

The CLINICIAN

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

PRESIDENT'S MESSAGE

October 2014: Annual Progress Report

Presented at the 46th Annual General Membership Meeting

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

The 46th Annual General Membership Meeting of the Society was held on Saturday, October 18, in New York City. The purpose of our annual meetings is to report the State Board's recent activities on the members' behalf, as well as the fiscal health of our organization, and to recognize several colleagues who have made outstanding contributions to our common welfare during the year.

Most important, this year for the first time at an annual meeting, Society members voted in person, adopting the new bylaws with unanimous approval, and electing a slate of new state officers. They are: President-elect: Shannon Boyle, LCSW; Second Vice President: Helen Hinckley Krackow, LCSW, BCD; Secretary: Richard B. Joelson, DSW, LCSW; and Members-at-Large: Beth Pagano, LCSW and Chris Ann Farhood, LCSW.

CONTINUED ON NEXT PAGE

ANNUAL EDUCATION CONFERENCES



**2015 Education Conference
Call for Proposals (Page 3)**

**2014 Education Conference
Keynote Reviews (Page 8)**
*Facing Impasses: Identification
and Working Through*

2014 Keynote Speakers Lawrence Josephs, Ph.D. and Louise DeCosta, Ph.D., LCSW.

IN THIS ISSUE

- 4 New Members
- 7 CSWs as Diagnosticians
Part Two
- 14 Book Reviews
- 15 "Beholder's Share"

Legislative Committee

By Marsha Wineburgh, Chair

Legislative/Regulation Update

Changes in practice regulations continue, including in these areas: continuing education requirements, meditation as not acceptable clinical practice, workers' compensation coverage, and telepractice and coaching.

Acceptable continuing education hours will be required for LMSWs or LCSWs who re-register their licenses after January 2015. Thirty-six (36) units are required for each 3-year period. Those whose registration falls in the first few months of 2015 will need one credit for each month, for example: January 1, 0 hours; February 1, 1 hour; March 1, 2 hours; etc. (Details will be available at www.NYSSCSW.org and www.op.nysed.gov/prof/sw/) Only courses taken with New York State approved providers are acceptable. A list of providers will be posted and updated at NYSED's website. Because this is a new program, approved courses are just being registered by the state. To address the inability to find approved courses, you can ask

CONTINUED ON PAGE 6

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CONTINUED FROM PAGE 1

Each new officer has an impressive record of service to the State Board, contributing time and energy to strengthen our presence in the professional community and beyond. They will take office on January 1, 2015.

Our colleagues, recognized for their contributions this year, included Dore Sheppard, Ph.D., LCSW; Helen T. Hoffman, LCSW; Richard B. Joelson, DSW, LCSW; and, Beth Pagano, LCSW. The hardworking chair of the annual meeting committee, Dore Sheppard, found a wonderful guest speaker for the educational component of the program, Cathy Siebold, DSW, LCSW-R. A noted author, teacher and clinician, she presented after the business portion of the meeting.

Helen Hoffman wears many hats. She oversees the *Friday E-News*, which appears weekly in your email inbox filled with valuable information, including summaries of upcoming educational events offered by all of our chapters, as well as legislative and insurance news. As chair of the Website Committee, Helen masterminded the new "skin" for the home page, and continually revises the content to keep it as timely as possible. The Vendorship Committee, also under Helen's leadership, organized webinars on those pesky PQRS regulations that Medicare requires. One webinar was held in the spring, the other this fall for 40 more members.

Thanks to Richard Joelson's creative and down-to-earth leadership as the state Membership Committee Chair, the Society has grown by 238 new members. We honored him and his committee at a luncheon following the meeting.

The Bylaws Committee is chaired by Beth Pagano, the leader of a small group that systematically reviewed the Society's bylaws for six years. The group includes Past-president Jonathan Morgenstern, M.Ed., MA, LCSW; David Phillips, DSW, LCSW, who is the Ethics Committee Co-chair; and myself. Our work entailed walking the fine line between maintaining the historical simplicity of the 2003 version of the bylaws, while adding changes resulting from the passage of the clinical licensing law. We have had many colorful discussions during numerous conference calls. Our final draft of the new bylaws was reviewed, discussed, revised and approved by the State Executive Committee, and then by the entire Board, before it was sent to the members. Ultimately, the final version was approved at the annual meeting. It should be noted that Beth did a fabulous job of preparing the final document on a recalcitrant computer.

Fiscal Health: I am also pleased to report that the fiscal health of the Clinical Society is excellent. Shannon Boyle, LCSW, our State Treasurer and soon-to-be President-elect, has done an excellent job keeping us within our budget.

It takes many people to keep this organization functioning on your behalf. In addition to Sheila Guston and Kristin Kuenzel, our administrators at TMS, more than 80 colleagues have donated countless hours of critical thinking, planning and

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Ad Deadlines: February 15 and October 1

AD SIZE	MEASUREMENTS	1 TIME	2 TIMES
2/3 Page	4 ¹⁵ / ₁₆ " w x 10" h	\$325	\$295
1/2 Page Vertical	3 ⁵ / ₈ " w x 10" h	\$250	\$225
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1/3 Page (1 Col.)	2 3/8" w x 10" h	\$175	\$160
1/3 Page (Square)	4 ¹⁵ / ₁₆ " w x 4 7/8" h	\$175	\$160
1/4 Page	3 ⁵ / ₈ " w x 4 7/8" h	\$140	\$125
1/6 Page (1/2 Col.)	2 3/8" w x 4 7/8" h	\$95	\$85

Display ads must be camera ready. Classified ads: \$1 /word; min. \$30 prepaid.

Call for Proposals

For Workshops and Panels at the 46th NYSSCSW Annual Educational Conference

CONFERENCE DATE: APRIL 25, 2015

We are looking for presentations and/or panels on fresh, new approaches in clinical practice. These proposals can be from any theoretical perspective, any modality or setting, but individual presentations cannot exceed 20 minutes.

Proposals should be from three to five typewritten pages, double-spaced, and must include:

- A description: purpose, function, and teaching objectives. Include brief clinical illustrations.
- A workshop outline describing concepts to be developed.
- A bibliography.
- On a separate page, your C.V., and all other identifying information. Underline one affiliation that you would like listed on the brochure. Private practice is not considered an affiliation.
- On a separate page, a brief paragraph of about five lines, stating the purpose of the workshop and listing five to six aims and objectives.

DEADLINE FOR SUBMISSION OF PROPOSALS: JANUARY 13, 2015

Please e-mail one set of submissions to: mwineburgh@aol.com

The subject line of your e-mail should read: 46th NYSSCSW Educational Conference

PRESIDENT'S MESSAGE CONTINUED FROM PAGE 2

delivering of benefits such as educational and informational programs. Visit www.nysscsw.org for a complete contact list for the State Board officers and chapter representatives.

Taking the Lead

As some of you may remember, this clinical society was founded 46 years ago by a group of clinical social workers trained at the Postgraduate Center for Mental Health's adult analytic program (Recently defunct, it is not to be confused with the Postgraduate Psychoanalytic Society, which is doing well.) In the 1960s, national NASW decided to expand its membership base by including BSWs, identifying this group as the entry level into the social work profession. By focusing on BSWs, NASW essentially abandoned the interests of social work clinicians, particularly those in private practice (and this continues today, but for different reasons).

Out of their discontent and deep concern for the practice of psychotherapy/psychoanalysis by social workers, the NYSSCSW was founded in 1968 with an eye toward permanently and legally establishing clinical social work as one of the traditional mental health professions. Our Society, along with colleagues in other state societies, has been spectacularly successful in passing the essential legislation that establishes clinical social work as its own profession, on both the federal and state levels. We are reimbursed for mental health services by federal agencies, behavior health companies, insurers of all stripes, and New York State employees. Should the

governor sign our workers' compensation legislation, we will have accomplished everything we set out to do 46 years ago.

Of course, the job of protecting our profession through legislative efforts is never finished, but we have achieved the legal recognition we pursued since 1968. As of June 2014, there are 234,114 licensed clinical social workers in the country. If not for the initiative of the clinical societies and the National Federation of Clinical Social Work Societies, I do not know if we would be the autonomous providers of mental health services we are today.

Unlike many state societies, which folded once the battle for insurance reimbursement and clinical licensing was over, we are not inclined to close up shop. Instead, we are setting new goals for the Society. Fortunately, the New York State legislature has decided to require continuing education for social work beginning in January 2015, requiring 36 hours of CE every three years. This presents us with an opportunity to take the lead once again.

ACE Foundation of the NYSSCSW

Our State Board has funded an initiative to build a clinical continuing education program for our members and the other 50,000 LMSWs and clinical social workers in the state as well. We want to offer quality clinical education through our state and chapter programming. To do this, we have established a separate corporation that will be responsible for education, naming it the ACE Foundation of the NYSSCSW. ACE stands for Advanced Clinical Education. It is now a registered corporation.

CONTINUED ON PAGE 5

PLEASE WELCOME THE NEW MEMBERS OF THE NYSSCSW*

NAME	CHAPTER	NAME	CHAPTER	NAME	CHAPTER
Allman, Joanna	MET	Hvolboll, Eric	MET	Ng, Tracy	MET
Angel, Catalina	MET	Impert, Laura, LCSW-R	MET	Nugent, Jeanne A.	MET
Auslander, Ellie, LCSW	MET	Jaffe, Brad, MSW	MET	Okuhn, Susan	MET
Bellows, Sarah	MET	Jenkins, Paula	MET	Opara, Ijeoma	WES
Benedict, Anne	MET	Jeris, Darlene	WES	Patrick, Lisa	MET
Benjamin, Robin R., LCSW-R, LP	MET	Johnson, Brooke	WES	Pertnoy, Fanny	MET
Brodie, Janis E.	MET	Kalish, Elora L., MSW	ROC	Raimo, Rosemarie F.	NAS
Cannon, Lindsay N.	MET	Kapstein, Elizabeth	MET	Rak, Eda	MET
Carlson, Susanna	WES	Kassan, Lee	MET	Rivkin-Haas, Sofia C., MSW	MET
Charna Meyers, Jane, LCSW-R	MET	Kiesling, Stephen, LCSW	ROC	Rodriguez, Leslie	ROC
Colton, Leith A.	WES	Kindley, Louise, MSW, LCSW-R	MET	Rose, Jacqueline S., LMSW	WES
Cornelius, Donald S., LCSW	MET	Kline, Janice	MET	Rosenberg, Linda	MET
Cox, Julie	WES	Kohn, Martha C.	WES	Rosengarten, Caitlin, LMSW	MET
D'Alisera, Michael	ROC	Korsen, Meredith	MET	Russell, Mark J.	SI
D'Amico, Philip	SI	Labi, James, LCSW-R	MET	Schiliro, Margaret, MSW, LCSW-R	MET
DeCosta, Louise, LCSW-R	MET	Lakis, Maria A.	MET	Schneider, Mollie	MET
Dumais, David J., LCSW	MET	Landau, Laura	WES	Scott, Amanda	MET
Eklen, Helene, LMSW	ROC	Leeds, Kenneth, LMSW	MET	Seff, Sherie L.	MET
Eschelbach, Elin	NAS	Lenkowsky, Eve	WES	Shelowitz, Randi B.	NAS
Espinal, Luis R.	MET	Levine, Betsy, LCSW	MET	Simpson, Kaitlyn, MSW, LMSW	WES
Forest, ClaudiaT., MSW, LMSW	MID	Lisi-Haas, Carolyn, LCSW	NAS	Stein, Diana, LMSW	NAS
Fotheringham, Julie A.	MET	Lista, Janet A.	MET	Tassone, Almira	ROC
Geltzeiler, Rosann, LMSW	MET	Livingston, Elizabeth, MSW	MET	Touray, Binturabi K.	MET
Goldberg, Neal S.	MET	Locker, Emily K., LCSW	MET	Trainer, Denise, LCSW-R	MET
Goldfarb, Ranny, LCSW	MET	Marchessault, Maureen, LCSW-R	MID	Treder-Wolff, Jude	SUF
Gonzalez Ferro, Maria Victoria	MET	Markus, Carolyn B., MSW, LCSW-R	WES	Turco, Stephanie	MID
Gordon, Joan I.	MET	Marston, Maryann	MET	Vittor, Brooke S.	MET
Grazer, Sage A., MSW	MET	McFarlane, Josephine A.	MET	Ward, Rosemary T., LCSW-R	MID
Greer, Jane	MET	Mccarthy, Donald S.	QUE	Williams, Alexandra	MET
Hall, Danita	MET	Mcdavid, Megan T.	MET	Wilson, Katelyn, MSSW, LMSW	MET
Hall, Puja B.	MET	McGrath Murphy, Melanie, LCSW	MET	Wolf-Powers, Josh	MET
Hammer, Ida E., MSW	MET	Moas, Timor	MET	Woods, Margaret M.	MET
Harris, Michelle C.	MET	Moked, Daphne	MET	Youree, Rachel, MSW, LCSW-R	MET
Healy, Maureen	MET	Moore, Kelly	WES	Zemor, Michelle, LMSW	MET
Hiland, Gordon K.	WES	Mosso, Judith A.	WES	Zigelman, Aviva, LCSW-R	QUE
Himmelstein, Laura	WES	Nadel, Sue	WES	Zisser, Jodi S., LCSW	MET

CHAPTER KEY: MET–Metropolitan, MID–Mid-Hudson, NAS–Nassau County, QUE–Queens County, ROC–Rockland County, SI–Staten Island, WES–Westchester County.

**These new members joined between March 1 and October 1, 2014.*

PRESIDENT'S MESSAGE

CONTINUED FROM PAGE 3

This new entity is applying for CE accreditation privileges from the state education department. If all goes well, ACE will be able to approve quality educational offerings across a variety of settings, e.g., conferences, workshops, and office based courses across the state. The Foundation can pay teachers and be self-sustaining, in other words, it can make a profit.

Our next step is to apply to the state for CE recognition, which we are in the process of doing. We are submitting three short-term office-based courses and a Nassau Chapter educational program, all planned for early winter.

I want to stress that this is a program in development. We require the teachers to be members of the Society, and they must have expertise in the clinical area they are offering. Please check E-News and CE website regularly for information on when these programs will be offered.

Workers' Compensation: We have been engaged in a 20-year-struggle for social work clinicians to become providers of mental health services for New York State workers' compensation victims. Our bill passed both houses of the legislature this year and, hopefully, the governor will sign it into law.

Why did we fight so long and hard for this law? For many years, only psychiatrists and psychologists were approved as providers. However, there is a shortage of mental health professionals in the state; Wyoming County, for example, has only one psychologist serving the entire county. By including LCSWs as providers, availability would increase by 400%. In addition, workers' compensation is a state-funded system, totally separate from federally funded or private insured insurance programs. Finally, because the system exists at all, it follows that we should be providing clinical services.

Business Partnerships: We are also seeking to change New York's corporate laws to allow us to be full business partners with other autonomous, licensed professionals, like veterinarians, dentists, physicians, psychologists, etc. Each of these professions has a psychological component and, with the new federal emphasis on continuity of care and one-stop medical homes, we have a rationale for changing the law. We need to be able to be full partners in mental health business entities, not just employees.

Obamacare: It remains to be seen how the Affordable Health Care Act (Obamacare) will impact private practice and fee-for-service, and what will happen to patient privacy and confidentiality. As for out-of-network benefits, under Obamacare, the government is reorganizing health care. Group practice is the preferred modality, and the intent is for all of us to be in medical homes where all medical services can be coordinated. These changes have shrunk out-of-network benefits and/or radically increased the deductibles before they can be accessed.

The Society's intent is to make sure that clinical social workers are the providers for mental health services across any model that emerges. For that reason, we have invited the administrator in charge of New York's health care marketplace to speak at our spring education conference in April 2015.

WWW.NYSSCSW.ORG

Your Online Connection

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It's all here. Visit today!

New York State Society for Clinical Social Work

CSWA: Our Society is the largest state professional group of its kind in the country. We have affiliated with the Clinical Social Work Association (CSWA) in the hope of having access to national health care information. They have an excellent website, www.cswa.org, with Medicare information, PQRS updates, and more. For instance, they reported that we do not have to use ICD-10 diagnoses until 10/1/15.

Online Learning: Finally, I commented on the quiet flowering of distance learning, or online learning, which is replacing traditional classroom learning and field placements in MSW programs. Two national groups are working on stemming the tide, CSWA and a new group called Excellence in Social Work Education (ESWE). We need a representative from NYSSCSW to be involved. If you are interested, please let me know: mwineburgh@aol.com. 

Vendorship and Managed Care Committee

By Helen T. Hoffman, LCSW, Chair

Here are some of the issues the Vendorship and Managed Care Committee has been following in the last six months.

PQRS: The Committee offered a teleconference presentation on October 15 by Linda Plastrik, LCSW on how to comply with the extremely complicated reporting requirements from Medicare called the Physicians Quality Reporting System. More information about PQRS is available at www.NYSSCSW.org.

NYHealthcare Exchange: Also called “The Marketplace,” the Exchange has a website at NYStateofHealth.gov. The Committee followed the rollout of the Exchange on October 1, 2013, the offerings of the various plans, patient responses, and the question of whether out-of-network benefits would be offered next year. This year, the Exchange offered no out-of-network benefits for medical or mental health services.

Out-of-Network Benefits: The Committee followed a bill in the state legislature last spring that included sections requiring insurers to provide transparency, network adequacy, and certain out-of-network benefits. This bill did not address the lack of out-of-network benefits in any of the Exchange plans or address mental health directly. However, one section that was voted into law required that FairHealth be used as the database for determining UCRs if out-of-network benefits are paid.

The Legality of Telephone Reviews, Online Reviews, and OTRs: While several plans discontinued the use of Outpatient Treatment Reports or 10-session authorizations this year, they continue to use review of “medical necessity” to manage utilization of the benefit. The Committee is following a lawsuit, brought by the New York State Psychiatric Association and others, that claims that mental health providers are unfairly held to a more stringent standards than medical providers in having to show medical necessity.

The Committee tracks trends in the insurance industry, gathers and disseminates information, and considers what can be done to improve the financial health of our profession. Short, informative articles, such as “Electronic Billing,” “Opting Out of Medicare,” “High Deductibles,” “Antitrust,” and “Peering into the Future,” can be found at www.NYSSCSW.org. If you have specific questions about your practice, please contact one of our members, listed on the Website. ☐

For news, articles and chapter contacts, please visit www.nysscsw.org/vendorship-a-managed-care

Legislative Report CONTINUED FROM PAGE 1

for *conditional registration*, or request an *adjustment* based on health issues that prevent compliance. If you are not intending to practice, you can request *inactive* status.

These forms and additional information are available on the NYSED website. Questions and answers can be found here:

Approved providers:

<http://www.op.nysed.gov/prof/sw/swceproviderlist.htm>

Provider requirements:

<http://www.op.nysed.gov/prof/sw/swceproviders.htm>

Social work website:

<http://www.op.nysed.gov/prof/sw/swceinfo.htm>

State Board for Social Work:

T. 518-474-3817, ext. 450; F. 518-486-2981;

E. swbd@mail.nysed.gov

Worker’s Compensation Reimbursement: Our bill has passed both houses of the state legislature and is awaiting the governor’s signature. A few LCSWs have been reimbursed independently by Worker’s Comp, but this law, if signed, will legally expand the pool of providers across the state, making LCSW mental health services available to injured workers.

Meditation: The State Board for Social Work has decided that the use of meditation in practice is not a clinical intervention and therefore cannot qualify for continuing education hours. It is considered a spiritual practice, not psychotherapy.

Telepractice and Coaching: The state’s position on these practice areas will be one of the subjects covered by David Hamilton, Ph.D., Executive Secretary of the State Board for Social Work and Mental Health Practitioners, at our 2015 Annual Education Conference on Saturday, April 25. Plan to attend! ☐

Clinical Social Workers as Diagnosticians: Legal and Ethical Issues

PART 2: Informed Consent, Malpractice, and the Standard of Care

By David G. Phillips, DSW, LCSW, Co-Chair of the Committee on Ethics & Professional Standards

The following material is summarized from an article published in Volume 41, No. 2 of the Clinical Social Work Journal, June 2013, a special issue on the Implications for Social Work Practice of the DSM-5.

Informed Consent

The principle of informed consent, like the principle of self-determination in social work, is based on the moral principle of “autonomy.” This principle is discussed extensively in the classic work by Beauchamp & Childress, *Principles of Bio-Medical Ethics* (2009, Chapter 4) and much of the material in this section comes from that source.

The autonomous individual is one who “acts freely in accordance with a self-chosen plan” (p. 99) but, of course autonomy is always limited, and respect for autonomy does not override all other moral considerations. Initially the “simple consent” of a patient was considered to be sufficient for the professional to proceed with treatment, but as cases entered the court system it was seen that there is a significant inequality of position and knowledge between a professional and a patient. A frightened and uninformed patient might easily agree to a treatment procedure without really understanding what is involved and what the possible consequence might be. A process of “simple disclosure,” in which the patient is simply presented with a list of technical terms which he or she might not be able to understand, is not an adequate process to obtain a meaningfully autonomous agreement for the treatment. If the patient does not have sufficient information about the proposed treatment and its possible consequences, then the concept of autonomous decision making has no meaning.

Gradually, the American court system began to spell out what is known as a doctrine of “informed consent,” and to expect that professionals will fulfill this duty in their practice. This doctrine requires that a prospective patient must be informed of the risks and benefits of the proposed treatment, the risks and benefits of alternative treatments, and the risks and benefits of no treatment. It is recognized that it is impossible to anticipate every possible risk and benefit of a proposed treatment, and it is adequate that the patient be made aware of the central facts of the treatment (p. 127-128). The prospective patient must, in other words, be made aware of the information that a “reasonable person” would want to know before deciding on a course of action.

It is obvious that not every individual is capable of making an informed choice and the professional must also consider these

factors. The person making the choice must be competent and mature enough to make an important decision; the information must be presented to the individual in a manner, which he or she is able to understand, and; the choice must be voluntary and not made under duress. Although the doctrine of informed consent was developed by the courts in cases involving physicians, it is no less a responsibility for non-medical professionals, and the obligation is spelled out clearly in social work codes of ethics.

Being labeled with a psychiatric diagnosis is not a trivial matter, and the doctrine of informed consent extends to this choice which the patient might consider. A psychiatric label may affect many aspects of the patient’s life including employment, potential decisions in child custody disputes, and the ability to purchase other forms of insurance, such as life insurance. Patients seen in psychiatric hospitals do not have a choice as to whether or not they will receive a diagnosis, but voluntary patients seen in outpatient settings such as private practice do have a choice. Professionals have an obligation to explain this choice, and its possible consequences, to patients who are considering using third party payers to support their treatment. As Barsky points out in his discussion of the issues involved when a patient gets a DSM diagnosis, the clinical social worker should, “Provide patients with information and strategies to help them avoid and/or cope with the risks of diagnosis (e.g., explain their rights to confidentiality, equality, and non-discrimination...)” (2010, p. 323).

Malpractice and the Standard of Care

Reamer points out (2003, p. 2) that it is unfortunate that we need this knowledge, but “every contemporary social worker needs to be acquainted with the nature of professional malpractice and liability”. In order to understand how the issue of malpractice may apply to clinical social workers in their activity as diagnosticians, it is first necessary to explain some of the basic concepts. If a professional person is accused of negligent practice (sued for malpractice) the individual making the accusation (the plaintiff) must demonstrate evidence of four points. Reamer’s outline (2003, p. 3) is a clear summary of the requirements involved in proving professional negligence:

1. At the time of the alleged malpractice, a legal duty existed between the practitioner and the client...
2. The practitioner was derelict in that duty, either through an omission or through an action that occurred...
3. The client suffered some harm or injury...
4. The professional’s dereliction of duty was the direct and proximate cause of the harm or injury...

CONTINUED ON PAGE 16

FACING IMPASSES: IDENTIFICATION AND WORKING THROUGH

IMPASSES IN TREATMENT can signal the end of our work with a client, or the beginning of a new and deeper transformative experience. The topic provided a compelling theme for the 45th NYSSCSW Annual Education Conference. Our distinguished speakers approached it from many vantage points: different modalities—individual, couple and group; different theoretical perspectives—relational, object relations, hypnosis, neuro-psycho-educational, and ego state approaches; and different topics—social class, eating disorders, transference/counter-transference collusion, politics in sessions, treatment dyad issues, sexual issues, and substance abuse. The innovative and informative keynote addresses (reviewed here) and a wide array of workshops made the conference an enlightening and enjoyable educational experience.

—Meryl Aster, MSSW, LCSW-R, 2014 Education Conference Chair

KEYNOTE REVIEW

Back to the Future: First Sessions with Klein, Winnicott, and A. Freud *How Their Approach to Treatment Speaks to Us Today*

Keynote presented by Louise DeCosta, Ph.D., LCSW; Reviewed by Marie McHugh, LCSW-R

Louise DeCosta captivated the audience at this year's annual education conference with an innovative and fun presentation in which two child analyses (one by Klein and the other by Winnicott) were performed on stage. Differences in technique and theory were elucidated in these dramatic period re-enactments in which Marsha Wineburgh, NYSSCSW President, was featured in a starring role as Melanie Klein and Stewart Crane, Postgrad Psychoanalytic Society president, as Donald Winnicott. DeCosta cast herself in the role of the child patient. Verbatim dialogue and interpretations taken directly from the original sessions gave authenticity to the performances. Though a dramatization of Anna Freud's work was not performed due to time constraints, her theoretical viewpoint and technique were presented, as well.

DeCosta provided a detailed clinical history of these pioneers in child therapy and Object Relations theory that illuminated the influences on their schools of thought. Included was the complexity of their relationship, set against the backdrop of pre- and post- World War II Europe. Anna Freud and Klein were contemporaries and rivals, battling matriarchs for 15 years, and although they held shared beliefs, they disagreed on technique.



Louise DeCosta, Ph.D., LCSW

A. Freud's observation of children was a comprehensive diagnostic profile with a treatment focus on building maximum ego strength. She argued that children went through developmental stages (with no ego or super ego) and symptoms were often transitory. In contrast, Klein believed that the psychic structure of the child included both the ego and the super ego.

Winnicott pledged allegiance to both schools of thought and was noted to have had a complicated and intertwined collegial relationship with Klein. Klein was Winnicott's supervisor when he was in training, and these analysts lived in a time when it was common to analyze themselves, each other, and their children. Of note, Winnicott was a male pediatrician who saw 60,000 children in the course of his career, and he went on to develop his own original ideas.

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The Case of Richard

Klein's treatment of Richard, a ten-year-old boy, consisting of six sessions per week from April to August 1941, focused on the resolution of the Oedipal Complex. Richard presented as bright, articulate, and well mannered, with a good upbringing. He had moved with his family from London to a small Scottish town because of the war. In session, he focused on the disruption of his outer world, important figures in his life, and being unable to attend school. On the surface, his anxiety appeared to be related to his exposure to the war. But Klein focused on his inner world, and giving deep interpretations right from the start to provide the child with the opportunity to feel understood. She interpreted Richard's latent content as anxiety about unresolved Oedipal issues.

The Case of Bobby


In contrast, Winnicott's patient, a six-year-old boy named Bobby, is described as an emotionally deprived child who had been in foster care since the age of two. Bobby's symptoms included mood swings, suicidal threats, and violent outbursts. His treatment occurred during the 1960s in London and lasted several years. In session, Winnicott regulated the clock and made use of drawings and play therapy in his analysis of Bobby, noting that there were many sexual symbols, which he interpreted.

However, Winnicott's concept of the value of being able to tolerate "not knowing" in the analyst and replacing it with the capacity to play were demonstrated. According to Winnicott, this style of non-verbal interpretation allows the child to gain insight by finding and ascribing meaning to his experience, at his own level of development and understanding.

Additionally, Winnicott's emotional attunement and nurturing of "the true self" were evident subtleties present in his work with the child.

Summary

DeCosta concluded the presentation by emphasizing the valuable and lasting contributions of these pioneers in Object Relations Theory. A lively question and answer period followed.

A. Freud, Klein, and Winnicott evolved as clinicians throughout their lifetimes and made valuable and lasting contributions to Object Relations Theory. Each one developed a distinct viewpoint still clinically relevant, in some cases with terminology that has been incorporated and integrated into different theoretical frames. Winnicott's theory is one of the most widely accepted, and claimed by many divergent schools of thought. A. Freud and Klein's contributions to Play Therapy continue to be used today. 

Louise DeCosta, Ph.D., LCSW is a faculty member, supervisor and training analyst currently affiliated with the Postgraduate Psychoanalytic Institute, and a member of the C.G. Jung Foundation for Analytical Psychology. In private practice for more than 30 years, her training includes work and study in the USA, Mumbai, India and London at The Tavistock Clinic. DeCosta is the Creative Director for both dramatic readings: *The Freud/Jung Letters* (premiered New York City, 2011), and *The Freud/Ferenczi Letters*, which premiered in Prague, August 2013.

Marie McHugh, LCSW-R, a certified psychoanalyst in private practice in Manhattan.



Conference Committee Members (L to R): Marie McHugh, LCSW; Daphne Leahy-Matteo, LCSW, SEP; Meryl G. Alster, LCSW, Chair; and Dale B. Schneitzer, LCSW.

FACING IMPASSES: IDENTIFICATION AND WORKING THROUGH

KEYNOTE REVIEW

Working Through Sexual Disgust in Couples Therapy

Keynote presented by Lawrence Josephs, Ph.D.; Reviewed by Marie McHugh, LCSW-R

Lawrence Josephs presented a scholarly lecture on couples therapy at this year's annual education conference, *Facing Impasses: Identification and Working Through*.

Combining psychoanalytic theory, research, and clinical experience, Josephs' discourse was an erudite study of a challenging aspect of couples work, specifically, sexual disgust. Using the basic tenets of attachment theory interwoven with marital and disgust research, Josephs predicated that attachment styles tend to predict communication styles. Whereas securely attached individuals tend to approach marital conflicts in the most constructive ways, the avoidantly attached tend to avoid conflict discussions, and the anxiously attached tend to escalate conflict discussions into dysregulated angry interchanges. Correspondingly, the quality of a couple's communication tends to be reflected in their sex life, and affects the adjustment level of their children, as well.

Based on this premise, Josephs expounded on the two most common processes observed in the treatment of couples in conflict. While some couples are engaged in cycles of escalating power struggles, others are in a more emotionally detached place, appearing distant and indifferent to each other. Josephs postulated that hidden beneath the façade of sexual indifference and boredom that characterize a declining sex life are many repudiated emotions. Feelings of hurt and anger originating from unmet needs for sexual intimacy and secure attachment are disavowed as a defense against shame. Rejection and shame often underlie these negated emotions and passive aggressive partners that reject, through sexual indifference and emotional detachment, may be defending against their own underlying, often repudiated, feelings of rejection. Josephs proposed that sexual disgust is another repudiated emotion, often disguised as sexual indifference.

Theory and Research

Citing research, Josephs segued into an in-depth analysis on the nature and origins of disgust, defining it as a visceral feeling of revulsion. With regard to sexual disgust, various theoretical perspectives were presented. Freud linked sexual disgust to its unconscious association with fecal matter and fears of contamination. He noted that with the advent of toilet training, feces and urine become core disgust elicitors, which current



Lawrence Josephs, Ph.D.

developmental researchers have found to be true. According to this perspective, sexual disgust towards various forms of sexuality possibly could be overcome through hygienic sexual practices.

However, many forms of sexual disgust appear not to be related to fears of contamination, but rather to issues related to the Oedipal conflict. As Josephs stated, "Oedipal splitting splits the world of adult romantic relationships into two competing

camps; disgustingly promiscuous individuals who are prone to cheat on their partners or steal other people's mates, in contrast to morally pure and wholesome individuals who honor monogamous commitments."

Josephs noted how a more relational theory seems to naturally evolve from Freud's notion of Oedipal splitting. Studies have shown that children seem to experience insecure attachment based on their exposure to infidelity. Additionally, sexual behaviors that involve a betrayal of trust and undermine attachment security, such as deceit or coercion, elicit feelings of disgust. Nonetheless, Josephs advanced the concept that some forms of sexual disgust seem more related to narcissistic dynamics than attachment dynamics, as in the case of Oedipal shame, in which shameful feelings of sexual unattractiveness and inadequacy derive from the Oedipal conflict. Other factors noted that further complicate the treatment process were disgust associated with aspects of a person's sexuality that parents, peers, or the culture at large think is disgusting, as well as the effects of trauma resulting from sexual abuse.


Treatment and Summary

Josephs asserted that the ultimate goal of couples therapy is to increase attachment security so that each partner feels it is safe to expose hidden vulnerabilities to the other partner, as sexual disgust is a serious threat to attachment security. The objective of treatment is to help the couple cultivate empathy

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for each partner's underlying vulnerabilities and frustrated desires. Empathy is achieved when there is a mutual understanding that nobody should be subjected to something that disgusts him or her, or be made to feel like a shamed object of sexual disgust. Furthermore, the partners themselves must negotiate what is or is not disgusting. Josephs observed, however, that from a relational perspective, the therapist's own sexual aversions and preferences will most likely be unconsciously communicated, if only fleetingly, in facial expressions or tones of voice.

Josephs illustrated his concepts through two clinical examples from his practice, each with a different outcome. He noted that many layers of hurt and anger have to be worked through so that sufficient trust is developed in each partner, and in the treatment process, before the shameful issue of sexual disgust is allowed to openly emerge in treatment. He contended that people in a successful romantic relationship figure out how to have empathic sensitivity toward one another, despite their conflicting preferences and aversions. However, sometimes the result of couples therapy is divorce or separation, as each partner concludes that romantic fulfillment is not possible in the relationship. Nonetheless, Josephs posited that couples therapy is still valuable, as it can help divorcing couples go their separate ways with their dignity intact.

Josephs ended his presentation on an optimistic note, asserting that it is often possible for couples to discover a way of transcending the sexual disgust that inhibits sexual intimacy and undermines the secure and trusting attachment that romantic partners hope to achieve. 

Lawrence Josephs, Ph.D. is a professor at the Derner Institute of Advanced Psychological Studies of Adelphi University. He has served on the North American Editorial Board of the *International Journal of Psychoanalysis* and has been a Fellow of the College of the International Journal of Psychoanalysis. In addition, he has served as a reviewer for *Psychoanalytic Psychology*. In recent years, Dr. Josephs has published articles in the *International Journal of Psychoanalysis*, *Psychoanalytic Psychology*, and *Dynamic Psychiatry*, building bridges between psychoanalysis and evolutionary psychology in the area of adult romantic relationships. Dr. Josephs is in the private practice of individual and couples therapy in New York City.

Marie McHugh, LCSW-R, a certified psychoanalyst in private practice in Manhattan.



Workshop Speakers (L to R): Betsy Robin Spiegel, LCSW; Susan Pinco, LCSW, Ph.D., BCD, CCR, Certified EMDR Consultant; Robert S. Pepper, LCSW, Ph.D.; Susan Kavalier-Adler, Ph.D., ABPP, D.Litt, NCPsyA; and Teresa Solomita, LCSW, PC PsyA.



Workshop Speakers (L to R): Cathy Siebold, DSW; Sari Eckler Cooper, LCSW; Sandra Indig, LCSW, LP, ATCB; and Inna Rozentsvit, M.D., Ph.D., MSciEd, MBA.

Conference photos by K. C. Tawfik

Chapter Reports

Queens Chapter

Fred Sacklow, LCSW-R, President
Fredsg9@aol.com

The Queens Chapter will present five speakers this year. The four remaining events will take place at York College on these Sundays: November 16, January 11, March 15, and May 17. Each day's agenda begins with our board meeting, followed by a networking session, from 11:00 a.m. to 11:30 a.m., and then the speaker's presentation, from 11:30 a.m. to 1:00 p.m.; ample parking and convenient public transportation are available. Complete details can be found at www.NYSSCSW.org, and on the Queens Chapter listserv. In addition, please note that the chapter offers peer consultation and mentoring groups.

Mid-Hudson Chapter

Rosemary Cohen, LCSW, President
rosemarycohen@gmail.com

The Mid-Hudson Chapter will continue this year to hold four annual workshops. They will take place in the conference rooms of Mental Health America of Dutchess County in Poughkeepsie and Benedictine Hospital in Kingston. On September 13, Michael Blanschen, Ph.D. presented his workshop, *Self Psychology: The Impact of Regression and Narcissism on Psychotherapy*, on recent developments in the field of Psychoanalysis/Depth Psychology, especially on how Self Psychology has altered the course of analytical thinking and influenced the development of new ways of working with individuals.

On November 15, Anton Hart, Ph.D. will offer his workshop on *Entanglement with Adolescents: Enacting and Addressing Resistances to Curiosity*. Hart will explore the concept of "cultivating curiosity" in psychotherapeutic work in order to develop an understanding of resistance to curiosity as a central dynamic in many forms of psychopathology.

Met Chapter: Four MSW Students Win Writing Scholarships

By Chris Ann Farhood, MSW, LCSW, Coordinator

The Met Chapter is pleased to announce the recipients of the 2014 Diana List Cullen Memorial First Year MSW Student Writing Scholarship Awards. The scholarship program, now in its fourth year, was named in honor of Diana List Cullen, a past president of the Met Chapter, a dedicated member of the Education Committee, and a lifelong believer in the power of education.

Four metropolitan area graduate schools of social work each submitted three student papers, which were reviewed by the Education Committee. The students selected for scholarships are Devan Zambito, from the Graduate School of Social Service at Fordham University; Antonia Maeck, from the Silberman School of Social Work at Hunter College; Sebastian Shaw, from the Graduate School of Social Work at Lehman College; and Dana Kelly Nadel, from the New York University Silver School of Social Work. An Awards Ceremony on November 5 will be attended by deans and faculty of the schools of social work, Met Chapter Board members and committee members, as well as family and friends of the scholarship recipients.

The Mid-Hudson Chapter again co-sponsored, with Adelphi University Graduate School of Social Work and the NASW NY State Hudson Valley Division, a third conference on the clinical treatment of veterans and their families; and a conference was held jointly with the Hudson Valley Chapter of Gay, Lesbian & Straight Education Network on LGBTQ clinical issues. Gloria Robbins, LCSW, now our Treasurer and Chair of the Membership Committee, serves on the planning committees.

In addition, we gave our support to the Hudson Valley Guild for Mental Health Professionals in Ulster County for their November 1 conference, *Advances in Psychotherapy: Mind-Body Approaches to Attachment Disorders*, presented at SUNY New Paltz.

Our Mentorship Group, led by Carolyn Bersak, DSW and Crystal Marr, LCSW, supports second-year social work graduate students and recent LMSW clinicians. Monthly meetings are held at Adelphi Hudson Valley in Poughkeepsie.

Metropolitan Chapter

Karen Kaufman, Ph.D., LCSW, President
Karenkaufman17@gmail.com

The Met Board continues to expand to serve the membership with a vast array of educational, social and networking programs. This fall, the LGBTQ Committee welcomed Seena Freedman, LCSW as its new Co-Chair, serving with Judy Gringorten, LCSW.

The ever-popular groups and events: Education Brunches, Speed Networking, Trauma Studies, Family Practice, Substance Abuse, The Aging Client and Clinician, and Mentorship groups for new and recent graduates, are all continuing with new offerings throughout the year.

Our fall and spring Member Receptions have proven to be very popular as well. Please encourage friends and colleagues to attend. The receptions are open to all members and prospective members and are a great way to meet board members and committee chairs. In addition, the Listserv Committee continues to work with members to get the most out of this valuable communication tool.

Members of the Met Board and our committee chairs are always happy to hear from you about your interests and professional needs, and we invite you to get involved in a stimulating community of clinicians. Find an area of professional practice that piques your interest and join us. Share your ideas and expertise and get involved in the leadership of your chapter. Contact information for board members is available in the Met Chapter section at www.NYSSCSW.org.

Rockland County Chapter

Orsalya Clifford, LCSW-R
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We are off to an exciting start with a new slate of stimulating educational programs. Presentations for the rest of this year will address these topics: treating eating disorders, utilizing coaching in clinical practice, and spending and wellbeing. The line-up of presentations for 2015 can be found at www.NYSSCSW.org.

One highlight of our schedule is an event in December, which will include dinner, the viewing of a movie, *The Story of the Weeping Camel*, followed by a discussion. The event is dedicated to Sylvia Porter, LCSW, a respected and beloved board member who died last year.

Our educational presentations were so well attended last year that we are now offering one every other month in a larger space. We continue to hold clinical case discussions before the presentations, which generate supportive dialogue among newer clinicians and seasoned practitioners.

We maintain an ongoing focus on mentorship programs for students and those entering the field, on growing our chapter, and on supporting our mutual growth as social work professionals. [Report written by Catherine Bailey, LCSW.]

Staten Island Chapter

Janice Gross, LCSW, President
jgross1013@aol.com

The past months have been very busy. In March 2014, we held our Annual Educational Conference, *Working with the Difficult Client*. The two speakers, Dore Sheppard, Ph.D., LCSW and Lynn Saltiel, LCSW gave very informative presentations.

In April, two of our own marital therapists, Andrew Daly, LCSW and Janice Gross, LCSW, squared off on treating couples from their respective theories. Daly uses the theory of Murray Bowen, and Gross spoke about the approach of Emotionally Focused Couples Therapy. Our attendees engaged them both with many questions.

Our calendar year ended with a very informative presentation by a local psychiatrist, Dr. George Tawfiq, who presented *Natural Approaches to Psychiatric Illnesses*. His described the effect adrenal fatigue may have on clients we work with, which proved to be an informative and beneficial discussion.

The 2014-2015 year began with an evening educational presentation and dinner at Staten Island University's Regina McGinn Educational Center. Constance Salhany, Ph.D. provided an overview of *Cognitive Therapy* to a large attendance of members, prospective new members, and students. Please visit www.NYSSCSW.org to view our full calendar.

We are happy to announce that Staten Island's membership is growing. We are also proud of two of our members who will be adjunct professors in the new MSW program at CUNY College of Staten Island, Catherine Putkowsi O' Brien, LCSW and Janice Gross, LCSW. The program emphasizes disability issues. 🗳️

Headquarters Update

The leaves are turning beautiful colors and beginning to cover the ground. We will soon be welcoming the festive end of the year. The Society has a lot to welcome as 2014 ends and a new year begins.

The past few months brought to fruition the idea of establishing a foundation to serve as the educational arm of the Society. The ACE (Advanced Clinical Education) Foundation of NYSSCW was formed in August and recognized by the IRS as a 501(c)3 organization. Its new board will begin to plan educational opportunities to enable members and non-members alike to obtain the needed credits for licensure and re-accreditation.

The revised By-laws of the Society were adopted by a unanimous vote at the Annual Membership Meeting in October. This brings the Society into compliance with the new state Non-Profit Law, enabling electronic notification and in-person voting. It also updates the procedures for other aspects of the Society's activities.

In November, we begin to think about 2015 and dues renewal time. The renewal form has been redesigned to allow you to make a tax-deductible donation to the ACE Foundation. Please be on the alert for it, and pay your dues for the coming year as soon as you receive it.

The staff of Total Management Solutions is pleased to assist members of NYSSCSW in any way we can. Please feel free to contact us. As 2014 comes to a close, we wish you and your loved ones a very happy, healthy and peaceful New Year.

Cordially,

Sheila

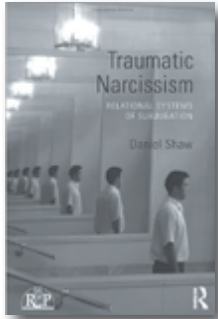
Sheila Guston, CAE, Administrator
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BOOK REVIEWS

Books Written by NYSSCSW Members

Reviewed by Helen Hinckley Krackow, LCSW, BCD



Traumatic Narcissism— Relational Systems of Subjugation

By Daniel Shaw
Routledge Press, 2014, pp.167

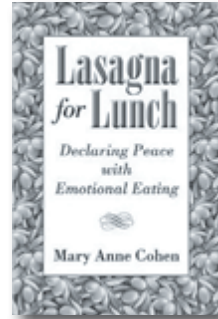
Daniel Shaw, LCSW, a training analyst at the National Institute for the Psychotherapies, has written an illuminating work on traumatic narcissism that fully describes the personality structure of narcissists, their victims, and the relationships over which these abusers often reign.

Shaw addresses the treatment of victims using Ferenzi's analytic love and relational analytic techniques. The great strengths of the book are the generous number of clinical examples, transcripts of actual treatment sessions, and personal material from the author's life.

Shaw spent many years as a member and an administrator of a cult based on spirituality and yoga. During his post-cult analysis, he developed a deep understanding of the narcissistic dyad. He was able to separate from the cult as he began to recognize the cult leader's abusiveness toward others.

Shaw's experience regarding the dynamics that enable members to leave these groups rings very true to me. I have had a number of clients who left political, religious, psychotherapeutic, and sexual orientation cults, and the influence of abusive cult leaders. Like most clinicians, I also work with many clients who were victimized by narcissistic family members. I believe Shaw's work will be helpful to therapists in resolving this dominance, freeing our patients in the process.

Shaw draws an accurate picture of vulnerability to the dominating narcissist, who is, in fact, quite dependent on his admiring followers or partners. He also offers a rich chapter on couples treatment. His discussion in the last chapter, on the nature of analytic love in healing narcissistic wounds, is valuable for all therapists.



Lasagna for Lunch— Declaring Peace with Emotional Eating

By Mary Anne Cohen
New Forge Press, 2013, pp. 346

This is a superb text for both eating disordered clients and the psychotherapists who treat them. Mary Anne Cohen, LCSW, BCD, has written a work that is both scholarly and accessible. The founder of the New York Center for Eating Disorders (EmotionalEating.org), Cohen has specialized in the treatment of eating disorders for over 40 years, helping women, men, and adolescents recover from binge eating, chronic dieting, bulimia, anorexia, and body image dissatisfaction. Complex treatment issues are clearly illustrated in her book, with many clinical examples drawn from her practice and from her personal life. She richly demonstrates her warm and empathic therapeutic style with patients. I found the many footnotes and annotations helpful as well.

As I write this review, I think about my work over the past week and how many of my clients have referred to their struggles with emotional eating. One man, feeling more at peace than he has in some time, reported that he stopped consuming his habitual pint of ice cream at midnight. In contrast, another client is a woman who gained 50 pounds over the course of the year, while her mother was dying. She recently rejoined Overeaters Anonymous, but she must continue to work through her grief as well. A third client is a 20-year-old who is struggling for an adult life and an adult woman's body.

So much pain is enacted through the body because we do not have words for it. Cohen's work is very helpful in this regard, particularly her chapters on grief, body image in our society, abuse, addictive behaviors, and pathological attachments. She also includes very fresh material on impasses and client resistance. I urge you to read this book, written by a clinician who is a credit to clinical social work.

Helen Hinckley Krackow is a former president of the Society. She chairs the state Mentorship and Newsletter committees, and co-leads a practice committee on The Older Clinician and the Older Client.

Neurobiology of the Beholder's Share and the Mystery of the Ordinary

By Sandra Indig and Inna Rozentsvit

The “beholder’s share” (originally “beholder’s involvement”) concept was developed by art historian Alois Riegl, and his great disciples Ernst Gombrich and Ernst Kris. They described the workings of the mind of the viewer (the beholder), including decoding the visual information, determining its meaning, understanding it, and interpreting it—depending on one’s prior life experiences, emotional memories, and idiosyncrasies.

Rene Magritte said once, “Everything tends to make one think that there is little relation between an object and that which represents it.” Magritte’s painting, *La Clairvoyance*, which was a part of the recent MoMA exhibition, “The Mystery of the Ordinary,” confirms his words. In this picture, we see the artist sitting at the easel, looking at an egg on the table, while painting not the egg, but the bird (!) with its wings extended and ready to fly away. In other words, the artist is painting what this egg *will become*, and not what the visual percepts (the oval smooth contour and the solid white color) allude to.

This picture is a great representation of the concept of the beholder’s share, the very unique share that each separate human mind brings to the “opinion table.” While none of the opinions could be measured and compared, and all of the opinions are “valid,” they represent one’s own creation.

The Nobel laureate, neuroscientist Eric Kandel tries to tackle the issue of the beholder’s share—from the scientist’s and the art lover’s points of view—in his 2012 book, *The Age of Insight: The Quest to Understand the Unconscious in Art, Mind, and Brain*. His book is not just a psycho-historical endeavor; it is not a textbook, where all the theories are provided and are proven; it is not a memoir. This book stimulates one’s mind to connect the dots and to find one’s

own answers, the answers that might be proven “wrong” after a while, but which contribute to one’s personal development, one’s “work-in-progress.”

Kandel, who had to make a choice once—between psychoanalysis and hard-core neuroscience—made his choice in favor of science, and now he shares with us the production of his cross-pollinated mind, his beholder’s share. “[P]ainting is not complete until the viewer responds to it...,” says Kandel. In his interview with BigThink

“There really is no such thing as Art. There are only artists.” —E. Gombrich

“We don’t see things as they are, we see them as we are.” —Anais Nin

after the book was published, he admitted that we actually do not know what exactly the “beholder’s share” is. Then, he proceeded to say that our knowledge of brain pathology (or brain conditions), traumatic or not, provides us with some “outline” of what the beholder’s share possibly is, and what kind of processes are involved in it.

In *The Age of Insight*, Kandel offers a tour of neuroanatomy, especially of neuroanatomy of the visual system, which is very important in our perception of visual art. The images created in our brain are not the same as what we “perceive” when looking at the object. In other words, the vision is the information processing, and not the image transmission! What our visual receptors perceive is called (by the modern visual neuroscientists) “a percept” rather than “an image.” Then, our brain runs the percepts through the labyrinth of its unique memories of prior experiences, emotional

responses, and mirror neurons, and it creates the image, which we decide to like (and empathize with) or to hate; to put it on a pedestal or to throw into the wastebasket. As Kandel wrote in *The New York Times* after *The Age of Insight* was written, “the real ‘eye’ of the beholder is the brain itself.”

Abraham Maslow said in 1966, “I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.” In his book, *The Psychology of Science: A Reconnaissance*, he praises science

for providing us with the ability to measure, compare, and verify things in the quest for “truth” regarding some specific parts of the whole; to get to the *Weltanschauung*, the “world view”—or

the point of view, depending on interpretation. However, the same Maslow confirms that “this impersonal model failed with the personal, the unique, and the holistic. Nor has an alternative model yet been offered to deal validly with the fully human person.”

When dealing with the whole person, as Maslow saw it, science has to abdicate because of its “hidden but fatal weakness—its inability to deal impersonally with the personal, with the problems of value, of individuality, of consciousness, of beauty,

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Sandra Indig, LCSW-R, LP, ATCB is a Chair of the Committee for Creativity & Transformation (CC&T) in Clinical Practice, NYSSCSW.

Inna Rozentsvit, M.D., Ph.D., MSciEd, MBA is a leader of the Neurobiology and Creativity workshops at CC&T, inspired by Eric Kandel’s book, *The Age of Insight*.


It is easy to see that any one of these points may give rise to a number of complications, but for now, we will just consider the second point. What defines the legal obligation that a professional person owes to a client, and what are the criteria by which it can be judged that the professional was derelict (negligent) in meeting that responsibility? This legal concept has been the subject of a series of court decisions dating back many decades in this country and is clearly summarized in the following quote (Holder, 1983, p. 220):

When a physician or surgeon assumes to treat and care for a patient, . . . he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to affect a cure and negligence cannot be imputed because a cure is not affected, but he does impliedly promise that he will use due diligence and ordinary skill in the treatment of the patient. . . .

This legal concept means simply that when a professional undertakes a legal duty or establishes a professional relationship with a client, then the client is entitled to expect that the professional possesses a reasonable degree of skill and qualifications to treat the condition for which the client is seeking help. There is not necessarily a presumption of negligence if the client doesn't make progress, because the law recognizes that not every client benefits from treatment. But if the client doesn't progress or is harmed because the professional doesn't exercise a reasonable degree of skill or doesn't have reasonable qualifications for the treatment of the condition (doesn't meet the relevant standard of care) then the professional may be liable for his or her negligent practice. There is, in other words, a tacit, legal contract established between the client and the professional when the professional undertakes the treatment of the client. This legal concept applies equally to non-medical professionals:

Non-physician health professionals are held to the standard of skill, care and knowledge possessed and used by the "reasonably prudent member" of the professional group as long as the activity undertaken is one commonly performed by members of the group. . . . (Holder, 1983, p. 222).

In addition to possessing a reasonable degree of skill, care, and diligence in treating the condition for which the client is seeking help, the professional must also practice within his or her "scope of practice," another important concept also defined by law. A licensing law, such as the one that clinical social workers now have in New York State, is referred to as a scope of practice law, since it defines and gives legal sanction to the area in which the professional is entitled to practice. But although licensure is one important component, it is not all that goes into defining the professional's scope of practice. The other components include the professional's knowledge, training, and experience and the possible limitations and requirements of the setting in which the professional functions. The important point here is that diagnosis has now become part of the scope of practice of licensed clinical social workers in New York State and that activity is now subject to the same legal concerns and warnings that apply to their other professional functions. Just as licensed clinical social workers should not treat outside their scope of practice, they should not diagnose outside of their scope. Barsky (2010, p. 323-24) points that misdiagnosis is common type of malpractice for social workers in the mental health field and offers the following clear warning:

Do not provide DSM diagnoses unless you are competent to do so. Competence to diagnose may be achieved through relevant education, experience, licensing or accreditation, specialized DSM training, consultation and supervision. If you are not competent to conduct a diagnosis and one is needed, refer the patient to a properly accredited mental health professional who is competent to provide one. Further, when conducting a diagnosis, you may need to refer the patient to certain specialists for areas requiring special expertise. . . . 

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of transcendence, of ethics." Then, he talked about the modern process of "trans-humanizing science." He spoke of the "unfortunate" circumstance that Freud, who was a scientist and a humanist, was raised in the era of 19th century science, with its limitations related to determinism, causality, and "reductiveness." Most of Freud's followers of those times were not scientists, so they could not contribute to the subject of "trans-humanizing" science by some constructive criticism; they just shied away from it.

Kandel does not shy away, but does the opposite. His tools include not only neuroscience, but psychoanalysis and his love for arts, and his socio-cultural roots. His book is an example of "trans-humanizing science," as he shares with us his beholder's share. □

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