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THE CONSEQUENCES OF COVID FOR MENTAL HEALTH

Covid, Vulnerable Populations, And Futurized Stress

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

At the end of 2020, there was a moment here in the U. S. when a light appeared at the end of the very dark tunnel known as Covid-19. The vaccine trials were being completed and the efficacy rates offered us hope. We were bracing for another surge of the virus, but this was expected as the weather got cooler, and activities needed to take place indoors again. As vaccines began to roll out in 2021, we all started to imagine birthday parties and weddings and going to see movies and plays. Therapists and clients envisioned being able to sit across from each other again. We thought we were going to gain a level of safety we hadn't felt in a long time.

An exacerbated need for mental health services seemed to be revealed during the "re-entry process," when therapists were being bombarded by phone calls, emails, and text messages from people seeking their help. Some patients who left treatment years earlier wanted to return. Many therapists could not take any more patients, and their attempted referrals to colleagues were for naught. Providing psychotherapy became overwhelming and exhausting as clinicians adapted to working in a virtual world.

CONTINUED ON PAGE 22

The Consequences of Covid for Mental Health is the theme of many articles in this issue.

Please see stories on Pp. 1 and 22 to 38.

PHOTO: Anthony Quintano

New York State Society for Clinical Social Work

The Professional Voice For Clinical Social Work Since 1968

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MESSAGE FROM OUR OUTGOING PRESIDENT

Shannon Boyle, LCSW

I hope you enjoyed the holidays and wish you all the very best for the New Year, and a happy and healthy 2022!

It is hard to believe that my second term as the President of this Society, and my six years in this position, have officially come to an end. A lot has happened these past six years—for the world around us, in our field of Clinical Social Work, and for me personally. It has been a great pleasure to lead this organization and work so closely alongside our very active and passionate members. We have also accomplished a great deal in the past six years to continue to protect and advance the field of Clinical Social Work.

There is much more to be done and thankfully we have our new President, Karen Kaufman, Ph.D., LCSW-R coming in to lead us. As Past President of the Met Chapter for many years, Karen was an active member of the State Society Board and brings a great deal of knowledge and expertise to lead this organization through the ongoing challenges that we all face in the coming months and years. I am looking forward to working with Karen and all the members of the State Society Board to tackle the difficulties as well as accomplish our goals and continue to advance Clinical Social Work in New York State.

I would like to share my heartfelt gratitude to all those at the state and chapter levels who I have worked with the past six years as President. The work of this organization is truly done as a team, and it has been a pleasure to lead this team. Thank you to all the members of the State Society Board over these past six years for your help and support. I would like to give very special recognition to the TMS team, Kristin, Jen, and everyone, for your constant behind the scenes support and hard work assisting me as President. I simply could not have done this work without you.

The past couple of years have shown that we never know what will happen in our world. I look forward to facing what comes in 2022 with all of you collectively, with the spirit of helping those who need us. This is what has made the New York State Society for Clinical Social Work great for more than 50 years.

All my best,

Shannon Boyle, LCSW
Immediate Past President

The Clinician

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AD SIZE	MEASUREMENTS	1 TIME	2 TIMES
2/3 Page	4 15/16" w x 10" h	$325	$295
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Display ads must be camera ready. Classified ads: $1 /word; min. $30 prepaid.

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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SAVE THE DATES!

The New York State Society for Clinical Social Work with The ACE Foundation Presents Their

53rd ANNUAL EDUCATION CONFERENCE

LIVES DISRUPTED: *Resilience in the Face of Loss*

APRIL 2 & APRIL 9, 2022

Live Virtual Programs on Two Saturdays
Both Days: 6.5 CE Contact Hours

SATURDAY, APRIL 2, 2022, 3.5 CE CONTACT HOURS

PRESENTATION: 9:30am–10:30am; 10:30am–10:45am, *Audience Participation with Dr. Fanny Brewster*

Circling the Unthinkable: Death Anxiety Today

Presenter: Fanny Brewster, Ph.D., MFA, LP, is a Jungian analyst and Professor of Depth Psychology at Pacifica Graduate Institute and at New York C.G. Jung Foundation. She is a member of the Philadelphia Association of Jungian Analysts. Dr. Brewster is an international lecturer and workshop presenter specializing in Jungian related topics and African American culture and creativity. She is the author of: *African Americans and Jungian Psychology: Leaving the Shadows*, *Archetypal Grief: Slavery's Legacy of Intergenerational Child Loss*, and *The Racial Complex: A Jungian Perspective on Culture and Race* (Routledge, 2019).

Moderator: Susan Klett, Ph.D., Psy.D., LCSW-R

PRESENTATION: 11:00am–12:30pm.; 12:30pm–1:00pm, *Audience Participation with Dr. Elkhonon Goldberg*

NEUROCOVID-19: Cognitive, Psychiatric, and Psychological Manifestations

Presenter: Elkhonon Goldberg, Ph.D., ABPP., is a clinical neuropsychologist and cognitive neuroscientist, Clinical Professor in the Department of Neurology, NYU School of Medicine and Diplomate of The American Board of Professional Psychology in Clinical Neuropsychology. Dr. Goldberg has authored numerous research papers on functional cortical organization, hemispheric specialization, frontal lobe functions and dysfunction, memory and amnesias, traumatic brain injury, dementias, and schizophrenia.

His books, *The Executive Brain* (2001), *The Wisdom Paradox* (2005), and *The New Executive Brain* (2009), have met with international acclaim. Dr. Goldberg coauthored *The Sharp Brains Guide to Cognitive Fitness* (2013). He was a student and close associate of the great neuropsychologist Alexander Luria.

Moderator: Marsha Wineburgh, DSW, LCSW-R

SATURDAY APRIL 9, 2022, 3.0 CE CONTACT HOURS

PRESENTATION: 9:30 am–10:30am; 10:30am–10:45am, *Audience Participation with Dr. Leslie Caldwell*

The Place Where We Live: Being at Home Being Alone

Presenter: Professor Leslie Caldwell is an Honorary Professor in the Psychoanalysis Unit at University College London (UCL) and a psychoanalyst of the British Psychoanalytic Association in private practice in London. Dr. Caldwell is a Training Analyst for the Independent Child and Adolescent Psychotherapy Trainings and a member of its Training Analysts' committee. She is a London rep for COWAP, the IPA committee dedicated to women and psychoanalysis. She has been external examiner for the Tavistock Observational Studies in Infant Mental Health. Dr. Caldwell is the former Editor and Trustee for the Winnicott Trust (2002 to 2016) and its Chair of Trustees (2008 to 2012). With Helen Taylor Robinson she is Joint General Editor of the *Collected Works of Donald Winnicott* (OUP, 2016) which won The American Board & Academy of Psychoanalysis book prize (History section) in 2017. As Director of the Squiggle Foundation (2000–2003) and Editor of its *Winnicott Studies* monograph series (Karnac & Squiggle Foundation, 2000-2008), Dr. Caldwell published *Art, Creativity, Living* (2000), *The Elusive Child* (2003), *Sex and Sexuality: Winnicottian Perspectives* (2005) and *Winnicott and the Psychoanalytic Tradition* (2007). With Angela Joyce she published *Reading Winnicott* for the New Library teaching series (2011). Professor Caldwell is also Honorary Senior Research Associate in the Italian department at UCL and has written extensively on the Italian family, the topic of her book, Italian Family Matters (Macmillan,1991), on Italian cinema, and on the city of Rome.

PRESENTATION: 11:00am–12:00pm; 12:00–2:15pm, *Audience Participation with Dr. Richard Gipps*

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

Presenter: Dr. Richard Gipps has a Ph.D. in philosophy and a doctorate in Clinical Psychology. His psychotherapy practice is in Oxford, UK. He is the author of *On Madness: Understanding the Psychotic Mind*, forthcoming with Bloomsbury, and co-editor of the *Oxford Handbook of Philosophy and Psychoanalysis*, and the *Oxford Handbook of Philosophy and Psychiatry*, published by Oxford University Press. Dr. Gipps' interests include philosophical issues in psycho-pathological theory and psychotherapeutic practice, the liberatory philosophy of Wittgenstein and ordinary language philosophy, moral psychology and virtue ethics as a resource for psycho-therapy, and the life writing of those suffering severe mental illness.

12:15pm–12:30pm, *Leslie and Richard on panel and open to audience participation*

Moderator: Louise DeCosta, Ph.D., LCSW-R

CE Contact Hours for NYSED Licensed Psychologists, Licensed Psychoanalysts, Licensed Clinical Social Workers, Licensed Masters Social Workers, Licensed Marriage and Family Therapists and Licensed Mental Health Counselors.

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

Challenges to LCSW Practice Never Seem to End

The 2021 Legislative Session adjourned on June 10 with Democratic majorities in both houses. While the chambers and halls remained nearly empty due to Covid19 restrictions, a record number of bills, more than 900, were passed in this, the first year of a two-year session. At the time when former Governor Andrew Cuomo resigned and Governor Kathy Hochul assumed her leadership role, 313 bills had been signed by the former Governor. The remaining bills must be considered by the new governor by the end of December 2021, or they die.

Our NYSSCSW lobbyist continued to represent us throughout the year working closely with the Executive Chamber, the State Education Department, key legislators, and their staffs as well as with our partner organizations to address issues critical to clinical social work practice and our patients. Biweekly conference calls were scheduled between the lobbyist and Legislative Chair and were often held more frequently depending on significant activity. We successfully partnered with NASW-NYC on several bills in addition to our coalition work with New York State Psychiatric Association and New York State Psychological Association.

Some of the issues that concern clinical practice:

• Updates on emergency Tele-mental health services. Direct Medicaid billing for LCSW private practitioners: This bill, A.7187 (Bronson)/S.6576 (Savino), passed both the Senate and Assembly, and now awaits the Governor's review, which must be done by December 31, 2021, or it dies. Meantime, the Licensed Mental Health Counselors (LMHCs), and Licensed Creative Arts Therapists (CATs), Licensed Marriage and Family Therapists (LMFTs), and the Licensed Psychoanalysts (LPs) proposed their own version of a Medicaid bill, (A.6323 (Bronson)/S.6575 (Savino), which also passed both houses of the legislature. For these mental health practitioners, it is a back door to obtaining the privilege of diagnosis. We await the Governor's review of both bills.

• Updating the Governor's office and our membership on pandemic -driven emergency regulations: Limited permits, out-of-state providers practicing in New York, licensing delays. We are recommending these practices should only be allowed for continuity of care and end with the pandemic.

• S.6431 (Brouk)/A.7405 (Harckham): An extension of the exemptions from licensure requirements for hiring any licensed mental health professional was again approved. This effects State Agencies OMH, OPWDD, OASA, etc. for one more year. This exemption has been passed since the mental health professions became licensed in 2004, i.e., social work, psychology, and the mental health practitioners.

• NYSSCSW submitted a Memo of Opposition for A.6008/S.5301, which expands the scopes of practice of the four Mental Health Practitioners to include diagnosis. NYSSCSW maintains our longstanding position that as a Master's level profession, they must have the same clinical education and supervised clinical experience as the LCSW.

• NYSSCSW opposed A.1171-A (Bronson)/S.6574 (Kennedy), a bill which required health insurance policies to cover outpatient treatment by the Mental Health Practitioners. This is another back door to the diagnosis privilege—this year the bill only passed the Assembly.

• No tele-practice or single payer bill passed both houses.

• S.4347-A (Brouk)/S.3221 (Helming) is seeking licensure for school psychologists which would allow them to practice outside of the school setting; and S.1662-B/A.3523 A seeks to expand the scope of practice for Applied Behavior Analysts who specialize in autism.

• A.7767 (Lupardo)/S.6717 (Stavusky) is of interest. It is a proposal which allows at least 1/3 of required clinical training and competency to be completed through simulation experience. This would apply to all professions that require supervised clinical training, clinical education and continued clinical competency. For social work, this would legitimize on-line actors providing fieldwork experience for MSW programs.

CONTINUED ON NEXT PAGE

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

The largest single change since the last issue of *The Clinician* has been the ending of the emergency declarations that waived cost-sharing for in-network providers. Just as the commencement of the cost-sharing waiver caught many of our members by surprise, the precipitous ending of the emergency waiver caused confusion and consternation.

Interstate practice and telehealth continue to be problem areas for some of our members. Trainings are available so that clinicians can learn the legal and ethical issues involved in telehealth and interstate practice as well as how and where to seek answers for their questions. But some members continue to act as though these are just practice as usual with the addition of technology. This is far from the truth of the situation.

Some of the usual insurance carriers have either changed their names or merged with others so, for instance, GHI and HIP no longer exist as behavi oral health carriers and instead have been subsumed under Emblem Health, which is being managed by Beacon Health Options, and Affinity Healthcare is no longer covered under Beacon Health Services and is now managing claims and payments on their own.

Based on what we're seeing on the listservs, patients seem to be increasingly asking for in-office treatment and guidelines have been offered by various sources or protocols about returning to the office and in-person treatment. Some of the protocols suggest that we cannot treat vaccinated and unvaccinated patients differently because that could be seen as discriminatory. Under these guidelines, we are not allowed to ask patients if they are vaccinated or insist that unvaccinated patients wear a mask while allowing vaccinated patients to go without one. As cases and complaints go through the courts case law will be developed and more refined guidelines/protocols will be developed.

The big questions we're left with are—Will the insurance companies continue to pay for telehealth? Will New York participate in an interstate compact if one is created? Will non-HIPAA compatible platforms (and other than synchronous A/V platforms) continue to be allowable? And will Medicare continue to pay for telehealth with patients in their homes, other than in limited circumstances?

We will be watching to see what changes are coming down the pike. As they do we will inform the members.

Challenges Continued from page 6

On a happier note, NYSSCSW was invited to present testimony at a Joint Public Hearing by Senator Shelly B. Mayer, Westchester and Senator John Liu, New York City, both serving on Education Committees. Large sums of money from Foundation Aid had been distributed to all the school districts in 2020-21 and the Senators wished to hear how it was spent in order to adjust future distribution plans. NYSSCSW was asked to comment on school social work needs.

With few exceptions, none of this money impacted school social work services. (See Legislative section of NYSSCSW.org for the actual memo with recommendations for appropriate school social work spending.) Notably, the school social work organization, NYSSWA, was missing as an invitee. The organization was contacted to see if NYSSCSW could collaborate on issues in the future. It might be possible to have a school social work interest group within the Clinical Society as they are LCSWs and LMSWs. The United Federation of Teachers currently represents them, with little or no result.

As one can see, enacting the LCSW insurance and licensing laws is but a beginning of the need for a Legislative Committee and a competent lobbyist. Challenges to our ability to practice as we see fit never seem to end.

LMSW Scope of Practice: *DOs & DON'Ts*

By Hafina Allen, LCSW-R

With a recent class of MSWs graduating and looking for work, it raises the question of what practice settings LMSWs can work in. For LMSWs who want to work towards their LCSW, this further raises the issue of accruing clinical experience or "hours" towards the Clinical License. As many new graduates are asking about working in private practice settings, we have put together the following list of frequently asked questions for both LMSWs and LCSWs considering incorporating LMSWs into their practice.

FAQs for Both LMSWs and LCSWs

I've graduated with my MSW and have a job offer. How soon can I start working?

That depends on the scope of the work you will be doing. Many agencies or private practices will hire new MSWs and have them complete the hiring process and agency trainings while they work towards licensing. Some agencies will assign case manager tasks until you get your LMSW. Once you have your LMSW or limited permit, you can do any work within the scope of your license. However, as an LMSW you can only provide "clinical social work" services, which includes diagnosis, psychotherapy, and assessment-based treatment planning under supervision of a New York State licensed LCSW, psychologist or psychiatrist.

OK, I got my LMSW, and I want to start my own practice.

As an LMSW, you can open any business that is within your scope of practice. "Clinical social work" services (diagnosis, psychotherapy, and assessment-based treatment planning) are NOT within the LMSW scope of practice and providing these services is not allowed unless you are under supervision. New York law does not allow an LMSW to establish a private practice or professional entity (e.g., professional corporation or professional limited liability partnership) for the purpose of providing "clinical social work services" since that is outside the LMSW scope of practice/authorization.

If you open a business that is providing non-clinical services, you should be careful about any mention of your degree or license. We recommend that you consult a lawyer to provide advice on this to avoid any confusion on the part of your clients/customers who may think they are receiving clinical service from you. Please know that practicing outside of your scope of practice may result in the loss of your current license.

Can I hire my own supervisor?

In short, you cannot count paid supervision as hours towards your clinical license. LMSWs and LCSWs can engage supervisors for professional growth but this DOES NOT cover clinical experience for the purposes of licensing or providing services. "Arrangements where an individual hires or contracts with a licensee to provide supervision are problematic and, as a general rule, unacceptable. Supervision of your practice requires the supervisor to independently direct your practice; this is not possible when the supervisor is employed by you or acts as a paid contractor to supervise the person who can only practice under supervision. Additionally, you should not accept employment in any setting where you are not supervised by a qualified supervisor. The agency or employer is responsible for the services provided to each client, and clinical social work services may only be provided by an individual licensed and authorized to practice clinical social work. If the agency does not have a qualified supervisor on staff, it is their responsibility to hire a qualified supervisor who is responsible for the clinical practice of an LMSW or other person who is only authorized to practice under supervision. In such cases, we would suggest that there be a three-way agreement between you, the proposed supervisor, and your employer." [http://www.op.nysed.gov/prof/sw/swpracfaqs.htm]

Can I work in a private practice as a fee for service therapist?

It depends… If you are hired as a W2 classified employee and you will receive clinical supervision from an LCSW, licensed psychologist or licensed psychiatrist, then YES you can work in in a private practice. In this case, you should clarify that your employer will be covering you with all of the appropriate insurances (including but not limited to Workers' Compensation, unemployment, etc.) and paying FICA. If your employer is asking you to cover any of those costs then you are not truly an employee (you would be re-classified as an independent contractor).

If you are being offered fee for service work as an independent contractor (1099), you CANNOT provide clinical services. According to the U.S. Department of Labor, independent contractors are not covered by anyone else's licenses. As an LMSW, clinical services are not within your scope of practice. If someone offers to pay you as a W2 employee but asks that you obtain your own workers' compensation or unemployment insurance, the Department of Labor or the IRS may re-classify you as an independent contractor. Providing clinical services as an LMSW independent contractor (1099) is practicing outside of your scope of practice and can lead to suspension or revocation of your license.

But the LCSW who is hiring me as an independent contractor will provide supervision. Doesn't that mean I can provide clinical services?

NO! According to the Department of Labor, anyone who is an independent contractor is working solely under their own licenses; it does not matter if you receive additional supervision.

I have completed all of my clinical hours towards the LCSW. Can I open a private practice?

Congratulations on completing your clinical experience!!! The next step is to apply for the LCSW and then sit for and pass the ASWB Clinical exam. Once you have been issued an LCSW license number by New York State, you are eligible to provide clinical services independently. Until you are issued an LCSW license number, you are not yet an LCSW and you continue to require clinical supervision.

I am an LCSW in private practice and I would like to know how I can incorporate an LMSW into my practice.

You can employ an LMSW if they will be a W2 employee and you are providing all necessary insurances including but not limited to Workers' Compensation and unemployment, and you will be paying their FICA. You must provide appropriate supervision to the LMSW.

[http://www.op.nysed.gov/prof/sw/swsupervision.htm] If you plan to bill insurance for services provided by an LMSW, you should check each insurance contract to see if this is allowed. You need to understand that clients are being seen under your LCSW license and you are responsible for the care they receive. You should consult with a lawyer well-versed in representing mental health clinicians and in helping clinicians set up practices to ensure that you are meeting all regulations, licensing requirements and labor laws.

I am an LCSW who has been approached to provide supervision to an LMSW. Can I do this?

When you provide supervision to an LMSW, you are "legally and professionally responsible for the diagnosis and treatment of each client and must have access to all relevant information."

Some agencies contract LCSWs to provide supervision to their LMSW employees under a third-party agreement. "Any arrangements for third-party supervision must include a written agreement between the employer, third-party supervisor and the LMSW to specify the supervisor's access to clients and client records to ensure appropriate supervision of the LMSW. The client must be informed of how confidential information is handled in the case of third-party supervision and how to raise questions with the employer and/or third-party supervisor."

[http://www.op.nysed.gov/prof/sw/swpracfaqs.htm] In these cases, the LCSW is paid directly by the employer.

In short, the supervisor must be employed by the employer, not the LMSW. For the purposes of practicing and licensing, an LMSW cannot employ or contract a supervisor. Should you choose to become a third-party supervisor, you should consult with your insurance to see if this affects your policy.

I am an LCSW, and I want to get my "R" Psychotherapy Privilege. Can I pay for supervision towards this?

NO. Just as with the LCSW, you cannot pay for supervision towards the "R."

"Arrangements where an individual hires or contracts with a licensee to provide supervision are problematic and, as a general rule, unacceptable. Supervision of your practice requires the supervisor to independently direct your practice; this is not possible when the supervisor is employed by you or acts as a paid contractor to supervise the person who can only practice under supervision."

FOR MORE INFORMATION:
http://www.op.nysed.gov/prof/sw/swpracfaqs.htm

Note from Hafina Allen: Please note that I am not a lawyer and I recommend that any more detailed questions you have be directed to your malpractice insurance's risk management unit and/or that you consult a lawyer well-versed in representing mental health clinicians.

LICENSING STUDY GROUP

Free to NYSSCSW Members

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.

This study group brings attention back to the basics of textbook knowledge to help participants understand applying that knowledge to the exam. We have successfully helped many people, including established therapists, pass both the Masters and Clinical exams.

A TIERED APPROACH

In the study group, we take a tiered approach to the material:

- We look at sample questions and use anonymous polls to answer them.
- We discuss the correct answers and why the other possible options were incorrect.
- We share test-taking strategies to help narrow the options of answers for challenging questions.
- We then take a closer look at the knowledge, skills, and abilities tested.

This tiered approach is designed to help people with a variety of different learning styles get the most possible out of the group. Once you figure out which learning style helps you the most, you can continue to use it on your own between groups.

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.

☑ Here's what some people are saying about how the group helped them pass their exams:

"Thank you, Hafina! I passed! Needed 102 correct, scored 116. Really appreciate all the help—the group sessions were great in keeping me focused and on task." —**Kathryn, October 2021**

"I very much appreciate your course. VERY helpful!!!" —**Valerie, September 2021**

"I passed the exam! Needed a 98 and I got a 134!! Woo hoo! So glad to have this behind me. Thank you so much Hafina,* for everything!" —**Lydia, April 2021**

"Thank you for guidance. I passed the Master's level exam on Saturday. I really appreciated the strategies you shared they were really helpful during the exam. Thank you again for sharing so much of your wisdom." —**Kristen, April 2021**

"I passed the LMSW exam in January. Thanks so much." —**Emily, April 2021**

"I passed my exam in March! I'm licensed;) thank you for the ongoing support. It has been very helpful." —**Kristan, April 2021**

"Just to let you know I took the ASWB exam and passed!" —**Regina, January 2021**

"This is excellent. There are no short cuts." —**Brenda, January 2021**

"Hafina is the expert on licensing." —**Chris, December 2020**

"Great. Thank you!" —**Kenisha, October 2020**

"I attended the LCSW study group… Terrific, this is super helpful. Thank you very much!" —**Gilbert, September 2020**

"Awesome, thanks!" —**Anonymous, August 2020**

"I am happy to report that I no longer have a reason to take this class :-)! I passed!!!" —**Jacqueline, August 2020**

"I passed yesterday. I am still in shock! Seeing the "passed"" —**Anonymous, June 2020**

"We'd both attended your presentation in March…we both have passed our licensing exams…As always, thanks so much for your guidance." —**Nora & Jean, June 2020**

"This is great!" —**Linda, June 2020**

"Amazing" —**Lydia, June 2020**

* Hafina Allen, LCSW-R

Met Chapter Committee on Racial Equality

Excerpt from September 2021 Newsletter

Editor: **Jane Gold, LCSW-R** Email: **janegoldlcsw@gmail.com**

Why Affinity Groups?

By Christine Schmidt, LCSW, CGP

In clinical and community settings, homogeneous affinity groups are designed to offer a safe space for people to support each other in learning and healing situations. They foster interpersonal connections in pursuit of a broader unifying vision. While affinity groups may form around common needs or behaviors (e.g., single parenting, substance abuse, survivors of domestic violence), they also form around key identities (gender, sexual orientation, race) and offer a safe space for members to examine the elevation or subjugation associated with their identities (Watt-Jones, 2010).

Understanding white resistance to racial affinity groups:

Frequently, the loudest objections to racial affinity groups in clinical training and services come from white people. White people who have not yet grasped that affinity groups occupy a dynamic place in healing processes which could lead to more robust cross-racial dialogues. Embracing of a racial equity vision is important in our organization, and an authentic embrace of the core values of clinical social work (NYSSCSW, n.d.)

Let's look at some concerns about the formation of racial affinity groups:

Why are we meeting separately by race?
Members of different racial groups have different internalized experiences of whiteness. In an effort to create maximum psychological safety, affinity groups may reduce the emotional triggers encountered during exploring conscious and unconscious experiences of race.

Isn't this a step backwards?
It is a step forward towards healing. It offers a safe space to bear what has been unbearable and to examine what was unexaminable. This will hopefully lead to more productive mixed-race work in the future.

Aren't affinity groups exclusive and discriminatory?
White-identified people have discriminated against people of color for centuries and are reluctant to acknowledge this violence. White people are more likely to be honestly introspective in a space composed of white-identified people. View this as an essential step in a psychosocial and psycho-historical healing process.

How can a white person learn about racism without hearing from Black people about their experience?
White people know a lot about racism. In fact, white people invented it. Diverting attention towards people of color is a defense against facing the unvarnished truth about white racism.

Why is this relevant to a clinical organization?
Clinical work is concerned with the psychological impact of trauma on individuals, families and communities and supports the development of resilience. Racism is a traumatic experience and developing resilience against trauma is an aim of clinical work. Affinity groups are relevant to the clinical mission.

What if affinity groups aren't allowed?
The prohibition of affinity groups and insistence on mixed race gatherings is a declaration to people of color that their needs aren't valued. It risks emotional shutdown and, at worst, re-traumatization. Queer, Black-identified clinical psychiatrist Dr. Kali Cyrus (2020) writes, "For me, when white people drift in and out of the fragile state, the best means of protection against the introjection of those paranoid anxieties is to dissociate.... For these reasons, in mixed racial groups, race dialogue is almost never for the people of color (p. 599)."

Christine Schmidt, LCSW, CGP, is a white-identified group psychotherapist who, in consultation with therapists of color, facilitates whiteness affinity groups. Christine Schmidt's full article is available at: schmidtlcsw.com/why-racial-affinity-groups

Met Chapter

Helen Hinckley Krackow, LCSW, BCD, President

The Met Chapter, as all of us, have had to function at a distance and on Zoom. We are hoping to begin in-person meetings in 2022. We are looking forward to a conference to be given by Michael Crocker, LCSW, Ph.D., and Art Baur, LCSW. Art is a former member of Met, now retired in Maine, but still active at NIP as a teacher and supervisor. The conference is entitled, *Owning Aggression: From Victimhood to Agency—How Playing with Sadistic Fantasies Leads to Growth.* It will take place on November 20. It will address the reclamation of mastery in a time of great anxiety and helplessness in the face of Covid and societal chaos.

We are reforming our racial equity reading group under the State Society Diversity Committee. We want to thank Sari Cooper, LCSW for running our Chapter reading group for a year and a half. The Racial Equity Committee in Met has been publishing monthly newsletters addressing issues relating to various minorities whom we are treating. Many of them have been shared with the other Chapters and republished in *The Clinician.*

We are also running a BIPOC support group under the leadership of Sandra Plummer Cambridge, LCSW. Chris Farhood, LCSW is running an extensive Mentorship program as well.

We provide extensive assistance to our members through our listserv. All members are welcome at our bi-monthly Board meetings and are encouraged to propose any new clinically oriented activities you might be interested in developing. As we close this last pandemic year, we look forward to seeing each other.

Rockland

Orsolya Clifford, LCSW President

The Rockland Chapter has begun to gather again in person. We began Sunday, November 7, with a much-needed Meet & Greet networking event, a longed-for opportunity to casually catch up with colleagues whom we have missed for over a year. We also look forward to restarting our in-person CEU programming in Spring 2022. All our events are held at St. Thomas Aquinas College, Sparkill, NY, which also hosts the Rockland Branch of NYU Silver School of Social Work. For more information or to join us, please contact Orsolya Clifford at 845-664-3820 or visit the Rockland Chapter at www. NYSSCSW.org.

We would also like to take the opportunity to recognize Stacey Schiff, the NYU/ NYSSCSW Student of the Year. Stacey graduated with her MSW in May 2021. Her first-year field placement was at the Center for Safety and Change, where she had previously volunteered, providing individual counseling to children, youth and adults who had experienced interpersonal violence and/or sexual assault. In her second placement, at Jawanio Personalized Recovery Oriented Services (PROs), she provided individual and group therapy to people with severe mental illness. Stacey was an excellent student and passionate about her work and we wish her continued success.

The Society's video recognizing all the winners is coming out in January. Be sure to congratulate Stacey when you see her at a future event!

Stacey Schiff, 2021 NYU/NYSSCSW Student of the Year

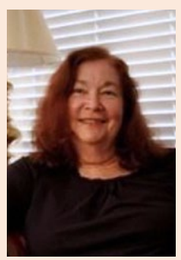
Stacey Schiff provided individual and group therapy to people with severe mental illness.

In Memoriam

Roz Cohen

Rosalind Cohen (Joelson) passed away in September 2021 at the age of 73 after a lengthy battle with cancer. Born in Trenton, NJ, Roz received her Bachelor's degree from Boston University and obtained two Master's degrees, one in Education from the University of Massachusetts and an MSW from Smith College School for Social Work. She also graduated with a Certificate in Psychoanalysis from the Westchester Center for the Study of Psychoanalysis and Psychotherapy, where she later taught and co-directed the Couples Therapy Training Program. She worked at the Montefiore Medical Center Department of Psychiatry for 38 years in many capacities, including as a family and group therapist, teacher, supervisor, and Coordinator of the Family Studies program. She also enjoyed a successful career in her private psychotherapy practice and was a coach for the Columbia University Executive MBA program.

Roz and her husband, Richard Joelson, LCSW, DSW, who was Chair of the Society's State and Met Chapter membership committees, were the gracious hosts of many Society receptions to help recruit new members. Roz was much loved by her family, and her many friends and colleagues.



Bobba Jean Moody

Bobba Jean Moody passed away at age 85 in March 2021. Born in Big Sandy, TN, she made New York City her home for over 65 years. A graduate of Hunter College and Fordham University, she retired from the New York State Psychiatric Institute and as a faculty member at Columbia University.

A dedicated and active member of the Met Chapter, Bobba also served on several state level committees. As Chair of the Legislative Committee, she helped to advance the campaigns for insurance and licensing. Bobba was a beloved friend, colleague, and mentor to countless people, some of whom spoke at a large memorial service in her honor. One Met leader said, "Bobba was one of the finest human beings I have ever known." Another colleague recalled when, decades ago, she was a work-study student and Bobba was her mentor: "She was a lively, fun, spirited professional and couldn't be nicer."

Mid-Hudson Chapter

Linda Hill, LCSW, President

The Mid-Hudson Chapter is delighted to welcome two new members to its Board. Christine Schaetzl is a Licensed Clinical Social Worker who maintains a psychotherapy practice in Fishkill, and Samantha Rathe has recently received her Masters in Social Work from NYU's Silver School of Social Work and is pursuing her LCSW. We look forward to Christine and Samantha joining us as we work together to provide ongoing programs and professional support to clinicians in the Mid-Hudson Valley/Upstate region.

In October, our Chapter hosted a live webinar presented by Amy Schaffer, Ph.D., entitled *Blooming in December: Jousting with Ghosts and Promoting Growth in the Clinical Treatment of Older Adults.* Employing both theoretical constructs and case vignettes, Dr. Schaffer discussed the needs of older adults from a developmental perspective and examined treatment implications for therapists working with this population. Many thanks to Cynthia Muenz, LCSW, Thaddea Compain, LCSW, and our Education Committee for arranging this illuminating and thought-provoking presentation that challenged the ways in which we perceive the capabilities of our patients as they age.

For our next educational offering, speaker Shideh Lennon, Ph.D., will share with us *Somatic Tools for Psychotherapists.* Clinicians attending this workshop will learn new mind-body techniques to add to our skill repertoires.

The Chapter has also been committed to fostering pathways for MSW students as they look ahead towards their futures in the field of clinical social work. Recently, Mid-Hudson Chapter Community Liaison Carolyn Bersak, LCSW, DSW, met with administrators of Adelphi University School of Social Work's Hudson Valley Center in order to create meaningful initiatives for these aspiring social workers. She and Cindy Marschke, LCSW, Ph.D., have established an online Mid-Hudson Mentorship Group designed to aid students in coping with professional life before and after graduation. Those participating will receive assistance and information on many salient issues, such as career planning, resume writing, job searches, obtaining the LCSW and the "R" designation, private practice considerations, and options for pursuing advanced training. Exciting plans are also underway to offer a $500 scholarship to a local Adelphi student in 2022. The Chapter is especially grateful for the help of NYSSCSW State Membership Chair Hafina Allen, LCSW, enabling us to provide this scholarship opportunity within our own community.

As part of our efforts to facilitate connections among licensed mental health practitioners in the region, we continue to hold Peer Consultation Group meetings via Zoom on the second Friday of each month. The first half of the meeting is devoted to practice-related concerns broached by members; the second half is reserved for clinical cases. Current topics addressed in group meetings include considerations regarding in-person versus tele-sessions, implications of shifting to a self-pay practice model, and a discussion of different online practice management resources utilized by members.

There has been an enthusiastic response to our Mid-Hudson Chapter Movie Nights, which shifted to online after the start of the pandemic. Participants come together to dialogue about a film of clinical/sociocultural interest after watching it on Netflix beforehand. Kudos to Susan Deane-Miller, LCSW, who has been instrumental in bringing these Movie Nights to fruition for us. Selected movies have included *Crip Camp,* a documentary about the disability rights movement; *To the Bone,* which depicts a teenager's eating disorder struggle; and, most recently, *I am Not Your Negro,* a reimagining of James Baldwin's unfinished manuscript about civil rights leaders Medgar Evers, Malcolm X, and Martin Luther King, Jr. Please feel free to put forth suggestions for other movies to be featured, or other programming ideas, as we value your input and strive to meet the needs of our membership.

Queens Chapter

Lynne O'Donnell, LCSW-R, ACSW, President

This is a sad time for the Queens Chapter, as we have suspended operations for now. Despite being a vibrant chapter with an active membership and well-attended seminars, we do not have members who can assume leadership positions at this time. We understand that the Covid pandemic has also played a role in sapping the energy of the membership.

Unfortunately, for multiple personal reasons, the current leadership is no longer able to maintain their positions. We have truly enjoyed our time working for the chapter and the Society. We hold on to the hope that some members will choose to lead our chapter again and offer our support to anyone interested in assuming a leadership role. It is a valuable opportunity for both professional and personal growth.

Nassau Chapter

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

On behalf of the Nassau Chapter Board, it is our pleasure to provide you with this update. First and foremost, we want to thank our Board members for their hard work, dedication, and commitment to the Chapter.

We continue to be impacted by the pandemic, as people continue to rely on Zoom and other telehealth platforms for patient sessions, meetings, and workshops. As more people are getting vaccinated, a few of us are venturing out to see patients in person, while others are home and considering giving up offices or have given them up. Chapter members are continuing to share the latest information regarding telehealth, consent forms, billing, and CDC regulations for reopening our offices, and have provided support to colleagues struggling to navigate their way through the stress and emotional trauma of the pandemic.

Over the past couple of months, the Nassau Chapter Board committee has continued putting together events and looking for opportunities to increase our exposure. A number of us attended a "Celebrate" party sponsored by the chapter and hosted at the home of Sheila Rindler, LMSW. People had a wonderful time connecting safely outdoors, eating, and listening to music. Jannette Urciuoli, Ph.D., LCSW, Website Chair, placed some pictures from our summer party on the website—check them out.

Our Diversity Committee, chaired by Jannette Urciuoli and Judith Pullman, LCSW, has met three times. They are considering having a speaker, in coordination with the Programming Committee.

Our Public Relations Committee, Nassau liaison and Chairperson Evelyn Kuntz, LCSW is working in conjunction with the State Chair and Nassau member, Barbara Murphy, LCSW. The State recently decided on the public relations firm, Eric Mower and Associates. The Nassau Chapter Public Relations and Website committees are looking forward to working with the State and public relations firm to increase exposure of clinical social workers and the benefits of being a member of the organization.

The Programming Committee, chaired by Ellie Perlman, LCSW, put together a presentation for in the fall entitled, *Creating Meaning out of Grief: How to Holistically Create Answers to 15 Common Grief Questions*, presented by Anne Grenchus, LCSW. The Committee has moved our presentation on Gestalt Therapy, led by Adam Weitz, LCSW, to May 1, 2022.

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

The Membership Committee, headed by Patricia Traynor, LCSW and Linda Feyder, LCSW-R, (also our dedicated Secretary), continues to collaborate with the Board's other committees to develop partnerships, expand our outreach, and sponsor conferences in an effort to increase awareness of the benefits of membership in the Society. We currently have 153 members, including six new members. One member joined as a result of a promotion we held in March, which awarded members if they were able to bring in a new member. We are looking forward to having another membership drive. Prizes, Prizes, and Prizes!

The Committee for the Aging, headed by Sheila Rindler, now meets bi-monthly, by Zoom; prior to the pandemic, they met in person. That committee has grown to eight regular members.

The Scholarship and Education Committee, led by Catherine Faith Kappenberg, Ph.D., LCSW-R, who is also our University Liaison, presented an award to our Molloy BSW scholarship winner, Amanda Sanchez, at our Zoom meeting on May 16, 2021. We will be awarding a scholarship to an Adelphi student, Courtney Oehl, in the fall.

Our *News Notes*, edited by Susan Kahn, LCSW, with Carline Napolitano, LCSW, Clinical Editor, was sent to members and put on the website in May. A request for new articles was just sent to all Nassau and Suffolk chapter members for our next edition.

Our Book Club, led by Susan Kahn, had its second meeting on Zoom on May 16. The discussion, on the book, *The Girl in the Red Boots*, by Judith Rabinor, was lively and was made particularly interesting by the attendance of the author.

We are planning a Zoom holiday party for mid-December. The Nassau Board members meet monthly by Zoom, with the date and the time posted on the Listserv. We encourage all members to attend and share their talents. We are continuing to look for members to participate in our Public Relations, Programming, and Membership Committees.

Westchester Chapter

Andrea Kocsis, LCSW, President

The years 2020 and 2021 brought serious challenges to the Westchester Chapter and to all chapters statewide.

Until 2020, we had held meetings on the first Saturday of each month. Nine of ten monthly meetings offered CEU presentations, the most of any chapter in the state.

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

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

Also in 2019, we welcomed several new members to our Education Committee, which successfully engages CEU presenters for the chapter.

Our schedule for 2020 began in January with a showing and clinical discussion of the film, Hidden Figures. We decided not to meet or present in February in order to conserve funds. We had presentations scheduled for March, April, May, and June, but the coronavirus emergency caused us to cancel the meetings, and reschedule them as Zoom events in the fall:

SEPT: Staying on Track: Support & Treatment for Individuals with Early Psychosis
OCT: Restoring the Resilient Nervous System: Principles of Somatic Experiencing & Expressive Writing
NOV: Running the Matrimonial Gamut: A Trilogy of Conflict Resolution
DEC: Gestalt Therapy 101: The Essentials

In response to our nation's social justice concerns that were exacerbated by the murder of George Floyd, we offered members a special presentation on racial justice issues in clinical practice. *Microaggressions in Our Sessions? Addressing the Subtle Slights with Intention and Intercession*, was presented in Oct. 2020 by Zoom without charge to members.

In 2021, our Board has met regularly by Zoom and our committees continue: Education; Membership & Program Registration (MPR); Newsletter; Legislative; and Website. Last year, MPR had scheduled an outreach program to students at the Fordham University branch in Westchester County to engage newer members, students, and graduates and to provide professional support as they enter the field of social work. This program was canceled due to the virus, but we will reschedule and also outreach to other local schools of social work.

Our Education Committee has offered Zoom CEU presentations this spring that addressed the mental health consequences of the pandemic for clients, for our clinical work and for the nation, as follows:

MAR: Navigating Grief and Loss During Coronavirus: Practical and Personal Implications for Providing Support
JUNE: An Overview of Palliative Social Work: An Ecological Approach to Care During Serious Illness
In April, we offered another free non-CEU presentation, The Implicit Impact of Racial Discrimination on Mental Health.

Also in 2021, like all practitioners, 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 of our State Board. Clinicians who work in agency practice have had to follow the 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. Since the CDC has begun relaxing standards of community behaviors as Covid recedes, some practitioners are now beginning to resume in-person sessions, with appropriate safety and vaccination precautions. We look forward to the guidance that the Society will offer our members as they contemplate next steps.

We are waiting to see how our activities will develop as the year unfolds, and how the pandemic will continue to challenge us all. Our chapter scheduled two 3-CEU presentations in the fall:

OCT 9: Seeing and Treating Survivors of Domestic Abuse
NOV 6: Contact and Relationship in Gestalt Therapy

Currently, these are presented by Zoom. However, our Board is discussing when to hold in-person chapter meetings and presentations. We are hoping that, by December, we will be able to see each other and celebrate actually, rather than virtually. However, due to the Delta variant, in-person meetings are still in question, and will be actively addressed as we move forward.

From Colorblindness to Kohut—

Recent Discussions with Patients on Racism

By Karen Kaufman, Ph.D., LCSW-R

This article is an excerpt from a longer paper in process for journal submission.

In a recent session, L, a mid-thirties white woman, described with great confusion an angry exchange with her then boyfriend, a Black man close in age. She was puzzled and upset by his reaction to her efforts to convince him that she is colorblind in the racial sense, claiming to see him as a person, not his skin color. He called her a racist, among other descriptives that left her upset and stunned. The relationship limped along for a short time before ending.

Since this patient lacks self-awareness, any reflective capacity or understanding of another person's feelings, I had to curb my countertransference and could only respond with a few words that mirrored her confusion and hurt, given her view of herself as a liberal thinking, inclusive individual.

Color blindness, in the non-ophthalmologic form, typically has in its intention the wish to equalize race relations and treat people of color as if differences are not seen. However, this is a damaging form of denial in which people of color do not feel authentically seen and embraced as the people they are, making it impossible to fully share the racist experiences they may have endured.

When clinicians and others in the patients' lives claim to be colorblind, they are avoiding responsibility and inhibiting discussion of the patients' real feelings and lived experiences. In psychotherapy this creates a climate in which the work is stunted and superficial, since the clinician's discomfort with differences, along with countertransference, may prevent learning about the real person in the room since open dialogue is censored.

Empathic Attunement

In contrast to color blindness, self-psychology informs us about empathy and empathic attunement, with the clinician working to understand the patient's life from an experience-near position. In this approach, we are embarking on a journey to discover what it is like to be this person in the world, rather than interpret their feelings and experiences from a distant position. A power imbalance developed in the distance that existed in the early history of psychoanalysis, prior to theoretical advances in self psychology, interpersonal, and relational treatment. Working in an experience-near manner involves an effort to suspend judgment and create a safe atmosphere in which material can be explored without the patient's fear of criticism or of offending the clinician. This closer proximity also challenges the clinician's comfort level, as we are called upon to respond authentically to the harm or trauma that patients experienced. We may be the first to validate our patients' experiences if their feelings were previously dismissed, minimized, or discredited. Countertransference must be addressed to prevent it from becoming an obstacle in deepening the work.

According to Kohut, clinicians can expect different forms of transference to unfold: patients may feel more safety in an idealizing transference, need mirroring responses for validation, or may be adversarial in the security of the treatment relationship. Nontraumatic empathic failures by the clinician may occur but can be worked through without damage to the relationship. The clinician's mistakes can be corrected if trust has been established and these may serve to strengthen the patient's resilience in other relationships.


Karen Kaufman

Racism and race relations in the U.S. are under much needed scrutiny following a year of protests after the death of George Floyd. Political turmoil includes efforts to attack voting rights across the country, primarily aimed at people of color. More than ever, clinicians must be alert to the challenges and often subtler nuances in clinical practice with a diverse patient population. We must reflect on the biased messages, however subtle or overt, that we absorbed in our own young lives, understand the effects of these on our clinical thinking and outlook, and take responsibility for our own deficits in understanding the profound effects of racism in this country.

As a clinician for more than 30 years in Manhattan and Westchester, I have had the privilege of working with a diverse patient population from a wide range of socioeconomic, educational, and professional backgrounds. As therapists, we believe that we are providing a safe space for all of our patients, despite their differences, but we must honestly reflect on and take responsibility for racially informed and uninformed beliefs; these affect engagement, the ongoing work, and our outlook on prognosis. Two clinical examples follow.

J, a 25-year-old Black male veteran, was referred by a psychologist at his local VA for free and confidential treatment, since I was a volunteer in a national organization that offered this service to veterans of Iraq and Afghanistan. J had been honorably discharged and had no future military aspirations, but he felt more secure with therapy outside the VA, since he received medical care at these institutions.

Obtaining therapy outside the VA is especially important for service people who want a military career. Despite public support by military leaders for treatment of PTSD following the many suicides in the military, service people continue to believe it would be detrimental to have therapy on their records.

While J had not seen active duty, he struggled after discharge, having experienced the loss of a close friend from a drug overdose and a difficult re-adjustment to civilian life. J reported experiences with racism in Japan, his final posting. Upon returning to the states, he could not find any direction for his future.

The beginning of our work involved coordination of care for needed medical attention and a psychiatric evaluation for depression and anxiety. Early in the work, it became clear that J had also suffered trauma in his early family life: physical abuse, exposure to alcoholism, and the disintegration of his family following his parents' divorce. He lived for some time with extended family but felt emotionally homeless, adrift, and without the support he needed. After leaving the military, he lived for a short time in a veteran's shelter in New York City, where he never felt that he or his scant belongings were safe.

Eventually, with the help of caring counselors and government aid, he received a housing voucher and was subsequently able to share a house with two other young men. Although he lived in an economically disadvantaged area, he found work that sustained him, and he began to explore interests and goals that he hoped would elevate his life.

As a white clinician practicing in an upscale Manhattan neighborhood, at an early point in our work I felt it necessary to discuss our differences and to inquire how he felt working with me. After the barest acknowledgement of my words, he proceeded to describe with detail and great emotion what his life was like as a young Black man in a large racially and economically diverse city. He reported being followed in stores by white security officers and sales staff, particularly if he was dressed casually in a hoodie and with the hood raised. He described incidents of harsh looks and felt he was not welcome in various establishments and neighborhoods. He presented no history of paranoia and, sadly, the experiences he reported were commonplace.

As we ended the session in which I had asked the question about our differences, he smiled and said: "You're beautiful, Doc," and proceeded to leave. These spontaneous few words were validation of my effort to bring our differences into the room and gave him permission to discuss his experiences without fear of offending me.

> "I received important validation about addressing the differences in the room (or on screen) early in the relationship. Expanding on the question: What is it like to be this person in the world? I added: What is it like to work with me?"

R, a 50-year-old Black professional man, married and the father of two teenagers, began therapy during the pandemic due to marital problems and increasing difficulty dealing with his anger. R reported that he had never considered himself a candidate for therapy but, after a male coworker shared his own positive experiences, he felt more accepting of a referral. Our work began on video since he contacted me during the spring of 2020, the height of the pandemic.

After establishing our weekly routine, I broached the subject of our differences with R, like I had with J. I inquired how R felt working with me and, after a few agreeable words that indicated it was "fine," he proceeded to describe three events in detail that had enraged him.

In one instance, he had entered an elevator in his office building, dressed professionally with his ID badge in full

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When the Therapist's Heart And Soul Come Alive

By Mary Anne Cohen, LCSW

The clinician skilled in the field of eating disorders will master the techniques of dynamic psychotherapy, psychoeducational principles, behavioral/cognitive strategies, and when to make a medication or nutrition consultation. But the most healing ingredient of the treatment would still be missing: the heart and soul of the therapist reaching out toward the heart and soul of the patient. The therapist's thoughtful sharing of her emotional reactions can make the therapy come alive and ignite the inner spark of the client.

Sherry, an anorexic young woman with "zero friends" (according to her), is sitting in my office as the sun is setting and casting a rose gold halo around her face. She looks beautiful, like an illuminated Medieval painting. I cannot resist saying, "Sherry, the sun is setting so beautifully on your face."

"Anyway, as I was saying…," Sherry ignores me and continues her litany of self-hatred without missing a beat. I feel a surge of anger in my stomach at her dismissal of me. I learn two things: she is as "allergic" to taking in admiration as she is to taking in food, and I've just witnessed how she can abruptly slap people down, and maybe that's why she doesn't have any friends!

But, knowing about her family life, I also realize she is roundly rejecting me in the same way she experienced her parents growing up—a swift dismissal and slapping down of her emotions. I am now feeling the anger that she must carry within her at this constant history of rejection. I am experiencing this in real-time in our session, and I'm feeling it in my stomach—the organ that she is always fighting with! I will share this with her.

Of course, Sherry is not obligated to take in or enjoy my compliment, but this moment helps me realize how subtly dismissed I have felt throughout our work together. She exudes a constant begrudging undercurrent of, "You're not important to me, and I couldn't care less what you think or have to say." It is hard to work with someone who couldn't care less what you think or have to say!

The anorexic is the most difficult patient to work with—she refuses help just as she refuses food. Anything nourishing feels like a threat to her sense of self, boundaries, and independence. The anorexic has been called "lactose intolerant to the milk of human kindness." Sherry fits the bill, and for good reason.

One of nine children, she is the oldest daughter and became mother's little helper at a very young age. Both parents were chronically overwhelmed, and the mother suffered a series of emotional breakdowns and hospitalizations. Sherry vowed never to need anyone or any help or even food, for that matter. She learned not to hope for things and then wind up disappointed; she took pride in her self-sufficiency.

But Sherry's stance of self-reliance fell apart when she was 15 and hospitalized for anorexia. It is ironic that the girl who strove to need nothing now needed everything if she was going to live. After seven hospitalizations throughout her teenage years, Sherry arrived in my office. We had worked together for a while before the sunset incident.

I ask, "So, what bothered you about my admiring how pretty the sun looked on your face?"

"I'm not really interested in what you have to say." says Sherry.

MA: Any idea how you might have made me feel when you slapped me down?

S: Any idea how annoying your questions can be?

MA: No, tell me. How annoying can I be?

S: All you want to do is talk about feelings. B-O-R-I-N-G.

MA: And all you want to do is talk about nothing. N-O-T-H-I-N-G!

Sherry laughs. And adds, "You know, my mother never told me even once that I was pretty. I just assumed that was because I wasn't."

MA: Wow. That would have hurt me and made me angry.

S: What's to be angry about? The truth is the truth.

MA: If your mother has difficulty telling you positive things, that doesn't mean that's the truth!

Sherry pauses.

MA: So, the strangest thing happened. When you brushed off my compliment, I felt angry in my stomach. It made me wonder if I was feeling something that is familiar to you. Do you feel anger in your stomach when someone hurts you?"

Sherry (with surprise): I hurt your feelings?

MA: Yeah, you did.

S: I guess that means what I say is important to you?

MA: Yeah, I guess it does.

Sherry looks pleased and blushes. And on the way out of my office, she slams the door.

> "In the treatment of the eating disorder patient, therapists need to grab onto any attempt to enliven and enrich the conversation to break through obsessive ruminations about weight and calories."

What unlocked this session was my revealing some personal vulnerable feelings to Sherry—she hurt my feelings and made me angry. Swallowing that reaction would have deprived both of us from entering into a deeper discussion of Sherry's inner life. My comments reached Sherry who never knew anyone had personal reactions to her. She never knew she was important enough to evoke reactions in others.

Does that mean that Sherry's anorexia is now cured and a thing of the past? Of course not. But the session created an emotional bridge between us, a more enlivened way of being with each other. We created a language of speaking about our feelings in the here and now that we can hopefully build upon.

And next time I will discuss with Sherry her feelings about slamming my door!

In the treatment of the eating disorder patient, therapists need to grab onto any attempt to enliven and enrich the conversation to break through obsessive ruminations about weight and calories. A bulimic patient will say, "I made myself get sick over the weekend." I will respond, "You made yourself puke over the weekend." A patient will say, "I took laxatives last night." I say, "You made yourself shit your food out."

The therapist is not afraid to challenge, reframe euphemisms, to get to the energy behind the behavior. I will say, "If your vomit could talk, what would it say? And to whom?" …

"If your cutting your arm could talk, what would it say? And to whom?" In this way, we translate behaviors into emotional language to foster communication and connection.

Given that attachment theory teaches us that our early relationships create the blueprint of who we are, how we love, and how we care for ourselves, those with eating disorders have experienced deficiencies in these early bonds. Eating and food become the vehicle to express and discharge unresolved and undigested emotional needs. The emotional eater's world has narrowed down into a rigid world of numbers: What is the number on the scale today? How can I lose 20 pounds quickly? How can I diet to a size 6 dress? I'll just have an apple for lunch— it's only 100 calories. Emotional eaters are fluent in the constricted language of food, weight, calories, and size but not so much in the language of feelings and self-expression.

The therapist needs to teach the patient fluency in the language of connection, compassion, and collaboration. When a wide range of emotions suffuse the session between client and therapist beyond the obsessive concerns with body, weight, and food, the human connection is deepened, the attachment comes alive, hope takes root.

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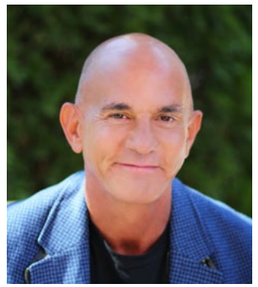
Covid, Vulnerable Populations, and Futurized Stress Continued from page 1



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To our surprise, however, the research, surveys, and articles published recently paint a very different picture of our society's mental health. Now that we are almost two years into the pandemic, the data show unexpected trends that are playing out. Despite our anecdotal experience, the research indicates that exacerbation in disorders of stress, anxiety and depression are overstated. Could this be true? Possibly, when you look at the big picture. By staying non-granular, we noted the *decrease* in completed suicides and psychological disorders, and the *consistent levels* of anxiety, depression, and life satisfaction (Gallup World Poll) that match those of recent years.

Why are we seeing so much resilience, overall? Some articles point to the power of our "psychological immune system" that is activated at times of crisis. This system works to engage resilience so we can move past collective traumas with social support and bonding. We can also imagine that the increased exposure to, and use of, telehealth in the U.S. has helped many who were suffering. Did the social safety net of stimulus checks, enhanced unemployment benefits, and funding for mental health services help tip the scales? Perhaps there is a collective strength that we have been able to engage in the face of a common enemy.

What should we be concerned about if people worldwide are capable of such resilience? Well… there is a particular segment of the population that *isn't* doing so well, a fact that has been referred to as "different slopes for different folks." These folks are disproportionately people of color, particularly Black and Latinx, families with financial hardship, as well as people with pre-existing, often untreated, mental health difficulties.

We cannot be comforted by data showing a 5.6% decrease in national suicide rates from 2019 to 2020 when we learn that the suicide rate *doubled* for Black people in Maryland during the same period. We cannot be reassured by the increased use of telehealth when so many marginalized communities do not have access to the Internet or a way to find privacy in overcrowded homes if they could access teletherapy. Some 27.6 million households, or nearly 1 in 4 in the U.S., do not have high speed Internet. That is equivalent to the number of homes in 13 states combined.

When Covid becomes endemic, infection rates, hospitalizations, and deaths will continue to be correlated with poverty.

After zooming in on mental health trends based on race and economic class, we homed in on age demographics. They also reveal a disturbing picture—that young people are suffering at a much higher rate than the rest of the population. The CDC reports that the "completion of suicides" increased among people aged 10 to 34 in the past year. More specifically, rates for males in age groups 10 to 14 and 25 to 34 increased by 13% and 5%, respectively, which are statistically significant increases. Young people between 18 and 24 also represent 56% of adults reporting anxiety and/or depressive disorders during Covid, even though they only make up 10% of the overall population.

We might have imagined that younger people would be more resilient, yet research reveals that, as people age, they are less apt to have exacerbated levels of anxiety or depression during Covid. Why is this?

Lenore Terr, a psychiatrist and author who is known for her research on childhood trauma, differentiated between Type 1 trauma, the result

of a single, sudden blow, and Type 2 trauma, which develops from long standing or repeated exposure to extreme external events. In Type 2 trauma, "the first such event, of course, creates surprise. But the subsequent unfolding of horrors creates a sense of anticipation. Massive attempts to protect the psyche and to preserve the self are put into gear." (Terr, 1991).

If, during the pandemic, so many people worldwide have survived Type 2 trauma, why have younger people been impacted more adversely than others?

Let's consider the fact that anxiety and depression rates amongst children, teens, and young adults have been steadily rising since about 2005. Any number of factors could be contributing to this increase, including the fallout from 9/11, economic recessions, increased political partisanship, a bleak job market, and a massive increase in screen time and social media consumption. These factors could all be contributing to an increased PTSD response to world events.

Worse still, our vision of the nation's future no longer aligns with our concept of America's past. Environments that were once safety zones are now considered dangerous. In our schools, for example, we are instituting active shooter drills because of the prevalence of gun violence. With every drill, students are reminded that the children next to them could be dangerous. How does that affect their neuropsychology?

Our bodies are wired to respond to danger by protecting ourselves as the fight or flight response is activated. Levels of adrenaline and cortisol spike as part of the protective system. However, long term release of these hormones becomes a problem. Our bodies suffer when we are consistently on alert or numb.

As clinicians, we work with our clients to hold space for what has occurred—for the traumatic experiences from the past—and to create hope about moving through these experiences and their aftermath. We do this work knowing there are minefields of triggers which can create a "backwards domino effect" of suffering. This will often activate the symptoms of the trauma.

Terr includes the idea of a "prolonged and sickening anticipation" as an aspect of Type 2 trauma. This made us wonder about another type of

> "Why have young people been impacted more adversely than others? … The authors are introducing an idea, *"futurized stress,"* an overwhelming dread of the future."

PHOTO THIS PAGE: BARRY WEATHERALL

stressor affecting the lives of younger people: *The Future, a "forward domino effect."* For those that acknowledge climate change, every thought of the future is fraught with disaster and the unknown. We can liken this to the trauma of anticipated loss. For young people, the planet is like a parent with cancer or Alzheimer's, and they, the children, await their inevitable devolution and demise. Almost 80% of Americans aged 18 to 29 say they are "worried a great deal" about climate change compared to an average of 60% in the older age brackets combined. Theorist Timothy Morton writes about global warming as a radical trauma, "*the* ecological trauma of our age," so large and all-encompassing that every human on this planet is touched by it.

As described by Lenore Terr and Judith Herman, another prominent trauma researcher, those who experience Type 2/Strain trauma have a "dim sense of the future." They imagine they will suffer, continuously experiencing negative effects such as fear, distress, and boredom, and most likely will die early. Their vision of the future is bleak. It is different from the vision of those of us who had the opportunity to look at the future wide-eyed and with hope.

As clinicians, we need to understand how to formulate this experience and how to address this phenomenon. The authors of this article are introducing an additional idea, *"futurized stress,"* an overwhelming dread of the future.

What outcomes can we expect from this futurized stress and strain trauma? We have some clear answers to that in the Adverse Childhood Experiences research. This straightforward survey has questions that relate to abuse, poverty, parental suicide, domestic violence, parental alcoholism and mental illness, divorce, and issues of neglect. The researchers

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Covid-19 and Clinical Social Work Practice

By Jay E. Korman, MSW, LCSW-R, BC-TMH, *Practice Management Chair*

The Covid-19 pandemic created widespread changes in our practice, both for ourselves as clinicians and our patients. The most obvious immediate change was the sudden shift from a combination of in-person and online practice to totally or almost totally online practice.

This shift occurred without much preparation in providing online service, also known as telehealth, for many clinicians and patients alike. Some patients were unable or unwilling to make the change to telehealth and either dropped out of treatment or sought treatment with other providers who were still providing in-person service. Some clinicians, who were having difficulty navigating the ins and outs of telehealth, put their practices on hiatus or decided to retire. This shift to telehealth was fueled by attempts to mitigate the spread of the disease, especially here in New York where the effects were devastating on the population and the healthcare system.

Adding to the practice difficulties were the migrations by our patients either caused by their deciding to work from home, fleeing the city to avoid contagion or, in the case of college students, being sent home to continue their education remotely. The issue of whether we could continue to treat our patients who had now crossed state lines became an ongoing question and a source of great confusion. Some states enacted emergency measures that allowed telehealth, specifically for mental health, while others did not. These rules were in place for continuation with current patients only, but some clinicians thought to use this as a way to expand their practices without getting a full license in another state. This created a situation where clinicians were able to get temporary or emergency licenses in some states to which their patients had fled and not others. Clinicians worried about the cost to their practice of patients fleeing the state and being unable to legally continue to provide treatment to these patients. Lack of clarity and seemingly constantly changing rules created and continues to create questions and anxiety among clinicians. Resources became available for information sharing but some clinicians, not comfortable with online practice or use of the Internet, were unable to access these sources.

Waivers of Co-pays

On top of that, both Medicare and the State of New York mandated a waiver of co-pays for treatment, but this was also not as straightforward as it seemed. Whether or not the co-pay was waived depended on what type of plan the patient had, including where the contract was delivered (meaning where the carrier was located, not the patient or employer) and was independent of who the insurance carrier was. Two patients with the same carrier could have a co-pay waived in one case and not in another. The difference between self-funded, ERISA, and other plan types, which previously had been of little importance to providers, now became essential information.

Many clinicians only found out that the co-pay was not waived when they saw the deposits in their accounts or read the EOBs. Because many clinicians were submitting their billing on a monthly or even longer basis, they were having to either refund their patients or request that their patients pay a co-pay when they thought there would be none. Again, this increased anxiety on the part of clinicians who did not know what they were supposed to charge their patients and how to ask for the co-pay when the patients thought that there was not supposed to be one. To add to the confusion about whether or not co-pays were waived, then-Governor Andrew Cuomo only extended the emergency declarations for one month at a time, so the Department of Financial Services was notifying the insurance carriers and clinicians at the last minute whether or not the waiver was extended.

In addition to the cost-sharing waivers from Medicare and the State of New York was the waiver by the Office of Civil Rights (OCR) of HIPAA requirements for telehealth sessions. Medicare and others had previously not paid for sessions conducted via telephone and insisted that all telehealth be conducted via HIPAA-compatible platforms, meaning that FaceTime, Skype, and other non-secure platforms were not included. But now, because of the emergency, they were okay to use as long as the emergency orders were in place. This waiver included lifting the location requirements Medicare imposed on telehealth. Patients could now participate in sessions from their residences, whereas previously that was only allowed in very limited circumstances.

Telehealth's Legal & Ethical Issues

Trainings for telehealth suddenly became a large issue. Many clinicians thought that telehealth was just the same thing they had been doing all along, except that now they were doing it through a computer with a microphone and a camera. They didn't recognize that there were legal and ethical issues that were created by this new form of practice—issues such as knowing what resources were available in the patient's new community how to access emergency services in the patient's location; questions of suitability of the patient (and the clinician) as candidates for telehealth; and whether or not both the clinician and patient had adequate equipment to participate in telehealth. These items were covered in trainings, but not necessarily paid attention to by people who did not participate in telehealth training. The disparity between two classes of clinicians (and patients), those who were tech literate and those who were not, became glaringly obvious and sometimes problematic.

> "As always, clinical social workers are adapting to the needs of the time and learning this new, not quite post-pandemic world. We will continue to change and adapt to meet the needs of our patients and society."

Over time, both patients and clinicians alike became comfortable with working remotely and some clinicians gave up their offices. This raised new questions and new problems, as some insurance carriers require that the clinician have a physical address, rather than a P.O. Box, where they can meet with patients. As patients are becoming more comfortable with not having to travel for treatment, the eventual shift back to in-person treatment is becoming more difficult. Both patients and clinicians have sometimes changed schedules because of working from home and now are having to shift schedules around as clinicians begin to return to the office. In some cases, patients are reluctant to return to in-person treatment, preferring the convenience of treatment from their couches rather than ours. A new task for clinicians has become explaining the difference and the benefits of in-person treatment as opposed to remote treatment. In some cases, patients are unable to return to the office because of their relocation. Clinicians are now having to consider a hybrid practice, working with some patients in person and others remotely.

Questions are raised by the diminution of the urgency around the pandemic and the lapsing of the emergency orders.

- Will Medicare continue to allow telehealth with patients in their homes or will the location restrictions be reinstated?
- Will insurance companies continue to pay for telehealth now that the emergency is (allegedly) over? New York has a telehealth rule about parity but not about mandatory payment for telehealth.
- Will states continue to allow interstate practice? There is a multistate compact being developed, but it seems unlikely at the moment that New York will participate, meaning that clinicians would have to be fully licensed to continue practice with patients in another state.
- Will we continue to be allowed to use non-HIPAA compatible platforms for telehealth (doubtful)?
- Will we be allowed to use means other than synchronous audio/video communication?

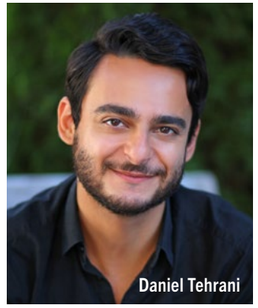
All of these questions remain to be answered as we settle into a "new normal" that is anything but.

As always, clinical social workers are adapting to the needs of the time and learning this new, not quite post-pandemic world. We will continue to change and adapt to meet the needs of our patients and society.

Pride in Private:

Working with the LGBTQ Community During the Covid-19 Pandemic

By Daniel Tehrani, LMSW, MFA


Daniel Tehrani

As a queer psychotherapist working primarily with clients who also identify as LGBTQ, I found that providing therapy through the Covid-19 pandemic revealed so much about the population I serve and belong to. I witnessed our strengths as a community—resilience, creativity, and our capacity to form strong bonds we often call "chosen families"—but also the obstacles we are singularly vulnerable to. Looking back more than a year later, it is clear to me that nothing was more impactful and damaging than the loss of queer spaces during the pandemic.

Covid-19 made socializing no longer safe. And yet socializing is the very thing that makes the queer community possible. While others may identify with one another based on heritage or shared beliefs, queer people are not born into their communities. We must seek each other out—that often means at gathering places like bars and clubs. The only means that many of us have of meeting or being around one another had been shut down during the pandemic, leaving us without any real hope they would reopen. The loss of the ability to go down to a local pub to grab a drink and meet some friends may have been difficult for others, but within the queer community this loss was far more profound.

These spaces offer the opportunity to shrug off the hypervigilance each of us carries throughout the day and to be as we are without fear of judgment, a rare chance to model authenticity to each other. Their importance has been well documented—indeed, the gay liberation movement began in a bar, with a riot at the Stonewall Inn, which still stands proudly in the West Village. Beyond the closing of our watering holes and dance halls, a huge loss for the community was that other gathering places—schools, houses of worship, even offices—places for simply being around others, had also been stripped from us. It may not seem as though these places could provide refuge for queer people, but the way they disappeared from our lives for several months revealed to me just how important they actually were. Clients who had seen community, indeed *other people*, as a refuge from stigma, marginalization, and mental health issues were left to face them mostly on their own.

A client who was seeing me primarily for intense conflict in his relationship was an active member of his local church. He took so much from each Sunday service, but he was now unable to connect with his friends in the congregation. Being forced to remain at home, without a break from his relationship, further worsened the divide between him and his partner. The strain this produced and the isolation he felt manifested in intense panic attacks and a deep depression.

Another client, who had been struggling with substance use, was now working alone from home. Without coworkers and a designated office space, he found it harder and harder to resist the urge to drink. The loneliness he felt without the ability to connect with his friends and family only increased his urge to drink away the pain of this uncontrollable feeling.

I saw the greatest negative impact on another client of mine, a college student who had just begun his transition. He had enrolled in school with the name he now uses and the gender he identifies with. His teachers and classmates called him by this name, and he was known to all as the man he is—not in any other way. With every interaction, his identity was validated.

But the pandemic brought all of that to a screeching halt. Instead of being surrounded by an affirming community of classmates and educators, he was trapped at home, attending Zoom classes in an apartment he shared with his mother. She did not fully accept his identity, misgendered him constantly, and called him by his dead-name, leaving him exposed to crippling gender dysphoria. My client was suddenly stuck, living at the mercy of his mother, in a home where he did not feel supported.

In fact, the pandemic forced my clients, and me, to reckon with the complicated nature of home. For our straight and cis peers, home is often a refuge in and of itself. To be displaced from one's home, kicked out or abandoned, is considered an anomaly and a crisis. But for queer people, the potential for disownment is more than commonplace—it is a fear nearly every one of us faces while coming out. According to a study conducted by Chapin Hall at the University of Chicago, "LGBTQ young people are 120% more likely to experience homelessness than non-LGBTQ youth."

Queer spaces exist because, for so many of us, home is not safe. My clients were able to be themselves, to be around others who validated their identities, when they left their homes. I know now, more than ever, that schools, houses of worship, offices, community centers, in fact any places to get together can be queer safe spaces.

What ties together the three clinical cases presented here is how each of my clients' identities were strengthened and supported outside the home. The first client was a leading member of the congregation at his church; the second, a valued professional at an international luxury brand; and the third, a student who was able to fit in on his own terms without being questioned about his identity. But forced to remain at home, without others to reflect their secure—and valued—identities, each of them regressed into a deep depression.

Staying at home is one thing for queer people, but being isolated is another, entirely. Loneliness, I have found, is a deeply triggering emotion for us all, but especially for LGBTQ people. This, I believe, comes from the fears so many of us have upon discovering ourselves: *Will anyone accept me?* And, *Is there anyone else like me?* I have come to see that the safe and validating places outside the home are protective factors that have kept many community members going. But the pandemic—like an unexpected tidal wave—washed them away.

> "As a clinician, I was faced with what felt like an insurmountable task. How could I support my clients when the places and people that held them up and held them together were no longer accessible to them?"

As a clinician, I was faced with what felt like an insurmountable task. How could I support my clients when the places and people that held them up and held them together were no longer accessible to them? The inspiration for managing this dilemma came from an unexpected place.

In June 2020, a client I had been seeing for several years asked me to join a virtual Pride event he would be hosting over Zoom. The invitation stirred up so many complicated feelings and questions for me. The main one was the boundary issue—would it be ethical for me to attend? And second, what did inviting me to a Zoom Pride party mean for my client, and how he felt about me and our work together? I asked him both questions.

He assured me that attendees at the Zoom event would not be visible to others; only the presenters, DJs, and drag queens who were hosting would be seen on screen and all others would remain anonymous. That sorted out the HIPAA compliance issue, but what about the second ones?

My client smiled at me with deep compassion. He said that he could imagine that I might be feeling like he did about the loss of connection; that I, too, might be missing queer spaces. His invitation would offer me the opportunity to be in one safely.

His response moved me greatly because he was right—I had missed them, so much.

At the time, I was working from home in a small Clinton Hill studio, hunched over the laptop propped up on my kitchen table. It was a difficult time, and I spent so much of it alone, with few other places to go but the grocery store. I was lucky to have friends who formed a small Covid bubble with me, and a supervision group that held me up throughout the difficult work we were all doing. But, like my clients, I longed for my old life—I missed going to the office, picking up coffee on the way. The idea of meeting friends at a restaurant afterwards, or dancing with them on the weekends, felt like a distant dream.

Our clients know us well. The client who invited me to the Pride event could see that—like him—I was missing queer spaces. I was lucky, my home was safe, but it was empty without the music and laughter of my loved ones. I was lonely. Selfishly, the opportunity to enjoy a safe, virtual Pride felt like something I could not pass up. When my client expressed that it would mean so much to him for me to attend, I knew I had to.

So, there I was, at a Pride unlike any other, hunched over my kitchen table, my laptop lit up with the

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swirling movements of a dancing drag queen. My home, which had been empty and quiet for so long, was now vibrating with electronic music. The DJ was playing euro-trance, the kind of music commonly found on a Japanese video game series that was popular in the late 90s and early 2000s—*Dance Dance Revolution*, or DDR for short.

I'm sure the attendees, many of whom, like me, were children during the height of DDR's popularity, felt a nostalgic tug as we listened to the thumping beat and sugary vocals. It struck me then how apt it was to choose this music style. DDR is a rhythm-based game in which you step in time with the beat of the music on screen. It was meant to emulate the feel of a nightclub, and whether you played it at the local arcade or at home, the game transported you to a discotheque.

I thought of myself as a kid, stomping to the techno music in my basement, alone—not yet out and so confused—hoping someday to be dancing with people like me, people who were queer. Though I had no assurance or guarantee that this could ever happen for me, I had hope. And it did happen. After college, I made my way to New York, I found my chosen family, and we danced together. I look back at that resilient kid with a little bit of awe.

Pride 2019 celebrated the 50th anniversary of the Stonewall Riots. World Pride was hosted in New York, and I spent it surrounded by my friends, my loved ones, and our community. For Pride 2020, I was alone—but thanks to the compassion and empathy of my own client—I wasn't really alone at all. I was together with all those whose faces I couldn't see on the Zoom screen, united with all the other queers at home bobbing their shoulders to the techno beat. I could imagine that so many were feeling the same way I did, nostalgic for a video game we once loved, and hoping against all odds for the opportunity to dance together again.

This was a profound experience, and from it I learned that I could make the Zoom screen itself a queer safe space, just as my client's virtual Pride event had. I realized that there was so much I could do to transform the experience of psychotherapy into a queer space. To me, that meant affirming gender identity and sexuality, expressing to my clients that they are not alone in their suffering, and instilling hope for the future.

I tried my best to double down on affirming my clients' gender identities and sexualities. That meant making space for them to grieve the pain of being misgendered, but also holding space to confirm that my trans and non-binary clients are indeed who they are, regardless of other people's feelings about them. While it is important to see our identities mirrored by others, we must be the ones to identify who we are, for we are the ones who ultimately know who we truly are, and no one can decide that for us.

I also tried saying to my clients, in whatever way I could, *You are not alone.* I would do that by using mindful disclosure, sharing if I connected with a feeling they had shared, sometimes even saying, *You are not alone* flat out. When they expressed their fears about the virus, their feelings of loneliness and isolation, often I would only nod my head and say, *I feel the same way.* Because I did! We all did. Covid-19 was a great equalizer; it felt vital during the pandemic to remind my clients (and myself) that we were all in the same boat.

A mentor of mine once told me that a primary goal for every therapist must be to instill hope in our clients, and that is what I tried my best to do. Taking a strengths-based perspective to evoke their resilience, I would ask, *What was the toughest time you've been through?* or *What was coming out like?* They would say that it was hard, but somehow they had survived, and their lives improved. Not quite perfect, but indeed their lives got better. They got to live as queer people, with others like them.

And so, I would say, perhaps inspired by my own nearly-blind hope as a kid dancing to DDR, *Did you ever think the way you live now could be possible?* For so many queer, trans, and non-binary clients—the answer was often no—that they once believed they would never have their gender identity validated or their sexuality accepted by a whole community who shared their ideals and experiences. And yet, their lives were evidence that their hopes—against all odds—could come true. So, I would say, *And you will get through this difficult time, too.*

I had my doubts, as everyone did, but I had hope that we would return to our old ways of living, to our classrooms, our offices, and dancefloors. The community of that virtual Pride in 2020 helped me connect with that hope. I tried to share that gift with each of my clients, that we as a community would dance together again. And we did. In June 2021, with the vaccination readily available, in-person Pride events returned. I danced with a new appreciation for the music, for the friends beside me, and for the community I belong to. Because of that Pride, I had spent the year before by myself—but not alone.

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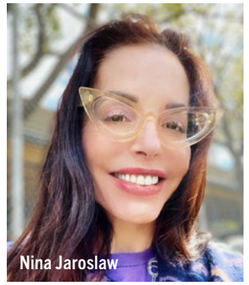
Reflections on Hatred in a Time of Contagion

By Nina Jaroslaw

Ava DuVernay's *13th* presents a litany of historical and contemporary horrors, a tsunami of graphic evidence; a mountain of wrongfully, maliciously, brutally convicted bodies. But, the film makes plain, precedent to and distillate of all of these is the tenacious, hideously robust, infinitely adaptable power of racial anxiety, and the racist hatred it actuates.


Nina Jaroslaw

Nina Jaroslaw is a current MSW candidate at Columbia School of Social Work, graduating in 2022. She is the NYSSCSW Student Representative to the school. In 2020, she received a NYSSCSW Diana List Cullen Writing Scholarship Award. Nina has been an interior designer, an actor, a playwright, and an editor. She holds a B.A. in American Studies/Theater Studies from Yale and studied interior design and architecture at Parsons.

As DuVernay traces, step by insidious step, the trajectory of the pernicious tropes by which Blackness came to be defined in the United States—in the service of a burgeoning, capitalist economy entirely dependent for its extraordinary growth on the ceaseless availability of kidnapped, enslaved Africans and their descendants—it is perhaps not the grotesque, malevolent nature of these tropes that is most astonishing. Rather, it is the robust, boundlessly flexible nature of the fear and anxiety engendering the tropes, and sustaining them to this day, which sears the deepest.

DuVernay, describing the nature of inherited beliefs and inferences in an interview with Juleyka Lantigua-Williams for *The Atlantic* (2016), said, "The idea you have in your head was not built by you per se, but built by preconceived notions that were passed down generation after generation. The very ideas that we hold in our head are for someone's profit and political gain (para. 7)." Here, she articulates the essence of culturally inherited dynamics of power and powerlessness—they *must* persist, they *have to* be transmitted in order that the very economic and political systems, which oppress and crush the many, can continue to benefit the few.

Of course, all cultural tropes, both constructive and destructive, are in some essential sense conservative, in that their intention is to conserve, to preserve, what has already, what has "always," been. Too, the fraudulent presumption that cultural traditions are so indubitable and fundamental that they simply exist as truths, detached from time and intention, belies their essential mechanistic utility. "Traditions" are fabricated of necessity, by people, in the interest of preserving order, power and control; their resonance is contingent on the degree of our susceptibility to their seduction. And when, in order to preserve that control, it is necessary to inflict harm on others, it becomes imperative to fabricate "truths," to invent ostensibly ancient "traditions," through which those "others" are rendered as "less," as "sub," as defective and deserving of abasement.

Thus, calculatedly fictive inventions are rapidly converted by the pull of self-interest into timeless, indisputable truths, and a cultural narrative of dehumanization is retrofitted, latched to other foundational principles like a barnacle. In describing the nature of prejudice and discrimination, Pierre-Andre Taguieff (2001) notes that a truth, "is inseparable from the strategies of dissimulation that allow it to bypass obstacles and thwart the traps of its adversaries" (p.245), and it is through such dissimulation—through the grinding down of the elements of racist tropes into a powder fine enough to become both invisible and ubiquitous—that the perennial, invidious racism painfully threaded through *13th* derives its enduring power.

In his analysis of cultural transmission and adaptation, Luca Cavalli-Sforza (1988) formulates four discrete mechanisms of cultural transference, and suggests that the more imperative and foundational the cultural concepts, the more they are shared *epidemically*, in a phenomenon

CONTINUED ON PAGE 30

he calls *horizontal transmission*, through which "a trait is spread by contact between an infectious individual and an uninfected one" (p. 243). He goes on to explain that in "the cultural parallel, innovation replaces infectious disease, and transmission of innovation that of infection." In the white transmission of the dehumanization of Black bodies, the utilitarian "innovation" was the adherence to a fraction—3/5ths—by which those bodies were forever rendered sub-human, violable, sinister and grotesque (Simba, 2014).

The infection grows more tenacious over time, perpetually morphing to accommodate new incursions. "If all individuals of the younger generation," Cavalli-Sforza goes on, "receive the same multiple treatment by everyone from the older generations, it is most likely that they will develop into a very uniform new generation, very similar to the old one. If there was some variation among individuals it would tend to disappear with time. The outcome is high uniformity; high conservation" (p.245).

It is painfully ironic that a critical strategy in the spread of racist contagion is the conversion of victims into perpetrators—into menacing vectors of defilement and impurity. Through this twisted calculus, victims are rendered agents of contamination. "There is a link," as Susan Sontag wrote in *AIDS and its Metaphors*, "between imagining disease and imagining foreignness" (1989, p. 89); the genius of the myth of infected Black bodies is to render those bodies irrevocably other, essentially unwelcome and worthy of expulsion. And it is this very rendering from whence, DuVernay makes clear, is derived justification for sequestering those bodies by the millions into cages, out of sight—their agency, their dignity, their selfhood obliterated. Thus, the "protocol" endorsed for the "contagion" of Blackness replicates the protocol for Covid-19—isolation, quarantine and, in particularly intractable cases, solitary confinement. "Any important disease," Sontag wrote, "…tends to be awash in significance. First, the subjects of deepest dread (corruption, decay, pollution, anomie, weakness) are identified with the disease. The disease itself becomes a metaphor (p.96)." The Black subject—

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or the 3/5ths measure of subjectivity conceded to it—becomes object; the body becomes fetish.

As we have grappled for over 18 months with Covid-19, a pandemic, a physiological sickness that can, with barbarous efficiency, paralyze the pulmonary system and restrict lung function to the point of asphyxiation, we white people have had laid bare before us a concomitant pestilence—the systematic dehumanization/oppression not only of Black people/bodies but of a more abstracted "Blackness" itself. The redoubling of "I can't breathe," George Floyd's excruciating plea, with the pulmonary paralysis engendered by Covid-19 is an irony almost too brutal to bear. But unlike the gasping Covid victim, whose breath is restored through fervid mechanical and pharmaceutical intervention, the gasping Black body is worse than ignored. The gasping Black body is disdained, debased, displayed like a totemic admonition. In that display, that body, denied its very sentience, is rendered a thing, to be shunned and simultaneously ogled as a potent mechanism of indoctrination. And here we must ask—to what extent, despite acknowledging the remarkable, activating power with which our ubiquitous phone cameras have imbued us in 2021, do those very images simultaneously function to activate for white people the same powder-fine, atmospheric racist tropes of debasement, dehumanization, objectification, and power as once did picture postcards of lynchings? In the white unconscious, does the act of witnessing such a violation both awaken us (again) to the horror of a profound injustice perpetrated against a Black subject/person whose humanity we are obligated to uphold, yet simultaneously confirm for us (again) the fundamentally abject, criminal nature of a Black object/beast whose sub-humanity we are obligated to extinguish?

The best protections against the contagion of Covid-19, we are told, are a vaccination and a mask. The Covid mask promises safety, yet it also signals compliance, cooperation, the recognition of the need to privilege the collective good over the convenient. In contrast, the eradication of our racist contagion will be achieved not by masking, but by unmasking. In *Black Skin, White Masks*, Frantz Fanon described a Black people compelled to wear multiple, figurative masks perpetually, both as protection against the gaze of the oppressor, and to signal another sort of compliance—one essential for literal self-preservation in the face of the presumption of threatening, criminal intent (Fanon, 1968). But, until the white loathing, oppression, and violence to which this unmasking would categorically subject Black people is obliterated; until white people have engaged in a fundamental, visceral reimagining of the nature of true equity and justice for all; until, as DuVernay insists is necessary, you "Rethink everything that you think, challenge yourself. Do you think that? Or do you think what someone wants me to think of that?" (Lantigua-Williams, 2016, para 4); until we acknowledge that "stamping out" racism is insufficient, that we must *excavate* it out from *beneath* the surface/visible, rip through centuries of boulders and bones and pry it out by its impacted roots—until we commit to this work, there will be no unmasking; no answer, no antidote to the corrosive, murderous power of racial anxiety and murderous racist hatred.

> "The Covid mask promises safety, yet it also signals compliance, cooperation, the recognition of the need to privilege the collective good over the convenient. In contrast, the eradication of our racist contagion will be achieved not by masking, but by unmasking."

Despite the enormous resources funneled into Covid-19 prevention and containment, the Covid Prison Project reports that, as of October 21, 2021, 431,850 incarcerated people in the United States have tested positive for Covid-19, and many thousands have died (CPP, 2021). Five of the largest viral clusters in the United States have been in prisons, yet the incarcerated suffer without soap, masks, gloves, fresh air, disinfectant or medical attention (Williams et al., 2020). Doubly victimized, imprisoned Black people suffer the scourge of two pandemics. We devote ourselves assiduously to the eradication of this novel coronavirus, yet fail to commit to the eradication of a disease decidedly anything but novel; a murderous disease we have perpetuated since 1619. Glen E. Martin warned in *13th*, "Systems of oppression… [are] durable. They tend to reinvent themselves, and they do it right under your nose." But as durable as they are, they are not invincible. They are created by people, and they can be relinquished by them. The question is whether white people, having waved our Black Lives Matter signs and sent our checks to the NAACP, are willing to embark on the project of collective reckoning necessary for the undoing of the racist pandemic, the untangling of its viral tropes, the unmasking of the oppressed.

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The Mental Health Consequences of the Covid-19 Pandemic

By Ashley Leeds, LCSW


Ashley Leeds

The mental health consequences of Covid-19 for my patients have been amorphous and heartbreaking. This era has been one of missed milestones, overtaxed partnerships, and worn-down parents. It is ushering in the next phase, one that is riddled with anxiety as to whether it could happen again, and reassessing values of what is important. As we watched the news of death counts and new cases and variants, latent emotional suffering surfaced in unanticipated ways. For some, these consequences have taken shape in old habits: increased drinking, agoraphobia, and obsessive behaviors. For others, new feelings of hopelessness and despair settled in and have yet to pass.

I see patients from childhood to middle age, and not a single person feels that they have "recovered" from the Covid crisis or reconnected with a pre-pandemic self. My younger patients are riddled with anxiety when it comes to socializing in person: *What is okay?* they ask. *Am I being too awkward?* In-person experiences feel foreign to them and hanging out on FaceTime is preferred. These are seismic shifts whose long-term effects have yet to be seen. Tactile experience is an important way for young people find who they are and how they fit in the world, and experience that has been largely thwarted.

One patient and his long-term partner decided to part ways as the months of lockdown shed light on cracks in their relationship that had been avoided and overlooked. Their social life and love of travel had sustained them, but once those outlets were removed, it became harder and harder for them to connect. Another patient became incredibly depressed; months of self-reflection had uncovered a conflict of gender identity, one they felt was unacceptable so late in life. Dressing in their preferred gender clothing in private became their only outlet.

We can perhaps look at mental health during the pandemic through two separate lenses; one, as the opportunity for self-discovery, and the other, as a time to acknowledge that all of our buffers, our safeguards, our joys, balance us out, and without them, suffering ensues. As we explore what has become of our individual and collective mental health, it cannot be overlooked that our ability to support our patients was limited. We therapists were worried about our own health and the health of those we care about. We adapted to telehealth, whether we wanted to or not. But for those patients who desired to be seen, we could only provide a partial view.

In the early months of the pandemic, I had a patient who was dangerously gripped in her eating disorder. She lied her way through an outpatient treatment because her groups were remote, and she was strategic when photographing her daily weigh-ins from her own bathroom scale. When it came time to go inpatient, she feigned a Covid diagnosis and was not able to go.

It seems that, at this moment in time, we are straddling the gap between quarantining and the reopening of the world, and my patients are fearful: *Will we be forced to go back inside? Will the current trajectory into the "new normal" continue?* Those who have transitioned back to in-person work fear the return of the Zoom session. Moreover, they anxiously await possible new departures from routines that have fostered comfort and predictability. As with all ambivalence, the longer it lasts, the more anxiety it breeds—the long-lasting relic of the pandemic.

Ashley Leeds, LCSW is a psychotherapist training analyst at the National Institute for the Psychotherapies in New York City. She has a special interest in adolescent and young adult psychotherapy and psychoanalysis. Ashley has published articles on stress management and life in New York during COVID. She maintains a private practice in Brooklyn, NY.
ashley@leedspsychotherapy.com

Closing a Practice–

One Mental Health Consequence of Covid-19

By Rosa Smith, LCSW

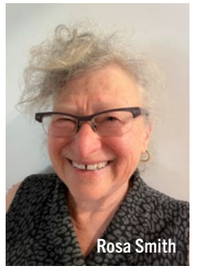
I received a text message from a former client recently asking for an appointment. My reaction was mixed. I was happy to hear from her, as we had several prior series of clinical encounters over the years, and she had been one of my favorite young clients—interesting and highly motivated. But I had a moment of dread and feelings of loss at the prospect of telling her I that I have fully retired, my office and practice are permanently closed, and consequently, we will not be meeting again. Her last sessions had been completed and we had said our previous goodbyes well before the March 2020 start of the pandemic, I with my usual, *Don't hesitate to call again if anything comes up.* Well, she called again.

It is no secret that the pandemic has precipitated re-evaluation in peoples' lives and instigated many unanticipated moves, job changes, relationship re-evaluations, etc. In August, over three million people quit their jobs, a new record, apparently. It is not known how many people landed new jobs. Drug overdoses, addictions, and suicides have skyrocketed. Homicides in New York City and many other municipalities have increased. Many issues—defunding the police, Black Lives Matter, Native American empowerment, immigration—have added to our concerns during the pandemic. The biggest impact may be on children whose education was disrupted by remote learning instead of being in school. All these factors have increased the number of people of all ages who would benefit from or require mental health treatment provided by skilled clinicians within organizations and in private practice.

Many newly graduated MSWs are eager to become private practitioners just as soon as they are fully accredited. I suspect, although I don't have any statistics to back this statement up, that one of the mental health consequences of Covid-19 has been the closing of private practices. I struggled with the issue of re-opening my office or not for some time during the initial phases of the pandemic as I transitioned abruptly, like many clinicians, from in-person to remote HIPAA- compliant Doxy.me sessions. Although perhaps not totally HIPAA compliant, even during the so-called State of Emergency, phone sessions, Face Time, and WhatsApp provided adequate platforms as well for non-tech savvy clients who could not manage or did not have access to the right device to access Doxy.me or Zoom.

On the one hand, it seemed selfish of me to think of not re-opening and contemplating terminations with those clients who had bravely weathered the transition to remote work, or even new clients I had never met in person. I was also receiving many inquiries for treatment, and it became harder and harder to repeatedly state that I was not accepting new clients during such a time of great need.

I started to feel annoyed and conflicted about those calls, and finally asked the insurance companies to remove me from their lists; however, prospective clients kept on making inquiries. I resolutely maintained strict part-time hours. By then, the thought of actually opening an office in a physical location provoked considerable anxiety in me, with all of the possible safety precautions which were being bandied about, and the contingencies about seeing people in person. Even after people were getting vaccinated, the uncertainties of having to constantly re-evaluate safety measures and switch between in-person and remote treatment seemed overwhelming. My "part-time, post-agency retirement, remote practice" could easily have grown into full-time, but this definitely did not seem right for me. As I wrestled with my future life plans, goals, and the transitions I was undergoing, I also remembered that the mental health of the therapist—meaning me and countless others, I suppose—is important, too.


Rosa Smith

I did not have a home office and I had, like many others, given up my office lease in fall 2020. I was able to provide remote treatment and found it to be quite effective and helpful for many clients. For me, it was enjoyable and stressful, both.

Questions arose: Will there be a good Internet connection? Am I practicing within the scope of my license? Is this phone call really HIPAA compliant? Is it okay to be providing services to New Yorkers when I myself am physically out of state? The thought of re-opening an office was not a satisfactory or fulfilling solution.

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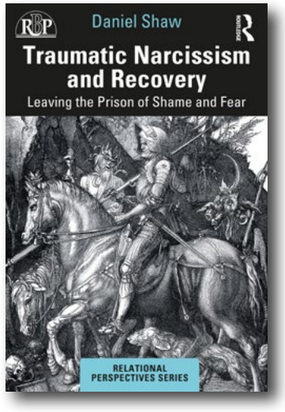
Traumatic Narcissism and Recovery

Leaving the Prison of Shame and Fear

Published July 27, 2021 by Routledge

Book written by **Daniel Shaw, LCSW**
Reviewed by **Debra Kuppersmith, LCSW**



Near the end of this evocative book—a book that takes us into the damaged and dissociated minds of pathological narcissists—there is a chapter on Authoritarianism and the Cultic Dynamic. Written ***before*** Trump was in the middle of denying the threat of Covid-19 and refusing to address what was needed to save lives, before his followers funded rallies demanding the end of quarantines even though daily death rates were skyrocketing, before he suggested drinking bleach, and before the January 6 storming of the Capitol, Dan Shaw wrote the following about malignant narcissism:

The traumatizing narcissist who operates at the level of power that Trump has reached exhibits more and more extreme behaviors as the pressures of living up to their delusion of perfection mount and they inevitably become exposed to scrutiny and criticism…. Terrified and enraged by challenges to their fantasy of omnipotence, malignant narcissists lead their followers on to acts of violence against others or even against themselves.

This book is by no means political or left wing, nor does Shaw suggest that he has a stake in analyzing the pathology of oligarchs and theocrats, much less Trump. But what he does provide his readers with, that is as compelling and poignant as it is terrifying, is the danger of the warped mind of a narcissistic leader—whether that leader be a guru, a president or the leader of a family or cult. Those leaders' minds—minds often consisting of powerful delusional fantasies, manic and paranoid—believing themselves to be superior and perfect, are defending against the shame of traumatic impotence and powerlessness (p. 27) that they are constantly and manically attempting to suppress. Those who follow these leaders or, more to the point, are seduced into submission, lose their contact with truth and reality. The effect of trauma caused by a traumatizing narcissist is deadly, creating an environment of fear and shame so profound and a psychic dependency so strong, that being able to extricate oneself from such a destructive spell requires the courage and perseverance to make bearable a reentry into a separate psychic space. The healing process requires the potential for self-reflection and self-regulation, which, ultimately, results in an expectation of mutual recognition. It is this relational construct, among other aspects of the relational perspective, that Shaw stresses in his ideas regarding recovery. As with any dyadic experience, whether it be parent and child, and particularly in a psychotherapeutic context, a disorganized attachment, an attachment of domination and submission and without reciprocity and mutual recognition, is traumatic.

What has been pivotal in Shaw's involvement in this subject was his own experience of and indoctrination into a cult led by a group leader who, by using shame and fear as a means of control and domination, was able to entice him into a universe of subjugation, in which there was no subjectivity or ability to think autonomously. Essentially, the subject is "inducted into the narcissist delusion" (p 50.) to such an extent that there is complete submission to the guru's power. It is only after leaving the cult that there is enough differentiation so that a beginning of understanding and recovery can occur.

Shaw covers a variety of topics as he helps us understand the emotional worlds of the traumatized victim. He speaks about early neglect, cruel and destructive family dynamics, and complete negation of subjective desires. In order to tolerate such destruction and deprivation, dissociation becomes a major defense in cult leaders as well as followers. What is so painfully ironic is that both groups are ultimately dissociated and traumatized, both seek connections in pseudo relationships, and ultimately, both become connected in a vastly disorganized way.

The book is divided into eight chapters, in which the theme of trauma prevails in diverse ways and the author provides many clinical examples from his extensive work in this area—from people in the throes of a narcissistic leader's persuasive and manipulative recruitment tactics, which result in the disassociated dependency of those submitting to it, to the traumatising narcissistic parent, who denies the isolation and humiliation of her disabled child, resulting in that child's internal demoralized core. In all of these examples of abuse, the painful search for autonomy is the focus.

> "Shaw … helps us understand the emotional worlds of the traumatized victim. He speaks about early neglect, cruel and destructive family dynamics, and complete negation of subjective desires."

In the chapter entitled, "Aggression in Traumatized Patients," for example, the quest to help those in recovery understand how their impotent rage toward their abusers gets mis-directed to others, particularly in the transference, Shaw beautifully describes his work in calming the anxiety and showing compassion. In another chapter, entitled, "Make Someone Happy," Shaw describes his experience of waking from a dream one morning with this Comden and Green show tune in his head. A beautiful lyric in the song is, "Fame if you win it comes and goes in a minute, where's the real stuff in life to cling to? Make someone happy, make just one someone happy, and you will be happy too." His associations are so moving, as he analyzes his own longings for love; and his awareness that his patient is struggling to understand that, in order to love someone, you must first have an internal model of healthy love, reciprocity and mutual respect.

> "Shaw describes … waking from a dream with [a song] in his head: *Make someone happy, make just one someone happy, and you will be happy too.* His associations are so moving as he analyzes his own longings for love … and [what] his patient is struggling to understand…"

Shaw pays homage to clinicians he deeply admires. Winnicott's work and commitment to the idea that the early facilitating environment of unconditional love is crucial to becoming a true self seems to have a particular importance to his theoretical constructs. He is also inspired by the work of more contemporary relational psychoanalysts, such as Steven Kuchuck and Jody Davies.

I highly recommend this book for any clinician. Shaw's capacity to communicate the depth of his empathy, the power of his attunement, and the authenticity of his warmth is wonderful and touching. So, as heartbreaking as his stories are—both his own and his patients'—the hope for rebirth and recovery assuages the despair. There is hope and a new day ahead.

Daniel Shaw, LCSW is a psychoanalyst in private practice in New York City and in Nyack; and Faculty and Supervisor at The National Institute for the Psychotherapies in New York. His papers have appeared in *Psychoanalytic Inquiry, Contemporary Psychoanalysis, Psychoanalytic Perspectives* and *Psychoanalytic Dialogues*, and most recently, his book, *Traumatic Narcissism: Relational Systems of Subjugation*, was published by Routledge for the Relational Perspectives Series and nominated for the prestigious Gradiva Award. His book *Traumatic Narcissism and Recovery: Leaving the Prison of Shame and Fear* was published in 2021. In 2018, the International Cultic Studies Association awarded Dan the Margaret Thaler Singer Award for advancing the understanding of coercive persuasion and undue influence.

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

HEADQUARTERS UPDATE

TMS had a busy summer updating the website, welcoming new members, posting education programs, and gearing up for renewal season.

We also helped Marsha Wineburgh, DSW, LCSW-R, our longtime Legislative Chair, in preparing a timeline of the Society's history to be added to the M.E Grenander Department of Special Collections and Archives in Albany. Fourteen boxes of the Society's historical materials were sent to the archives! In addition, decades of past issues of *The Clinician* were posted on our website.

Membership renewals were sent out electronically on November 1 and hard copies followed in the mail in December. Please do not hesitate to call the office if you have any questions.

Sadly, TMS lost one of our team members, Concetta Tedesco—Conchettes, as she was known—in July 2021. Hers was the first voice members heard when calling the office about Society matters. Compassionate and kind, she quickly formed close bonds with our members.

She joined TMS in 2018 after moving to New Jersey. A born and bred New Yorker, she loved the city, baseball, food, friends, and of course her devoted family: husband, Mike Brito; son, Serafino; and sister, Lee and her husband, Patty. Diagnosed with pancreatic cancer early in 2020, she continued to work remotely until three months before she died. Conchettes was a dedicated part of the TMS family and is sorely missed.

We wish you all a healthy and happy holiday season.

Kristin

Kristin Kuenzel, *Administrator*
Jennifer Wilkes, *CMP*

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Colorblindness Continued from page 19

view, when he detected that the other passenger, a white woman, clutched her purse closer to her body. He ignored what felt like an affront and proceeded to his office on leaving the elevator. In his summary of the event he added, with a big smile, that before he started his work with me, he likely would have said to the woman, "I bet I have more money in my pocket than you have in your bag." But since engaging in our work, he found himself better able to reflect, and felt it was a strength to curb his anger.

He then reported another incident one evening, when he left work late as the streets in his business district were getting dark. He noticed two white women walking toward him who then changed direction and crossed the street, seemingly to avoid passing near him.

The final affront came as the result of an invitation R received to the home of a white colleague who lived in an affluent suburb. R planned to drive there, but his colleague offered to meet him instead in a nearby town. The co-worker felt this would prevent R from being stopped or harassed when someone, a neighbor or law enforcement, saw him and doubted that a Black man driving through an exclusive white enclave "belonged" there. R declined the co-worker's invitation.

Months later, R reported telling one of his friends at church how grateful he felt for our ongoing work: "I thank God that I was smart enough to start therapy."

In my work with these patients, I received important validation about addressing the differences in the room (or on screen) early in the relationship. Expanding on the question: What is it like to be this person in the world? I added: What is it like to work with me? This resulted in the freedom for both men to express themselves without fear of offending me, a white clinician, or of any reprisal, or of having their experiences labeled paranoid or exaggerated.

Exploring differences is not limited to race or ethnicity; there are many instances in which major differences exist between clinicians and their patients and addressing these directly adds to the richness of the work. Being seen and accepted leads patients to greater openness in reporting feelings and experiences with less concern about the clinician's feelings and reactions. Examples from my work have included differences in age, physical stature and weight, and gender identity. On occasion, I have received some humorous and extreme responses in the patients' projections, none of which required correction, but became part of enriching the work.

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Futurized Stress Continued from page 23

found evidence that trauma can result in the development of illness. Toxic stress interferes with developing healthy neural, immune, and hormonal systems and can alter our DNA expression. Over time, trauma affects the immune system, and we get sick. There are decades of research linking high ACE scores to an increased risk of developing chronic diseases and behavioral challenges, including obesity, autoimmune disease, diabetes, heart disease, poor mental health, alcoholism, and even reduced life expectancy by as much as 20 years. Research also reveals that sustaining early trauma very often leads to increased levels of mental illness later in life, including dissociative identity disorder, adults who are borderline, and an increased likelihood of committing violent crimes and murder.

The powerlessness and fear we have experienced through the pandemic are undoubtedly traumatic for all of us. However, the trends and patterns revealed in this article lead us to wonder how our profession can focus on helping those who are most at risk. We must be thinking about the folks who have already experienced the domains of trauma noted in the ACE survey. According to Terr, Herman, and John Briere, these individuals are most vulnerable. Once bitten, twice shy; the traumas of the past impact the currently experienced stressors. And what about futurized stress? What is the true impact on those with traumatic bookends in their lives, those for whom the historical, current, and future traumas all collide?

Once we have identified the most at-risk members of the population, what kind of treatment can we offer to mitigate the effects of these compounding traumas? Howard Bath explores this in his concept of the three pillars of trauma-informed care, which involves actions to strengthen safety, connections, and managing emotional impulses. In his research he found that the strength of the therapeutic alliance had more lasting effects on patients than the specific trauma treatments offered by the therapist. The attachment theorists had it right when they correlated connection with healing.

Writing this article was eye-opening for us, and we hope reading it offers you the same experience. While Covid-19 caught all of us off-guard, we wonder if it has become a scapegoat and a distraction from the deeper concerns of our time. A picture is just forming of the actual issues we face. Practitioners in our field must do more research to find methods of providing safety for the most vulnerable people, and to understand how we can best treat the combined strain trauma of the global pandemic and futurized stress.

EDITOR'S NOTE: Covid, Vulnerable Populations and Futurized Stress was written months ago for *The Clinician*. The authors describe their disturbing findings in the mental health data that young people are suffering during the pandemic at a much higher rate than the rest of the population. As we went to press, a news story broke that brought national attention to this crisis (excerpted below).

The Pandemic Worsened Young People's Mental Health Crisis

New York Times, Dec. 7, The Surgeon General issued a rare public warning that young people are facing "devastating" mental health effects as a result of the challenges experienced by their generation, including the coronavirus pandemic. Dr. Vivek H. Murthy issued a report noting that the pandemic intensified mental health issues that were already widespread by the spring of 2020. *Read full NYT story:* https://www.nytimes.com/2021/12/07/health/teens-mental-health-murthy.html

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At this point, clinical work was a part-time, semi-retirement endeavor. I am fortunate enough to have a stable retirement income; therefore, the supplemental income or lack thereof would not affect my lifestyle significantly. In addition, it was, and still is, uncertain what the accepted future practice requirements will be. At a different stage of my life, I might have chosen to address all these challenges, just as I had addressed the challenges of initially opening my practice over 15 years ago. But now, I had a grandchild I wanted to spend time with, and some health issues to attend to.

After 50 years in the field, it seemed like the right time to close up shop. I made this decision and informed my clients in March 2021 that my practice would be closing at the end of June 2021. During the termination process, I was actively involved in referring clients to other providers, as needed. It was not always very easy to identify other providers who were accepting new patients.

One of the mental health consequences of the pandemic, it seems, is an urgent need for a new "supply" of skilled, experienced, seasoned, and well-supervised therapists. This might be an ideal time for someone to start and grow a private practice. On the NYSSCSW website, I have noticed many questions about licensing and supervision requirements for the LCSW license. The requirements are not new, but the nuances of the answers may be new to clinicians and potential supervisors as they figure out how to navigate the field. There are restrictions about the legal ways to get the supervision you need if you are a new practitioner. And there are some not-insurmountable barriers to get to the point where your credentials allow you to practice independently. This was addressed at length during the recent, very informative Annual Meeting of this Society.

When I read the text message from my former client, I decided to set up a call with her rather than text a reply. She told me she was doing fairly well and looking to touch base on some issues with one of her children. She was quite gracious and understanding of the fact that my practice was closed and said she would be able to find another therapist in the future if needed. Although, for a moment, I re-experienced the loss of my practice and held back a couple of tears, I was grateful for the opportunity to say goodbye in this way.

In a subsequent message, she informed me that she is going to look for a new therapist. I won't be surprised if I hear about similar plans from other former clients, as there are some who had completed therapy prior to the pandemic, or who chose not to continue remotely when the pandemic started.

I am no longer seeing patients and I no longer have that voice mail message—*Please call 911 if this is a psychiatric emergency.* But my phone number has not changed, so former clients can reach me. The pandemic motivated me to close my practice as I re-evaluated my life, but I think it will motivate and inspire other practitioners to jump-start their careers, knowing that the need is so great.

Rosa Smith, LCSW grew up in Vermont and Massachusetts and attended Smith College, where she received her BA in American Studies in 1969. She received her MSW from Simmons College in 1980 and worked in Boston for several years before moving to New York. She practiced social work for 24 years at Montefiore Medical Center in the Bronx, retiring in 2012 from the Department of Psychiatry. Her private practice was also located in the Bronx. She currently divides her time between Yonkers, NY, and Weathersfield, Vt.

COMMITTEE REPORT | CREATIVITY & NEURO-PSYCHO-EDUCATION

Members were treated to a guided tour of the *Louise Bourgeois: Freud's Daughter* exhibit at the Jewish Museum in Manhattan on July 11. Sandra Indig, Committee Chair, had previewed this exhibit. All who attended found the aesthetic complexity, and the presentation of the artist's journals, poetry, and sculpture by the curator exciting and insightful. A few of the wall plaques quoted observations by Freud alongside those from Bourgeois' perspective. A Zoom presentation and interactive discussion by Indig and Dr. Inna Rozentsvit, Co-Chair, facilitated by Kristin Kuenzel, the Society's Administrator, was given to an enthusiastic audience on July 25. This exhibit was a more than perfect fit between art and the practice of psychoanalysis.

The Committee is looking forward to inviting members to the Whitney Museum's *Jasper Johns: Mind/Mirror* exhibit and suggests that those interested view the Museum's website. 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. Time and date will be scheduled and posted.

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