools of thinking from an eclectic approach. To better understand a severe borderline patient and to effectively employ DBT techniques, she utilized Freudian, self psychology, intersubjective, and relational theories. Emphasis was placed on object relations and developmental perspectives. Klett shared her thought process when faced with her patient's self destructive enactments. It was evident that reflection on infant research findings related to attachment theory, affect regulation and, neuroscience has facilitated her ability to persevere in providing a strong containing and holding environment for her tormented patient.

The product or object of a creative process, whether it is a work of art or a session in the practice office, usually has a recognizable outcome, i.e., the patient who has resolved a troublesome issue, the actor who is called back for multiple curtain calls, etc. However, it is almost impossible to say with any great certainty just how that outcome was accomplished. In this case, we were invited to hear how the therapist engages in the creative process in her treatment of her

patient (hereafter referred to as JR). As evident in the case material presented and discussed, Klett breathed life into an extremely structured, perhaps by some standards, rigid and codified system for altering negative behavior in borderline patients. She generously shared with us, but was not limited by, the creative, innovative approach of Marsha Linehan, Ph.D. (the creator of DBT), for treating BPD.

We were provided with a hand tailored booklet which contained a definition of borderline personality disorder, the differential diagnosis, and a biography of Marsha Linehan, an overview of DBT, and the psychoanalytic comparisons discussed throughout the paper. An extensive biography and list of resources for patients seeking DBT treatment was included. Best of all was a chance for us to look at and respond to a copy of *The Skills Training Manual for Treating Borderline Disorder Personality* (workbook) by Marsha Linehan (1993, The Guilford Press) which is used to provide homework assignments and step-by-step instructions for running DBT groups. Klett emphasized the importance of good training and supervision when running a DBT group and working individually with the borderline patient.

A very succinct definition of DBT was given. Linehan had analyzed each aspect of the borderline's behavior and developed a systematized and integrated approach to target each of them. She skillfully blended psychotherapy, Zen philosophy, CBT, and the use of dialectics, along with skill training for distress tolerance, affect regulation, interpersonal effectiveness and core mindfulness. By way of information and/or review, we went over some key concepts, including the fact that *The Diagnostic and Statistical Manual of Mental Disorders* (fourth edition) defines Borderline Personality Disorder: 301.83 as "a pervasive pattern of instability of interpersonal relationships,

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SANDRA INDIG, LCSW, ATR-BC, is chairperson of the Arts and Creativity in Clinical Practice Committee. She is: an exhibiting painter and member of the Abingdon Square Painters, performs with Dances for a Variable Population, on staff and writes for the E-Zine, *Manhattan Arts*. She maintains a private practice in Manhattan.

Arts and Creativity in Clinical Practice Committee

self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) indicators.”

Klett stressed the importance of exercising caution when diagnosing a person with a borderline personality disorder. Referring to the DSM I-V (p.653): This disorder often, but does not always co-occur with mood disorders. A clinician must be sure to investigate whether the behavioral pattern has an early onset and long standing course in order to diagnose appropriately. The most common misdiagnosis occurs with histrionic, schizotypal, paranoid, narcissistic, antisocial and dependent personality disorders, because of an overlap of some personality features.

From here on, we will review some salient points gleaned from Klett’s discussion of her patient. Throughout a heart wrenching and difficult “story”, reference was made to the psychoanalytic concepts, supporting techniques, and treatment strategies utilized in this case.

JR was referred to Klett following her unsuccessful suicide attempt after her prior therapist refused to take her back. The first session begins with dialogue loaded with feelings of tension, anxiety and restrained rage, reminiscent of Ingmar Bergmann’s *Persona*. A Kleinian might say that murder is in the air. We shadow Klett as she stays closely attuned to JR, listening with even hovering attention as she assesses JR for suicidality, challenges her level of commitment, covers and explores her feelings of terminating with her prior therapist. We gain a succinct snapshot of her internalized object relations and her early attachment style. *Klett closes the first session with JR contracting for safety and signing of a DBT working agreement.*

The second session with JR consists of taking a thorough history. Point by point, it was a powerful illustration of Linehan’s *Behavioral Patterns in BPD (Cognitive-Behavioral Treatment of Borderline Personality Disorder* (book) p.10, Guilford Press.)

The clinical case material covered in the meeting clustered around six descriptors identified by Linehan:

- 1) Emotional vulnerability
- 2) Self-invalidation
- 3) Unrelenting crises
- 4) Inhibited grieving
- 5) Active passivity
- 6) Apparent competence

The patient’s family and developmental history appeared to stir up feelings of distress and general discomfort in the participants. There was increased squirming, facial grimaces, and general unrest. That history revealed exposure to a pervasive, invalidating environment and biological loading for emotional dysregulation. JR has a history of major depression and bulimia which transitioned into an eating disorder of restricting her diet at age thirteen. JR reported hating her developing body and having a strong need to control it. Her history consisted of multiple suicide attempts and self mutilation, at times, severe mutilation, sadistically imposed upon herself as the victim of her own self inflicted torture. JR had vague episodic memories of her childhood and adolescence which raised the question of exposure to trauma. She described her early relationship with both caretakers; her father was unpredictable, his impulsive temper resulted in her experience of her home as a chaotic environment. JR recalls reacting by curling up in a ball beneath her blankets, hiding in fear and vomiting during points of tension throughout her childhood. Her environment never felt safe, she reported that her father was sexually inappropriate. She described her parents relationship as cold and distant. JR believes that her mother is narcissistic, she reports that her mother always made her feel like a burden. While JR states that both of her parents were very critical and verbally abusive, she denies any history of familial sexual or physical abuse. JR’s portrait of her parents character structure/personality provides insight into her emotional vulnerability.

No discussion would be complete without asking what happened in the sessions following the therapist’s vacation. JR’s reaction was expectable, none the less shocking in its severity and, I might add, repulsive for some to hear described. Borrowing from the self psychology vernacular, the rupture and repair process, while stormy, constituted a pivotal point in the treatment. The following session illustrates the use of DBT in action. Klett reported that the patient arrived in her office following a recent self mutilating episode on her first day back from her vacation. In session Klett encouraged patient to express her feelings in hopes of releasing her anger and inhibited grieving. JR was defended, resistant to engage in exploration of feelings.

Following this session JR’s behavior was discussed with the DBT team, and an addendum was added to patient’s contract, whereby, she would not be seen if she arrived after a self mutilating episode other than for ten minutes,

for an assessment on whether she should be hospitalized.

During the following session, therapist revisited JR therapy interfering behavior (self mutilation) and discussed this decision with RJ. She responded with rage against this limit setting. RJ felt like a victim, reporting that when she needed therapist the most, she would be turned away. Klett discussed "observing the limits" and informed JR that there were limits to what she could tolerate. In reaction, RJ devalued therapist, perceiving her as weak and limited. Klett challenged her thinking, as setting limits requires self respect, self awareness and strength. She continued confronting JR's maladaptive interpersonal behavior. While JR reported turning anger toward herself, she also spoke of self injury as a way to show her parents

how much pain she was in and the damage they caused her. Klett validated patients' biological loading, having difficulty regulating intense emotions and receiving relief from self injury, however, she also confronted patient's aggression toward her, by exposing her to raw bleeding wounds with intent of evoking guilt. Klett questioned JR's ability to separate her self from others, as when she is angry with someone, she turns the anger toward herself and back at that person, accusing the person of causing her self damage. Klett encouraged patient to articulate her pain, as she had in prior sessions and through the use of a behavioral chain analysis. Therapist disclosed her subjective experiencing of patient, who often appeared as two separate persons (addressing her splits and increasing

her awareness of this ego defense) One that wants to get better and one that wants to remain ill. This led to exploration of patient's fear of getting well.

Klett spoke of not tolerating the JR's unhealthy self attacking her healthy self.

In time, JR began to demonstrate cognitive restructuring and developmental progression in her ability to synthesize good and bad aspects in herself, others and situations. There has been a marked decrease in her splitting between staff members. She demonstrates a more cohesive sense of self and began setting boundaries herself in relationship outside of session for the first time. Klett no longer experiences JR's split selves (in the room) the one intent on self injury/destruction and the half who seeks help,

CONTINUED ON NEXT PAGE

THE ARTS AND CREATIVITY IN CLINICAL PRACTICE CALENDAR

New York State Society For Clinical Social Work

SCHEDULE OF MEETINGS 2009/2010

October 4 – Gloria Robbins, LCSW, BCD

"Ego in Motion: Examining Patterns of Ego Structure in Child's Play"

November 8 – Gary Prottas, LMSW, LP

"Containment of Trauma and Shame with Survivors of Sexual Abuse"

January 24 – Hilary Ryglewicz, LCSW

"Color Me Green: Using Graphic Metaphors in Dialectical Behavioral Therapy Related Group Work and Other Therapies"

March 28 – Roberta Ann Shechter, DSW, LCSW

"Source Material of the Writer: Reflections on Jane Austen"

May 16 – Bryan Hazelton, LCSW, CASAC, BCD

"Embracing Empathy Through the Use of Imagination in Treatment"

Where and When:

Sundays from 11:00 am to 12:30 pm

130 Fifth Avenue, Suite 900 (by 18th Street)

Please call Sandra Indig to verify address and to reserve a seat:

212-330-6787

Chair: Sandra Indig, LCSW, LP, ATR-BC: 212-330-6787, psych4arts@hotmail.com

Committee: Joy Sanjek, LCSW: 646-469-9733, joyoveranger@bigplanet.com;

Sema Gurun, LCSW: 212-982-2489, gurunsema@verizon.net;

Bryan Hazelton LCSW, CASAC, BCD: 516-678-4079, Klynnworks@aol.com

completing all homework assignments and never missing a session.

After 18 months of treatment JR now enjoys contributing to Intensive Personality Disorder Program, this contradicts her negative self talk that she is worthless. JR struggles to break her behavioral pattern of self invalidation, one way she validates her self worth has been by contributing to our learning. She has provided a list of DBT skills training sites on line and has critiqued each one, she also provided therapist with an anagram of DBT techniques (which Klett has photocopied and passed out to the audience) Klett continues to validate patient, who has begun to smile and at time to laugh, referring to her favorite DBT concept of “Radical Acceptance” and “Making Lemonade out of Lemons”.

A thoughtfully applied DBT approach with JR, the interpretation and relationship to therapist has led to a transformative experience. The timing, listening to self and patient on multiple levels simultaneously led to uncovering and working through of JR’s uncontrollable rage. JR’s ability to experience increased self awareness and ego strength was, I believe, due to empathy on the part of both therapist and patient, an awareness of her undifferentiated self state, and the recognition of a strong need for boundaries. In treatment JR was offered the experience of a reliable, consistent object which had contributed to her ability to separate and to experience the continuation of a relationship without loss of the object. She developed object constancy and the ability to contain her own frustration.

A sense of closure was offered through Klett’s generous disclosure of her own countertransference. Reference to Winnicott’s paper on “Hate in the Countertransference” helped to normalize feelings stirred up in most therapists when working with psychotic, severely disturbed

borderline patients with self injurious behaviors. The negative transference expressed by enactment in the treatment was discussed. Participants were encouraged to share their own countertransferences.

The excellent quality of sharing and having, as a group, come through participating in a very meaningful event seemed to have energized us. It was especially encouraging for those of us interested in receiving training in DBT to learn that it is used in private practice as well

“It was especially encouraging for those of us interested in receiving training in DBT to learn that it is used in private practice as well as agency settings.”

as agency settings. After one to two years at the most of DBT in an out-patient hospital setting, a patient such as the one discussed could conceivably be transitioned to (out of hospital private practice or clinic setting) for psychodynamic psychotherapy.

Sandra Indig, LCSW, ATR-BC, is chairperson of the Arts and Creativity in Clinical Practice Committee. She is: an exhibiting painter and member of the Abingdon Square Painters, performs with Dances for a Variable Population, on staff and writes for the E-Zine, *Manhattan Arts*. She maintains a private practice in Manhattan. ■

EDITOR’S NOTE

**Our last issue featured Part 1 of
“Borderline or Bipolar?”
by Brian Quinn, LCSW, Ph.D.**

**Part 2 will appear in the
Spring 2010 issue**

Chapter Reports

CONTINUED FROM PAGE 12

far and wide to a presentation by Dr. Sue Johnson, co-founder of Emotionally Focused Therapy (EFT), titled "The New Science of Love and Bonding: A clinical map for couple therapy." We are grateful to the volunteer committee for putting together such a rewarding day.

The monthly meetings of the chapter on the first Saturday of each month from September to June continue to strengthen our supportive bonds and advance our skills, from the special interest group meetings that start the day to the educational presentations that end it. The last presentation of the year, as an example, was by Marin London, LCSW, CEAP, titled "Web Secrets for Clinical Social Workers." In an engaging and challenging way, she helped us leap into the 21st century, so to speak, by opening up the Internet and the new media as a way to enhance our individual private practices and our visibility as an organization. The most immediate use of the Internet is the Chapter Listserv, which facilitates ongoing communication, providing an opportunity for exchanging information and making referrals. As we gathered this September to begin a new year, we looked with particular interest to the Membership Development Committee, one of the various committees that support our efforts at strengthening our identity, fostering networking, promoting expertise and advocating for clinical social work. The Committee's role in attracting and retaining members is key to growth for the year. Thanks to all who have volunteered to make the Westchester Chapter what it is. ■

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Group Case Consultations with Dr. Wolf Pappenheim – Member British Psychoanalytic Assoc. *Transference: Recognizing & Interpreting It*. Two small groups, one for treatment of adults, the other of children. Readings: Winnicott, Klein, Bion, Joseph, Fairbairn; Relational, Intersubjective, Self-Psychological contributions – whatever might be useful. Call 212-831-1637 or email wpappen@Netscape.net for further details. Private or phone consultation by arrangement.



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Robert Bosnak

Embodied Imagination: Exploring Creative Imagination Through Dreams
Saturday, November 14, 2009 10 a.m. to 3 p.m.

Christopher Eldredge, MA, LCSW

Relational Psychotherapies, Attachment Theory, Neuroscience and Body-Oriented Treatments in an Expanding Conversation
Saturday, December 5, 2009, 10 a.m. to 3 p.m.

Ron Balamuth, PhD

The Odd Patient: Relational Psychoanalysis Meets the Asperger Patient
Saturday, March 20, 2010, 10 a.m. to 3 p.m.

Robert Grossmark

Heterosexual Masculinities in Clinical Practice
Saturday, March 27, 2010, 10 a.m. to 3 p.m.

Donnel Stern, PhD

Partners in Thought: Working with Unformulated Experience, Dissociation and Enactment
Saturday, April 17, 2010, 10 a.m. to 3 p.m.

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