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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

IN THIS ISSUE

www.nysscsw.org

The Clinical Impact of the Pandemic and Social Unrest

By Michael M. Crocker, DSW, LCSW, MA, CGT

On Sunday, March 22, 2020, New York City was effectively shut down. Governor Cuomo announced, "No more play dates, no more picnics in the park with friends, no more pickup games of basketball. No more commuting or using public transport—unless absolutely essential." These dramatic restrictions were an attempt to slow a pandemic that had swept across the globe and threatened to make New York City the world's largest Covid-19 hot spot. We were in the midst of a crisis on a scale most had never encountered before.

As the city scrambled to enter a period of pause, with the news cautioning us to "shelter at home" and "quarantine," numerous industries shut down overnight. Tens of thousands of workers were laid off. We learned that there is an essential workforce in America, and that clinical social workers are part of it.

CONTINUED ON PAGE 20

SPECIAL PANDEMIC ISSUE: CSWs are part of the corps of essential workers meeting the intensified need for mental health services in the pandemic. How the crisis is impacting their clinical work, their patients and themselves is explored in this issue. LEFT: On the hospital frontlines; ABOVE: Providing therapy online. [AJ_Watt/Getty Images]

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PRESIDENT'S MESSAGE

We Are Playing a Vital Role in an Historic Period

By Shannon Boyle, LCSW

When the last edition of *The Clinician* was published, we never anticipated what was to come in 2020. In late 2019, I said that there was more work for our Society to do, and we would continue to tackle issues as they arose. None of us could have anticipated the sharp, unexpected turn our journey together would take these past months. We are continuing to tackle these unprecedented challenges and offer community and support to all our members.

The impact of the Covid-19 pandemic on our clinical work, our patients and ourselves is explored in this special issue of *The Clinician*. The articles paint a portrait of a resilient, resourceful, and vibrant profession. With the additional financial and social justice crises upon us, this is indeed a unique time in our history but as Michael Crocker highlights here, our profession is uniquely prepared to help our patients and communities during this time. I hope you enjoy reading his article as well as the others featured here by all six distinguished authors.

From conversations across our chapters, and as you will read in this issue, clinical social workers are rising to meet the challenges we face. Many have been a part of the "essential workforce," helping to meet the intensified need for mental health services in the pandemic. Our practices have had to adjust as well, rapidly pivoting to provide psychotherapy virtually or by phone. Telehealth has become

Shannon Boyle, LCSW

essential, as Jay Korman, our Practice Management Committee Chair, discusses in his report.

This Society has played a vital role during this time. In March and April, we saw an upswing in membership as other clinical social workers recognized the need for greater professional connections. Education has also been transformed. In May, the ACE Foundation offered the first of now many virtual continuing education opportunities. Society chapters are holding meetings and other programs online as well. And chapter leadership has forged stronger connections with other local and state leaders to brainstorm, often virtually. Our legislative work remained strong, even when the Legislature was closed to "non-essential" staff and visitors.

We are also helping newer clinicians working to advance their careers during such unusual times. The Membership Committee launched an online licensing study group and the Society welcomed 40 members of the MSW Class of 2020 this spring.

During this historic period of upheaval, we have continued to strengthen our community, enhance our field, and tackle extraordinary challenges. As a profession, we are trained to meet our clients where they are, but never has that been more daunting and more essential for all of us to do! Our Society is here to support you. We hope you will join us for the rescheduled 51st Annual Education Conference, "Emerging Voices," now taking place online via Zoom over three consecutive Saturday mornings: October 24, October 31, and November 7. Please find the details here and on our website.

We cannot anticipate what the coming months will bring, but we know that as a Society we will continue to face it together and with the support of our community.

With peace and gratitude,

Shannon Boyle, LCSW
President

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Ad Deadlines: March 15 and October 15

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Emerging Voices

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3 SATURDAY MORNINGS:

October 24, October 31 & November 7, 2020
10:00 AM – 12:30 PM

7.5 Contact Hours will be awarded for the entire series
2.5 Contact Hours for each webinar

For more information visit WWW.NYSSCSW.ORG

SPEAKERS/PRESENTATIONS:

SATURDAY, OCTOBER 24, 2020
Gender Relations Today | Graciela Abelin-Sas Rose, MD
What Women Want and What is Wanted by Women? | Arlene Kramer-Richards, Ed.D.

SATURDAY, OCTOBER 31, 2020
What Should a Wife Want? | Janice S. Lieberman. Ph.D.
Single Mothers by Choice; Challenging Psychoanalysts' Prejudices | Margarita Cereijido, Ph.D.

SATURDAY, NOVEMBER 7, 2020
Fixed or Fluid: Gender and Sexuality in Same Sex Partners | Michael M. Crocker, DSW, LCSW
Temperament: Clinical and Cultural Implications | Brian Quinn, Ph.D., LCSW

By Hafina Allen, LCSW, Chair

A Leading Resource in Fast-Changing Times

So much has changed since I last wrote to you in the fall of 2019. The Membership Committees across all the chapters have been adapting to the realities of networking in a pandemic. In early March, just as most of the MSW programs statewide were switching from in-person instruction to online and remote learning, the Membership Committee was able to host one in-person event, our annual Graduation Boot Camp.

Boot Camp

At this event, I presented on LMSW and LCSW licensing requirements in New York State. Chris Ann Farhood, LCSW, Secretary of the State Society and a member of the Met Chapter Membership Committee, joined me and presented on resume writing and job search tips. Before becoming a social worker, Chris worked in Human Resources, giving her a unique perspective on how to catch the eye of hiring managers. As always, this event was well attended and we gained many new members who, seeing value in our programing, signed up. I always enjoy this event, as it provides an opportunity to meet graduating students and welcome them to our field.

At the Boot Camp, Chris Farhood, LCSW presented on resume writing and job search tips.

Jump in New Memberships

Having missed out on several potential recruitment events in the spring, the Membership Committee has been exploring new ways of connecting with new and perspective members. In March and April, we saw an unexpected jump in new memberships and returning members. I believe that many people who were facing the realities of telehealth and looking for ways to stay connected to other clinicians have found that NYSSCSW fills these needs.

As always, NYSSCSW has been a leading resource for our members, with the Practice Management Committee keeping us up to date on ever-changing state policies and providing guidance on billing for telehealth sessions. Our listservs have also been highly active as members look for ways to stay connected and share resources.

Online Licensing Study Group

The Membership Committee's newest offering is an online licensing study group. This is a program that we have been thinking about in the Met Chapter for some time, but we were unable to find a suitable location for the group. Now, with online meetings being the norm, we have been able to make this group a reality and open it to members in all chapters. This group is appropriate for individuals studying to take both the ASWB Masters Exam and the ASWB Clinical Exam. We use sample questions and discuss the answers, as well as the knowledge, skills, and abilities tested. In the week leading up to the first meeting in June, seven new members joined four different chapters to gain access to this study group!

CONTINUED ON PAGE 6

Hafina Allen, LCSW

"As State Membership Chair, I have felt more connected to all our chapters than ever before as committee members (statewide) have reached out to brainstorm ideas."

 Continued from page 5

Meeting Online

While in-person events have been on hold for the past several months, many chapters have been using online meetings to stay connected. As State Membership Chair, I have felt more connected to all our chapters than ever before, as Membership Committee members from many chapters have reached out to brainstorm ideas. Some chapters have been hosting online happy hours and many chapters have opened their meetings to the full membership, who can easily join online meetings from the comfort of their homes or offices.

More than ever, word of mouth is the best way for us to network and connect with each other and with potential new members. Thank you to everyone who has been spreading the word about the Society! Please keep telling your non-member colleagues about what you find more rewarding or beneficial about your membership.

On behalf of all the Membership Committee members statewide, I hope you are staying safe and healthy and I look forward to "seeing" you over the coming year.

THANK YOU GIFT: When someone you recommend joins online and lists you as the referral, we'll send you one of our special tote bags as a thank you.
nysscsw.org/benefits-of-membership

Update Your Website Profile If You Provide Distance Psychotherapy

If you have transformed your practice by the use of video and telephone sessions, please add that information to your profile on the Society's website: **www.NYSSCSW.org**

Since the onset of the pandemic and shelter-in-place requirements, many people are using the "Find a Therapist" tool on our website to locate a clinician with long-distance skills.

Now is a great time to take a few moments to update your profile. Add distance psychotherapy if it applies and check the other information to see that it is correct. Please note that we have added a new category: *Telementalhealth Certified*.

The online profile is a great tool to help people connect with clinicians who match their needs! We hope you are taking full advantage of it.

—Helen T. Hoffman, LCSW, NYSSCSW Website Editor

To change your profile on the website:

- **Go to "Member Log-in"**
- **Select "Click here to view and edit your profile"**
- **Click "Edit" to make changes**
- **Scroll down and check "yes" under *Telemental-health Certified* if you have this certification.**
- **Under "Other Interests" you might want to add "telephone sessions and video sessions available."**
- **Consider adding a headshot or professional photo to personalize your profile.**

MSW Class of 2020 Graduated Sans Ceremony, But with Great Resolve

By Helen Hinckley Krackow, LCSW, Met Chapter President

FORTY MEMBERS of the MSW Class of 2020 joined the NYSSCSW this year. We heartily welcome them to our vibrant profession. They are our future, with all the talents, skills, and passion that are needed now, more than ever, to help heal and rebuild society.

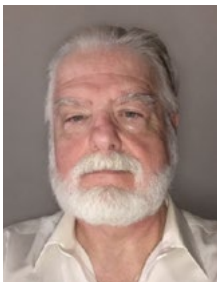
Many of these graduates spent the final months of their studies under lockdown due to the Covid-19 pandemic. Their coursework continued online, but they lost about a third of the in-person classes and missed out on the proud moments and fanfare of in-person graduation ceremonies.

Some of them or their family members lost their jobs and now face difficult employment prospects. Some have suffered the illness or death of friends or family members.

Earning an MSW is a significant achievement in ordinary times, more so during this tumultuous period. These graduates have shown extraordinary resilience.

Survey of the New Professionals

We conducted an online survey of the 40 new graduates who joined the Society to find out how they were affected by the pandemic and to assist them in entering the field.

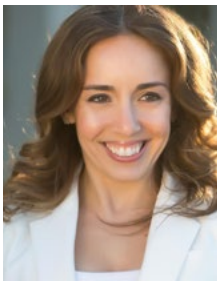


Patrick O'Connor, a graduate of the Hunter College Silberman School of Social Work, responded to the survey question about what led him to pursue his MSW. He said that "the need to improve conditions in society" was the reason he enrolled, following a four-decade career in technology. He was on the AT&T team that helped the New York Stock Exchange reopen after 9/11.

Patrick's current areas of interest are in gerontology, substance abuse and clinical practice. However, he said he has "stopped looking for work," until he can find a safe work environment and protect himself and his family from contracting the virus.

Fieldwork placements ended abruptly for most students when New York's shelter-in-place orders came down. It resulted in the loss of valuable face-to-face experiences, so necessary to social work training.

Elisha Fernandes Simpson, another graduate of the Silberman School at Hunter, was working at a women's hospital, in the psychiatric unit, when her placement was cut short. She was also disappointed when graduation was held online. "It didn't feel real," she said. "I need closure for this tremendous milestone." Before pursuing her MSW, Elisha founded the Crossover Yoga Project, a nonprofit that has empowered over 4,500 girls involved in the criminal justice system through trauma-informed yoga, mindfulness, and creative arts expressions.



Sarah Hatkoff earned her MSW at the Fordham Graduate School of Social Service. "The pandemic sent me home from my placement on March 11," she said. "My internship was with VCS of Rockland, providing counseling services and mental health treatment. I provided individual counseling, taught a parenting skills class, and provided education for separating or divorced parents. Even though the placement ended in March, I am continuing to volunteer to support these vital programs."

While sheltering in place for months, Sarah said, "I have learned to be more flexible and developed new skills, like cooking African, Indian, Israeli and Latin dishes. I also have learned to germinate seeds into a beautiful lush garden."

In general, the surveys revealed a strong, dynamic group of graduates. The Society can help them grow into a "lush garden" of new practitioners. We encourage them to try the Mentorship Program, chaired by Chris Farhood, LCSW, and the Licensing Workshop, led by Hafina Allen, LCSW [see Page 2 for contact information]. These are unusually hard times for new and seasoned professionals alike. Surviving them will make us all better clinicians.

By Marsha Wineburgh, DSW, LCSW-R, Legislative Chair
(With thanks to Karin Carreau, LCSW Lobbyist)

LCSW Advocates Never Missed a Beat!

New York's 2020 legislative session was proceeding with business as usual until mid-March, when two members of the Assembly tested positive for Covid-19. Within 24 hours, life swiftly changed as the capitol was closed to "non-essential" staff and all visitors. The legislature quickly employed social distancing protocols and realigned the way it works, shifting much of the communications and negotiations to video conferencing, phone, and email. Governor Cuomo became our daily conductor through the ensuing confusion.

Despite this unforeseen disruption, representation of Licensed Clinical Social Workers by our Albany lobbyists continues effectively. Working closely with the Governor's office, the State Education Department, key legislators and staff, and peer organizations, we have addressed the following issues:

- Clarifying the infrastructure and logistics associated with broadening the allowance of tele-mental health services. This included issues such as permitting all CE credits in 2020 to be accrued via online technology and the specifying the location and the technology for permitting mental health services provided by supervised LMSWs to count as clinical hours leading to LCSW licensure.

- Advocacy highlighting the barriers to reimbursement for tele-mental-health services for private practitioners who are not currently authorized to directly bill Medicaid for their services.

- Assistance to the Governor's office in recruiting clinicians willing to provide pro bono services through the Stateline Mental Health Hotline and, subsequently, assuring such providers have liability protection.

- Advocacy to limit out-of-state providers to practice in New York State. The original Order allowed any provider licensed in the country OR Canada (all of whom have a lower threshold of licensure requirements) to practice in New York during the crisis. Along with partner organizations, we recommended language that would only allow for such practice in only two instances: for the sake of continuity of care, or if one's specialty practice area is required in the state (such as renal social workers).

- Social work schools were asking for a temporary waiver of licensure. We successfully opposed this idea, pointing out that testing facilities had begun to re-open. In addition, many settings have exemptions still in place (until June 24, 2021), which allow the practice of the LMSW and LCSW in a broad array of settings. Those setting include any setting operated, funded, or regulated by OMH, OCFS, OPWDD, DOCCS, OASAS, SOFA and DOH. We are currently working to determine if there is any need for extending limited permits.

- We have advocated that the Governor include the profession as a member of the "frontline" work force, *and*

- We have advocated for extending tele-mental-health services in in partnership with NASW, psychology and psychiatry beyond the Covid emergency. *(See NYSSCSW website – Covid-19)*

Our lobbyists have been highly effective and imaginative in protecting our professional status in these challenging times. Having quality representation in Albany is one of the most important membership benefits of the NYSSCSW.

 By Jay E. Korman, LCSW-R, BC-TMH

When Covid-19, Ethics, and the Law Collide

THE ADVENT OF the Covid-19 pandemic brought the flight of many patients from New York to their summer homes, parents' homes, or other locations. This has created a great demand for clinicians to continue their work through means other than traditional face-to-face meetings. Telehealth has become essential to our practices, but it has also resulted in tension between our conceptions of what is ethical practice and what is legal practice. Questions raised by this new wrinkle have not always been answered clearly.

For one thing, our Code of Ethics and that of other organizations to which we may belong, as well as our licensing regulations, require us to be competent in any methods of practice we employ in our work with patients. From EMDR to hypnosis, from Imago therapy to Schema therapy—whatever methods we have chosen—we first sought training before incorporating them into our work.

How many of us knew how to use telehealth technologies before the pandemic struck? How many of us took training in the legalities and ethics involved in using these means of delivering services to our patients?

If we are required to be competent in every aspect of our work, what happens when we are suddenly thrown into a new way of working? Don't we need a rapid way to learn how to use it effectively? What would be the best way to accomplish that? Opinions on this topic are varied, suggestions have been made, but no solution yet has been found. We stumble forward, learning as we go. Even those of us with some training always run into new wrinkles: technical problems with our equipment, the vicissitudes of the Internet, the decrees of the government(s), or the ups and downs of life in general.

When patients relocate

Most codes of ethics require us to not "abandon" our patients. This means continuing to work with patients until such time as they are ready to leave treatment or, if the need arises, referring them to someone else. These codes also ask us to be mindful of and work within the local laws governing our practices.

States regulate the practice of social work through granting licenses and permits. Some states have made emergency declarations allowing clinicians to work with *current patients*, either without a special permit, or with an easily obtained permit or a temporary license.

However, not all states have adopted such measures. What are we to do when patients leave New York for another state that requires a full license to practice? Should we ignore the laws of either state and follow what would seem to be the ethical course of action in the situation? Should we abandon our patients, or assist them in finding a local clinician, thereby losing them as patients?

If we are ethically bound not to abandon our patients and to follow all local laws, then it would seem that the proper course would be to assist our patient in finding a local clinician, even if that costs us a patient.

Returning to the office

Another ethical consideration is when to return to our offices after the sheltering-in-place restrictions are lifted. How will this affect our practices? Do we expose our patients, and ourselves, to the possibility of contracting the virus when traveling to and from our offices? What about the maintenance of the common areas and cleaning our offices in between patients to prevent cross-contamination? If a patient should become sick, what is our liability? When a conta ct tracer asks questions to track the course of the disease, are we expected to reveal patients' names and information?

Perhaps we should not open our offices to patients until there is a vaccine or treatment that minimizes the effects of the virus. Prudence suggests not meeting with patients in our offices until such time as it can be done safely for everyone involved. However, that would leave out the patients who cannot use telehealth technologies. Would they have to suffer without treatment? What about clinicians who cannot navigate the new technologies? Do they have to close their practices?

As this health emergency enters a new phase, and the dust settles, we will enter a "new normal." Today's ethical quandaries will likely become more routine, our questions less novel, and we will find more solutions. Telehealth, for example, will probably become an accepted and enduring method of treatment, with some clinicians eventually returning to traditional practice. Training and interstate cooperation will likely change accordingly, though that may be slow in coming. One thing is sure: The more things change, the more they stay the same.

By Jay E. Korman, LCSW-R, BC-TMH, Chair

Covid-19: Challenges and Opportunities

WHEN THE WORD CAME OUT in mid-March/early April that offices were to be closed because of the coronavirus sweeping New York, many of us were caught flat-footed. Our practices were not set up for therapy in any form other than the traditional face-to-face, in-office visit. Many of us didn't have the training, the technology, the knowledge, or the set-up to transport our practices from office to home.

Many issues and questions arose: Where should I work? What about where my patients are? Can they be outside of New York? How should I communicate—by phone? Or online, with telehealth? What about HIPAA compliance?

The question of finding HIPAA-compatible chat software became moot when the Department of Health and Human Services determined that, for now, they would ease the HIPAA restrictions on patient/clinician communications. For the first time, Medicare would allow the use of the telephone to provide remote sessions to patients. Supposedly, this policy will last only for the duration of the emergency. Frankly, though, it is hard to imagine it will end when the emergency is over, because it is difficult to take away services once they have been granted. We'll have to see what happens as conditions change and the emergency is declared to be over.

Across state lines

Society members also posed questions about patients who work in New York, but live in New Jersey, Connecticut or even Pennsylvania: Can we work with them when they are at home? Or can we work with students who are enrolled in school in New York, but went home to stay with their parents who live throughout the United States or across the globe?

Suddenly, the scramble was on to learn about licensing in other states: was there reciprocity, or was a permit, a temporary license or nothing less than a full license required? Members wanted to know why the federal government wasn't stepping in to declare that, during the emergency, it would be permissible to work across state lines. The answer, of course, is that regulation of professions is left to the states and the Constitution enshrines states' rights as untouchable. Many members applied for and received emergency permits, temporary licenses, or even full licenses in other states where necessary.

Questions about international practice also arose. There were no clear answers, but the advice was to contact the country's embassy and the U.S. Department of State for information. Malpractice coverage for work across state or international borders also became an issue when some insurers said they will cover us, while others will not.

Billing for telehealth

The next question to raise its ugly head was: How do I bill insurance companies for telehealth?? Unfortunately, the answer was neither clear nor simple. In-network clinicians were first told to use one set of Place of Service and modifier codes, only to find that in doing so they were paid less by Medicare and some of the commercial plans. Then Medicare told us to use a different set of POS and modifier codes, while some of the commercial plans kept to the original set.

Cost-sharing, the copays and co-insurance that patients pay, was to be waived for all patients by in-network providers, except in the case of self-funded or ERISA plans. The costs, however, would not be waived by out-of-network providers. Members were unclear who would pay the cost-sharing charges when the patient did not. Were we expected to take a loss because the charges would go unpaid? Which plans would cover the cost-sharing and which would not? Should we collect the cost-sharing charges from our patient and then refund them? Or not collect them at all? Clinicians who were billing monthly were left in the dark longer, while those who submitted claims more frequently found out sooner whether the carrier was going to pick up the costs.

Some clinicians already had set up home offices, so when the New York shutdown began, it was relatively easy for them to transition to providing telehealth services from home. However, many of us had to create a home office from scratch that was suitable for "meeting" with patients.

Working remotely would mean less control over the physical framework of our sessions. Clinicians were accustomed to the relative anonymity of our offices, where there were just a few personal touches. Now, we would be inviting patients into our homes. Could we create a separate space for sessions with appropriate background features? What would it signify, if anything, to our patients? On the other hand, with telehealth, we would have a window into the patient's home. What information or meaning could we derive from what could be seen? Would we be able to see our patients' movements, expressions, and reactions clearly?

These challenges have given us the opportunity to re-examine our

practices through a new lens. What additional tools we can bring to bear, and what skills do we have or still need to develop and hone? While there are advantages to telehealth, there are definite losses as well. What do we gain and lose because we are unable to meet with patients in person?

Currently, we don't know when we will be able to safely return to face-to-face work. In-person practice might involve wearing masks and taking other safety measures that could change the dynamics enough to make our work more difficult.

It can be said that we all wear metaphorical masks and that, in treatment, we learn to put them aside, even if only for a time. Now, we are wearing actual masks, and it may not be safe to take them off, especially in the consulting room.

Only time will tell how this health crisis is going to permanently change the landscape. Telehealth is likely to become more prevalent than it was pre-Covid, with some clinicians choosing to give up their offices and only work online. Others may keep a mix of in-person and remote sessions. Safety precautions are likely to be in the forefront for a while, with everyone very conscious of contact and spacing. Clinicians may rearrange their offices to create more space between themselves and patients and eliminate choke points that force close contact or passing in a narrow space. Even payment methods may change, with more clinicians opting for contactless payment through an online service or payment via phone app and reader, like some stores are doing.

One thing is certain: this crisis already has changed the way we practice and will continue to do so. As a profession, we will continue to be flexible and meet the challenges.

By Marsha Wineburgh, DSW, LCSW-R, ACE President

Zoom Education Takes Off

The coronavirus outbreak early this year has propelled many innovative changes. For ACE, the major addition has been the arrival of Zoom educational programing.

As of February, we had approved 278 clinical programs available for continuing education in the traditional in-person format. This achievement was due to the hard work of our Director of Professional Development, Susan A. Klett, Ph.D., Psy.D., LCSW-R.

In May, we initiated our first Zoom presentation in what we plan as a continuing opportunity for online learning. Thanks to the skill and determination of the Society's Administrators, Kristin Kuenzel and Jen Wilkes of Total Management Solutions, we have created a professional educational experience which satisfies the requirements of the New York State Education Department.

The Mid-Hudson Chapter bravely accepted the challenge of our initial foray into online education with a presentation on May 2. The popular and able speaker, Brian Quinn, Ph.D., LCSW, presented *Depressed, Borderline or BiPolar?* to good reviews.

For upcoming webinars, including the 51st Annual Education Conference of the NYSSCSW, visit www.ace-foundation.net

ACE Teaching Requirements

For many months, there has been confusion over the requirement for teaching experience for NYSSCSW members who apply to present an educational program. After considerable discussion, the ACE Board approved the following policy:

> ***ACE Guidelines for Contact Hours***
> *Effective immediately, the following policy is enforced:*
> If a licensed presenter has no teaching experience or clinical experience, ACE will determine if their qualifications are sufficient to present a specific workshop. If the presenter, once approved, is unlicensed, a licensed mental health professional must be in charge of the presentation.

Going forward, the Board is considering building a library of clinical presentations that will be available to the mental health community. We note the disappearance of psychodynamic and/or long-term therapy education across all mental health fields and we want to promote access to the theory and treatment that support this important modality. Anyone interested in working on this project, please contact: mwineburgh@gmail.com.

The Advanced Clinical Education (ACE) Foundation is the educational arm of the NYSSCSW. ACE provides continuing education opportunities to licensed clinical social workers, licensed master social workers and other mental health professionals. Visit ACE online at www.ace-foundation.net.

Liability of Professionals for COVID Transmission at Their Offices

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1. In general, for a practitioner to be found to have negligently allowed the transmission of an infectious disease such as COVID, a duty of care, already established by the practitioner-patient relationship, must be breached. For a mental health practitioner, breach ordinarily means violation of a directive of a State Department of Health or the federal Centers for Disease Control. For COVID, these might be: failure to "test" (testing may be by questioning rather than by physical testing) employees and patients for the virus; failure to screen employees, patients and any guests for symptoms; failure to enact reasonable safety protocols such as mandating the use of masks and requiring social distancing measures to protect patients; failure to adequately train staff in implementation of safety measures, and; failure to enact disinfectant and social distancing guidelines for employees.

Assurance of compliance with State guidelines is maintained by completing and affirming online the New York Forward Business Reopening Tool, found at: businessexpress.ny.gov/app/nyforward

Not only should appropriate measures be taken and confirmed, but patients and staff should be notified of them. The best consent and notice to patients that I have reviewed is one published by the American Psychological Association: apaservices.org/practice/clinic/covid-19-informed-consent

After establishing a breach of duty, there is a need to demonstrate that the breach was the actual cause of the plaintiff's harm, in other words, that the virus was transmitted at the premises of the practitioner. Such proof may be quite difficult to establish.

2. In April, New York State passed the "Emergency Disaster Treatment Protection Act," (the "Act") that provides immunity from liability to healthcare professionals for certain actions taken during the pandemic. Healthcare professionals covered by the Act include all mental health professionals and their contractors and employees. Under the Act, healthcare professionals are immune from any civil or criminal liability for harm alleged to have been sustained as a result of an act or omission in the course of providing "health care services," if the healthcare services were being lawfully provided in accordance with State directives; the act or omission occurred while providing healthcare services; the treatment of the patient was affected by the professional's actions taken as a result of the COVID outbreak; and the professional acted in good faith. Under the Act, "Health care services" include: any treatment for COVID, but more importantly for mental health practitioners who do not directly diagnose or treat COVID, "the care of any other individual who presents ... to a healthcare professional during the period of the COVID-19 emergency declaration." Immunity does not apply to gross negligence* or intentional or reckless misconduct. In my opinion, at least for the duration of the pandemic, the Act contains significant protection for practitioners against any allegations that their actions negligently caused the transmission of COVID to a patient. It also establishes a public policy of shielding practitioners who act in good faith that may influence legal decisions afterwards.

* Gross negligence is deliberate and reckless disregard for the safety of others. In contrast, "simple" negligence is the failure to use the level of care and caution that an ordinary person would use in similar circumstances, usually involving carelessness or inattentiveness that causes an injury.

3. Any claim by an individual that she or he became infected at a professional's office may be covered for defense costs and indemnification under the professional's business owner's or general liability policies* that insure against "bodily injury" arising from an "occurrence." An individual who becomes sick as a result of exposure to COVID suffers a covered "bodily injury." Such policies also commonly require an "occurrence," which is usually defined as being "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." From the standpoint of the insured, any viral transmission was the result of an "accident," i.e., was unexpected and unintentional. To decline coverage, insurers may try to argue that there was no "occurrence" or "accident" as such if (1) viral spread is so significant that a substantial portion of the relevant population are carriers (i.e., contagion was expected) or (2) a claimant asserts that the virus was transmitted by an employee or independent contractor of the insured who showed visible symptoms of COVID or who is known to have contracted the virus (i.e., contagion was intentional).

* Business and general liability insurance are different from professional liability (or malpractice) insurance. The main difference between business and general liability insurance and professional liability insurance is in the types of risks they each cover. Business and general liability covers physical risks, such as bodily injuries and may also cover property damage. Professional liability covers errors and omissions made in the course of providing your professional services.

NEW MEMBERS OF NYSSCSW*

NAME /CHAPTER	
Ackerman, Brian W.	MET
Adams, Ariel	MET
Anene, Stella Nkem	MET
Atwell, Emily, LCSW	WES
Bae, Angela	MET
Bagnini, Jenna L., LMSW	WES
Ballesteros, Diana	MET
Bamberger, Emma, MSW	MET
Belin, Stacey	MET
Bennett, Alexandra L.	MET
Benson, Yeside	MET
Berman, Marjorie	MID
Birenbaum, Susan, LCSW, MBA	MET
Borgida, Mitchell C., LCSW-R	MET
Botta, Diane	MET
Breen, Mary, LCSW	WES
Brown-Mandel, Susan J., LCSW-R	MET
Buckley, Jillian	MET
Campos, Vikki T.	MET
Cannon, Emily Rose	MET
Chen, Chen, MSW	QUE
Chen, Deborah	MET
Contreras, Michelle	MET
Cotrone, Emily	MET
Coyle, Melissa	SUF
Dakss, Lynn A., LCSW-R	NAS
Daugherty, Emily Erin	MET
Davis, Diane L.	MET
Deprince, Amie	MET
DeSiena, Candace, LMSW	WES
DiMuzio, Katie	MET
Domanico, Rachael	NAS
dos Santos Teixeira, Robert, MSW	MET
Duffy Traslavina, Eileen	MID
Edmond, Katrina D.	MET
Ehrenfeld, Tamar, LCSW	NAS
Einhorn, Elyse B.	WES
Farzam, Melissa P.	MET
Feinstein, Gayla	MID
Fernandes Simpson, Elisha	WES
Figueroa, Elba, LCSW-R	MET
Forrest, Charlotte, MS	MET
Friedman, Emily	WES
Galligan, Diane	MET
Geldof, Carol G.	MID
Gilman, Jane, LCSW-R	MET
Gooding, Aline M. L.	MET
Gordon, Hailey R., MSW	MET
Graff, Michelle L., LCSW	SUF
Greenberg, Jennifer	MID
Greenfield, Jessica, MS	MET
Haddock, Daphne	MET
Harkins, Joseph	MID
Harrington, Kristen	MID
Hatkoff, Sarah, MSW	ROC
Heimowitz, Ira J., MSW	MET
Hershey, Sean, LCSW	MET
Higgins, Lynn	NAS
Hirsch, Ruth	MID
Hirschhorn, Bonnie L., LCSW-R	MID
Hoffnung, Amy	ROC
Hollenkamp, Kathryn R.	MET
Hughes, Shanae	MET
Juliana, Patti, LCSW-R, Ph.D.	WES
Jung, Huihwa	MET
Kakon, Yocheved	MET
Kalai, Ruthie, LCSW, M.Ed., MSW	WES
Kay, Caitlin E.	MET
Kazinduka, Doreen	MET
Kemp, Karin	MET
Kenney, Elizabeth A., LMSW	MET
Kenny, Christine, LCSW	ROC
King, Corrine E., MSW	MID
Kuhlor-Plummer, Shenelle D.	MET
Ladino, Ana J.	MET
Larson, Jennifer A., LMSW	SUF
Lawrence-Savane, Tricia, Ph.D.	MET
Lee, Hannah R.	MET
Lelin, Sarah, LCSW	NAS
Levy, Judith L.	MET
Lippin-Foster, Rachel A.	MET
London, Cara, M.R.	MET
Lustgarten, Lindsay	MET
Magno, Laura	MET
Maloney, Katherine C., LMSW	MET
Manukian, Elza	MET
Marra, Erin M., LMSW	WES
Martin, Lucille A.	MET
Mathe, Denise	MET
McKenzie, Paula S.	WES
Miao, Qiyuan (Grace)	MET
Millian Katz, Melissa, LCSW	WES
Miretsky, Anna	MET
Mirjany, Mana, MSW, LCSW, Ph.D.	MET
Moore, Kenisha, MA	MET
Mozeson, Ariel, DCSW	MET
Neuhaus, Jonathan	MET
Nussinov, Tariro	MET
O'Connor, Christine G., LCSW, Ph.D.	MET
Osuna, Jane, LCSW-R	ROC
Otis, Victoria	MET
Parichy, James	MET
Parkhurst, William, MSSW	MET
Paster, Rebekah	MET
Paul, Elizabeth J.	MET
Perez-Machado, Jacqueline N.	MET
Perkins, Catherine, LCSW	NAS
Peterson, Marcela A.	MET
Pressman, Julia, LMSW	MET
Rader, Carlen, MSW	MET
Roddick, Gwilym, DSW, LCSW	MET
Rosen, Loren	NAS
Rosenberg, Jessica, LCSW-R	MET
Ryan, Elizabeth J., LCSW-R	WES
Sagram, Amreeta	MET
Saldana, Marlene	MET
Santiago, Rebecca A.	MET
Schaffer, Roberta, LCSW-R	WES
Scheinberg, Danielle, J.D.	NAS
Schuck, Julie C., LCSW	MET
Schwartz, Lilah	MET
Serantes, Lauren N., LMSW	ROC
Shiovitz, Talia	MET
Shubaev, Juliet G.	MET
Skillman, Pamela, LCSW	WES
Skinner-Spain, Aaron, LCSW-R	MET
Snyder, Kate	MET
Stanger, Elana F., LCSW	MET
Stanger, Melissa, LMSW	MET
Sullivan, Jessica C., LCSW-R	MID
Sutton, Carolyn	MID
Tabossi, Carla	MET
Whyde, Ezra, LMSW, MSSW	MET
Wischstadt, William	MET
Wiss, Rachel, LMSW	MET
Yazdani, Erik O., LCSW, MBA	MET
Yeo, Michelle, LMSW	MET
Yussuf, Hayat M., MBA	MET
Zairis, Lena, LMSW	ROC

CHAPTER KEY: MET–Metropolitan, MID–Mid-Hudson, NAS–Nassau County, QUE–Queens County, ROC–Rockland County, SI–Staten Island, SUF–Suffolk County, WES–Westchester County. **These new members joined between October 1, 2019 and June 30, 2020.*

Mid-Hudson Chapter

Linda Hill, LCSW, President

The first half of 2020 has been a time of change, of challenge, and of adaptation. We began the year when our winter workshop, *Time and Slowing, Attachment and Loss in Time-Limited 16-Session AEDP Therapy*, presented by Gail Woods, LCSW, LMFT, took place at Mental Health America in Poughkeepsie at the end of February. The following weekend, the chapter held its first movie and discussion event, featuring the film *Marriage Story*, at member Mila Sverdlov's home.

Little did we realize that within two weeks we would be "on pause," leaving our offices and providing treatment via tele-mental health from our homes. In response to the myriad questions that arose regarding the use of virtual platforms, insurance coding, and other practice-related issues, we began holding Chapter member meetings via teleconference and Zoom, in addition to our monthly Peer Consultation Group meetings, that were able to continue as we shifted from in-person gatherings to the use of these technologies.

Another exciting first was the advent of NYSSCSW live webinars at the end of May, when our Chapter hosted, *Depressed, Borderline, or Bipolar?* presented by Brian Quinn, LCSW, Ph.D. The tele-workshop format allowed for members from all chapter locations to participate and learn together without concern for travel and distance. In June, Chapter members Carolyn Bersak, DSW, LCSW, and Jacinta Marschke, Ph.D., LCSW, conducted an instructive Zoom presentation for local Adelphi students entitled *Path to Private Practice.* Most recently, we held our first online social event for members, a well-attended *Happy Hour from Home.*

Although the pandemic has certainly proven to be formidable, it has also fostered our resilience and strengthened our sense of community as we seek to help one another in acquiring the new information and skill sets that this crisis demands of us. We are grateful for all the support we have received that has enabled us to continue our programming despite the pandemic. Our heartfelt thanks to Society President Shannon Boyle, LCSW, Marsha Wineburgh, DSW, LCSW-R and Susan Klett, Ph.D., Psy.D., LCSW-R, of the ACE Foundation, and to Brian Quinn, Ph.D., LCSW-R, for their enthusiasm and perseverance in learning how to convert our workshop into webinar form; to Jay Korman, LCSW-R, State Practice Management Committee Chair, for graciously attending our meeting and for all his knowledge and effort in educating us about navigating the insurance maze and managing our clinical practices during the pandemic; and to Kristin Kuenzel, Administrator and her invaluable team in the NYSSCSW Office for the ample time, patience, and technical support we have received to make our Chapter activities possible.

Nassau Chapter

Eleanor Perlman, LCSW-R and Patricia Traynor, LCSW, Co-Presidents

On behalf of the Nassau Chapter Board, it is our pleasure to provide you with this update. First and foremost, we want to thank our Board members for their hard work, dedication, and commitment to the Chapter. Thank you Carline Napolitano, LCSW (Website, Programming Committee, and Newsletter), Barbara Murphy, LCSW-R, ACSW, BCD (Public Relations), Susan Kahn, LCSW-R, BCD (Newsletter, Book Club) Joseph Reiher, LCSW, BCD (Treasurer, Programming Committee) Jenifer Shapiro-Lee, LCSW (Mentorship), Linda Feyder, LCSW-R, ACSW (Secretary, Membership), Jannette Urciuoli, Ph. D., LCSW (State Member-at-Large), and Faith Kappenberg, LCSW (Scholarship Committee and University Liaison).

Since the onset of the pandemic, our professional lives have been in a state of constant change. We've dealt with the necessity of continuously making quick adjustments to ensure the safety and well-being of our patients. Chapter members have worked together to share the latest information regarding telehealth, consent forms, billing, and CDC regulations for reopening our offices, and have provided support to colleagues struggling to navigate through the stress and emotional trauma of the pandemic. By adapting to telehealth, obstacles that could have prevented patients from receiving mental health services have been overcome. Many of us are finding some unexpected benefits using telehealth. For example, even when offices are reopened, we will still be able to conduct sessions when people cannot get to the office, either because they do not have transportation or due to illness or inclement weather. A silver lining indeed.

Over the past couple of months, the Nassau Chapter Board has been busy putting together events and looking for opportunities to increase our exposure. The Programming Committee organized a free Zoom conference on *Treating Anxiety in Children and Adolescents: A Behavioral, Emotional and Neurological Perspective.* Facilitated by Roger Keizerstein, LCSW, the conference had 33 participants. During this program, we had the pleasure of awarding the Sheila Peck Scholarship in the amount of $500 to Carmen Lemus, BSW, a graduate from Molloy College.

On October 25, we will again offer a conference on *Depressed, Borderline, or Bipolar?* led by Brian Quinn, Ph.D., LCSW.

Since April, the Mentorship Committee has duly and energetically held monthly meetings. The Membership Committee continues to collaborate with the Board's other committees to develop partnerships, expand our outreach, and sponsor conferences to increase awareness of the benefits of membership in the Society.

The Committee for the Aging, headed by Sheila Rindler, LCSW, meets monthly. Prior to the pandemic, they met in person; now they meet by Zoom.

The Website Committee has been actively working with Kristin Kuenzel, our Society's Administrator, to update the Nassau Chapter's web page. The Public Relations Committee has been working closely with the State Board to develop outreach and marketing tools to promote the benefits of membership in the Society. Both committees are engaged in improving our website's social work directory to increase referrals to our members.

The Scholarship Committee is in the planning stages of forming a partnership with Adelphi University for an MSW student scholarship. We will be meeting to fine-tune requirements and dates for the scholarship. In addition, we will be recruiting MSW students who can serve as liaisons between the school and the Society. We will continue to offer a scholarship to a BSW student at Molloy College who plans to attend an MSW program in the fall.

This fall, by popular demand, we will be reintroducing the Book Club. Presently, the Nassau Board members meet monthly by Zoom, with dates and the times posted on the Listserv. We encourage all members to attend and volunteer their time and talents. As soon as possible, the Board will organize an in-person event to celebrate our members, who are the heart and soul of our chapter.

Westchester Chapter

Andrea Kocsis, LCSW, President
Susan Jocelyn, Ph.D., Leadership Committee Chair

Our chapter continued to grow in membership and vibrancy through 2019. However, the year brought some challenges that we are addressing in 2020.

In 2019, we held meetings on the first Saturday of each month at the Mental Health Association of Westchester County in White Plains. Nine of our ten monthly meetings offered CEU presentations, the most of any chapter in the state.

Most months, our meeting day started in the morning with clinical practice groups, including Peer Consultation; Group Therapy Practice; Mentorship/Private Practice /Career Building; and Integrating Mindfulness, Applied Neuroscience and Psychotherapy Practice. Networking and a brief business meeting followed, and then a 2- or 3-hour CEU presentation and discussion.

In January 2019, our annual film presentation and discussion featured *Three Identical Strangers*. Our 2019 CEU presentations included *The Empathy Wars: Understanding Empathy Across the Disciplines; Emotionally Focused Therapy; The Integration of Harm Reduction Therapy in the Treatment of Substance Abuse Disorders; EMDR: A Primer-Treatment for Trauma, Anxiety & Depression; Medical Marijuana; Out-of-Control Sexual Behavior as a Symptom in Insecure Attachment; Working with Dreams in Individual Treatment: A Case Study of a Young Adult Male Presenting with Depression & Academic Difficulties;* and *Addressing the Clinical Needs of Families with Transgender and Gender Non-Conforming Clients.*

In 2019, the Westchester Chapter continued to earn NYSSCSW and ACE the most revenue of all chapters in the state from these CEU presentations. However, this distinction was detrimental to our chapter. The combination of the ACE and TMS costs and honoraria, in addition to other chapter expenses, has left us with an operating budget deficit in recent years. This challenge prompted our Leadership Committee to consider offering fewer CEU presentations in 2020 to preserve our fund balance.

An additional issue has been the lack of members willing to step up to leadership positions. Several positions went unfilled throughout last year. Recently, however, we welcomed a new Recording Secretary, Treasurer Assistant, Newsletter Chair, and Education Committee Chair. Also, several new members joined the Education Committee, which does a great job engaging CEU presenters. Currently, we have one open position – Audio/Visual Assistant.

Our 2020 schedule began with a showing and clinical discussion of the film, *Hidden Figures*. We decided not to meet in February to conserve funds. Presentations were scheduled for March, April, May, and June, but the coronavirus emergency caused us to cancel and reschedule them for the autumn.

We look forward to a full schedule of quality presentations this fall. Most, if not all, of these presentations will appear via Zoom:

September 12 – *Staying On Track: Support & Treatment for Individuals with Early Psychosis*

October 3 – *Restoring the Resilient Nervous System: Principles*

CONTINUED ON PAGE 37

Deprivation and Abundance in the Time of Coronavirus

By Mary Anne Cohen, LCSW

Mary Anne Cohen, LCSW, is Director of The New York Center for Eating Disorders for over 40 years. She specializes in the treatment of compulsive overeating, binge eating disorder, bulimia, anorexia, chronic dieting, and body image dissatisfaction.

She is the author of *French Toast for Breakfast: Declaring Peace with Emotional Eating*, and *Lasagna for Lunch: Declaring Peace with Emotional Eating*. Her most recent book is *Treating the Eating Disorder Self: A Comprehensive Model for the Social Work Therapist*, which is reviewed in this issue.

Coronavirus has upended our lives and impacted every fiber of our being. I think about Rodolfo, a family friend, who had suffered through the earthquake of 1985 in Mexico City which killed 10,000 people in one fell swoop. Rodolfo sadly explained, "Because of this earthquake, I no longer trust gravity—something I just always took for granted."

Rodolfo lost confidence in gravity just as we, during this pandemic, have lost confidence in the daily objects of our lives. Touching the handle of a supermarket cart or even just breathing if someone walks too close to us on the street can now be fraught with danger. We have been obliged to learn a new vocabulary—novel virus, social distancing, respiratory droplets, N95 masks, pulse oximeters, P.P.E., herd immunity, flattening the curve, and mandated mitigation methods.

But no amount of "mitigation methods" can heal the grief for the people who have died worldwide from this silent killer. We also grieve the extensive loss of jobs leading to economic insecurity for so many, and the disproportionate suffering of older people and those in minority communities.

How do we clinicians address these losses and the upending of our lives and our patients' lives? My experience during 9/11 helped pave the way for me.

The morning of 9/11, Paula, an anorexic young woman patient, rang my office bell and told me a plane had hit the World Trade Center. We went up to my roof deck silently together and watched in shock just as the second tower slowly collapsed to the ground. Paula, who was always so emotionally constrained—as anorexic with her feelings as she was with her food—reached for my hand and began to pray. There we were—a Jewish therapist and a born-again Christian—huddled together as she prayed to Jesus. In sharing this moment of fear yet also connection, Paula turned to cry on my shoulder. I held her. And this moment paved the way for her to become more trusting and comfortable with me. As we continued to move forward in her treatment for anorexia, she became better able to "flesh out" her emotions rather than only discuss the "bare bones" of her situation. This shared fear and pain of 9/11 became the "connective tissue" that drew us closer.

The Frame

Sometimes, as in the case of Paula, the shared humanity of the moment needs to override the traditional framework of how we conduct therapy. In the time of coronavirus, the frame feels more flexible and malleable than before, perhaps leading to more authentic connection.

Esther is crying as she speaks to me by Zoom from her dining room table. Her mother is in a nursing home, and she has not been allowed to visit her for months, something that she has done every day for five years. Her mother has been intubated because of health issues not related to the coronavirus, so there is no possibility of speaking to her on the phone or Facetiming her. Esther's mother is a Holocaust survivor as was her father. As Esther cries, I take note of the framed photographs of her family on the wall behind her. She does not "introduce" me to them, but I imagine the couple in the old-fashioned wedding attire must be her parents.

Their presence silently "witnesses" our session as their daughter, now in her 70s, cries by remote video. I want to reach through the screen and touch Esther, something I would not do in person, but my frustration with the distance between us on screen impels me to want to touch and comfort her. I am not sure our video session is expressing to her the full amount of compassion I am feeling. I'm having three dimensional feelings in a two-dimensional space. I want to be like Alice Through the Looking Glass and step through the screen to be with her. I tell her this. She smiles through her tears.

Olivia appears on my Zoom screen for her session. "I have no idea how I feel today," she announces, "let me consult my tarot cards." Before I have a chance to say, "Why don't you consult your *inner self* to see what's going on," Olivia has whipped out her tarot deck and splays the cards on her table. They are astonishingly beautiful, and she explains they are an antique deck from Italy. I watch her manipulate the deck and learn about her fascination with the Dark Goddess. For the first time, this gives us (or at least me) a deeper look at her fascination with the occult.

Tanya introduces me to her hamsters, Lucy and Ricky. I am amused by the names she has chosen. I never knew she had a sense of humor nor even a tender side since she never mentioned the existence of these furry little beige creatures.

David introduces me to his mother on Zoom—he and his wife and children are quarantining upstate with his parents. Mrs. S. waves to me and tells me David is nicer to her since he began therapy with me—a chance encounter only experienced in virtual reality. Many of our recent sessions have revolved around David's feelings of betrayal at his mother's refusal to acknowledge his grandfather's sexual abuse of him as a child. I secretly wonder if David becomes less guilty about expressing his anger to his mother, she may not greet me so cheerfully if we are still quarantining down the road!

A most creative softening of the frame was recounted to me by a friend, a psychoanalyst. Dr. B's on-the-couch patient did not want to lose the analytic connection. Because the patient lived with his large family, he would head to his car for the session, recline the seat to approximate his analyst's couch. He also found the right angle to position his cell phone behind his head so Dr. B's voice was coming to him at just the same angle as in the office.

The Silver Lining

Sharona tells me how not being able to come to my office and see me in person really adds to her feelings of deprivation and scarcity. Sharona, who is not a native English speaker, pronounces scarcity as if it were "Scar City." How apt, I think!

And, yet, in addition to deprivation and scarcity, patients—as well as colleagues—have reported a silver lining to this lockdown.[1]

I have been surprised by the extent of the pleasurable, yet guilty, reactions to the "new normal" of sheltering at home. I refer to those patients who are not sick, have not lost a loved one, and who have sufficient money for now to weather the storm.

And, of course, this could all change if the noose of the virus continues to pull ever tighter on the lives of everyone, if more people get sick or have deepening financial struggles. After acknowledging their anxiety and fear of the unknown, here is what some patients and colleagues have discussed as the silver lining of the corona virus.

Alicia: "My world of rushing and juggling the stress of work, caring for my sick mother, plus running a household is halted in its tracks for now. I feel like I am breathing freer for the first time in years! No commuting daily on crowded subways, no sitting in packed conference rooms. I spend my days in my pajamas taking care of my work at my own pace. I didn't even know I had a thing called 'my own pace.' I'm used to everything being constantly grueling. I've even begun to start exercising at home which feels great. I know I shouldn't feel that I'm more relaxed while others are suffering, but ironically this quarantining feels like a well needed hiatus from my whole life."

Paul: "This may sound like a terrible thing to say. But I am relieved that my parents are no longer alive. Trying to cope with my kids all cooped up while my wife and I are both working from home is hard enough. I am glad my parents are spared this crisis and, frankly, that I am spared from having to worry about them."

Emily: "The biggest worry in my life is FOMO (the fear of missing out). All my friends are always socializing and dating and going out all the time. I'm jealous of them and nervous there won't be any boys left for me to date if I don't get over my shyness. Now that everyone is stuck at home, we're all in the same boat. So, just for now, I don't have anything to be jealous about. Actually it's a big relief!"

Sandra: "Last week, we moved our family out of Brooklyn to our house in New Jersey. We have a huge house and, even though my both my son and son-in-law have the virus, we have enough bedrooms to accommodate them in quarantine! I feel so happy to have my grown-up kids back in the house living with us again. The house is lively and being a full-time mother again is giving me a purpose. I used to love my identity of being a full-time mom. I know this won't last forever,

CONTINUED ON PAGE 18

CONTINUED FROM PAGE 17

and I'll still have to work on figuring out my new empty nest identity. But, for now, it feels like we're in this warm cocoon, and I love it."

Carol: "I got a dog! I've been wanting one for a while but just didn't have the time to train and acclimate a new animal into my busy life with patients coming to my home office. Now that I'm home and only working by internet, it's the perfect time to get myself a maltipoo. I'm in love!"

Ruth: "There are so many sick people in my community, and we're all uniting with group chats and rabbi classes. It's a very uplifting time as well as scary. I believe that so much good is going to come from this time in terms of the way life will continue for everyone hopefully bringing everyone's heads down in terms of money, materialism, extravagance and prioritize what's important with everyone being closer to God. I really believe this, although my doubts and anxiety definitely do creep in."

Jessica: "I'm cooking for the first time in ages! My husband gave me a new cookbook for my birthday last July which I never opened. Now I'm just checking out what I can make. It's a secret pleasure because I know I shouldn't be enjoying myself when others have lost their jobs."

Barbara: "This lockdown at home has been kind of a gift. I'm ashamed to feel that way because a colleague's husband died last week from the virus. But I have to confess that I've been needing to recalibrate my life for a while now, and now I have a chance. I really believe all of us New Yorkers collectively have needed a chance to pause. It would be a crime not to find a way to take advantage of this. What are we all chasing so intensely all the time anyway?"

Ellen: "The concept of finding the silver lining is something that has been helping me through this difficult time. Many of my patients are expressing similar thoughts and feelings. Early yesterday I took a walk along the river promenade near my home. At one point I sat down on a bench and closed my eyes. After a little while I truly felt that I was sitting on a beautiful beach somewhere—the sounds of seagulls and the water transporting me to a place of calm and quiet. I would never find the time to do something like this when things are 'normal.' May we all find the grace to hold on to these positive changes in our way of being in the world."

Of course, we are not yet done with the quarantine. Things are still fragile, and we cannot predict the future. And yet, I observe that many of my patients—and myself included—have found a small, yet meaningful, slice of silver lining in this situation.

Humor, Resilience and Post Traumatic Growth

Karen says she feels guilty laughing at all the jokes and cartoons that flood her email. We conclude it is good to fight an infectious virus with some infectious laughter.[2] I'm reminded of the quote by Charlie Chaplin, "To truly laugh, you must be able to take your pain and play with it."

My personal favorite meme is a dejected dog with his head bowed in remorse: "After listening to his human for 12 days in quarantine as she complained for hours on end, Sparky realized he was not cut out to be an emotional support dog."

We work with our clients to instill hope that this pandemic will pass, to strengthen their coping skills and resilience, and find ways to make personal meaning out of this time of lockdown.

Dr. Tian Dayton writes, "Resilient people do have emotional and psychological scars that they carry from their experience. Resilience is not the ability to escape unharmed. It is the ability to thrive in spite of the odds." Dayton adds, "Resilient people…find reasons—religious, creative, or good common sense—to place a temporary framework and perspective around the problems in their lives.[3]

We introduce our patients to the idea of post traumatic *growth*, and we ask how they envision what that would look like for them.

FAROL

(feelings about reentering our lives)

There is FOMO (fear of missing out) and now I've coined the term FAROL (feelings about reentering our lives). Farol in Spanish means a lantern that illuminates.

My stepson Sean tells me, "When it's over, I want to import into my life the things I've discovered during lockdown that are making me happy—like not rushing around as much."

I add, "Yes! And then let's export the things that haven't been working." Sean and I agree laughingly that we will be entering the import-export business when all this is over.

And I think of the words of T. S. Eliot which seem so comforting at this time, "Teach me to care. Teach me not to care. Teach me to be still."[4]

At 7 PM every night, my neighbors in Park Slope emerge from their homes to clap for the health care and essential workers. This clapping has evolved to hooting, banging pots and pans and, recently, someone brought out a large beaded African drum. For a brief two minutes, the cloistered neighbors emerge from their cocoons, stand on their stoops, and begin to cheer. For two minutes, we become a village of caring and connected souls. I wish this tribute to humanity continues even after we're all healed.

All names and identifying data have been changed to protect confidentiality.

SEE PAGE 30 FOR NOTES

Twelve Steps and the Coronavirus

By Betsey Robin Spiegel, LCSW

Betsey Robin Spiegel, LCSW is a psychotherapist in private practice for over 30 years. She is Supervisor/Senior Psychotherapist at the Blanton Peale Counseling Center and Institute. She has published on the topic of working with addictions through integrating AA steps of recovery with concepts from psychoanalytic theories. She has also published on woman's issues in the workplace. Ms. Spiegel has facilitated numerous workshops and has been an adjunct faculty member at NYU Silver School of Social Work and Adelphi School of Social Work. She currently serves as Co-chair of the Addiction Committee of NYSSCSW's Met Chapter.

STEP ONE: We admitted we were powerless over the outbreak and pandemic of the coronavirus and that life as we know it is unmanageable. We are not powerless to stem the tide of illness and death by adhering to social distancing and an abundance of caution.

STEP TWO: We came to accept that being individually powerless and taking Step One will lead us to a commitment to social interest and a belief in the power of community which will restore our faith in our humanity.

STEP THREE: We agreed to turn our individual lives and wills over to a belief in social interest, and an orientation to our community by regarding our fellows as ourselves.

STEP FOUR: We made a searching and fearless moral inventory about ways we have traditionally been led by the cult of individualism and negative thinking, greed, low self-esteem, and aggression.

STEP FIVE: We shared our fearless moral inventory of our self-aggrandizement with a spiritual and emotional person who is trustworthy and safe.

STEP SIX: We became willing to stop this individualism from dominating our yearning for the greater good.

STEP SEVEN: We humbly asked our investment in social interest to triumph over our individual aspirations and self-centered behavior.

STEP EIGHT: We made a searching and moral inventory of those relationships that have been destructive and that separate us from others. We will resist continuing the national preoccupation with power over others rather than power to help others.

STEP NINE: We made amends to those we have sought power over and thereby harmed others, except when to do so would be harmful to those people.

STEP TEN: We made an inventory on a daily basis of how we have exhibited self-centered behavior in our relationships and community. When we are wrong, we promptly admitted it.

STEP ELEVEN: We sought through prayer and meditation the ability to integrate a commitment to serve others with all we can do and all those we love.

STEP TWELVE: Having been transformed as a result of taking these steps and following these ideas for the greater good, we will try to pass this message to our friends and family and channel our behavior to the public interest. We will reach out to others with service and love.

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He is the founder of the Sexuality, Attachment & Trauma Project, a group practice of clinicians who treat issues of out-of-control sexual behavior and other trauma related disorders. His group practice includes individual, group and couples psychotherapy. He has published articles on attachment theory, out-of-control sexual behavior and affect regulation. He is currently the Vice President and the chair of the Committee on Sexuality and Gender of the Met Chapter of the NYSSCSW.

Continued from page 1

Many of us were able to work from home, while some continued working in hospitals and clinics, albeit with a heightened sense of fear. For most of us, the nature of our work changed radically, virtually overnight. We could no longer safely travel to our offices. We could no longer see our clients in person. We had no choice but to hone our technological skills to become proficient with Zoom or Doxy sessions as a substitute for seeing our clients in person.

In my role as the Vice President of the Met Chapter of the NYSSCSW, I instituted a listserv, the *Remote Psychodynamic Treatment Forum*, to assist clinical professionals in making this transition. The forum allowed clinicians to support one another, to vent their frustrations, and to brainstorm about the most effective strategies to address the changes in treatment. Everyone needed help: some were wrestling with understanding the technology platforms, others needed support about new or exacerbated clinical issues that were presenting in treatment, and all of us needed to address the concrete issues of lighting and sound to ensure we were being seen and heard in the most optimal manner. As therapists shared anecdotes about their unnamed clients, we realized that our clients would need help as well in adapting to this new mode of therapy. The epidemiological crisis caused unique personal crises, in patients and therapists alike. Our professional and personal lives were colliding in spectacular ways.

Ecological Challenges

The pandemic has produced ecological challenges, meaning that it has impacted intra-personal, inter-personal, and societal systems. The American economy shut down, and communities were forced to grapple with ways to keep essential workers safe and to keep food and other key supply chains open. Our clients are now addressing the challenges of being stuck at home and of new family dynamics. Couples are together 24 hours a day. Children are being home-schooled. Some people are locking themselves in a bathroom or a car to find privacy. Families members sheltering together cannot find the psychic space that is so necessary for mental health.

Clinical social workers are navigating our own trauma and anxiety in confronting the challenges of a new way of working. We have come to recognize that telehealth sessions are robbing us of our own psychic space. They deprive us of the freedom to glance out a window or take in a piece of art that hangs on the wall. Instead, the therapist and the client stare at one another with a fixed gaze, never turning away.

The onset of the pandemic, and the period of reflection that followed, opened the door to another social crisis: a reckoning with the racial inequities that plague America. The brutal deaths of George Floyd and Breonna Taylor at the hands of the police have opened the floodgates for the Black Lives Matter protests and demands for sweeping changes in the law enforcement system.

For the first time in our careers, clinical social work is standing at the crossroads of a health crisis, a financial crisis and a social justice crisis. No profession is better prepared to navigate this moment. We, as clinical social workers, are trained in understanding the ecological implications of social crisis. As a profession that is rooted in understanding society, culture, family, and the individual, we are well equipped to sort all of this out. This is exactly what we are doing, despite a constantly shifting terrain.

Using the ecological model, I will outline the multiple layers of impact occurring in our work. I will begin at the intra-personal level, with the impact on the clinician, and then move on to our clients' experience on the various levels of the model.

The Impact on the Clinician

Loss of Office: On one wall of my office hangs a work of art given to me by my beloved clinical supervisor. On the opposite wall hangs a series of framed song lyrics that have always brought me comfort. These are my transitional objects that give me the strength to do this important work. For many clinicians, our offices are like second homes. The office is a place of comfort, serving as container for both patient and therapist. What transitional objects do you have in your office? What do you miss most about working there?

For the first time in our careers, clinical social work is standing at the crossroads of a health crisis, a financial crisis and a social justice crisis. No profession is better prepared to navigate this moment.

Our homes are now our workplaces. In working from home, we lose our transition to a space that was designed for the meaningful work we do. This is a complicated ordeal for many clinicians. Consider the phenomenon of state-dependent learning, where what we do in an environment gets imprinted and activated when we return to that environment. What we do at home is quite different than what we do at the office. Upon entering our offices, we enter a role of, hopefully, the calm, reasonable, clear-headed clinician ready to support, empathize, understand, and interpret. At home we usually relax, relate to our families, and binge watch TV shows as a respite from our intense work. Now our homes, where the state-dependent learning should be relaxation and family time, is contaminated and conflicted due to the multiple meanings of our home space. We've lost both the container for our work as well as our place of respite.

Loss of Ritual:

My Pre Covid-19 Life: On Monday mornings, I arrive at my office for a weekly peer supervision group. Monday afternoons, I walk to the Upper West Side for my own therapy session. Tuesday and Wednesday, I make time for the gym. Thursday afternoons, I pick up my car from the garage and park it near my office so that I am ready to drive out to my weekend home at the end of the day. Every Thursday evening, I take out my appointment book and ensure my appointments are noted for the following week. Every fourth Thursday of the month, I organize my billing and update notes and any necessary follow up activities.

My Post Covid-19 Life: Those rituals have evaporated from my life. I wander from the kitchen to the bedroom between sessions. There is no gym to visit on a mid-day break. I fall behind in filling in my schedule and organizing billing.

Many clinicians who participated in the *Remote Psychodynamic Treatment Forum* discussed the loss of rituals that create grounding. These clinicians feel disoriented without these rituals. The rituals are containers and ground us when we are in the trenches of our work.

Loss of Transition: Most clinicians work in an office separate from their home due to the reasons I mentioned above about state-dependent learning. Most of us in New York City walk or take a subway to work and again back to our apartments. This transition allows for a separation of work from home and time to reflect on our preparation for work. During the pandemic, the transitions are gone. Some feel they do not miss the commute, and others feel a deep loss about their commutes no longer being part of their day. It is another point of grief.

Management of Privacy: A big point of discussion on the *Remote Forum* revolved around where to set up a workspace in our homes. Many of us do not live in spaces large enough to create the privacy we guarantee to our patients. We all created makeshift sound machines using fans and A/C units. We struggled to ensure there was some sound proofing. Those of us with dogs or children had to contend with barking, yelling, and "guest appearances." These challenges resulted in frustrations, familial conflict, and anxiety about the level of work we felt we can do in these compromised spaces. This is an added stressor to an already overwhelming experience.

CONTINUED ON PAGE 22

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Impact of Technology: Many clinicians are not technologically savvy. Now, in the age of the pandemic, we have unforeseen technological challenges to confront. Clinicians are clamoring for advice on questions like: How do I set up Zoom or Doxy accounts? Are these platforms HIPAA compliant? Can I meet with patients remotely across state lines? How do I set up my device and lighting so that I do not look like a confidential informant being interviewed on "Sixty Minutes?" These issues may seem surmountable, yet they create heightened anxiety for clinicians who, working without technical support, cannot be sure if they are doing things right.

Issues of Abandonment: Clinicians often choose this line of work due to their own sublimated needs, including the need for connection, attachment, and helping others to live optimally. Often, we are looking for a second chance to help others when we feel we could not do so with our parents or siblings. The work is as important to us as it is to our clients. In some cases, we work with people for decades.

During the pandemic, some clients have needed to leave treatment and, in some cases, to leave New York City. Many of these losses were abrupt and touched on the edges of what Balint calls our basic fault lines, areas in our life where we are most vulnerable. Loss of contact and loss of the relationships has been devastating for many clinicians.

A patient that I have seen for 20 years left New York City abruptly three weeks ago. We will not get to say goodbye in person. This touched on my basic fault line.

Compassion Fatigue: One of the most challenging impacts of the pandemic on the clinician is vulnerability to compassion fatigue, also known as vicarious trauma or, as I see it, acute stress by proxy. The clinician is now exposed to many clients who are sharing their suffering while stuck at home—unemployed, powerless, and often hopeless. None of us had experience with the sheer volume of clients facing these traumas. Clinicians jumped into action unprepared for the compassion fatigue that followed, which in many cases led to burnout.

Clinicians dealing with a crisis of such proportions need to take time off, change their schedules, and get more support for themselves. I am reminded of the need, when on an airplane, to put your oxygen mask on first before you help others with theirs. Many of us forgot about our own oxygen masks. I've spoken to therapists who have fantasized about leaving the field, retiring early, or cutting down their practices if possible. In some cases, therapists have more serious fantasies about planning suicide or wishing to die. Compassion fatigue can kill off many aspects of our selves and is a huge occupational hazard. We all need more support.

The Impact on Our Clients

Loss/Grief: A central result of the pandemic for clinicians is that most of us have experienced loss and have been grieving. We have lost person-to-person connection, contacts, embraces, pats on the back, hands being held—painful losses for many.

Some clients have lost their jobs, others were furloughed, and some remain in limbo as their store or office remains closed and empty. Clients mourn the loss of their apartments after they fled the city to the shelter of vacation houses or the homes of their in-laws, a sister or a brother. Most clients have reported heightened anxiety and/or depression. Pleasure, laughter, and joy are harder to find. They mourn the cancelled family vacation, or a child's graduation, or a casual dinner in the West Village in late spring. Clinicians are now full-time grief counselors.

Financial Insecurity: Many people say that it is not fear of getting the virus that causes their distress; it is fear of financial ruin. Regardless of financial status, they share financial fears, from losses in retirement funds to losses that threaten day-to-day survival. Some clients have expressed suicidal ideation related more to this issue than to fear of contracting the virus and serious illness.

As we know, economic status is relative. People who are financially sound, but have lost money in retirement accounts, are truly distressed. As clinicians, we support people of every financial status, whether their finances seem fine or they are out of work and worried about day-to-day survival. It is our ethical stance.

One of the most challenging aspects of the pandemic for clinicians is vulnerability to compassion fatigue, also known as vicarious trauma or, as I see it, acute stress by proxy.

Anxiety and Depression: All these issues can create vulnerability in our clients to the onset of anxiety and depression or the exacerbation of an already-existing disorder. We are seeing in our clients moments of hopelessness, confrontation of powerlessness and, sadly in this country, a sense of neglect—feeling uncared for by our nation's leadership. Whatever a client suffered with prior to the pandemic, now there is a little more of it.

CONTINUED ON PAGE 33

On the Front Lines: Social Workers in Covid-19

An Interview with a Hospital Social Worker

By Lisa Beth Miller, LCSW-R, BCD

Lisa Beth Miller, LCSW-R, BCD is currently Outreach and Referral Coordinator at Lighthouse Guild, following her previous role there as Social Work Manager of the Continuing Day Treatment Program. She served on the Board of the New York State Society for Clinical Social Work Met Chapter, initiating the Listserv, and co-chairing the Listserv Committee. She has been helping to develop a not-for-profit for creators and consults with organizations and individuals in her private practice in Manhattan.

The question on every thoughtful person's mind these days, is: How will we re-open safely, knowing we're all vulnerable to this deadly disease? Many states are pausing, following their eagerly rushed re-openings, after record increases in new cases. The sobering reality is settling in, and yet so many are still blind to the need for caution, wearing masks and social distancing. How can we create a culture of caution and caring?

Social workers in hospitals find themselves face to face with mental and physical illnesses that have been exacerbated by Covid-19. To learn important lessons from their experiences, we need to be honest about what has occurred.

A well-respected social worker on the front lines has agreed to be interviewed for this article and has shared her experiences. It seems necessary to keep her identity vague, to share more openly. Her name and place of work will not be disclosed to preserve her privacy.

Daily Risks

Working on an inpatient adult psychiatric unit in Manhattan, a licensed clinical social worker who we'll call Shawna takes risks daily to help those in need. Never before have the risks been so great.

She was interviewed on May 9, 2020, during the New York City shutdown due to the coronavirus pandemic. She had been back to work for three weeks after being out sick for three and a half weeks straight. She was symptomatic but untested for a week and a half before that.

Shawna was exposed to Covid-19 on her unit, most likely during the last week of February or first week of March, when protective personal equipment (PPE) was in short supply and people relied mostly on wishful thinking to stay safe.

During this time, two nurses on the unit also got sick and eventually tested positive for Covid-19. In addition, two psychiatric emergency room social workers fell ill, likely infected by not wearing PPE. Another social worker on the unit had been out sick since early February, possibly because of undiagnosed Covid-19. She was not replaced, and the reduced staffing was taking a toll on Shawna and the other remaining social worker.

There was no testing available at this time for the psychiatric unit staff and they wore no masks. A street homeless woman who had been admitted to the unit had a persistent dry cough. Shawna met with her often, conducting psychosocial patient assessments in a tiny TV room, where they sat about a foot apart with a small table between them. The patient brushed off the staff's concerns. She told Shawna, "I'm just a heavy smoker."

On Monday night, March 9, Shawna felt really run down. She had a sore throat but none of the other expected symptoms of the coronavirus infection, such as shortness of breath or fever. She returned to work on Tuesday and then realized she was sicker than she had thought. She found

CONTINUED ON PAGE 24

CONTINUED FROM PAGE 23

out that the homeless woman was transferred to the medical unit during the Monday overnight shift with a fever of 102.8 degrees and confirmed pneumonia. This news prompted Shawna to think her own illness might be Covid-19.

Late Tuesday morning, she went to the Employee Health Services Office to be assessed. They told her to stay home until Friday, albeit without a doctor's note. Hospital policy required that, at the discretion of supervisors, employees need to get a doctor's note to qualify for sick pay. It is a cumbersome process, especially when one is sick.

Shawna tried to set up a doctor's appointment but the doctors she asked wouldn't see her. Access to testing was still very limited and patients were being advised to go to the hospital if they were seriously ill to avoid spreading the virus. By then, Shawna was feeling better and decided it might not be Covid-19 after all, so she returned to work on Thursday. The illness seemed to have passed until the following Wednesday, when she checked in at Employee Health Services again, and found she had a temperature of just over 100 degrees. The nurse told her to self-quarantine for a week.

By then, Shawna felt exhausted; the fatigue was overwhelming. One day she would feel okay; the next day, she couldn't get up and had lost her sense of smell. When she finally reached her primary care physician, the doctor said it was probably Covid-19 and gave her a note, excusing her from work for two weeks, and recommending she be tested.

Short Supply of Tests

Testing began sometime in mid- to late-March, and the first patient discovered to have Covid-19 on the Psychiatric Unit was put in isolation. By early May, tests were still very difficult to get—both the nasal swab viral tests, which reveal whether a patient currently has Covid-19, and the antibody blood tests, which determine whether a patient has ever had the virus. Shawna applied for testing on the Department of Health website but was never contacted.

Working on an inpatient adult psychiatric unit in Manhattan, a licensed clinical social worker who we'll call Shawna takes risks daily to help those in need. Never before have the risks been so great.

Though still feeling weak, Shawna had recuperated enough to return to work on Monday, April 13, five weeks after her first symptoms appeared. By that time, nasal swab testing was being administered just once for every patient admitted to the hospital.

Scientists are still learning about the novel coronavirus and it remains unclear how long it takes for the virus to show up on a test. Reports of numerous false negatives have cast doubt on the reliability of testing. It is not clear if swab testing can immediately detect the virus, furthering concerns that a patient might transmit the virus even after testing negative. A person can be exposed, test negative, and then show symptoms, and test positive.

One of the first patients admitted to the psych unit to test positive was discharged as early as possible, but then was readmitted shortly afterwards. On re-admission, he tested negative, but within a few days his symptoms had returned, and he tested positive again.

The rooms all the way at the back of the psych unit were set aside for Covid-19 cases only. Testing was still unavailable, but Shawna thought it was likely that she was now immune to the disease. She decided to take all the CoVid-19 patients onto her caseload, so as not to risk the health of the other social workers. Any more staff illnesses would cripple the functioning of the unit.

By early July, it was still unproven that patients who recover from the coronavirus infection have gained immunity. In fact, it is possible that the virus has been mutating and that the infection may not create immunity at all. There have been reports of people getting reinfected, but it has not been determined if the virus lies dormant within the patient or if reinfection is occurring.

Effects on Mental Health

Shawna has observed that, during the Covid-19 crisis, a large percentage of the psychiatric patients have had no previous history of inpatient psychiatric admission. For these patients, increases in suicidality and deteriorating mental health seem to be related to the stresses of isolation and the sudden loss of income. For the chronically mentally ill patients, stress often worsens their psychotic symptoms, including paranoid delusions. Many of these patients believe the pandemic is a government hoax, a common type of delusion at any time, and that either it has been exaggerated for political gain or has been

purposely spread by the government to kill people off.

Shawna worked with one mother (details changed to maintain confidentiality) who was recovering from Covid-19 that she had contracted while working in a healthcare facility. She had felt overwhelmed during lockdown by the challenges of caring for five school-aged children while sick. Her husband, also recovering from weeks of illness with Covid-19, was finally getting back to work. The first day he left her alone to re-open his store, she attempted suicide. Shawna remembered the pain of telling this mother she had called the Association for Children's Services (ACS), as a suicide attempt by a person with young children requires mandated reporters to make such a call.

Shawna has also noted that wearing full PPE creates challenges to developing a therapeutic alliance and providing good clinical care. She and the other clinicians struggled behind their masks, shields, steamed-up glasses, and scrubs to be helpful to their patients.

Shawna's strength came back slowly as she returned to the functions of the unit. She found that during her absence, while staff was prioritizing necessary precautions for safety, their case notes and other paperwork had fallen behind. The team worked together to get things up to code but, as social workers know, our licenses are on the line when we are signing our documentation. The challenge to do things properly felt overwhelming and Shawna had had enough. She gave notice that she would be leaving her position.

When problems with "crisis pay" emerged, staff morale suffered another blow. The Governor had said all hospitals would need to pay additional sick time for staff needing quarantine. The health care workers' union, SEIU 1199, had negotiated that all hospital staff working on-site would receive $100 per week of crisis pay, starting from the beginning of March. However, on the last day of April, the hospital announced they would be canceling crisis pay. In fact, no one Shawna spoke with received more than one week of crisis pay. As for Shawna, the hospital docked her pay, as some of her time off was "unexcused" when she had been unable to obtain a doctor's note.

By early May, New York had "flattened the curve," and there were no Covid-19 patients left on the psych unit. Still, there was limited access to PPE. The staff wore surgical masks when they were with patients, but it was a challenge to get appropriately sized N95 masks, which are necessary since a poor fit provides poor protection.

Over the course of the pandemic, the hospital lost many doctors and nurses for a variety of reasons, both known and unknown. Although every newly admitted patient is tested before being sent up to the unit, testing is still restricted for current patients and staff. Patients do not wear masks unless their initial admission testing indicates they are Covid-19 positive, in which case they cannot leave their rooms.

All patients agree that the swab testing experience is "horrible." A swab in the nose that goes all the way into the upper sinus is very painful. The test results are returned in 12 hours.

Under Stress and Overwhelmed

Character traits are revealed by people's responses under stress. Shawna noted that staff teamwork had fallen apart because of stress, and that some staff members became overwhelmed and irritable, blaming each other when things didn't go well.

Of the unit's Psychiatric Rehabilitation Team (PRT), three staff members had already quit, seemingly due to the strain of reduced staffing and the difficulty of negotiating time off with their supervisors. PRT staff was not allowed to lead their groups since it could not be done safely and some people felt uncomfortable providing individual sessions, which would require physical closeness to Covid-19 patients. Groups led by temporary staff restarted on May 11, with spaced seating and masks.

During the week of May 18, the hospital finally paid Shawna for all the sick days she was entitled to; they granted two full weeks of quarantine pay and her unused sick days covered the rest of her time out.

Shawna left her job on May 22. The union is still fighting for crisis pay.

Now, the NY PAUSE mandate has expired and "Smart Re-opening" has begun. Shawna's antibody test was positive, which has given her a small sense of relief, although it is not a clear indication that she has acquired immunity. Her husband tested negative and she wants to keep him and her cat safe. She plans to continue her clinical social work career, though not in a hospital setting.

Exposure is a constant concern for us all and will remain one until we have a vaccine. How best can we socially distance and stay safe as we re-open? Thoughtfully, slowly, and attentively. Wear a mask, wash hands often, be vigilant about social distancing, work from home whenever possible, and create a culture of staying safe for the sake of those around us. Will we have a second wave? As Governor Cuomo says, "It depends on what we do."

The Forbidden Pleasure of Sheltering in Place:

Reminders of Shiva and Recuperation

By Debra Kuppersmith, LCSW

Debra Kuppersmith, LCSW is a psychoanalyst, clinical social worker, and educator. She is on the editorial board of *The Psychoanalytic Review*, Editor-in-Chief of the AAPCSW online monograph, and a training and supervising psychoanalyst at NPAP. She teaches at NPAP and the Harlem Family Institute. She has written and presented papers, nationally and internationally, on early childhood parental loss and trauma, among other topics. She has a private practice in New York City and Dobbs Ferry.

I was having a hard time writing this essay for the newsletter. I wanted very much to "write from the heart," but each time I attempted to put something down on paper, I became lost and distracted. I was trying to write about personal and professional challenges brought on by this pandemic but nothing that I was writing coalesced into anything meaningful.

But when I sat down this time, something different happened. As I started to write, I began to free associate. With my defenses down and lost in my reverie, I suddenly became aware of how good I felt and how pleasant the whole experience of sheltering in place has been for me.

And alas—I then proceeded to spill hot coffee all over my new desk, saturating the needlepoint I have been working on for three years, a check I had been waiting to deposit, and my current to-do list.

After I scurried to move everything to the floor and wipe off the liquid, what emerged in front of me was the unencumbered beauty and richness of the oak that was hidden by the clutter. I realized that what had just happened symbolized my experience of trying to write this essay: that I cover up with lots of clutter how I feel emotionally and have to give myself one more final whammy before I can get to an obvious truth—a truth that I may be ashamed of or that may conflict with what the super ego or ego ideal tells me it should be.

My truth during this pandemic is that it has been delightful to shelter in place. I know this is a dark and troubling time and I should be suffering, but for the most part that hasn't been my experience. I realized that these months have been a repetition of two earlier experiences of feeling a kind of idyllic pleasure of sheltering in place in the face of what was supposed to be a time of sadness and despair: sitting shiva for my mother when I was 14 and recovering from breast cancer surgery when I was 48. The experience of having to stay home now—of staying put, with a lack of movement, literally and figuratively, with no pressure or even the possibility of interacting with the external world and what it has to offer, of just sitting with the sole purpose of taking care of myself and of being safely enveloped and contained—brings me back to those earlier times.

I lost a patient to this pandemic and it was this patient, I believe, that gave me the virus, making me sick for 12 days in March. I believe I got it because of her act of kindness: she brought me coffee and cake, which I gladly took, the last time I saw her, on Tuesday, March 17. I was never to see her again. She called me two days later, sick and coughing, having been tested for the virus and awaiting the results. We were both relieved that her lungs were clear.

By Friday evening, I started to feel sick. I spoke to my patient again on Monday and she was feeling much better. We made an appointment to have a virtual session that upcoming Friday.

This would be the last time we would speak. She was dead the following week.

Later that month, my doctor told me that, in some cases of Covid-19, after the initial symptoms go away and one the patient is feeling better, they then come back with a vengeance.

This is a shiva—this period of quarantine. As I shelter in place with my husband of 38 years, I am brought back to the period leading to my recovery from breast cancer 16 years ago. The time from my diagnosis to my eventual return to the office was about five months, probably the same amount of time that I will quarantine now. My husband stayed home with me then, just as he does now. Despite my fears of dying and my despair of at losing my breasts, my recovery was a period of absolute contentment. Everyone took care of me. I was taken care of by everyone. And lucky for me, besides my adoring husband, I had fabulous medical care and a team of doctors who made me feel I was the main object of their attention.

And this experience was repeated with my current doctor during this pandemic. I called him to report a fever, aches, and chills, the symptoms of Covid-19. From then on, his kindness, expertise and availability throughout my illness much was a re-experience of being the focus of attention. This is the mirroring Winnicott describes—the good enough caretaker. Of course, these are idealized versions of events, both then and now. But I think that is part of the point: that a fantasy of an idyllic sanctuary in the face of despair is a needed defense to the fear of loss and annihilation. Obviously, for me, I was repeating this.

I feel like I am faced with an impossible reckoning as a survivor, relieved to be alive and, against the odds and in defiance of my super-ego, enjoying this time. This is the repetition of how I dealt with earlier traumas.

I am also reminded of sitting shiva for my mother, who died from breast cancer in 1970 at the age of 42. Shiva for her felt like a shiva for the loss of my life as I knew it. My parents were in the middle of a divorce and my father, who had left home, had to move back home because his wife was dying. My grandparents (her parents) and my father were not on speaking terms and they were all in the middle of a lawsuit about who owned the house where we were living. Nonetheless, I was enveloped in peace. I most certainly was the concern of all who entered that house of mourning—really, it felt as if the mourning was for me. Many people were not sure what was to become of me. The truth is, I absolutely loved being the center of this attention.

Both my mother and I had breast cancer and I lived. Both my patient and I had Covid-19 and I lived. I am certainly sitting shiva for both of them as I am remembering my past periods of sheltering in place. But I feel like I am faced with an impossible reckoning as a survivor, relieved to be alive and, against the odds and in defiance of my super-ego, enjoying this time. This is the repetition of how I dealt with earlier traumas.

Navigating Grief and Loss during the Coronavirus Pandemic

Practical and Personal Implications for Providing Support

By Emily Treat Atwell, DSW, LCSW, LMFT

Emily Treat Atwell, DSW, LCSW, LMFT is a Licensed Clinical Social Worker and Licensed Marriage and Family Therapist with years of experience facilitating meaningful connection between individuals, and within family and couple relationships in home-based, outpatient, educational, and private practice settings. She currently maintains a private practice with offices in Westchester, NY and Greenwich, CT. She has training and interest in supporting clients with issues of grief and loss, relationship conflict, parent-child communication, anxiety and depression, and perinatal and postpartum experiences, among others. She has been a professor at several Master's Level Social Work Programs including: University of Pennsylvania, New York University, Rutgers University, and Daemen College.

Amidst the global coronavirus pandemic, the world has entered a state of disarray due to physical confinement, shifts in everyday routines, and adjustment to "remote" living, among other lifestyle changes. Months into these changes, some have experienced a move from uncomfortable chaos to mundane conformity. Although the effects of such circumstances yield different individual responses, what remains consistent throughout the world is an experience of loss.

Obviously, many individuals and families have faced actual deaths as a result of Covid-19. Grief associated with death-related loss have been widely articulated, particularly the unique challenges of experiencing a death during this time. However, this article targets ways to respond to non-death related loss associated with the pandemic.

Think about your own definition of loss. Is it solely based on death? Does it represent the absence of something? If so, that is natural. Other experiences of loss that are less conceptualized are situations of non-death loss. Examples include loss of identity, loss of relationship, loss of control, loss of trust, and loss of opportunity. This pandemic has directly impacted us because of such losses. Confusing by nature, these losses can leave individuals with a lack of resolution consistent with a constant state of mourning, unlike when one experiences a traditional (death-related) loss. Pauline Boss coined this experience of unresolved loss as "ambiguous loss" and offers insight about cross-contextual ways in which individuals respond to the unresolved demise of life that once was.

Confusing and Unresolved Loss

Through her circular process model, Boss (2016) describes six guidelines for responding to confusing, unresolved loss: finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope.

Finding meaning provides an opportunity to look at a loss through a lens of growth. Losing someone/thing is inherently a change. But by gleaning meaning from this change, growth can occur. **Tempering mastery** suggests that, as human beings, we like to have answers. During untenable situations, such as that of the coronavirus pandemic, getting answers is impossible. Therefore, being "okay" with not having answers is part of the adjustment process. **Reconstructing identity** suggests that during confusing experiences, our identities are often challenged, providing an opportunity for re-evaluating the roles one plays in life. **Normalizing** this **ambivalence** provides necessary clarity. **Revising attachment** relationships can be a crucial part of maintaining connection during this crisis. Renegotiating relationships can lead to productive repair or cultivation of closeness. **Discovering hope** explains that

having a hopeful attitude about the impermanency of the current experience can allow for a helpful shift in perspective.

Due to the pandemic, loss is universal. The discomfort we feel in relation to loss is grief—we are mourning normalcy before the pandemic and yearning for our old life back. It is common for our true feelings to be masked by a shroud of forced complacency as work life, school life, family life, and other activities does not stop. Challenges that used to be individual are now felt collectively. Those who are usually our support networks during times of stress have become fateful teammates fighting for the same goal—to get back to life as we knew it.

The collective experience of grief can be rife with thoughts that might be deemed trivial by others, albeit real, for example, *All I want to do is get a haircut!; I wish I could go on that vacation that we planned; My job is going to be so much more frustrating from home.* To some, these issues might seem inconsequential in the grand scheme of life. To others, they might be met with unhelpful **"at least you…"** statements: At least you have hair. At least you can afford to go on a vacation. At least you have a job. These are a means for minimizing non-disastrous responses to the pandemic. When seemingly trivial responses to loss are undermined, what results is **disenfranchised grief** (McCoyd & Walter, 2016). As a society, we like to play the proverbial game of "who has it worse?" to justify our own grief. It is important to approach others who might complain about such experiences of inconvenience with compassion rather than ridicule.

Historically, losses have been studied through the lens of linear stages: Denial → Anger → Bargaining → Depression → Acceptance, as the classical grief theory of Kubler-Ross offers. The progression through these stages implies a "normal" response to experiences of loss. Any deviation from the norm sends us into a cognitive spiral of: *Am I responding the right way? What's wrong with me if I'm not?* The answer is… nothing.

The current state of the world, under government orders to stay at home, maintain social distancing, and the resulting missed opportunities, makes responding to grief the classical way very difficult. When it comes to mourning the losses associated with Covid-19, we are in uncharted territory. Discovering ways to embrace your feelings, listen to your thoughts, and respond to your physiological reactions with patience can make all the difference.

Examples of non-death loss include loss of identity, loss of relationship, loss of control, loss of trust, and loss of opportunity. This pandemic has directly impacted us because of such losses.

Conceptualization of Loss Responses

Three common ways individuals respond to loss are characterized by how one has learned to process uncomfortable experiences inter-generationally with repression, inundation, or integration. A foundational defense mechanism, **repression** is often used as a means for avoidance of feelings to achieve instant gratification. **Inundation** is the process of being consumed by distressing experiences, often leading to an increase in mental and physical distress. This type of response is multi-faceted and complicated to address therapeutically. The last response, and the most functional psychologically, is the idea of **integration**. This response encourages an experience of "liquifying grief"—making fluid the experience of loss by embracing feelings in the present moment often, rather than repressing them and letting them build up inside, like an unyielding mass. Liquifying grief ultimately leads to more favorable mental health outcomes.

Techniques for Achieving Integration in the Face of the Pandemic

1. **Make feelings tangible:** Channel your feelings outward as a means for liquifying your grief. This could be in the form of mindfulness, exercise, an art project, or journaling. This allows for gaining control over uncomfortable feelings with the goal of integration.
2. **Validate your own experience alongside others' experiences:** Everyone responds differently to loss and every response is okay! Resist "at least you" statements.
3. **Identify personal triggers:** Everyone has emotional triggers, which are commonly based on early childhood experiences of pain, hurt, trauma, and the like. When we go through intense experiences of loss, we might be more vulnerable to triggers than at other times. Be self-aware about what "pushes your buttons" and implement strategies to anticipate them. Come up with contingencies for how to respond.

CONTINUED ON PAGE 30

Navigating Grief Continued from page 29

4. Surviving rather than thriving: In a society that prides itself on productivity and success, it is difficult to experience emotional or financial stagnation. During times of chronic stress, shifting your expectations about these terms is necessary. Allowing yourself to survive and lowering the bar of what you can get accomplished will provide an opportunity to be self-forgiving. Expecting to thrive when we have many barriers in place is unreasonable. Instead, acknowledge small victories.

5. Adopt an hour-by-hour mentality: Thinking ahead about the day, the week, the months can seem daunting, especially when no one knows what to expect. Thinking hour-by-hour can make the experience of discontent much more tenable.

6. Help others and know how to ask for help: Everyone responds to needing help differently. Know your comfort level, be able to communicate it, and inquire about others' needs is necessary for providing and receiving support.

7. Lean-in to alternative ways of connecting: Depending on one's comfort level with navigating technology, we have been forced to get creative when it comes to communicating. Understand that these efforts are bound to create resilience and can be supportive tools after the pandemic is over.

8. Implement resourceful activities: Repurposing objects around the home will not only activate creativity, which is helpful to prevent depression and anxiety, it could also provide confidence in your ability to be resourceful in the state of crisis. Empowering yourself to "think outside of the box" can heal grief in the face of loss.

9. Continue to practice self-care: Self-care is crucial to maintaining mental health functioning. Finding ways to prioritize yourself, even momentarily, can be essential in coping with stress related to the pandemic.

10. Reflect and talk: Doing check-ins with yourself and in your relationships will not only cultivate connection but provide an opportunity to make feelings tangible.

As we are faced with life "reopening" at different rates across the country, our stress is likely to be perpetuated by continued loss of certainty. Decision-makers are naturally uncertain about the best approaches to take. As decisions are made, it is important for individuals and families to preserve their own agency. Make choices that are best for you given your circumstances. Implement the aforementioned strategies and proceed with caution. The experiences of loss during this time have strengthened our stress tolerance and can be used as catalysts for empowering our resilience in the future.

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Deprivation Continued from page 18

NOTES

1. These observations about the silver lining express ONE facet of the myriad of reactions I hear from patients and colleagues that include anxiety, fear of the unknown, worries about health and financial insecurity, as well as loneliness, isolation, deprivation, and especially grief. This Covid-19 crisis has been called "a trauma pandemic in the making."

https://psychcentral.com/blog/the-covid-19-crisis-is-a-trauma-pandemic-in-the-making/?utm_source=Psych+Central+Weekly+Newsletter&utm_campaign=35bd6d7ce5-

2. *The New York Times* article, "It's OK to Find Humor in Some of This," by Alex Williams opines, "Laughing while others die may seem inappropriate, even tasteless, like concentration camp prisoners finding humor during the Holocaust. But in fact many did, according to a 2017 documentary, 'The Last Laugh.' Throughout history, humor has played a role in the darkest times, as a psychological salve and shared release."
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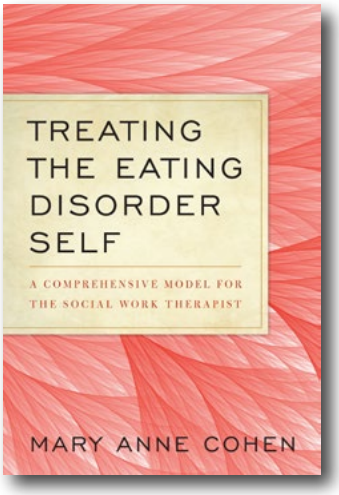

Treating the Eating Disorder Self:

A Comprehensive Model for the Social Work Therapist

NASW Press, 2020

Written by Mary Anne Cohen, LCSW, BCD
Reviewed by Richard B. Joelson, DSW, LCSW

I am very hopeful that this volume in Mary Anne Cohen's series of books on eating disorders and emotional eating, while her latest, will not be her last. *Treating the Eating Disorder Self: A Comprehensive Model for the Social Work Therapist* is a must read for the social work clinician who is eager to be much better informed about this complex area of clinical work and wants a highly readable guidebook for the difficult endeavor facing all of us who work with this population.

It is hard to imagine that anyone looking for a good book on the subject would not get hooked after reading the excellent introduction. The first two paragraphs immediately drew me in and made me eager for more.

> "For many people, trusting food is safer than trusting people. For many, loving food is safer than loving people. Food never leaves you, never rejects you, never abuses you, never dies. It is the only relationship in which we get to say where, when, and how much. No other relationship complies with our needs so absolutely.
>
> "This book will explore the two worlds of the binge eater, bulimic, anorexic, and chronic dieter: the inner world of emotions and the outer world of cultural pressures. These two worlds collide together to cause the development of an eating disorder."

Fortunately, and not surprisingly, this book offers some of the same benefits as Ms. Cohen's two earlier Works, *French Toast for Breakfast—Declaring Peace with Emotional Eating* (1995) and *Lasagna for Lunch—Declaring Peace with Emotional Eating* (2013). It reads like part non-fiction novel, part textbook, and is never dull. The author's openness and excellent use of her own clinical experiences is invaluable and offers a high degree of authenticity. The book is truly a mini encyclopedia that helps the reader understand various approaches to different eating disorders as well as customized applications for different clients.

I got a great deal of value out of each chapter and found two chapters to be particularly useful. "Treatment Part 2: Action Strategies" covers a variety of cognitive and behavioral strategies and discusses ways that DBT and EMDR can be effectively utilized. I especially appreciated Ms. Cohen's recognition of EMDR as a valuable interventive tool, since I have used it successfully with eating disordered clients in my own practice.

The other outstanding chapter was "The Therapeutic Relationship: Cultivating Hope and Connection." Here, the author very effectively utilizes a treasure trove of clinical material from her many years of working with clients in her practice and years of experience as the director of the New York Center for Eating Disorders. She actualizes her long-standing belief that every person's eating disorder is as unique as a fingerprint, and there is no "one size fits all approach" to healing. She tells us that "the goal for the social work therapist is to create an individualized and comprehensive treatment approach in collaboration with clients that will help them break the chains of emotional eating and body image distress."

CONTINUED ON PAGE 32

The Initial Consultation

There are many questions that all clinicians ask their clients during the initial consultation. I have always asked questions about sleeping behavior, medical conditions and attitudes about obtaining needed medical care, and drug and alcohol use, among many others. These questions are designed to elicit information that might not be easily forthcoming. Some years ago, I added a question that has added immeasurable value to my early knowledge and understanding of the new client before me: "What is the worst thing that has ever happened to you?" This question, while always a surprise to the new client, is most often thoughtfully answered and I gain information that might otherwise have taken considerable time to emerge .. .if it ever did! It helps open a discussion that might provide a trauma history that could help me understand a presenting anxiety disorder or illuminate a mood disorder that could then be more thoughtfully investigated and treated.

After reading Mary Anne Cohen's earlier books, several years ago I added an additional question to my initial consultation: "Are you having any difficulties in relation to food and eating behavior?" It is equally valuable as the "worst thing" question, and similar in that the answer often uncovers material that might not otherwise be offered as soon as the initial hour. This is the moment when I might hear about past or present experiences with anorexia, bulimia, binge eating, dieting misery, body shame, and the extent to which matters of food, weight loss, and impulse struggles are life consuming. Thanks for that, Mary Anne!

I may have run the risk of making this book review an exercise in hyperbole; however, my appreciation for its value for my own practice is boundless. I imagine it could be valuable to any reader.

Richard B. Joelson, DSW, LCSW is a clinical social work therapist in private practice in New York City. He is the author of *Help Me! A Psychotherapist's Tried and True Techniques for a Happier Relationship To Yourself and the People You Love.* www.richardbjoelsondsw.com

HEADQUARTERS UPDATE

Since our last update in fall 2019, things have really changed dramatically for everyone, both personally and professionally. The Society's administrative office, Total Management Solutions (TMS), moved its operations to the staff's homes and began working remotely on March 15. Since then, we have made every effort to keep things as normal as possible, working to the best of our ability with the Society and the ACE Foundation.

We held our first Zoom webinars in May, and we're happy to report that they were quite successful. Brian Quinn, Ph.D., LCSW and Roger Keizerstein, LCSW presented their programs virtually, with many members and non-members in attendance. We look forward to presenting may more programs this fall with this new platform.

Many chapters have also gone virtual with their chapter and committee meetings. It's been a steep learning curve for us all but, as they say, "the show must go on."

The NYSSCSW/ACE Foundation's 51st Education Conference will also be held virtually, on three Saturday mornings, October 24, October 31, and November 7, 2020, from 10:00 am to 12:30 pm. More information will be distributed shortly. The NYSSCSW Annual Membership Meeting will take place before the program on October 24.

During the pandemic, the Society added a Covid-19 tab to our website. Various articles with valuable information are posted there and sent to members in the *Friday E-news* each week. We will continue to update this information as needed.

From all of us at TMS, we hope you and your families stay well during these trying times.

Kristin

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Continued from page 22

Psychic Space: Human beings have a need for psychic space, a sense of privacy of thought, ideas and sometimes feelings. Our ability to find this space during the pandemic has been compromised, leaving us with a sense of impingement. Many people have reported a feeling of suffocation as they search for space for privacy, either for work or relaxation. As noted above, this space is also not as available during remote sessions, as we assume a fixed gaze with our clients and they with us.

Impingement: A clinical issue that our patients are reporting is the sense of impingement. They feel there is no escape, and they wonder if this implies a defect in them. In my work, I urge them to understand how essential it is to have space, and to discover new, innovative ways to find these escapes while we are all on lock-down. One of my patients discovered the value of jogging alone. Another found meditation and designated a room in the apartment for meditative practice. Helping our clients find space is essential.

The Impact on the Family

Home Schooling: Some children have responded well to the experience of homeschooling. They enjoy the comforts of their homes and, in some cases, feel relief from difficult peer relationships. Others feel trapped and in grief over losing person-to-person contact with their friends. Having no natural break from their parents can also feel stressful. Overall, many children have responded better than their parents, perhaps due to having been raised with technology. Most parents feel like they are not putting as much time and energy into home schooling as they should be.

Work-at-home Parents: School provides a natural break from parents and facilitates the Mahlerian stages of separation and individuation. These steps allow for the important development of peer relationships, particularly through the experience of play. Although playfulness can be accessed online, it is different from person-to-person contact. Even the child's daily trip to school allows for a natural and necessary separation from family. This has been lost in the lockdown. Children are now exploring more contentious ways to institute separation, which is distressing their parents.

Parents also feel the struggle of finding space to work the way they worked in their offices. Issues of distraction and interference are common in a family where everyone is stuck at home. Parents feel more frustrations in addressing family issues 24 hours a day, seven days a week. Whatever family stressors existed prior to the pandemic, now there are a little more of them.

Issues of Attachment: Bowlby spoke of the need for secure-attachment, as did Ainsworth and Main. My colleague Art Baur and I have introduced the concept of a "secure-enough-attachment," the idea that we also have essential needs for privacy and space. These are intense, emotional needs that occur for us to restore and prepare to interact in attuned, loving ways. Winnicott noted the destructiveness of parental intrusion. In many ways, the pandemic has created an induced sense of intrusiveness from all angles.

The Impact on Society

Social Fear: We have seen an increase in social anxiety with each new phase of the pandemic. In the beginning, several clients told me they thought the concern about Covid-19 was just hysteria. As reality hit, their anxiety rose. When we went into shutdown, reality hit really hard. From then on, clients spoke almost exclusively about the pandemic and its impact on their lives, including their fear of getting sick, of financial insecurity, and other issues of safety and security. Erikson's hierarchy of needs had shifted for many clients. Before the crisis, when their basic needs were being met, our clients were able to work on issues of affiliation and self-actualization. When the pandemic hit, these same clients shifted focus to their growing financial problems and insecurity about food, shelter, and their futures.

Social Isolation: Harlow, Bowlby, Ainsworth, Main, and others have helped us as a society to understand the need for contact comfort and attachment. Many of our clients enter treatment to help break down their obstacles to connection, attachment, and intimacy. Some of our clients were working diligently on their dating skills when, on March 22, that was put on pause. Our clients were now facing the pangs of desire for contact—right at the moment when we were instructed to isolate. "Stay safe; stay at home," was the mantra on the news and in online forums. And so, some people who suffered with isolation in the past went back to point one. Some that never left the world of isolation now felt that everyone was on the same page. Some clients reported a freedom from their struggles around the fear of missing out (FOMO). There is nothing to miss out on during a lockdown.

The Loss of Touch: Touch deprivation is a contributor to marasmus, the severe malnourishment of infants that leads to death. The studies of Spitz, Tronick, and Ainsworth provide good evidence for the impact of a loss of affection and connection with loving others. Harlow's monkeys informed us of the need for contact comfort. He

CONTINUED ON PAGE 34

CONTINUED FROM PAGE 33

helped to discover our drive for connection and attachment. Since March, we have been instructed to stay six feet away from others. There is no touch allowed. Hugs are anathema and no one shakes hands anymore. We are all grieving the loss of contact comfort.

The Loss of Facial Expression: Paul Ekman, building on the work of Silvan Tomkins, noted the importance of facial expression for showing affect—joy, anger, distress, shame, excitement, interest, disgust, and fear. When greeting people, we are embraced by their smiles first, even before we receive a hug, handshake, or pat on the back. Now, we are mandated to wear facial masks to cover our mouth and nose. Are you smiling or frowning? Seems hard to tell these days. We lost smiles.

Social Depression/Grief/Loss: We are left in a global state of grief, loss, and depression these days. Our society is a macro system that is depressed from living with social fear, isolation, loss of touch, and the loss of our shared facial expressions. As the pandemic continues, the losses accumulate. Those who thought it would last for a couple of weeks now understand that we are facing several months, or even years, of instituting these changes in our lives. The shock, helplessness and hopelessness are felt on the streets of New York City.

The Impact on Race and Culture

Racial and Religious Vulnerability: Covid-19 has struck Black communities at a much higher rate than White communities. This has many implications and exposes the systemic injustices and inequality that Black Americans face today.

Pre-existing health conditions are a major factor in racial disparities in Covid-19. Those conditions can be traced to lack of healthy food options and inadequate health care in subpar Black neighborhoods. Disparities may also stem from the fact that many Black people are essential workers and don't have the luxury of staying at home and avoiding mass transit. Black families also tend to live in more dense neighborhoods and may have to cohabitate with a larger number of family members. Another factor may be cultural relationships to contact and touch.

Orthodox Jewish communities were stricken by the virus more intensely than non-orthodox communities. Public health interventions have not been particularly helpful to any of these communities. They have not targeted the idiosyncratic aspects of each community as it relates to following Covid-19 guidelines and how those guidelines may be anathema to cultural norms.

Unprotected: We as a nation have failed to protect minorities. This fact has become more apparent during the pandemic, which has hit minorities hardest. It was further underscored by the horrific deaths of George Floyd and Breonna Taylor. Families of color are now demanding both legal and social protections. The clinical issues we will face with our clients of color and religious minorities will be to address the reenactment of being unprotected and neglected.

Neglect: In the lack of protection of minorities in this country, we have reenacted a state of neglect for these populations. The government has failed to recognize the need for specific client-centered approaches to address the unique dynamics of each group, including their relationship to connection, attachment, touch, and expression. All these issues have varying importance to different groups, and they require specific types of intervention. This implies that clinical issues that will enter our treatment rooms, whether through Zoom or some other modality, will include addressing neglect on both a personal and societal level.

The Potential for Positive Outcomes

The preceding overview focuses on the problematic consequences of the pandemic on the multiple layers of the ecological model, including society, family, clients, and clinicians. However, there is another side to explore.

Resilience: We, as clinicians, have observed a miraculous shift in some of our clients. Their resilience has kicked in and they have found ways to move through this crisis. One of my unemployed clients decided to spend time during the shutdown in his yard reclaiming his gardening skills. Others have been reading novels or learning an instrument that they always dreamed of playing. Clients that suffered from FOMO are relieved by the experience of not missing out on anything. Clients who are more introverted and enjoy their space feel that life finally has aligned itself with them.

Pre-pandemic, many of us were lost in our cell phones and laptops. Today, some families are cooking together; others are going for walks together and noticing nature sprouting all around them. We all hear more birds, notice more plants and flowers. There seems to have been a shift in many people, who are now more resilience.

Unexpected Benefits: A colleague on the *Remote Psychodynamic Therapy Forum* pointed out the unexpected benefits that remote or phone sessions have created for his clients. Karl Willims, LCSW from the Hill Country Community clinic, said:

I work at one of our satellite medical sites as the therapist conducting traditional and modified traditional therapy services along with the warm handoffs and consultations with medical providers. I am also a part of that site's MAT program. Once Covid-19 arrived and the stay at home orders were implemented, I started seeing patients from home. I have found for that for several of the individuals I was seeing in the clinic, for example, those who experience ADHD, anxiety, PTSD, and mood disorders, holding phone sessions has been highly successful, and preferred by them. They preferred this instead of video sessions. Two of my MAT patients are more engaged and have talked at a deeper level about long standing trauma and relationship issues. Both said it was less embarrassing to talk via phone then face to face.

I have another patient with severe PTSD that was able to explain to me what happens to them to just get to the clinic to see me. They told me their anxiety would increase prior to their appointment because of anticipations of what could go wrong getting to the clinic. Then along the way to the clinic there would be an interaction with the person providing them transportation. Then the waiting room. By the time they would get into the office they were just wanting to flee and get away from it all. Their amygdala was over stimulated. They said it made it nearly impossible for them to focus on doing any productive work. As a result of phone sessions, we were able to develop a plan for them to talk with their medical provider without yelling and cursing at them. They acknowledge that yelling and cursing was unproductive yet felt very overwhelmed by coming into the office. The phone session provided that safe space they needed.

Adaptations: Clinicians are finding ways to adapt to our "new normal." A colleague of mine who missed his daily commute found a way to travel locally, going the same distance he would if he were travelling to his office. He effectively recreated his old commute. Others turned spaces in their homes into makeshift offices with hopes of replicating their beloved offices.

Clinicians have reported that some of their work is deeper than ever. Something about the shared trauma has allowed us to find that space between us in which we can share, be more open, understand more than usual, and care more, as we ourselves were suffering. Many of our clients reported positive changes in their relationships.

Intimacy: It seems logical that quarantining at home would create vulnerability to increased contention and, at worst, an increase in domestic violence of all sorts. Some of this has happened. However, we have also seen an increase in intimacy and closeness as families go through this together. It is a shared trauma. Partners that could escape familial conflict by fleeing to work no longer had that option. They needed to stay in place and work out the difficulties rather than going into flight. Flight was no longer an option. So, in some cases, we observe a change in how partners and families are addressing their conflicts.

Negotiating and Navigation Skills: Those family members who would often move towards fight, flight, or fawn when in conflict discovered that they needed new skills to address conflicts. Their usual defenses were untenable when they were in lockdown with their families. Their fleeing decreased of necessity and fighting or being overly compliant was not the answer either.

We found families developing new skills to negotiate space, time, and activities. Their ability to navigate the pandemic has improved. Families now cook together, eat together, and they all watch the favorite TV shows of each family member in turn. Some families go on walks or bicycle rides together. Many families have drawn closer.

The Gains from Losing Our Manic Defenses: Over the last decade, I have made observations as to which social defenses operated most often in different regions of the world. It is clear that, in New York City, the majority of my clients struggle with a range of manic defenses. They stay busy, rushing from one appointment to another, always in an accelerated, hyperactivated state in order to make deadlines and stay caught up at work. They bring work home and stay up until the early morning to get things wrapped up. It never ends. They lose relatedness, feel resentful and then angry, and entitled to continue the intensity of their work. They rarely feel joy, pleasure, or playfulness. They just work.

The Covid-19 shutdown has forced people to slow down... and relate... and feel. For this reason, with all the drawbacks of remote therapy, there are also gifts to be had.

I wanted the last section of this article to be about positive outcomes, as so much of what I have written is about the hazards of the pandemic. Those hazards are real and serious, and we must attend to them as clinicians who are on the emotional front lines.

At the same time, we must note that the human condition is often transformed by crises. This is a good time to remember that the Chinese symbol for crisis is the same as the symbol for opportunity. This is an opportunity—if we are mindful enough to make it one.

I end this piece with a poem by Tomos Roberts, who delivers a poetic message of what this moment in time could all mean for us.

CONTINUED ON NEXT PAGE

The Great Realisation

By Tomos Roberts

"Tell me the one about the virus again, then I'll go to bed".
"But, my boy, you're growing weary, sleepy thoughts about your head".
"That one's my favourite. Please, I promise, just once more".
"Okay, snuggle down, my boy, but I know you all too well.
This story starts before then in a world I once would dwell".
"It was a world of waste and wonder, of poverty and plenty,
Back before we understood why hindsight's 2020
You see, the people came up with companies to trade across all lands
But they swelled and got much bigger than we ever could have planned
We always had our wants, but now, it got so quick
You could have anything you dreamed of, in a day and with a click
We noticed families had stopped talking, that's not to say they never spoke
But the meaning must have melted and the work life balance broke
And the children's eyes grew squarer and every toddler had a phone
They filtered out the imperfections, but amidst the noise, they felt alone.
And every day the skies grew thicker, 'till you couldn't see the stars,
So, we flew in planes to find them, while down below we filled our cars.
We drove around all day in circles, we'd forgotten how to run
We swapped the grass for tarmac, shrunk the parks 'till there were none
We filled the sea with plastic because our waste was never capped
Until, each day when you went fishing, you'd pull them out already wrapped
And while we drank and smoked and gambled, our leaders taught us why
It's best to not upset the lobbies, more convenient to die
But then in 2020, a new virus came our way,
The governments reacted and told us all to hide away
But while we were all hidden, amidst the fear and all the while,
The people dusted off their instincts, they remembered how to smile
They started clapping to say thank you and calling up their mums
And while the car keys gathered dust, they would look forward to their runs
And with the skies less full of voyagers, the earth began to breathe
And the beaches bore new wildlife that scuttled off into the seas
Some people started dancing, some were singing, some were baking
We'd grown so used to bad news, but some good news was in the making
And so when we found the cure and were allowed to go outside
We all preferred the world we found to the one we'd left behind
Old habits became extinct and they made way for the new
And every simple act of kindness was now given its due"
"But why did it take us so long to bring the people back together?"
"Well, sometimes you've got to get sick, my boy, before you start feeling better
Now, lie down and dream of tomorrow and all the things that we can do
And who knows, if you dream hard enough, maybe some of them will come true
We now call it The Great Realisation and yes, since then, there have been many
But that's the story of how it started and why hindsight's 2020."

of Somatic Experiencing & Expressive Writing

November 7 – *Running the Matrimonial Gamut: A Trilogy of Conflict Resolution*

December 5 – *Gestalt Therapy 101: The Essentials*

Like practitioners all over the state, Westchester clinicians in private practice have been creative in adapting to the challenges of the pandemic. Most are holding telehealth sessions with their patients. They are attending very carefully to the complexities of billing, thanks to the excellent guidance of Jay Korman, LCSW-R, BC-TMH, the Chair of the State Practice Management Committee.

Some practitioners are beginning to plan with their patients to resume in-person sessions, with appropriate safety precautions. Clinicians who work in agency practice follow the policies of their agencies as directed by state offices—health, mental health, substance use, and youth and family services. We are hearing that some clinicians are exhausted by the challenges of these times, but also are excited by the opportunities presented by telehealth sessions.

Our Leadership Committee meets regularly to sustain our work in general. Our other continually active committees are Education; Membership & Program Registration; Newsletter; Legislative; and Website. Our Membership and Program Registration Committee scheduled an outreach program to students at the Fordham University branch in Westchester County to engage newer members, students, and graduates and to provide them professional support as they enter the field of social work. This program had to be canceled due to the pandemic, but will be rescheduled, and we will also reach out to other local schools of social work.

Our monthly meetings have attracted dozens of members who seek to achieve their continuing education units through our presentations. Many more members and non-members alike attend, not only for the educational opportunities, but also for the warm collegiality and professional support that our chapter offers. Our schedule of activities will develop as the year unfolds, and the virus continues to challenge us all.

Online Licensing Study Group

Free for NYSSCSW Members

NYSSCSW is pleased to announce the launch of a new Licensing Study Group that will meet via Zoom on the second Wednesday of the month, from 6:30 to 8:00 pm.

This group is appropriate for individuals studying to take both the ASWB Masters Exam and the ASWB Clinical Exam. Using sample questions, we will discuss the answers, as well as the knowledge, skills, and abilities tested.

The Licensing Study Group is free with your membership. Please register at www.NYSSCSW.org/LSGA

If you know someone who is interested in joining the group, but is not yet a member, please direct them to www.nysscsw.org/benefits-of-membership so they can join the Society and then register for the study group.

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→ **Collegiality & Connections** • *State & Chapter Events, Committees, Listservs, Website, Facebook, Newsletters*

For more information please contact our office at info.nysscsw@gmail.com

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