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

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The Erasure of Identity and Removal of Safety: *Don't Say Gay*

By Michael M. Crocker, DSW, LCSW, MA, CGT and Shaun Peknic, MA

Until 1973, homosexual identity was listed in the DSM as a mental disorder. This was further reinforced by the idea in the 1980s that HIV was a "gay disease." LGBTQ individuals were forced to hide their identities in order to remain safe from others who viewed them as perverse. This often led to substance abuse, addiction, self-harm, or suicide. Many in the LGBTQ community spent considerable money and time in the painful effort to "convert" themselves to hetero-sexuality so that they could avoid discrimination. It was not until the late 1990s that gay identity was more openly accepted by society. The medical and mental health fields now acknowledge that LGBTQ identity is a biological condition occurring in at least 5% of people rather than a psychological disorder (LeVay, 1991; Allen & Gorski, 1992; Hamer, 1994).

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> "Let's not repeat history. A return to identity erasure will activate shame, stigma, prejudice, and bullying."

PHOTO: Abraham Gonzalez Fernandez

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Message from President Karen Kaufman

We continue to navigate a complicated world with mounting external threats. Prior to the war in Ukraine, for more than two years we managed the unknowns and uncertainties of Covid and its effects on our lives and those of our patients. While many believe that the mental health crisis has abated, the long-term effects on children and adolescents have gained more attention with the increased incidence of self-harm and suicide.

Along with a volatile political climate, we see dangerous erosion in areas of voting, civil and reproductive rights, increased crime, and the severe consequences of climate change.

As we support our patients and help them stabilize their lives during this challenging time, we too have concerns about health and the future, and many clinicians report feeling a diminishment in their own wellbeing. Many have taken on more work than usual given the great need for mental health care as families struggle with losses of loved ones, unemployment, and reductions in community support services, all exacerbating mental health symptoms. It can feel difficult to maintain hope and optimism about the future and is therefore of utmost importance that we preserve our own sense of wellbeing to ensure that we can support those who rely on us for help.

> "Like a suspension in time, the protected space of a garden allows our inner world and the outer world to coexist free from the pressures of everyday life. Gardens in this sense offer us an in-between space which can be a meeting place for our innermost, dream-infused selves and the real physical world. This kind of blurring of boundaries is what Donald Winnicott called a "transitional" area of experience…"
>
> **—Sue Stuart-Smith, *The Well-Gardened Mind: The Restorative Power of Nature***

I was reminded of a recent book on the psychological benefits of gardening, *The Well-Gardened Mind: The Restorative Power of Nature*. The author, British psychiatrist Sue Stuart-Smith, describes the transformative power of engaging with nature.* The success of programs involving nature and the arts is well known in settings such as nursing homes, prisons, with veterans, children, and in disadvantaged communities.

Karen Kaufman, Ph.D., LCSW-R

Along with encouraging good care and enjoyable pursuits for our patients, it is essential that we also find ways to support ourselves in order to reduce the risk of secondary trauma as we navigate the myriad of crises. Creative pursuits, whether in nature or the arts, along with exercise, good nutrition, and optimal health care, are valuable ingredients in promoting wellbeing for our patients and ourselves.

The Society's committees and the ACE Foundation provide programs on many of these topics of concern and continue to offer resources to members in all areas of practice. The 53rd Annual Education Conference, Lives Disrupted, focused on the long term psychological and physiological effects of Covid. Presented in April by experts from different areas of practice, it was very timely and well received [see reviews in this issue].

In addition, we will launch projects this year to increase communications, both within the Society and across New York State, and enhance our visibility on social media. We hope to grow the organization by connecting with clinical social workers statewide, and by promoting clinical social work and educating the public about it. Our Legislative Committee is expanding to address the professional needs of social workers with the state legislature in order to maintain the highest standards for social work education, practice, and licensure.

As members, you make an important contribution to the Society. The Board encourages you to get actively involved this year by contributing your talents and expertise at the chapter and state level and joining the leadership of your professional community.

karenkaufman17@gmail.com

ACE FOUNDATION | UPDATE

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

Despite the invasion of the pandemic and perhaps partly because of it, the Advanced Clinical Education (ACE) Foundation has been expanding. Our Board has continued to meet monthly, our chapter and committee continuing education programs have been successfully Zoomed, and April was witness to the best Annual Education Conference that we have had in many years.

We have added Dr. Arthur Gray, Ph.D. to our Board and with his assistance we are qualified to offer New York State psychology CEU contact hours. We renovated our website, created a new synchronized identity (rebranding) to distinguish ourselves. We built a new online platform with an audiovisual library and clinical program announcements. Beyond that, we launched the ACE Learning Center (see info below).

On a sad note, our creative Director of Professional Development, Susan Klett, Ph.D., Psy.D., LCSW-R, is leaving after seven years of service with the ACE Foundation and many decades of planning programs as Education Chair for the Society. We wish her well in her new pursuits which include writing poetry and professional papers. Perhaps kick boxing as well.

The new ACE Foundation Learning Center is a complementary online learning portal that provides on-demand clinically relevant content for clinicians at any level of their mental health career. It will include presentations on many subjects, including those approved for CEU contact hours.

Our Sunday Morning Series began on June 5 with *Corporatization of the Clinical: Systematic Control of Expertise*, a Zoom presentation by Ellyn Freedman, Psy.D., LCSW-R.

On Sunday, July 10, *Carl Jung, Wounded Healer: Linking His Biography with His Concepts and How They Are Relevant in Today's World*, will be presented by Louise DeCosta, Ph.D., LCSW-R. It is a return to office-based programs; attendance will be limited.

You can become a member of the ACE Learning Center when you register at: **https://ace-foundation.net/programs/sunday-morning-program-series**

The Clinician

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

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By Marsha Wineburgh, DSW, LCSW-R, Legislative Chair

LMHCs, MFTs and LPs Drive Final Efforts to Gain Diagnostic Privilege

With 12 days to go before the end of 2022 legislative session, the atmosphere in Albany was frenetic. Deliberations on the content of bills had been lost with few exceptions. The one exception that we are most concerned about is A6008D/S5301B, a bill to allow the three already licensed mental health practice groups the privilege to diagnose mental illness. This is a really big deal as it will extend to 12,000+ practitioners the possibility to be reimbursed for their services. At the moment, they, by law, can only make diagnostic assessments. Once they can furnish a diagnosis, they have potential access to the same group insurance plans—Medicare, behavioral health organizations, etc.—that LCSWs have now.

Since 2004, when licensing psychotherapy was finally accomplished in New York State, Licensed Mental Health Counselors, Licensed Psychoanalysts and Licensed Marriage and Family Therapists have sought to gain the privilege of diagnosis. NYSSCSW has consistently opposed their attempts until each group met the same clinical education and in-person supervised clinical experience that LCSWs are required to have. All master's level clinicians would then have the same minimum competence standards, protecting the public in a straightforward way.

Seems so simple. Yet here we are, nearly 20 years later, considering the fifth version of A6008D/S5301B, involving a stakeholders group of at least four legislators, 15 government relations reps (lobbyists), the State Education Department, professional association representatives, and we haven't even got to the Governor's office. Think of the time, energy, and money that has gone into this legislative effort.

By the time this issue of *The Clinician* is published, we will know if this bill has been passed or killed. If it doesn't survive, next year a version will be introduced in the new 2023-24 two-year session, and we begin again. This is where your dues money is spent, allowing the NYSSCSW to protect our profession in a fair and equitable way and safeguards for the public seeking competently trained mental health professionals.

Direct Medicaid Billing

Governor Kathy Hochul signed our private practice Medicaid reimbursement bill into law on January 2022 after a 35-year campaign by the NYSSCSW. Since the 1980s, private practice clinical social workers could only be reimbursed for Medicaid mental health services if they worked through a psychiatrist who did the actual billing for their services.

The Department of Health is now in charge of writing the regulations and billing procedures. Reimbursement has not been determined. Once a bill becomes law, implementation is an entirely additional matter that requires creating regulations that must be reviewed by all stakeholders. Given that the Department of Health is focused on the pandemic as well as attempting to bring all health care professions into its purview, any further action on this law will be several months away. Be assured that we will press for regulations as Covid dissipates.

Society's Legislative History Archived

Fourteen boxes of NYSSCSW's legislative history have been shipped to the M.E. Grenander Department of Special Collections and Archives at the University at Albany, SUNY. The archives library is under the supervision of Brian Keough, Head Librarian.

An archivist and graduate student are currently working on the materials. They will be scanned and coded to make them researchable online in Hyrax, the digital repository. To see what's happening, check in at:

https://archives.albany.edu/description/catalog/apap290

Note that Society newsletters from 1974 forward are now available on our website archive.

We welcome any materials you have from the 1970s. Please contact the office at 800-288-4279.

SAVE THE DATE

SATURDAY OCT. 29, 2022

11:00 AM – 3:00 PM

NYSSCSW ANNUAL MEMBERSHIP MEETING

RED HAT ON THE RIVER, ONE BRIDGE STREET
Irvington on Hudson, NY

11:00 AM Networking & Cocktails
12:00 – 3:00 PM Luncheon & Meeting

The Society Board of the NYSSCSW cordially invites you to attend our Annual Membership Meeting on Saturday, October 29, 2022. It will be the first in-person meeting since 2019 and we are delighted to repeat the memorable event we hosted at the Red Hat Restaurant nearly three years ago (shown in photos).

This will be a wonderful opportunity to network, socialize, and learn more about your professional organization. You will have an opportunity to mingle and network with members from all of the chapters in the state and meet the leadership of the Society Board. You will learn about current developments in the organization along with plans for the coming year. Members from each chapter will be honored for their contributions to the Society.

The Red Hat Restaurant is easily accessible by car and Metro North. Please consider carpooling with other members and get a head start on socializing!

Attendance for members is free of charge. Guests who accompany you—partners, colleagues, and other non-members—will be charged a fee of $25. We are following the recommended CDC guidelines for Covid precautions. More info available soon at **www.nysscsw.org** or **info.nysscsw@gmail.com**

Scholarships Awarded to Six MSW Students in 2021

Each year, the NYSSCSW presents a $500 scholarship and a Society membership to MSW students who demonstrate excellence in academics, field placement, research, writing and/or volunteerism.

In 2021, scholarships went to six students in three of our chapters (listed below). We invite you to watch a video celebrating their work: **https://youtu.be/o1SA9iv-j78**

The video features interviews of the students by Society Scholarship Committee members. The questions brought out common themes of their MSW experience: What drew you to social work? Tell us about the case you described: what interventions did you use? What placements and internships have you had? What were the challenges, the surprises, and your takeaways?

We thank the Committee Members: Hafina Allen, LCSW-R, NYSSCSW Second Vice President and State Membership Committee Chair; Susan G. Appelman, ACSW, LCSW, CASAC; Chris Ann Farhood, LCSW-R, State Mentorship & Peer Consultation Chair; Faith Kappenberg, LCSW-R, BCD; Orsolya Clifford, LCSW-R, President, Rockland Chapter; and Genie Wing, BCD, LCSW-R.

CLOCKWISE FROM UPPER-LEFT: Courtney Oehl, Nairobis Cuevas, and Stacey Schiff Klinger

Metropolitan Chapter Scholars

Janire Ayala, *Department of Social Work,* Lehman College, CUNY

Nairobis Cuevas, *Graduate School of Social Service,* Fordham University

Diana Durango, *Wurzweiler School of Social Work,* Yeshiva University

Roula Hajjar
Silberman School of Social Work
Hunter College, CUNY

Nassau Chapter Scholar

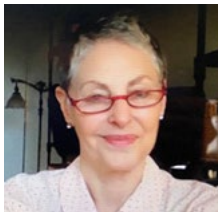
Courtney Oehl, *School of Social Work*
Adelphi University, Garden City Campus

Rockland Chapter Scholar

Stacey Schiff Klinger, *Silver School of Social Work,* New York University, Rockland campus

Met Chapter Committee on Racial Equity

Excerpts from monthly newsletters edited by Jane Gold, LCSW (janegoldlcsw@gmail.com)



Jane Gold, Editor

From Prison to Purpose

By Jane Gold, LCSW

***Positive Delusions*, by Chris Wilson**

After the tragic massacre in Buffalo that we are all reeling from, a Black middle-aged patient told me she looks forward to Juneteenth, but with a heavy heart, as she struggles to stay "hopeful." Rudimentary as her painting hobby is, she is using it to express and understand her feelings.

David Gussak, Ph.D., ATR-BC speaks about art therapy as a powerful vehicle in his blog, Art Therapy in Prison is Social Justice. "Art becomes the great equalizer humanizing those that have been previously dehumanized. Only when someone creates are they recognized as being alive. Art breaches the walls, providing a message to those outside ... art therapy allows the inmate to express him or herself in a manner acceptable to both inside the prison and the outside culture."

Interview of Chris Wilson by Trevor Noah on *The Daily Show*.

Chris Wilson survived solitary confinement with the help of his creativity and "delusional thinking." He speaks out about the value of therapy in his interviews and in his book, *The Master Plan: My Journey from Life in Prison to a Life of Purpose*. Don't miss his 11-minute interview with Trevor Noah. (ref. below) Here's part of a Wilson interview for his art show this month in New York City.

Surviving Solitary Confinement

"From my own experience in solitary, I knew I didn't want to create a morbid piece. So, I discussed it with my therapist. She asked me what got me through the experience. And that's what I decided to focus on. How did I stay sane? How do others? I thought about my grandmother's cooking, the people I care about, and the experiences I would have when I got out. I had to delude myself to get through that experience. Without focusing on those good thoughts, I never could have done it. People have to focus on those positive delusions to survive the situation."

Take us through the colors in Positive Delusions and what they symbolize for you as a visual artist.

"Light blue represents the ocean and blue skies. I daydreamed of being able to see them both again. Yellow is for the happy moments in my past. It's the energy to do the things that kept me motivated—sunshine and hope. Black represents my desire to rebel against the systems that oppress Black people in this country. Red is the rage I felt for being treated like an animal. Pink is to show my desire to protect people from the experience of solitary confinement. I want to end the practice completely. And finally, white represents white supremacy. That includes the police and policymakers who have been trying to destroy the Black community for decades. That's why the white behaves so violently toward the other colors in this painting."

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Artist for Social Justice: https://www.thedrawingroom.blog/chris-wilson-visual-artist-for-social-justice/

Chris Wilson with Trevor Noah: https://m.youtube.com/watch?v=hQPelJfpAbk

Met Chapter

Michael Crocker, DSW, MA, President

Before discussing the work/events of the Met Chapter, let me first thank Helen Krackow, LCSW-R, our recent past president, for keeping the Met Chapter cohesive and grounded during these traumatic years. Under her auspices, the Chapter continued to exist and grow. I know I speak for the whole chapter when I send thanks to Helen for her leadership and continued involvement. She will continue as leader of the Membership Committee and as an active member of the State Board. Helen has contributed so much of herself to the Met Chapter and her presence is infused in the spirit of our chapter.

The Met Chapter has developed several projects, committees, and workshops during the last year. In light of the violence, social injustices, and trauma that we have witnessed and experienced, the Chapter developed the Racial Equity Committee and the BIPOC support group. Under the auspices of Sandra A. Plummer-Cambridge, LCSW-R, RDT, the BIPOC group has met monthly. The Racial Equity Committee, which includes Jane Gold, LCSW-R, Helen Krackow, Michael Crocker and Shaun Peknic, MA has implemented two workshops in the past year: *The Clinical Implications of Systemic Racism, Power, Privilege and Culture for Mental Health Providers in Working with Clients* with Judith White, LCSW, CGP, Jonathan Rust, Ph.D., NCC, and Thomas Craemer, Ph.D.. The workshop, moderated by Plummer-Cambridge, was a great success with close to 100 attendees. Additionally, the committee provide a workshop, *Clinical Issues in the Treatment of Asian Americans* with Teresa Lee, M.D. and Robert Hsiung, M.D.

The Racial Equity Committee (REC) has been very active. Jane Gold has led the implementation and provision of the monthly Racial Equity Newsletters that provided monthly themes related to the racial issues we are dealing with in our world and as clinicians. One of the recent issues of *The Clinician* was completely dedicated to the clinical issues of racism. The REC also had a focus group on April 30 to get more clarity in addressing racism. The group was a great success in gathering helpful information to move forward.

The Psychoanalytic Committee presented a conference, *Owning Aggression: From Victimhood to Agency–How Playing with Sadistic Fantasies Can Lead to Growth*, with Art Baur, LCSW and Michael Crocker. The workshop, organized by the Chairs of the Committee, Barbara Lidsky, LCSW, BCD and Don Appel, LCSW was a great success with over 70 participants. Art Baur and Michael Crocker are evolving the workshop into an article for publication.

The Group Practice Committee, chaired by Joe Zagame, LCSW-R, CGP presented the workshop, *How to Start a Group* on April 29. The Addictions Committee was inactive in the last year; however, Betsy Spiegel, LCSW, and Michael Crocker met to put together some ideas for upcoming themes for the Committee including conceptualizing the impact of Covid, specifically regarding vulnerability for substance use.

The Met Chapter is looking to revive the Trauma Committee, considering the devastation in the last couple of years. Two issues of *The Clinician* focused on Covid issues, and it became clear that we need to address these issues head on.

I mentioned in my inauguration message that I want to hear from members to learn what you value about the Met Chapter, as well as your ideas about new programs and initiatives that can be implemented in the coming years. To that end, we are starting to put together a survey that will be sent out to the Met Chapter members later this summer.

The Met Chapter has worked diligently to provide support to its members through a very active Listserv and we will continue to do so. The Chapter has also addressed current societal issues that impact all clinicians. We went head on to address the trauma of Covid, the issues of futurized stress facing our youth, and the deep-seated systemic racism that continues to exist in our world.

MODEL MINORITY, *Myth & Reality*

By Elizabeth Ojakian, LCSW and Jane Gold, LCSW

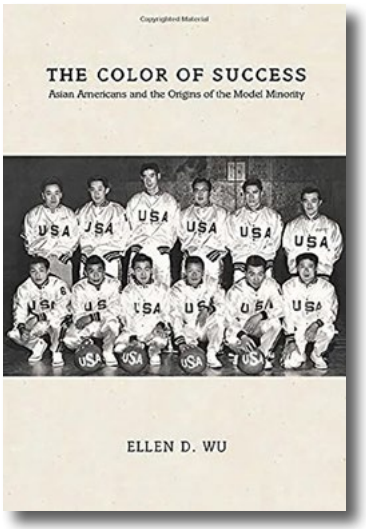
The model minority stereotype has been used to deny that racism is a reason for differences among racial groups, "If Asians can succeed so can the ___." But geopolitically it was advantageous for white America to present opportunities to Asians and provide a process where they could more easily enter the "American Dream." In order to be seen as the leader of the free world and gain power in Asia, the U.S. needed to improve the way Asians were treated at home. To this end, in 1943, the very people identified as the "Yellow Peril" were finally eligible to become naturalized citizens.

In her book, *The Color of Success*, Ellen Wu follows the journey of Asians (primarily Japanese and Chinese) in America from the 1800s, when they were viewed as threatening aliens, to today's image of them as the model minority. How did this happen? Having been seen as "foreign" and the enemy, being imprisoned in Internment Camps, Asians strove to fit in with the white middle-class and become "the good American."

The Immigration Act of 1965 further increased the immigration of Asians, as national origin was replaced with a preference for the highly skilled (Wikipedia. org). According to the 2015 Census, a larger percentage of Asian-Americans than European-Americans hold a bachelor's degree or higher. Yet, there is more income inequality within Asian-Americans than any other racial group in America (Pew Research Center, 2018).

> "Comparing racial groups is a highly flawed practice. It does not account for the 250 years of [slavery and Jim Crow]. . ."

In her book, Wu states that Asians were considered "Not-Black," and this turned into an advantage for them. She points out that comparing racial groups is a highly flawed practice. It does not account for the 250 years of humiliation and shattering of families of African slaves or the 100 years of Jim Crow, along with continuing discriminatory practices. It also does account for the displacement of Native Americans from their own land.



The model minority stereotype puts psychological stress on Asian-Americans who are not as financially or educationally fortunate, or whose behavior does not fall within a certain sphere, and prevents those in need of assistance from obtaining it. One study found that Asian-Americans were three times less likely to seek mental health services than Whites (Kojo Nishi).

Geoffrey Liu, psychiatrist at McLean Hospital Behavioral Health, describes the pressure of being part of a model minority—it stands in the way of treatment. "Many Asian Americans see themselves as part of a group that seamlessly integrated into their new society. They characterize themselves as intelligent, industrious, and fully in charge of their lives. For many, admitting to 'weakness' would be letting down the entire community."

However, public information efforts to increase awareness of mental health resources and to fight stigmatization are encouraging Asians, and people of all backgrounds, to speak up and ask for help.

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Why Do We Call Asian Americas the Model Minority, YouTube 10 mins, https://www.youtube.com/watch?v=PrDbvSSbxk8&t=14s

Mid-Hudson Chapter

Linda Hill, LCSW, President

The Mid-Hudson Chapter is pleased to welcome our newest board member, Eileen Duffy Traslavina, LCSW. She has joined our chapter's Membership Committee, which also includes Judy Elkin, LMSW and Barbara Solomon, LCSW. We are grateful for their efforts to support Chapter members and generate ideas that benefit our community of clinicians.

We have remained committed to sponsoring four high-quality workshops on an annual basis. This February, we were fortunate to be able to offer a follow-up course by Anne Grenchus, LCSW, ACPH-SW, *Complicated Bereavement: Clinical Interventions for Healing and Creating Meaning.* Her presentation integrated theory on trauma and complex PTSD with Dr. Dan Siegel's work on mindfulness and interpersonal neurobiology, applying these frameworks to case studies gathered from years of hospice and private practice experience. A heartfelt word of thanks to our dedicated Education Committee Chair Cynthia Muenz, LCSW, for arranging our educational offerings.

We are looking forward to two presentations. In June, Shideh Lennon, Ph.D., will return with a new workshop, *Somatic Experiencing for Anxiety.* This course will address working with anxiety states, both acute and chronic, and will discuss ways to increase awareness of the body through the use of use of somatic interventions. In the fall, Claire Beth Steinberger, Ed.D., LMFT, LP will present *Dances of Intimacy: The Nuts and Bolts of Couple Therapy.* The presentation will focus on the "location" of the therapist as participant-observer and the impact of the bio-social environment on coupling struggles and adaptations. Tamar Opler, LCSW, has been integral in helping us spread the word about each of our live webinars.

Another focal point of our Chapter's work has been outreach to social work students in the Mid-Hudson Valley and upstate. Carolyn Bersak, LCSW, DSW and Cindy Marschke, LCSW, Ph.D. have been co-facilitating monthly Mentorship Group meetings. The group is for current MSW students and recent graduates seeking career planning in such areas as job searching, resume writing, and obtaining the LCSW and R designation. Dr. Bersak also serves as liaison to the Adelphi University School of Social Work Hudson Valley Center and is overseeing implementation of our new scholarship program with Adelphi. The scholarship award will be granted based upon an outstanding understanding of the theory and practice of social work. We look forward to announcing the recipient during the summer.

Chapter Board members have been reaching out to other student communities as well. Katrina Yahraes, LCSW has been sharing news of Chapter activities with our friends at the Marist College social work program. We are pleased to have established a relationship with the School of Social Welfare at the University at Albany. Our "PR" representative, Samantha Rathe, LMSW, is our new Albany liaison and has been communicating with the school about opportunities for students. As a result, we are excited to now have Albany MSW students attending online Mentorship Group meetings.

> "Since its inception almost 20 years ago, the Mid-Hudson Peer Consultation Group has been meeting on the second Friday of each month. It provides a space where clinicians can network and assist one another through the sharing of practice-related information and through discussion of clinical dilemmas."

The Mid-Hudson Chapter continues to host online Movie Nights for NYSSCSW members and guests. In March, the featured movie was *Ladybird*, a coming-of-age story about an adolescent young woman navigating relationships and decision-making as she graduates from high school and enters college. The movie was well-attended, with participants hailing from as far north as the Rochester area. We are grateful to our "Tech" Adviser, Susie Deane-Miller, LCSW for her role in bringing this fun event to fruition.

Since its inception almost 20 years ago, the Mid-Hudson Peer Consultation Group has been meeting on the second Friday of each month. It provides

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Nassau Chapter

Ellie Perlman, LCSW & Patricia Traynor, LCSW, Co-Presidents

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.

We continue to be impacted by the pandemic, as people rely on Zoom and other telehealth platforms for patient sessions, meetings, and workshops. Chapter members have provided support to colleagues struggling to navigate through the stress and emotional trauma of the pandemic. Some people have returned to their offices on a part or full-time basis.

Over the past months, the Chapter Board has continued putting together events and looking for opportunities to increase our exposure. Our Diversity Committee, chaired by Jannette Urciuoli, Ph.D., LCSW and Judith Pullman, LCSW will be coordinating with the Programming Committee in setting up a fall educational program. They also will be working more closely with Helen H. Krakow, LCSW-R at the State level.

Jannette Urciuoli heads our Website Committee and has been spending hours improving our website and making sure events, pictures, and other information gets posted. She has been coordinating with Kristin Kuenzel at NYSSCSW headquarters.

Evelyn Kuntz, LCSW, the Chapter's Public Relations Chair, is our liaison to the State PR Committee, chaired by Barbara Murphy, LCSW-R, who is also a Nassau member. Our Public Relations and Website Committees are looking forward to working with the state and the public relations firm to increase exposure of clinical social workers and highlight the benefits of being a member of the organization.

The Programming Committee, chaired by Ellie Perlman, sponsored a wonderful presentation last fall entitled *Creating Meaning Out of Grief*, presented by Anne Grenchus, LCSW. Our spring presentation on Zoom will be on Gestalt Therapy, led by Adam Weitz, LCSW.

The Mentorship Committee, led by Jennifer Shapiro-Lee, LCSW-R has held monthly meetings with three to four regular attendees, and is looking to add more talented social workers to the group. If interested, or know someone who is, contact Jennifer. An overview of the group can be found on our website.

The Membership Committee, headed by Patricia Traynor, and Linda Feyder, LCSW-R (also our dedicated Secretary) continues to collaborate with the other committees to develop partnerships, expand our outreach, and sponsor conferences, all to increase awareness of the benefits of membership. We have 141 members, with two new members. During our membership drive, we awarded five prizes to the winners of a lottery for those who renewed before 2022.

The Committee for the Aging, with eight regular members, is headed by Sheila Rindler, LCSW. They meet bi-monthly on Zoom to discuss books and articles; the most recent book was *Blooming in December*.

The Scholarship and Education Committee is led by Catherine Faith Kappenberg, Ph.D., LCSW, who is also our University Liaison. We awarded a scholarship to an outstanding Adelphi student, Courtney Oehl, in the fall awards ceremony. We will be giving an award to a BSW student from Molloy College in the spring. Catherine is working to set up a liaison with LIU.

Our Book Club, led by Susan Kahn, LCSW, BCD plans to meet again in the fall. Last year they read, *The Vanishing Half* by Brit Brenner.

We have decided to discontinue publication of *News Notes*, as it is very difficult to obtain enough clinical material for it. We encourage members to submit clinical articles to *The Clinician*. We give our sincere appreciation and thanks to Susan Kahn for working on *News Notes* over these many years, and also thank Prue Emery, LCSW who was editor until the last few years, and Carline Napolitano, LCSW who served as editor most recently. We are grateful to all who contributed to *News Notes* over the years.

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Westchester Chapter

Andrea Kocsis, LCSW, President

In 2021 and 2022 to date, like practitioners all over the state, our Westchester clinicians in private practice have been very creative in adapting to the challenges of the pandemic. Most are having telehealth sessions with their patients, attending very carefully to the complexities of state regulations and of billing, thanks to the excellent guidance of Jay Korman, LCSW-R, BC-TMH of the State Board. Clinicians who work in agency practice have had to follow the frequently changing policies of their agencies as directed by state offices of health, mental health, substance use, 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.

Since the CDC has begun relaxing standards of community behaviors as the threat of the virus decreases due to vaccinations and boosters, some practitioners are beginning to return to in-person sessions with appropriate Covid precautions. We appreciate the guidance that articles in recent issues of *The Clinician* offered members as they contemplated next steps. We are all considering how our chapter activities will develop as the year unfolds, and how the virus will continue to challenge us.

> "Chapter Board members have cautioned that the pandemic has created a seismic shift in how people want to experience their work life and environment. Younger workers especially do not want to return to in-person meetings."

In 2021 and 2022, our Board met regularly by Zoom to maintain chapter functioning. Our committees continue: Education, Membership, Program Registration, Newsletter, and Website.

Our Education Committee has continued to organize and offer Zoom CEU presentations, ending 2021 in November with *Contact and Relationship in Gestalt Therapy*. We began the year with the presentation in January, *Depressed, Borderline or Bipolar?*; in April, we offered *Deepening the Connection: Psychodrama's Tools to Bridge the Gap in Times of Isolation*; and, in June, *Zoom Revisited: An Emerging Theory of Online Psychotherapy and Practical Applications*. We are planning another CEU presentation on gestalt therapy and one on group therapy in the fall.

Over the last two years, members have missed our in-person monthly meetings and the opportunities to converse, learn, and network with our colleagues. Using Survey Monkey, we recently polled members on how they feel about returning to in-person membership meetings. The majority of respondents want to meet in person again. However, Chapter Board members have cautioned that the pandemic has created a seismic shift in how people want to experience their work life and environment. Younger workers especially do not want to return to in-person meetings. They are comfortable working virtually and determined to maintain a work/life balance.

Our Board is motivated to address this shift in preferences and attitudes creatively, while also considering the wishes of members who want the stimulation and interaction of meeting face-to-face with colleagues. We will hold an in-person Board strategic planning session in June to address all the implications of these changing times and needs, of moving forward and transitioning to a different, perhaps a hybrid, chapter experience. Our question will be: What would an ideal virtual or hybrid chapter look like? We anticipate an exciting and challenging process in the weeks ahead.

HEADQUARTERS UPDATE

I know you all must be as happy as we are that the weather has finally changed for the better!

The membership renewal season went very well this year. There are currently 1,360 members in the Society, with 28 new members since March. The chapters were very helpful in reaching out to lapsed members about renewing. We thank you!

In January, TMS worked with Hafina Allen, LCSW-R on the Student Scholarship awards event. Although it was presented through Zoom, not in person, it was a wonderful event.

Bootcamp, held in March, was also a terrific event that was very interactive and well-received by all attendees.

The MSW Job Fair was also held in March. While the platform was not ideal for meeting students, Hafina and I did our best to network as much as possible. We did receive a lot of student contact information so we can follow up with them in the future.

Jen and I continue to work on the Chapter education programs presented through Zoom. The last two programs will be held in June and then we will resume in the fall.

For those of you who haven't seen the new ACE Foundation website—www.ace-foundation.net—you should check it out! There are many programs and other information that may be of interest to you.

Debbie Lebnikoff joined the TMS team in February as a part-time administrative assistant. I am sure many of you have spoken with her in the past few months. Debbie is helping us with the day-to-day membership work and education programs, as well as anything else that comes up.

We hope you have an enjoyable and relaxing summer.

Kristin

Kristin Kuenzel, *Administrator*
Jennifer Wilkes, *CMP*
Debbie Lebnikof*f, Administrative Assistant*

NYSSCSW c/o Total Management Solutions
800-288-4279; info.nysscsw@gmail.com

COMMITTEE REPORT

CREATIVITY & NEURO-PSYCHO-EDUCATION

Highlights 2021

Members took a guided tour of the exhibit, *Louise Bourgeois: Freud's Daughter*, at the Jewish Museum in Manhattan. Sandra Indig had pre-viewed the exhibit. All who attended found the aesthetic complexity, and the insightful presentation of the artist's journals, poetry, and sculpture by the curator, exciting and insightful. A Zoom presentation and interactive discussion led by Sandra and Dr. Inna Rozentsvit followed. This exhibit was a more than perfect fit between art and the practice of psychoanalysis.

Whitney Museum, *Jasper Johns: Mind/Mirror* exhibit: Johns at 91 is still creating art. This exhibit has been previewed and noted for its remarkable demonstration of the creative process and the part played by the unconscious.

Highlights 2022

Sandra and Inna participated in March in the virtual conference, *Transgenerational Transmission of Trauma and Resilience*. In addition, Sandra pre-viewed the Whitney Biennial Exhibit with an eye to its relevance to clinical interests. In June, Inna presented a virtual workshop on the topic of understanding and mending one's mental functioning through the tools of "functional" psycho-neuro-biology.

June 12: MoMA Matisse, *The Red Studio*; June 13: *The Year of Rest Group Virtual Exhibition*; TBA: Metropolitan Museum of Art, *Fashion and Beyond*.

Thank you for your interest in our offerings and announcements.

Sandra Indig, LCSWR/LP, NCpsyA, ATR-CB, Chair
psych4arts@hotmail.com

Inna Rozentsvit, MD, Ph.D., Co-chair
inna.rozentsvit@gmail.com

NEW MEMBERS OF NYSSCSW

NAME	CHAPTER
Agordo, Valencia	MET
Adeola, Moyosore	NAS
Adkins, Ian	MID
Alexis, Genevieve	ROC
Antrim, Lucinda	WES
Ayala, Janire	MET
Bahan, Kathleen	MET
Balkind, Betsy	MET
Bayer, Kaylee	ROC
Beer, Judith, Ph.D.	MET
Benca, Lubica	MET
Bossert-Ocner, Sandra	MET
Buteau, Catesby, MSW, LCSW	MET
Charme, David, J.D.	MET
Choi, Ashley, LMSW	MET
Cruz, Melissa, LCSW, MSS	MET
Cuevas, Nairobis	MET
Curabba, Juliann, LCSW	MID
Davidson, Naomi	MET
DeSiena, Bill, MSW, LCSW	ROC
Dugan, Kelsey	ROC
Durango, Diana	MET
Eisen, Rachel	ROC
Fox, Robert, LMSW	NAS
Frederico, Stephen, LCSW-R	SUF
Goodrich, Hayley	MET
Gorra, Nicole	SI
Greenberg, Patricia, LCSW	ROC
Grodney, Diane, Ph.D.	MET
Hajjar, Roula	MET
Hartwell, Barbara, LMSW	MID
Heitman, Brittany	NAS
Herburger, Kathryn, MSW	QUE
Hershkowitz, Robin, LCSW-R	WES
Horner, Kylie	MET
Katz, Gary, LCSW	MET
Kennedy, Sinead	NAS
Landau, Lorraine	WES
Lawson, Vanessa	MET
Lehman, Melinda, LCSW	WES
Lev, Jennifer	WES
Lipton Rothberg, Denise	MET
Manitsky, Beth, MSW, LCSW	MID
Markowitz, Dale, MSW	MET
McDowell, Fiona, MS	WES
Mellan, Susan	MET
Mickel, Marisa, LCSW-R	MET
Miller, Susan, LCSW	MET
Mintz, Chana	NAS
Moore, Sarah, M.S.Ed.	MET
Munoz, Charlea	MET
Navratil, Peter	MID
Neumann, Ken, Ph.D.	MET
Newton, Hillary, LMSW	MET
O'Brien, Catherine	MET
Oehl, Courtney	NAS
Park, Diane	ROC
Parodneck, Rachel, LCSW	MET
Parris-Buckingham, Carolyn, LCSW-R	MET
Pauyo, Marie Dominique	MET
Peluso, Diane, LCSW	MET
Phillips, Jr., Melvin, Ed.D.	MET
Prasad, Bianca	QUE
Ramales, Kimberley, MSW	MET
Rayvid, Denise, LCSW	MET
Rehfield, Blake	MET
Reichenthal, Barbara	MET
Rivas, Claudia, LMSW	WES
Rodriguez-Gomes, Marissa	MET
Rosenberg, Jamie, MSW	MET
Rubin, Sarah, LCSW	MET
Rudd, Jennifer, M.Ed.	WES
Santo, Nicholas, DSW, LCSW-R	MET
Schmerler, Leslie	MET
Schneer, Andrea, MSW, LCSW	MET
Schneider, Anna-Kate, Ed.D.	MID
Schneider, Jessica	MET
Schneider, Lisa, LCSW, MSW	MID
Schwartz, Beth, ACSW, LCSW-R	SUF
Shuman, Stephanie, LMSW	MET
Sielski Elizalde, Anastasia, MSW, LCSW	MET
Singh, Sapna	MET
Spitzer, Julie, LCSW-R, MSW	MET
Sullivan, Nicole, MSW, LCSW	SUF
Szeto, Johnny, LMSW, MSSW	MET
Tehrani, Daniel, LMSW	MET
Theodore, Nicole	MET
Troy, Shannon	MET
Trubek, Jessica, MSW	MET
Verge, Kristen, MSW, LCSW	MID
Weille, Jean, MSW, LCSW	MET
Weiss, Fran, LCSW-R	MET
Winarsky, Amy, LCSW-R	MET
Witherspoon, Maxine	NAS
Yard, Margaret, Ph.D.	MET
Yates, Kimberly V., LCSW-R	WES
Yudkin, Susanna, LMSW	MET
Zeth, Jeffrey, LMSW	MET
Zika, Valerie	MET

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.

Suicide Among Older Adults—And Help for Them

By Susan Birenbaum, LCSW, MBA, C-ASWCM

People do not realize that suicide is a major issue for the elderly. Since older adults have so many medical issues, it may be assumed that death is a result of co-morbidity rather than suicide.

Our society does not value older adults as other cultures do. In fact, the media reports statistics that show a rise in suicide in the youth and college-age population, but not the data for older adults. The mental health community is much more active in trying to stem the suicide rate among younger populations. Yet, according to the World Health Organization (2012), in the U. S., suicide among older adults is a far more common occurrence than it is among youth, and older adults have the highest rate of completed suicides.

Susan Birenbaum, LCSW, MBA, C-ASWCM specializes in Geriatric Mental Health. Follow her on Twitter @SBLCSW and Susan Birenbaum on Linkedin.
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In 2013, more than 7,000 people older than 65 died of suicide (CDC, 2013) and 14% of all suicides in the U.S. were among older adults. In addition to the thousands of older adults who die by suicide, many more have made suicide attempts and suffer from the emotional pain of suicidal thoughts.

Suicide by older adults is a rapidly growing problem. The increase in the population that is living longer and the large cohort of "Boomers" who are transitioning into this demographic, means that we are facing a major mental health crisis that needs to be addressed now. From a review of the literature, it appears that no actions have been taken, either by federal or state government health care systems, to help older adults prevent suicide. Despite the fact that suicide prevention continues to be a priority in healthcare, suicide among older adults remains a neglected subset with little interest and few studies.

Suicide rates are particularly high among white males 65 and older, higher than any other group in the population (SAMSHA, 2013b). Although suicides are more common among older women, attempts are more fatal among men; 35% of men use alcohol and firearms.

Risk Factors

Dr. Yeats Conwell, Professor and Vice Chair of the Center for Study and Prevention of Suicide, is Director of the Geriatric Psychiatry Program at the University of Rochester. He has identified four risk factors of suicide in older adults as depression, disability, disconnectedness. and deadly means. (He provides a useful overview of his findings in a video.[1])

- **Depression** Suicidal risk has a high association with depression. Signs of depression are lack of interest, sleep issues, problems concentrating, and changes in activities.

However, depression is a weak predictor of suicide. Hopelessness and suicidal ideation are neither necessary nor sufficient to predict suicide. Depression is a treatable illness, and education in depression can lead to a reduction in suicide.

- **Disability** Depression frequently occurs with the onset of disabilities in older people, such as impaired vision, hearing loss, heart attacks, and strokes, which can be major sources of feelings of loss and despair.

- **Disconnectedness** Major changes and loss in the lives of both men and women results in loneliness and isolation. Their spouses may die, and their friends may die or move away. They may have to change their lifestyles, moving out of the house that they have lived in for many years and away from their community. The move may be to an assisted living facility, a nursing home, or to a distant community to be near their children. Older adults also experience a loss of independence due to physical disabilities. They are often forced to give up driving and must rely on other people for transportation and other activities of daily living. They often feel disconnected, that they are no longer part of a community.

Women suffer these losses, but overall, they are more able to form new friendships and engage in new activities than men. Many older men have spent much of their time working and have relied on their wives to manage their social life.

The loss of identity is felt most among men beginning at age 65 due to retirement from work. It becomes more extreme by the time they reach age 85, when they can become very isolated, and unable to build new friendships. They may resort to alcohol abuse and feel deep loneliness. Often, they do not have family living close by or peers to leverage interventions for their benefit.

- **Deadly Means** In general, it is more common for men to end their lives by using firearms.

Dr. Conwell has reported that studies of older adults are composed of the female population, and do not include men.

Promoting Emotional Health and Preventing Suicide

Often, older adults do not believe in consulting mental health professionals, but they do rely on their primary care physicians (PCPs). However, most PCPs are not trained in geriatric mental health. In fact, it has been reported that many people who died from suicide had seen their PCP in the month prior to their death.

- It is important that PCPs, as part of their practice, have the tools to evaluate their patients for depression and suicidal risk. Ideally, it would be best if they had a trained mental health professional in the office who could screen patients. There are many measurement tools available to identify suicidal risk. If there appears to be a risk, patients should be referred to a mental health professional for treatment.

- Family members, peers, friends, and others should monitor the older adult's mood and, if there is a change in regular activity or mood, they should reach out to professionals. When speaking with older adults, do not ask if they are depressed, but rather, if they are sad.

- Suicide is rather rare in facilities, but the impact of an attempt is devastating to residents, their families, and staff.

Using a Tool Kit [2]

An individual should be designated and trained to use screening tools which identify signs of depression and suicidality in residents. A profile of the characteristics associated with depression among residents in facilities includes greater disability, negative attitude toward aging, poor self-rated health, loss of a sense of mastery, and less religiosity.

Many of the reasons that older adults have moved to facilities are very stressful and complicate adjustment to new surroundings, new neighbors, and new norms. The events include loss of a spouse or caregiver, increased physical vulnerability, illness, and cognitive impairment. The majority of residents are women.

RESOURCES:

American Foundation for Suicide Prevention (afsp.org)
http://www.afsp.org
The foremost organization for research, education, advocacy for prevention of suicide in the U.S.

National Suicide Prevention Helpline
1-800-273-8255 (talk). Text 741741 to speak with a trained counselor

Federal Communications Commission
http://www.fcc.gov
Beginning July 16, 2022, dialing "988" if someone is in crisis will route calls to the National Suicide Prevention Lifeline.

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1. YouTube video by Dr. Yeats Conwell, "Suicidal Behavior in Older Adults."
https://youtube/DhOmKsQNp4 (2013)

2. Tool Kit for Senior Centers/Assisted Living Facilities
https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515

Unspeakable Joy: Providing Comprehensive Gender Affirming Care

By Ash Choi and Daniel Tehrani, LMSW, MFA

Providing gender affirming care has increasingly become a necessary skill in a clinician's toolbox. But what are the critical steps to ensure one's practice is a safe space for transgender, gender non-conforming, and nonbinary (TGNB) clients? In this article, we will define gender dysphoria and gender euphoria, illustrate how to approach clients from the perspective of gender euphoria, and discuss specific issues our TGNB clients may face, such as healthcare avoidance due to transphobic practices. Finally, we make recommendations for clinicians who are looking for guidance on trans-affirming practices.

Daniel's work with Amy and her gender:

I have begun working with a client, let's call her Amy. She just came out to her parents as trans and was seeking support through the beginning of her transition. In our consultation call, she asked me what the work would look like.

I told her that it was different for everyone, that it was my responsibility to support her in accessing important resources if she wanted to seek them out (such as support groups, hormone treatment and other gender affirming procedures), but much of our work would look like the work I do with any of my clients—insight-oriented talk therapy.

I assured her that I'd be supporting her in deciding what was right for her, but ultimately, what we spoke about and worked on was up to her.

She thought about it and said, "Frankly, I don't even know where to start."

In many of our sessions since, she has been nearly silent. She responds to my questions to the best of her abilities but struggles to think of anything to say on her own. When I asked her why, she expressed—with great vulnerability—that much about exploring her gender feels daunting as she has hardly faced these questions herself, let alone uttered them aloud to another person.

I made space for this, reflecting on the resilience and courage it shows to take these steps, to utter what may have once felt wholly unspeakable.

Amy, like many, spent much of her life acting out what was expected of her. Finally, after making the brave decision to come out to herself and her family, she has the space to be herself. But she finds it so overwhelming that she does not even know where to begin.

To be frank, I was not sure either. I say that because most of my clients have so much to say that 45 minutes hardly seems like enough! I thought about what it was that was causing Amy's silence and I wondered what I could do to help make the session flow.

I "threw some things at the wall" but nothing really stuck. We began to progress a little when I asked her how she experienced gender dysphoria, what made her feel uncomfortable with her body. Amy spoke about how she had hidden herself in baggy clothes and sweatpants, how she felt about her height, her shoulders.

But when I asked her what made her feel good in her body, what caused her to experience gender *euphoria*—she finally began to talk.

Amy described the band she's in, the music they make, the kind of woman she sees herself as being. She told me that she had once applied nail polish, just a clear coat, nothing even really noticeable—but this stealthy freedom, revealing a little bit of her true self, had made her feel so deeply happy.

When I brought up gender euphoria, and Amy responded enthusiastically, it was like truly seeing her for the first time. This exemplified for me how important the concept of gender euphoria really is.

What is gender dysphoria and euphoria?

The American Psychiatric Association defines gender dysphoria as "psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity." It is this feeling, indeed this pain, that leads clients to seek support around and that gender-affirming treatments seek to alleviate.

Gender *euphoria*, on the other hand, is the feeling of joy one experiences when one's body and appearance *does* indeed match up with how one feels and identifies.

Although it is necessary for clinicians who work with the TGNB population to know how to navigate gender dysphoria, integrating the lens of gender euphoria into our clinical practice can be a life-affirming framework.

Amy does not want her experiences with gender to be solely defined as gender dysphoria. Exploring what "feels right" and gender-affirming orients the work around a client's positive experiences, prioritizing their joy and contentment.

Purely operating through a framework of gender dysphoria feeds into the erroneous and shame-based idea that many clients come in with: "There's something wrong that needs to be fixed." With Amy—as with many of my TGNB clients—breaking this idea down is step one.

The responsibility of clinicians providing trans-affirming care

What does it mean to be a trans-affirming clinician in a field that has historically traumatized and harmed TGNB people? The history of medicalizing trans healthcare dates back to 1980, when the DSM-III diagnosis of "gender identity disorder" was created to pathologize transness as a disorder.

This practice emphasized the harmful notion that if you are trans, then you have a psychosexual disorder. Unfortunately, in the healthcare industry, having this diagnosis was necessary for trans people to access medical and social care—a practice that continued until 2013. What's more, in order to receive this diagnosis, trans people had to "demonstrate" gender dysphoria, or distress. This translated into a focus on dysphoria as the defining experience of being trans.

However, one does not have to experience dysphoria to be trans. This idea that one can only be trans *if they experience distress* is rooted in psychotherapy's history of pathologizing transness.

Many trans clients come to clinicians to receive support letters to access gender-affirming care, such as top surgery, hormone replacement therapy, vaginoplasty, phalloplasty, etc. They expect to answer questions related to their gender dysphoria and to prove how much they hate themselves—how they were born in the "wrong" body, how they cannot stand to look at themselves in the mirror. Therefore, they are surprised by this question during our gender assessment: "What are you looking forward to most after you get your gender-affirming procedure?"

Through the lens of gender euphoria, we give our clients room to breathe life into their gender identity. From "I look forward to swimming again—I was a professional swimmer" to "I can't wait to wear a white fitted shirt without binding for 8 hours a day," clients have the autonomy to seek out what feels right for them, guided by an internal locus of personal pride and joy.

Where do we begin?

Nearly half of trans people, and 68% of trans people of color, have experienced mistreatment—such as physical and verbal abuse—from medical providers. Half of trans people do not seek healthcare due to its notorious transphobia. This results in delaying or not getting necessary medical care due to fear of discrimination and rejection.

Clinicians can also cause emotional injuries by misgendering* or deadnaming** their clients.

To be a trans-affirming clinician means to forge corrective experiences with healthcare for our clients. It means acknowledging any act of transphobia, whether it was intentional or not, by owning up to our mistakes and asking for an opportunity to repair them. It means prioritizing informed consent by restoring autonomy and self-determination to our trans clients. It means becoming less defensive with limitations in our own understanding of gender, and being more curious about possibilities beyond the gender binary model and typical medical interventions.

As clinicians working with TGNB clients, it is vital to support them in defining gender for themselves. That is true freedom; being able to define one's own happiness and pursue it, unobstructed by external or internal forces. We must create a safe space for our clients to utter the joy they feel, but may have thought was unspeakable.

*Misgendering: Referring to or using gendered language to describe a trans person that does not align with their gender (e.g., calling a trans woman "he/him/his" pronouns or "sir").

**Deadnaming: Calling a trans person by their "birth name" or "given name" when they no longer use it.

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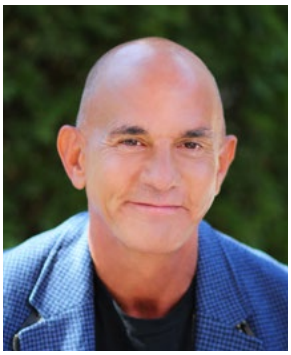
Don't Say Gay Continued from page 1



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In 1961, Erving Goffman's seminal book, *Stigma: Notes on the Management of a Spoiled Identity*, presented the notion of the "discredited," those who could be stigmatized easily because of the color of their skin or their physical or developmental disability. He then identified the "discreditable" as those with an identity that can pass for more "normal" and mainstream; those who can hide their identity to prevent stigmatization. The discreditable worked to erase parts of themselves—their own spoiled identity.

In 2022, we are facing the identity erasure of youth through legislation restricting teachers in helping students understand the natural fluidity and diversity in sexual and gender identity. The more things change, the more they stay the same.

Avoiding discussions that provide normalization of identity will create fear for both the discredited and the discreditable. Those whose identities are under attack will resort to hiding, compartmentalization, isolation, dissimilation, dissociation, and self-harm. It will exacerbate shame and put students at risk.

What is the "Don't Say Gay" Bill?

On March 28, 2022, Florida's Governor Ron DeSantis signed House Bill 1557 into law. Supporters are calling it the "Parental Rights in Education" bill, while opponents have deemed it the "Don't Say Gay" bill. Since March, similar bills have been drafted or enacted in Alabama, Ohio, Louisiana, Tennessee, and Texas. The language of Bill 1557 is both complex and vague at the same time. Most people are focusing on the aspects of the bill that will limit the discussion of sexual and gender identity in the classroom, but there are also implications for access to mental health services. Dana Goldstein of *The New York Times* did an excellent analysis (March 18, 2022) of the bill. The statements below are the important points pulled from that article:

- **Instruction on gender and sexuality would be constrained in all grades.**

This is the aspect of the bill that earned it the "Don't Say Gay" title. Teaching about and even discussing any issues related to sexual identity and gender identity is prohibited from kindergarten through third grade and must be "age appropriate and developmentally appropriate" for older students.

- **Schools would be required to notify parents when children receive mental, emotional, or physical health services, unless educators believe there is a risk of "abuse, abandonment, or neglect.**

This will have consequences for any student seeking counseling for an issue they are not ready to discuss with their parents. It would have a strong impact on LGBTQ students who often need to come to terms with their identities before sharing with others. This aspect of the bill is closely related to the next point.

- **Parents would have the right to opt their children out of counseling and health services.**

According to the bill, notices would be sent from the school district at the start of a new school year, allowing parents to opt out of mental health services for their children. It also implies that parents could additionally opt out when they are notified about their children seeking those services.

> "Teaching students about gender and sexuality can be beneficial for many reasons. First, students would learn about an important human experience: their developing identity."

- **Florida would rewrite school counseling standards.**

This aspect of the bill would allow Florida to break from the national school counseling guidelines of 2010 and create a new framework. The current framework, borrowed from the American School Counselor Association, states that students have the right to a counseling program that "advocates for and affirms" diversity in "sexual orientation, gender, gender identity/expression, family type," and many other identity categories.

- **Parents could sue schools for violating the vaguely written bill, and districts would have to cover the costs.**

This is how the politicians crafting these laws intend to enforce them. A small minority of parents who want to keep the identity and diversity conversations out of the classroom could do so at the expense of the school districts, making it too costly to push back against their wishes.

To Say Gay. Or Not to Say Gay.

Teaching students about gender and sexuality can be beneficial for many reasons. First, students would learn about an important human experience: their developing identity. They would understand the fluidity in identity and, as they get older, they may notice that they feel different in their bodies than expected based on social norms.

Students would also learn about the social constructions of gender—what it means to be a man or a woman—and that gender roles are more flexible than once thought. As Daniel Tehrani, one of our associates at The SAT Project, likes to say, "All gender is drag."

These outcomes would help to lower shame in the discreditable as the students gain awareness of these issues. It would help those that are confused about their sexuality and/or gender to understand that it is not unusual to be confused. Students can be confused, but not ashamed.

Drs. Alfred Kinsey, Wardell Pomeroy, and Clyde Martin developed the Heterosexual-Homosexual Rating Scale, more commonly known as The Kinsey Scale, shown in *Fig. 1*. First published in 1948, the scale changed the way we look at sexual orientation. It accounted for research findings that showed people do not fit into exclusively heterosexual or homosexual categories. This was the beginning of destigmatization for those with queer identities.

A return to the identity of erasure and lack of understanding of sexual/gender fluidity that occurred before the 1940s will activate shame, stigma, prejudice, and bullying.

Identity Formation

Vivienne Cass (1979) defined the stages that one goes through when developing an awareness of one's sexual orientation *(Fig. 2)*.

If we can imagine a world where children are able to learn about different invisible identities, then it becomes important to note the later stages of Cass's model—identity synthesis, pride, and acceptance. Individuals who progress this far develop a deeper sense of self.

Without education around these issues, students remain "stuck" in the first stages—identity confusion and comparison. They will experience tolerance only if they are fortunate enough. In many cases, progress would stop. The blockage, however, can be overcome with increased awareness of the implications of LGBTQ identities. Like addressing issues of race, these differences would be normalized and celebrated.

Kinsey and his colleagues began to crack open the binary way of thinking about identities, finding it limiting and unable to account for the full range of human behavior. In more recent years, researchers have begun to understand the fluidity of gender (Butler, 1990, 2020) as noted in the diagram *(Fig. 3)*. Contemporary research defines gender through the interrelationship of biological sex, gender identity, and gender expression, which adds more depth and complexity to our understanding.

CONTINUED ON PAGE 22

Without awareness, there is a greater risk of heterocentrism, resulting in heterosexism in the forms of prejudice, discrimination, homophobia, and transphobia. This, in turn, would result in more of the bullying and violence that we have seen for decades.

Creating spaces where diverse identities can be discussed and understood can change the mindset of cisgender and heterosexual students, and lead them to be kinder, more sensitive, and accepting of differences. It would minimize the risks of bullying and mistreatment of those who identify as part of the LGBTQ community.

Lastly, a very important aspect of the language of identity speaks to the various models of parental dyads and families that exist in today's world. What happens to a child who is uninstructed about gender and orientation if they are already a part of a gay, lesbian, and/or transgender family system? Should they not learn about the identities of those who live in their own home? What will teachers do when a child talks to other students about their own LGBTQ parents?

As noted, much of the benefit of developing awareness around sexual and gender identity is in reducing stigma, shame, and confusion. This is a benefit for all sexual and gender identities.

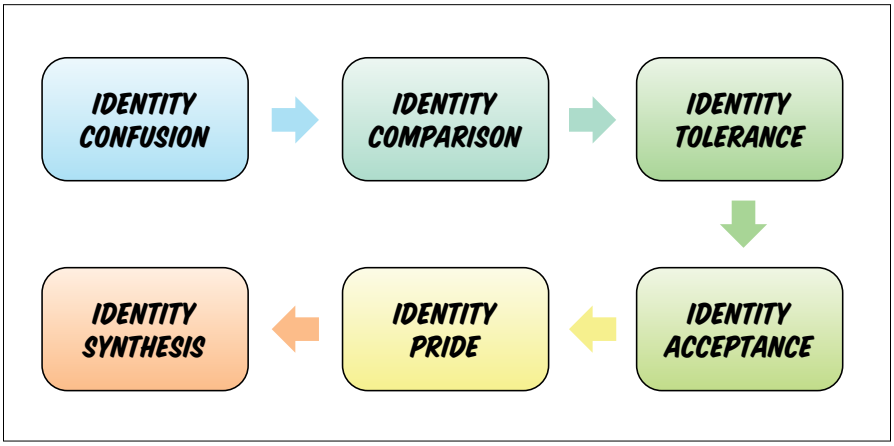

Fig. 2

The Cass Identity Model
(Vivienne Cass, 1979) describes six stages of LGBT identity development. While they are sequential, some people might revisit stages at different points in their lives. The model was one of the first to treat LGBT people as normal instead of treating homosexuality and bisexuality as problems

History Repeats Itself

The current legislative campaign for erasure of identity mirrors the pathologizing of homosexuality in the earlier versions of the DSM. It was less than 50 years ago that homosexuality was finally removed as a mental disorder from the manual.

In our work as clinical social workers, it is important to help clients move away from the idea that their behaviors are good or bad in order to engage their curiosity. Drescher (2015) states the following, which strongly relates to our concerns:

"Rigid gender beliefs usually flourish in fundamentalist, religious communities where any information or alternative explanations that might challenge implicit and explicit assumptions are unwelcome. When entering the realms of gender and sexuality, it is not unusual to encounter another form of binary thinking: "morality tales" about whether certain kinds of thoughts, feelings, or behaviors are "good or bad" or, in some cases, whether they are "good or evil." The good/bad binary is not confined to religion alone, as the language of morality is inevitably found, for example, in theories about the "causes" of homosexuality. For in the absence of certitude about homosexuality's "etiology," binary gender beliefs and their associated moral underpinnings frequently play a role in theories about the causes and/or meanings of homosexuality. When one recognizes the narrative forms of these theories, some of the moral judgments and beliefs embedded in each of them become clearer."

Let's not repeat history. Let's not re-pathologize gender and orientation issues. Early messages become imprints. There is no need for teachers to discuss sexual behavior or to ask students to "pick their pronouns" at five years of age, but we do need to let them know the range of possibilities in life. Possibility does not equal determinism.

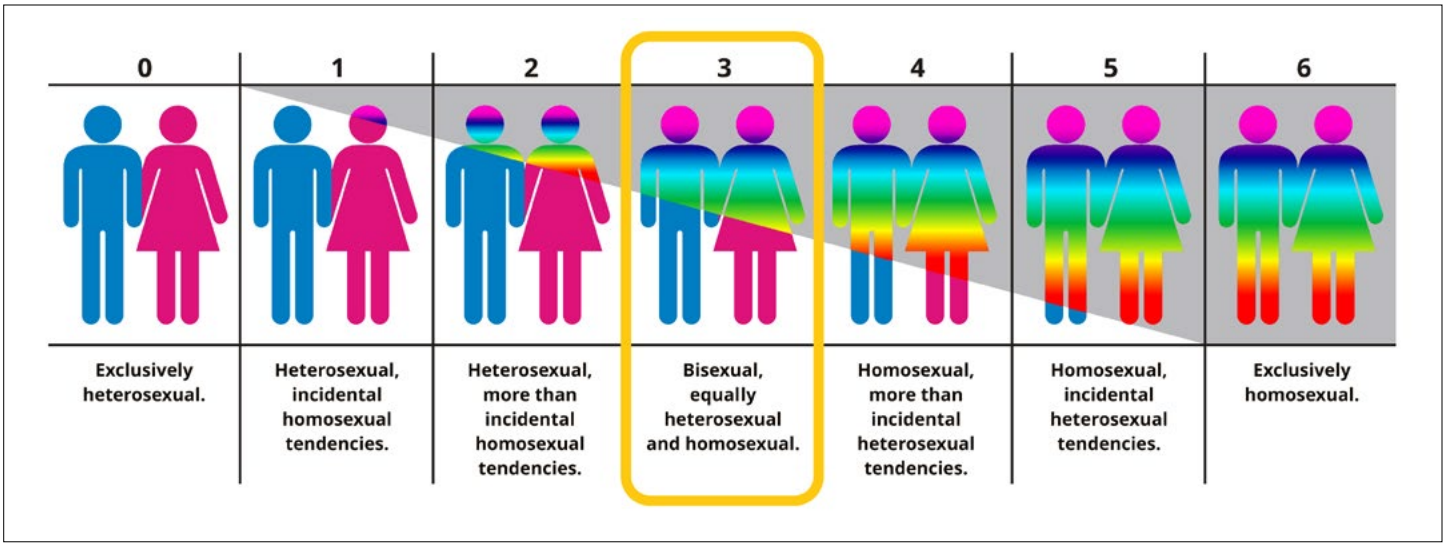

Fig. 1

The Kinsey Scale of Sexual Behavior

First published in *Sexual Behavior in the Human Male* (1948) by Alfred Kinsey, Wardell Pomeroy, et.al.

Identity Erasure and Subsequent Shame

Shame is a risky ordeal. Nathanson (1992) identified the dangers of shame, which can result in destructive behavior. The authors of this article use the term toxic shame with clients.

In Nathanson's model, The Compass of Shame *(Fig. 4)*, shame could manifest along one or more axes, which include (1) withdrawal and isolation, (2) avoidance and denial, (3) attacking self, and (4) attacking others.

This is consistent with the dangers that arise when students are not helped to understand various identities related to gender and sexuality. Nathanson (2003) felt strongly that if shame were addressed in the school systems, violence would be minimized.

The new Florida law creates impediments for students seeking mental health treatment. This has disturbing implications, as we see in the Compass of Shame, including suicidality, bullying, drug and alcohol abuse, and social isolation, to name a few. All of these issues are treatable, but students must have the freedom to seek treatment with a mental health professional.

As noted, the lack of information about gender and sexual fluidity can result in confusion and potentially destructive behaviors, either to oneself or to others. Those destructive behaviors stem from stigma, shame, fear, depression, homophobia, and transphobia. It is worth repeating that all of these symptoms are deserving of psychotherapeutic treatment.

One additional benefit of students learning about sexuality and gender is that it fits the larger picture of intersectionality, the various effects of identity and related marginalization. Students would benefit from understanding issues of privilege, domination, and oppression. Early awareness of these issues seems essential to students of all ages.

Parental Rights vs. Educators' Protections

The U.S. has had a long history of clashes over how to educate students about sexuality. This issue is a political lightning rod, with a frequent focus on morality and religiosity rather than the health and well-being of our students.

The Federal Government has left it up to each state to set a standard for guidelines and materials suitable for their students. Many states educate high school students to remain abstinent rather than teaching them about safe sex, sexually transmitted diseases, and harm reduction.

Yet, on the topic of child abuse, the Federal Government has weighed in several times. No, Go, Tell!, developed in the late 80s, was the child abuse

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prevention curriculum for children ages 3 to 7. Chapter 544 of the Laws of 1988 states that all physicians, chiropractors, dentists, registered nurses, podiatrists, optometrists, psychologists, and dental hygienists must provide documentation of having completed two hours of coursework or training about the identification and reporting of child abuse and maltreatment to obtain or renew a license. In 1989, the Mandated Training Related to Child Abuse Law was enacted in New York State, requiring all licensed professionals to be trained in child abuse identification and reporting.

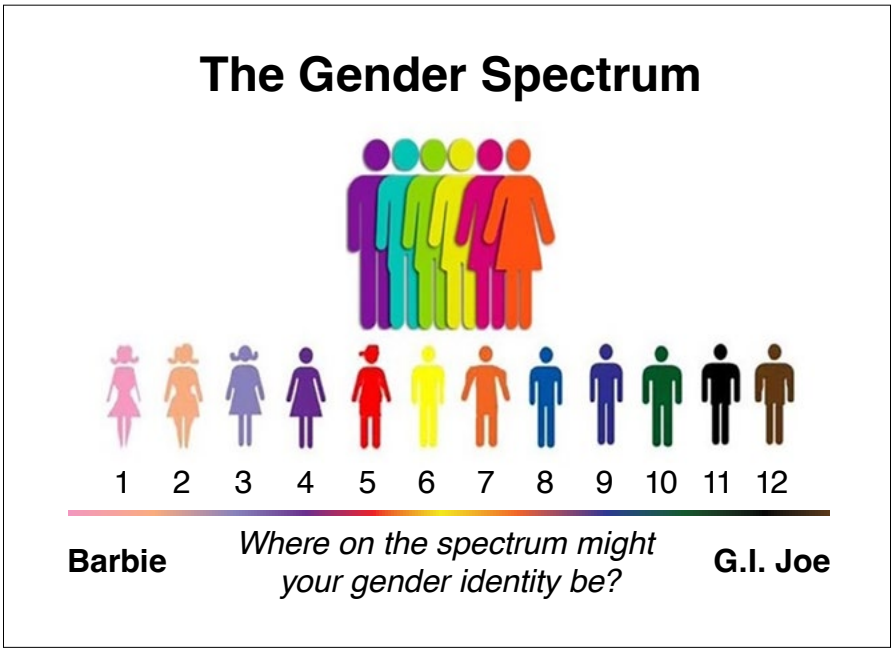

Fig. 3

The Gender Spectrum
Theorists are now using this model, similar to The Kinsey Scale, that can be broken down into biological gender, gender identity, and gender expression. Judith Butler (1990) and other authors are questioning the aspects of gender that are natural vs. those that are learned and performed.

There are more states that agree that we need to educate students about sexual abuse. In 2019, New York became the 37th State to pass Erin's Law, which requires public schools to teach child sexual abuse and exploitation prevention to students in kindergarten through eighth grade. It appears to contradict the "Don't Say Gay" laws.

Erin's Law is named for Erin Merryn, an abuse survivor and activist against child sexual abuse who has advocated for similar laws nationwide for over a decade. Erin's Law is intended to help children, teachers, and parents in New York State schools identify sexual abuse, and to provide awareness, assistance, referral, or resource information for children and families who are victims of child sexual abuse.

These laws give educators power to protect our students, an admirable and essential task. These efforts can be expanded to include an honest discussion of sexuality as we are instructing students on how to recognize inappropriate sexual touch. When we discuss identity in the classroom, we have an opportunity to create distance between unhealthy sexuality and alternative sexual identity. A child doesn't need to experience abuse to benefit from learning about it in the same way that a child does not need to be queer to benefit from learning about it.

How we teach vs. what we teach

Unfortunately, the new legislation focuses on what we teach rather than how we teach. We agree that there would be a problem if we direct educators to radically instruct very young students to choose their gender pronouns before they understand these concepts. However, if we approach this with an understanding of the need for knowledge about gender, sexuality, class, race, power, and abuse, we have given our students a gift.

The Sexuality Information and Education Council of the United States (SIECUS) was developed in 1964 by Dr. Mary S. Calderone. Its mission is to standardize at the federal level how we teach sexuality education.

SIECUS developed The Guidelines for Comprehensive Sexuality Education and recently published The Professional Learning Standards for Sex Education (PLSSE). PLSSE provides guidance to school administrators and classroom educators about the content, skills, and professional disposition needed to implement sex education. Many states have restricted the use of these materials by teachers.

The resources are there, but infrequently used. Now, due to the many bills being proposed throughout our nation,

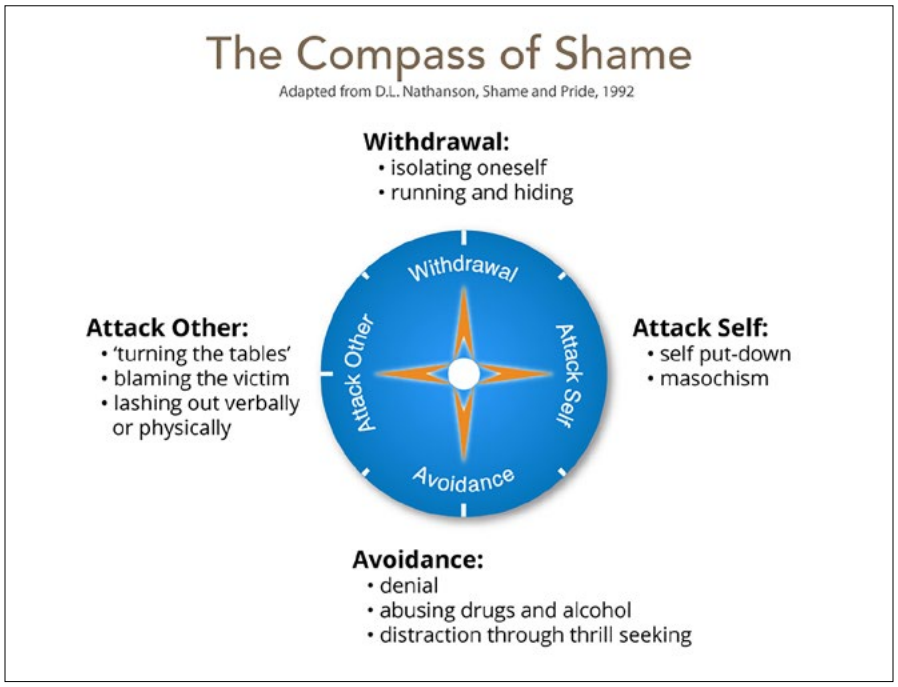

Fig. 4

The Compass of Shame Scale (CoSS) was developed to assess use of the four shame-coping styles described by Donald Nathanson (1992): Attack Self, Withdrawal, Attack Other, and Avoidance.

such principles are being eradicated and dismissed. Professionals are becoming deskilled, and many teachers are relying on curricula that they create on their own. Teachers do not have guidance in presenting a vital, complex subject. They may not know how to be helpful and to lower the odds of dangerous outcomes.

Conclusion

We are complex human beings. Intersectionality (Crenshaw, 1989) conceptualizes this nicely. It points out the power aspects of all identities. Some identities are privileged and bring with them domination and others are marginalized, bringing with them oppression.

Helping students to understand those complexities with a language and strategy that allows for this awareness is essential. If students learn that heterosexuality, bisexuality, homosexuality, trans-identity, race, class, culture, power, and even age have implications, then we have provided an essential aspect of their education that will reduce stigma and shame. The authors wholeheartedly believe this will save lives. Not naming something does not make it untrue, but it can and will lead to harm.

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Valerie and The End of Days:

A Case Study of One Trans Youth's Courage and Resilience

By Kathryn Sedgwick, LCSW

The argument advanced against transfolx from people on the right, your Tucker Carlsons and Jeanine Pirros, typically involves this bit of sophistry: (1) Calling yourself a tree doesn't make you a tree (2) There are only *two* genders, man and woman (3) Ipso facto, you [trans man or woman, non-binary person] are not real. You don't exist. You're not a tree.

This jejune *gotcha!* is propaganda intended to erase transness as a category, despite the fact that gender exists on a continuum. The equally fallacious "bathroom" and "grooming" arguments are likewise intended to advance the proposition that, unless the saviors of the right succeed in overthrowing the existing order, the decadent U.S. of the twenty-first century—epitomized by what Vladimir Putin refers to derisively as "gender freedom"—is, indeed, doomed. Snorted Sean Hannity as he closed one recent Fox segment on Caitlin Jenner—a conservative!—"This is truly the End of Days." (Oy.)

Such apocalyptic hysteria has been abetted in recent years by the increased media visibility of the trans community. One recent survey, for example, reports that Americans estimate transgender people constitute some 21% of the U.S. population—nearly a quarter. In reality, the figure is closer to 1%—that is, around 329,000 of the 329 million total. (The figure for all LGBTQIA+ is 8%.)

The hateful rhetoric and specious reasoning are bad enough. But what truly pains me, as a clinician working with a largely homeless, POC population of queer 16- to-24-year-olds at the Ali Forney Center in Harlem, is the profoundly disfiguring effect the culture has on the lived experience of LGBTQ youth, who are very real.

Here, by way of illustration, is the story of one of my clients. Valerie (not her real name) was well known to staff even though she seldom came to our drop-in. Her legendary phone calls lasted hours. Valerie, when she checked in, desperately needed to hear an empathetic voice—someone who could help her regain her composure while she breathlessly rattled off her concerns. These would sometimes be around practical matters, like finding a place to stay or getting her benefits turned on, but they were mainly about two things: her inability to accept her trans identity and her intense dislike of her physical appearance.

> "As Valerie began experiencing the horrors of adolescence, body changes she loathed, she began to 'live in my head.' There was little point interacting with the world, given the impossibility of availing any help from her family, church, school, or conservative outer-borough community."

Valerie knew she was female from early childhood—at age eight, for instance, she began imitating her mother's voice, developing a flawless femme vocal presentation. She had profound Body Dysmorphia and Gender Dysphoria (other diagnoses included Anxiety, Social Anxiety, and Eating Disorder). As she began experiencing the horrors of adolescence, body changes she loathed, she began to "live in my head." There was little point interacting with the world, given the impossibility of availing any help from her family, church, school, or conservative outer-borough community. She hated her face and body. She judged her "deformities" harshly, as if they were the sole measure of her worth. The flailing and circular thinking of her phone calls seemed the gestures of a drowning woman frantically trying to keep herself afloat.

> “After about a year of non-judgmental listening . . . Valerie began asking about my gender journey—what was it like to be trans in 1974? for one. As a therapeutic alliance began taking shape, she began to relate her childhood experiences in more detail.”

When she ventured outside, Valerie insisted on wearing a hoodie pulled tightly over her head, her curly brown hair and gorgeous eyes giving her a cute Little Gray Riding Hood look. Thus accoutered, she had managed to attend one of my trans support groups, following which I suggested she become my therapy client. She accepted.

Our first sessions occurred infrequently; when they did, they were like in-person versions of her calls, Valerie locked in ruminative-thinking mode, obsessively critiquing her flaws. This started to change after about a year of patient, non-judgmental listening (along with the occasional word I would manage to get in edgewise). Valerie began asking questions about my gender journey—what was it like to be trans in 1974?, for one. As a therapeutic alliance began taking shape, she began to relate her childhood experiences in more detail.

Her mother had insisted on taking her to many non-trans-competent psychiatrists in the hope that one could somehow convince Valerie she was not gay. This practice ended only after she’d been told repeatedly that, no ma’am, “gay” is not a diagnosis. One summer her mother confiscated all the money she’d worked for to buy desperately needed hormones. Valerie managed to wrest it back and headed to the drugstore, mom in hot pursuit. The traumatic scene that ensued left her feeling broken and hopeless.

Her father began comparing Valerie’s looks to her mother’s and other women he saw on television and in magazines. “You think you’ll ever look *anything* like them?” he’d sneer. Then, in a particularly emotional session, I learned that father’s critical faculties had not prevented him from sexually abusing his teenage daughter. The incest compounded Valerie’s humiliation, shame, and confusion, and lay at the root, I believed, of her obsessive concern with her appearance. Although she had struggled mightily to affirm herself, she’d ended up internalizing her parents’ hostility. She would survive—by agreeing with them, by adopting their transphobia, absorbing the negative cultural stereotypes, and through self-loathing.

Valerie and I talked about our experiences—our many similarities and the differences across generations that naturally separated us. I stressed to her that our singular experience as trans folx affords us a perspective on the world shared by very few people. We enrich trans lives by understanding ourselves as people at different points along that vaunted spectrum, not simply as one-thing-or-the-other (or a tree).

Amazingly, Valerie sustained an academic career through all of it—fighting with her parents, the bouts of homelessness, her issues with herself. In the pre-Covid era, this meant attending classes in person, where she often faced witheringly offensive comments from students and faculty (including one professor who insisted on addressing her by her birth name despite repeated corrections), obtaining an undergraduate degree in psychology. As she approached 25, the age when she would leave our program, Valerie had abandoned her family; she hoped to attend graduate school and get an MSW.

She’d also begun facial-feminization. Far from being simply cosmetic, these powerfully gender-affirming surgeries have given her the confidence to go out into the world sans hoodie for the first time in years. Incredibly strong and resilient, Valerie now has a great deal more to say on a variety of subjects, and, increasingly, a voice with which to make the world listen. I can’t wait to see her sparring with Tucker Carlson and Jeanine Pirro.

After a long career in printing and publishing, **Kathryn Sedgwick** went back to school at age 60, graduating with her MSW from NYU/Silver in 2015. She interned at the Ali Forney Center, where she is currently a mental health specialist (they liked the free sample). She provided teletherapy during the pandemic for Manhattan’s Blanton-Peale Counseling Center & Institute. Kathryn lives in Riverdale, the Bronx, where she is currently attempting to get her private practice off the ground.

Love's Possibility: On Loneliness, Madness, and Human Dignity

Presented by **Richard Gipps, Ph.D.** | ***Reviewed by*** **Karen Kaufman, Ph.D., LCSW-R**

Richard Gipps, Ph.D. gave a lively and at times personal presentation on lovability, loneliness, and dignity in the human experience. He included references to fiction, poetry, music, and philosophy as parallels to the complex feelings inherent in these experiences in clinical work.

He described love's possibilities as a state of being in which one feels lovable and possesses the capacity to dwell in this feeling; this state is viewed as the internalization of good objects rather than as narcissism. This can be a shared feeling involving loved ones or an internal feeling that does not require the presence of others. Since loving relationships disclose truths about the other, he described this as a hopeful attitude regarding love's possibilities.


Richard Gipps

In contrast, he described different forms of loneliness, conscious and unconscious, all of which were exacerbated by the prolonged isolation of Covid. One form of loneliness is experienced as if by a distant observer outside the self who possesses the awareness that love and life exist elsewhere; the person may feel exiled from love but knows of its existence. In the cases of severe mental illness such as schizophrenia and psychosis, this was described as loneliness beyond loneliness. It is a state of being beyond the absence of love or thoughts of life's disappointments; rather it becomes loneliness unto itself, as if dwelling in the feeling. It is the experience rather than an observation, or as Gipps described it, "in-dwelling." For clinicians treating these patients, the recognition of this painfully isolating loneliness, or what may be thought of by other theorists as loss of self, or disruption in attachment, is critical to patients feeling accepted and understood in the treatment relationship.

With the parallel of music, Gipps cited examples of Irish and classical musicians whose compositions simultaneously contain sadness and pain along with joy and transcendence. The experience of in-dwelt loneliness may be tolerated but mitigated by the emergence of the possibility of the return of love and ensuing hopefulness, another example of great contrast in feeling states.

Gipps discussed love and dignity as regulative ideals. Dignity was described as wanting the best for oneself in a non-narcissistic form; this includes a component of integrity, knowing and living in accordance with one's personal values. This self-possession creates discernment in one's life and the confidence of being lovable and is not influenced by the values of others.

In case examples, Gipps discussed the awareness of loneliness and the power of acceptance in creating a sense of wholeness; according to different writers, love may be experienced not as being in love with the patient, but as tenderness, toughness at times, unity, and a feeling of approval.

Searles, for example, in his classic book *Countertransference*, described love for his patients and questioned if the patients he loved progressed more in therapy or the love grew out of the patients' progress. It may be an unanswerable question, but it is courageous when clinicians speak freely of countertransference love and hate in the practice of psychotherapy.

This rich and creative presentation provided valuable reminders of the strength of positive regard and optimism in our clinical work and the healing environment this creates for our patients.

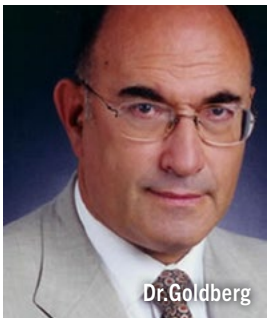
Karen Kaufman is President of NYSSCSW. She served as President of the Met Chapter from 2011 to 2019. She works in private practice in Manhattan and Westchester and was Adjunct Associate Professor at Fordham University Graduate School of Social Service from 1998 to 2014.

NeuroCovid-19: Cognitive, Psychiatric, and Psychological Manifestations

Presented by **Elkhonon Goldberg, Ph.D., ABPP** | ***Reviewed by*** **Margaret A. Yard, Ph.D.**

Dr. Elkhonon Goldberg, Director of the Luria Neuroscience Institute in New York City, gave a "wake up call" to our social work communities as we continue to support and treat our patients during this two-year-long and still ongoing Covid-19 pandemic. Currently, we are dealing with new variants, such as Omicron 2 and subvariants, such as BA.2 and BA. 2.12.1, as well as ever-challenging sociopolitical and locational contentions over treatment behaviors vis-à-vis vaccines, boosters, and masks.

Dr. Goldberg introduced "the elephant in the room" in the spectrum of SARS-CoV-2 (Severe Acute Respiratory Syndrome); this phenomenon is currently referred to as *Long Covid-19*. Recently published international scientific research derived from sets on long Covid-19 delineate numerous, mixed physical and mental post Covid-19 complaints, a plethora of long-term non-respiratory symptoms and pandemic related mental health issues.



This research also suggests the basis for the pattern of higher Covid mortality for elders (defined as over 50 years of age). The distinguishing feature of long Covid-19 is its neurological—not respiratory—etiology. This is due to transmission to areas of the brain across nasal mucosa, directly affecting various brain functions. Thus, the blood-brain barrier is directly breached by inflection points, one being infected nasal mucosa, which attacks the host's immune system.

Long Covid-19, or *NeuroCovid syndrome*, occurs in asymptomatic patients, as well as those with Covid symptoms ranging from mild to severe, and may require acute hospitalization, particularly in the vulnerable elder population.

International studies indicate that over 80% of hospitalized patients have neurological issues in recovery, including acute encephalopathy, altered sensory states, confusion, agitation, and delirium, as well as PTSD.

A silently invasive phenomenon, NeuroCovid or long Covid-19 evolves and its PASC (post-acute sequelae) appear four or more weeks after infection, extending up to six months after the initial infection and, in some cases, can appear after a symptomless infection.

To date, much of NeuroCovid is undiagnosed; the largest proportion of patients are unhospitalized. This presents the macabre effect of the "canary in the coal mine." Currently, much of the population attempts to deal with confusing, continuing complaints and vague symptoms on their own, while simultaneously pushing to "get on with life" post-Covid.

Ironically, however, recovering, or surviving Covid morphs into a plethora of complaints: persistent fatigue, SOB (shortness of breath), joint pain, continuing loss of smell, sleep disorders, depression, lapses or breaks in ADL (activities of daily living) and brain fog.

Brain fog is a type of mental fatigue, presenting as problems in memory, thinking, mood changes, confusion, and cognitive dysfunction (e.g., difficulty concentrating, lack of mental clarity). Neurological sequelae include aphasia (deficits in understanding and expressing written and spoken language), as well as a long list of lingering neuronal symptoms.

> "These outcomes signal an immediate need for worldwide neuro-rehab and social support systems."

Lingering is a keyword when positing post-Covid life marked by confusion, frustration, and perplexity, while living with insecurity, anxiety, reduction of lifestyle functions, lack of productivity, states of immobilizing exhaustion, phobias, and projective, compulsive, sadomasochistic and paranoid disorders. Features of undiagnosed mourning and grief abound, correlating to immense actual losses of family and peers, of career and identity, and disorientation regarding the future, given worldwide conditions.

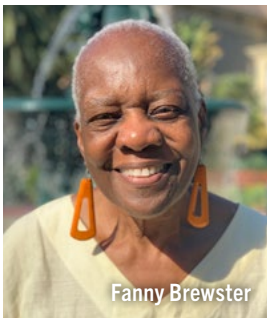
CONTINUED ON PAGE 31

Circling the Unthinkable: Death Anxiety Today

Presented by **Fanny Brewster, Ph.D., MFA, LP** | *Reviewed by* **Marsha Wineburgh, DSW, ACE Planning Committee**

What was I thinking, approving a presentation two years into the pandemic on death anxiety? It is almost as bad as introducing this lecture first thing on an early spring-promising sunny Saturday morning.

Much to my relief and fascination, Dr. Fanny Brewster's contribution was a creative, wise, poetic, gentle approach to a subject rarely offered in our field: loss, fear, and death. She began by observing that this has been an exceptional two years as the pandemic held the world in fear on the collective level. She spoke of an increased awareness of death and dying, beginnings and endings, darkness and fear, existential anxiety, and losing ego consciousness. Her crucial conclusion, "Death anxiety has never left us." Yet, "darkness is transformative; so is light."


Fanny Brewster

Brewster is a Jungian psychoanalyst, a poet, writer of nonfiction, educator, workshop leader and lecturer. A core faculty member in the clinical psychology department at Pacifica Graduate Institute, she has written extensively on the African American perspective. She has a charming, centering way of speaking which makes even addressing the reality of death palatable, yet another valued adventure on life's path.

It is difficult to capture in this review the sensitivity of her deeply moving approach to life's path. Her presentation focused on beginnings and endings, noting that "loss begins at birth." Suddenly, we are transported from a world of dark, warm, secure comfort where nutrition is routinely provided and sphincter control is unknown into a bright, chilly world where we must signal, even demand, to have our basic needs met. It is the beginning of a series of rites of passage (she mentions three) that we experience on life's path.

> "To balance these unavoidable life experiences, Brewster suggests that psychotherapy can be a modern rite of passage, a way to rebirth and reparent—to transform—ourselves."

• At birth, loss begins with physical separation from mother; later, weaning, and the first assertions of "no" further disconnection.

• Adolescence is another period of separation and loss for both the child and the parent who is pushed aside. Brewster describes adolescence as a "sacred and magical space" created for change. Graduation from high school and college are some of the rites that mark the transition to adulthood. She sees a need for more rituals in our culture for this important advancement.

• In adulthood, we are again confronted with loss: parents, siblings, friends, jobs, even money, suicide, illness, loss of a child. Brewster noted that, "Grief does not end, it sticks with us."

To balance these unavoidable life experiences, Brewster suggests that psychotherapy can be a modern rite of passage, a way to rebirth and reparent—to transform—ourselves. It is a way to find newly discovered aspects of our former selves, learn to tolerate suffering, admit past mistakes, and tolerate making new ones. It can lead to reorganization and reaffirmation of self. The psychotherapy experience can be a place where "I can visit the dark and move between light and dark."

Circling the Unthinkable Continued from page 30

She continued, "We must constantly ask to participate in life while at the same time expect small ego deaths which can make us stronger." Her personal solution to finding a balance is living in the fullness of life. For her, it is "living in the moment of creativity—writing."

A wonderful, sensitive presentation and, if you weren't an attendee, I am truly sorry you missed it. As partial compensation, I am including her bibliography.

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Marsha Wineburgh, DSW, LCSW-R, is a practicing psychotherapist, clinical supervisor, and educator, and has been a legislative advocate for several decades. She is President of the ACE Foundation, and Past President of the New York State Society for Clinical Social Work, the American Association for Psychoanalysis in Clinical Social Work, and the National Federation of Societies for Clinical Social Work.

NeuroCovid-19 Continued from page 29

Elderly patients (over 50) who have been hospitalized, often critically ill, may have experienced delirium from their brain inflammation. Delirium may be linked to an increased risk of dementia in elders resulting, in some cases, as a catastrophic cognitive decline of up to 8.5 IQ points (possibly portending the "dumbing down" of some future populations).

The long NeuroCovid patient presents as anxious and depressive and may have sequelae—pathological conditions of persistent brain inflammation and degeneration. In recent studies, these conditions are purportedly due to cytokine storming, as well as systematic intercranial involvement. Such "brain invasions" directly breach the blood-brain barrier through (unanticipated) inflection points (e.g., nasal mucosa) and may attack the immune system as well.

Nascent research shows previously diagnosed neurodegenerative diseases also heighten risk factors for significant cognitive decline which, so far, have been identified in cases of dementia and Parkinson's Disease. Long NeuroCovid-19 may heighten the risk of dementia, delirium, Lewy Body disease, Parkinson's disease, Alzheimer's disease, schizophrenia, and a myriad of neurological conditions.

In particular, the elder population (over 50) shows greater vulnerabilities to Covid-19 exposure, posing even higher functional and quality of life threats to a proportion of current and future NeuroCovid survivors. This increases the need for specific training and education for elder caregivers of all categories.

All of the prognosticated outcomes signal an immediate need for extensive worldwide neuro-rehab and social support systems. They sound a clarion call to social work and mental health professionals to accommodate and integrate these new neuropsychiatric findings. Detailed Covid histories, including attentional deficits, thinking disorders, decision lags or lapses, sudden or continuous fatigue or depression, changes in ADL (activities in daily living), and even PTSD symptoms and other evidence of "brain fog," must be documented.

Detailed histories of discharged elder Covid patients may require provision of post-Covid service and care systems, including neuro and social rehab.

Social work compassion, care and leadership will be at the forefront of contributing to future worldwide Covid mental health and rehab care and planning models.

Margaret Yard, Ph.D. is a psychoanalyst, sociologist, and scholar in the "precarity" of life, relational psychoanalysis, neuropsychoanalysis, and trauma. She is a poet, writer, librettist, and playwright.

We Welcome Submissions

We encourage you to submit an original article or review to *The Clinician*. In general, the article should—

- Be of interest to a broad range of clinicians.
- Focus on clinical issues and treatment.
- Be clearly written and jargon-free.
- Use case examples where possible.
- Not exceed 1,000 words. Shorter is better.
- Include your brief professional bio.

Please send a description of your proposed article in advance. We look forward to hearing from you.

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For more information contact:
Chris Farhood, MSW, LCSW-R, State Mentorship Chair at **Chrisfarhood@yahoo.com** or **212-582-7326**

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NYSSCSW is pleased to offer an on-line licensing study group for all of our members. This group is appropriate for individuals studying to take both the ASWB Masters Licensing Exam and the ASWB Clinical Licensing Exam.

Our students and new professionals are able to get help studying for the Masters level exam as they start their careers. LMSW members are able to study for the Clinical exam. The skills and abilities tested on the two exams are very similar, with only minor differences in the percentages of questions from different areas of knowledge. This similarity in exam content allows us to easily cover both exams in a single study group.

Many of our members were licensed in New York State before the ASWB exam requirements went into effect. When these established clinicians seek licensing in other states, either due to their own relocation or in order to continue therapy with a client who has moved out of state, they may be surprised to learn that the exam is required for licensing in all states. While there may be isolated exceptions, many people are faced with trying to pass this exam decades after finishing school. Since the exam tests textbook knowledge taught in currently accredited MSW programs, many people find the exam harder to pass after decades of practice.

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The Licensing Study Group is free with your membership.

The Group meets once a month for 1 ½ hours.

To learn more, check our website or contact the office at 800-288-4279.

Mid-Hudson Continued from page 11

a space where clinicians can network and assist one another through the sharing of practice-related information and through discussion of clinical dilemmas. Recent topics have included the No Surprises Act, online practice management services, as well as transference and countertransference issues related to the war in Ukraine. New group members are always welcome!

In June, our Chapter is holding its annual Spring Member Event, a chance for members to commingle in a social setting. This year, we hope to gather in person (weather pending) while keeping an eye on Covid safety through the use of an outdoor space. We are grateful to our Secretary, Louise Marcigliano, LCSW, and also to Susan Deane-Miller, LCSW, Barbara Solomon, LCSW, and Christine Schaetzl, LCSW for organizing this activity for our Chapter.

It has been a privilege to serve my term as this Chapter's President for the past three years. Many thanks to all for your support along the way. A special thank you to Rosemary Cohen, LCSW for her encouragement and good humor. We clinicians have been through a lot together during this time of Covid, navigating numerous changes in how we practice as therapists while facing the same environmental threats as our patients. In the face of these challenges, it has been inspiring to witness how our clinical community has come together to help one another. I know that this spirit of collegiality and collaboration will continue to serve our Chapter well in the days ahead.

Nassau Continued from page 12

The Nassau Board meets monthly by Zoom; dates and times are posted on the Listserv. We encourage all members to attend and share their talents. We are looking for members to participate in our Public Relations, Programming, and Membership Committees, and Jennifer would like someone to take over the Mentorship Committee. We would also like someone to take over as Chair of the Programming Committee.

Ellie and Patricia will be stepping down as Co-Presidents in September. They will need to be replaced, either by two Co-Presidents, one President, or a President and Vice-President.

These are elected positions, as is the position of Treasurer. Elections will be held in the fall. The other positions are appointed, and we encourage you to let Patricia and Ellie know if you are interested.

We are looking forward to our State Membership meeting on October 29. This will be an in-person event with indoor and outdoor dining locations to maintain safety. We encourage everyone to attend (formal invitations are forthcoming). We will be honoring a Nassau Board member for contributing valuable time and effort to benefit our Chapter.

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