

# The CLINICIAN

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

## Licensing Clinical Social Workers, Not Clinical Social Work Practice

By *Marsha Wineburgh, DSW, Legislative Chair, President-Elect*

It was a quirk of fate that brought me to NYU's social work school immediately out of college in the early 60s. And I was painfully aware of my youthful inexperience when confronted with the complexities in the lives of my clients, who were poor, ill and uneducated in the immensity of urban New York.

As a way of mitigating my uneasiness, my casework teachers and field supervisors assured me that, as a social worker, I would always have a supervisor to turn to and the mission of whatever agency employed me would determine the services I would provide. The setting I worked in would determine how I would expand my knowledge and use my skills, and supervision and consultation would be perpetually available, if not required. Practice autonomy was not to

be expected, with the exception of private practice, which was openly frowned upon.

This was common clinical social work practice then and, understandably, it reflected an earlier stage in the history of social work's development as a profession. We were the handmaidens of the social agencies, working under expert psychiatric consultants who made the diagnoses, approved treatment plans, and reviewed cases.

The setting where clients were served has historically determined the type of casework that social workers provided. The mission of the agency, whether it is a settlement house, religious charity program, or a psychiatric clinic, structured the services offered and, appropriately, still does, in as much as funding and other resources are directly tied to the type social services delivered.

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### PRESIDENT'S MESSAGE Poised Between Past and Future



*Jonathan Morgenstern, MSW, LCSW*

Change is hard. We generally consider change when we feel we need to — otherwise what's the motivation to do so?

For an organization it involves strategic planning that includes bravely questioning basic assumptions and premises, perceptions and beliefs. And while this is challenging and growthful, it is not always as delightful as one might hope — the process also involves uncertainty and decisions.

The past can represent certainty, but not necessary sustainability.

Our Society was born out of the special needs of clinical social workers not met elsewhere. A respectable body of work led up to independent practice founded on certification then licensure, and to independent reimbursement. Our Society had and continues to provide a professional home to clinical social workers across the state. A place to meet colleagues and friends who share

CONTINUED ON NEXT PAGE

### Newly-Elected Board Members (See article page 5)



Newly-Elected Board Members and others: *Front, l. to r.*, Linda Wright, new Member-at-Large; Sandra Jo Lane, Suffolk Pres.; Beverly Goff, new Rockland Pres., and Lorraine Fitzgerald, new Nassau Pres. *Back row:* Monica Olivier, new Member-at-Large, Dore Sheppard, new 2nd Vice Pres.; Robert Berger, new 1st Vice Pres. *Not pictured:* Marsha Wineburgh, new President Elect and Elizabeth Ojakian, new Board Secretary.

## State Board Members 2011

### STATE EXECUTIVE COMMITTEE

President	Jonathan Morgenstern, MSW, MED, MA, LCSW <a href="mailto:MjonathanM@aol.com">MjonathanM@aol.com</a>
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## NEW YORK STATE SOCIETY FOR



## CLINICAL SOCIAL WORK, INC.

## The CLINICIAN

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## President's Message

CONTINUED FROM PAGE 1

a world view, a professional commitment and a professional language. A community that offers technical and educational supports for the challenges of independent practice. A voice in relevant matters of policy and practice.

Our past has formed our identity. But what is our identity? This issue keeps returning in discussions by the State Board, the Strategic Planning Committee and the By Laws Revision Committee. Are we a society of clinical social workers in private practice, or are we a Society of clinical social workers in all professional settings? Having accomplished independent licensure and practice, how do we as a Society move into the future in the absence of a major unifying focus? Are the Society purposes stated in our by laws sufficient to sustain ongoing and future membership — maintaining standards of practice, promoting education and training, interorganizational collaboration, and support to members in their practice?

The answer, of course, is a resounding "of course." The purposes of the Society remain viable and provide direction for its work in both present and future. With that we must also recognize the impact of changes to our field and make some adjustments so that we remain welcoming to new membership and new leadership.

Leadership is entrusted with looking ahead and considering issues of past, present and future. How do we remain loyal to our foundation while charting a course into the future? How do we remain relevant and necessary?

It behooves us to prepare the way for our successors. Recent elections to State Board positions and state committees included a growing number of candidates for leadership positions — the help and support of our membership is essential to moving us into our future.

We welcome Marsha Wineburgh as President Elect, Robert Berger as First Vice President, Dore Sheppard as Second Vice President, Monica Olivier and Linda Wright as Members-at-Large, and David Phillips as Chair of the State Ethics and Professional Standards Committee. We acknowledge the contributions of Shannon Boyle, immediate past Second Vice President, of Fred Mazor, immediate past Member-at-Large, and prepare to bid farewell to Judy Crosley, Chair of the State Strategic Planning Committee, whose list of contributions to the Society took up a considerable amount of time at our recent Annual Membership Meeting.

The process of strategic planning and change is challenging but ultimately necessary and rewarding. The leadership appreciates the support of the membership in its work. ☑

### CORRECTION

Barbara Tholfsen, LCSW, was omitted from the list in our last issue of workshop presenters at the 41st Annual Conference.

We regret the error.



# The Multiple Dimensions of Narcissism and How to Survive them

Saturday, May 7, 2011, 8:00 AM – 4:00 PM

The Nightingale-Bamford School  
20 East 92nd Street, New York, NY

## KEYNOTE PRESENTATIONS

### Judith Siegel

#### “Breaking Through: Helping the Narcissistically Vulnerable Couple Engage”

Dr. Judith Siegel is an associate professor at the NYU Silver School of Social Work and the author of over 20 works on marriage and relationships, including four books: *Repairing Intimacy*, *Countertransference in Couples Therapy*, *What Children Learn from their Parents Marriage* and *Stop Overreacting*. Her work integrates object relations and systems theories with emotional regulation. She has presented at conferences throughout the U.S. and Canada and is in private practice in Mamaroneck.

### Jane S. Hall

#### “The Hidden Pain in Narcissism”

Jane S. Hall, LCSW, FIPA, is past president of the New York Freudian Society, a member of the IPA, ApsaA, AAPCSW, Div. 39. A training and supervising analyst, she has taught, lectured, and consulted for over 25 years on how to deepen psychoanalytic work. Hall is the author of *Roadblocks on the Journey of Psychotherapy* and *Deepening the Treatment*. A founder of the New York School for Psychoanalytic Psychotherapy and Psychoanalysis, she is on the faculties of three New York institutes, and in private practice in New York City.

## CHOICE OF EIGHT AFTERNOON WORKSHOPS

### 1. “Narcissism and the Sibling Relationship”

Joyce Edward, LCSW, BCD, Distinguished Practitioner, National Academies of Practice

### 2. “My Patient, My Stalker: Occupational Hazard and Cautionary Tale”

Sharon K. Farber, Ph.D., LCSW, BCD, Adjunct Faculty, NYU School of Social Work

### 3. “Learning to Love in an Intimate Attachment: Addressing Avoidant Attachment Dynamics in a Narcissistically Self-Preoccupied Man”

Marc Wayne, LCSW, BCD, Senior Supervisor, Training Analyst and Faculty, Training Institute for Mental Health

### 4. “Uncovering the Lost Self: Expanding Positive Narcissism in a Neurotic Patient”

Roberta Ann Shechter, DSW, Faculty, Supervisor and Training Analyst, Washington Square Institute

### 5. “Narcissism as a Defense”

Leah Pittell Jacobs, LCSW, LP, NCPsyA, Faculty and Senior Member of The National Psychological Association for Psychoanalysis

### 6. “Reconsidering An Elusive Concept: Narcissism As Superegotistical Attack”

Barbara Tholfsen, LCSW, Founder of the online-resource group Lacanian Foothold

### 7. “Narcissistic Injury in a Marriage Stung by an Affair: An Integrative Approach for the Clinical Situation”

Gildo M. Consolini, Ph.D., LCSW, Director of Behavioral Health and Social Services at Personal Touch Home Health Care; Tripp Evans, Ph.D., LCSW-R, Faculty/Supervisor, 2-Year Couple Program, Training Institute for Mental Health

### 8. “Shattering the Mirror of Narcissism: Treatment of an Adolescent Male”

Janice Michaelson, LCSW, Founder and First President, New Jersey Society for Clinical Social Work

REGISTER TODAY! *See reverse side* ❖

# The 42nd Annual Conference of the New York State Society for Clinical Social Work

## THE MULTIPLE DIMENSIONS OF NARCISSISM AND HOW TO SURVIVE THEM

SATURDAY, MAY 7, 2011, 8:00 AM – 4:00 PM. NIGHTINGALE-BAMFORD SCHOOL, 20 EAST 92ND ST., NEW YORK, NY

### SCHEDULE

### ADVANCE REGISTRATION: *Return by April 25, 2011*

		ADVANCE REGISTRATION	REGISTRATION AT DOOR
8:00 AM	Registration and Refreshments		
9:00 AM	Welcome Jonathan Morgenstern, LCSW President, NYSSCSW	Member \$115 Non-Member* \$130 MSW Students** \$ 60	\$125 \$140 \$ 65
9:15 AM	Opening Remarks and Introductions Susan A. Klett, LCSW-R, BCD, Chair of the Education Committee, NYSSCSW		
9:30 AM	Keynote Presentations		
12:00 PM	Luncheon		
1:45 – 3:45 PM	Choice of Eight Afternoon Workshops		
An All-Day Book Fair Will Feature Society Authors			

\*Non-member registrants will receive a \$10 rebate if they join the NYSSCSW within 30 days of the conference. For information, please visit [www.Clinicalsw.Org](http://www.Clinicalsw.Org)

\*\* Include photocopy of student I.D.



Name: \_\_\_\_\_

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**CHOOSE AFTERNOON WORKSHOP PREFERENCES BY NUMBER** (*Please refer to list on reverse side.*):

1st Preference \_\_\_\_\_ 2nd Preference \_\_\_\_\_ 3rd Preference \_\_\_\_\_

*I have enclosed a check for* \_\_\_\_\_ .

**CEU CREDITS ARE AVAILABLE:** CEU credits will only be granted for the workshop for which participants have registered. For information call (516) 627-3383.

**CANCELLATION POLICY:** Refunds granted on or before April 24, 2011

**MAKE CHECKS PAYABLE TO:** NYS Society for Clinical Social Work

**MAIL TO:** Susan A. Klett, LCSW-R, BCD, 157 East 57th Street, 6D, New York, NY 10022

### ANNUAL EDUCATION CONFERENCE COMMITTEE:

**Chair:** Susan A. Klett, LCSW-R, BCD. **Committee Members:** Meryl G. Alster; Gildo M. Consolini, Ph.D.; LCSW, Tripp Evans, Ph.D. LCSW-R; Gail Grace, LCSW-R; Susan A. Klett, LCSW-R, BCD, Chair; Marie Mchugh, LCSW; Ashanda S.Tarry, LMSW

## Headquarters Update

I am writing this after the fourth snow storm in eight days. I know that each of you is probably as sick of snow as I am (except for the skiers among us). Perhaps by the time you receive this, spring will be just around the corner.

We have had a very exciting few months. The Society's new website was launched on December 6. If you have not already done so, I hope you will visit the site:

[www.clinicalsw.org](http://www.clinicalsw.org). There is a page for each chapter announcing meetings and events, a searchable directory to find an LCSW, and a full membership directory in the Members Only section which allows members to sign in and edit their profiles easily. There also is a history of the Society and other interesting and in-depth information. In the future, we will archive past issues of *The Clinician* in the Members Only section as well.

Possibly the best part of the website is the fact members have the ability to pay their dues on-line. Since the dues bills were sent out in December, we have had almost 200 members take advantage of this service — saving them time and postage. If you have not yet paid your dues, please try this method. If you have forgotten your password, please call the office and Robin will be happy to assist you.

Speaking of dues, we hope all members have renewed by now.

As the new Board of Directors begins its work, many exciting programs are being planned both on the chapter and state level. We hope that you will take advantage of everything that your Society has to offer and invite colleagues who are not members to join.

If there is anything that we can do for you, please feel free to call the office, 1-800-288-4CSW.

Cordially,  
Sheila Guston, CAE  
*Administrator*

*The New York State Society for Clinical Social Work is managed by Total Management Solutions, Inc. Sheila Guston is the president of TMS.*

# Welcome to the Newly Elected Officers

*We congratulate our newly elected officers and applaud all the candidates who ran in this year's election. Your dedication and contributions to our Society and to the field of clinical social work are very much appreciated.*

## **President-Elect Marsha Wineburgh, MSW, DSW, LCSW, BCD**

President-Elect Wineburgh wrote: "In retrospect, it seems I was destined to participate in the professionalization of clinical social work. It was certainly nothing I sought to do; it was only accidental that I applied to social work graduate school. Awareness of the NYSSCSW began in the early 70s, when Helen Goldberg, an esteemed member even then, cajoled me into attending a meeting of the organization, then known then as the NYS Society for Clinical Social Work *Psychotherapists*. This was six or seven years after the Society was founded, way before the establishment of chapters.

As a founding member of the National Federation of Societies for Clinical Social Work, our Society actively participated in initiating efforts to pass legislation for insurance reimbursement and licensing for qualified social workers on the federal and state levels. Exciting times! Our meetings were intense, chaotic, very lively — and I was hooked. First, I worked on the newsletter, then served on the Board in various positions, becoming president in 1980–81. As president, I was honored to testify at federal hearings for clinical social work Medicare privileges, and helped develop the strategy for social work inclusion in FEBHA and CHAMPUS health care programs.

Interested in legislative work, I became the State legislative chair in 1981, and with my most effective committee and the brilliant Hillel Bodek, LCSW, launched the legislation for mandated insurance reimbursement for social work mental health services — the "R." When New York State finally opened the door to licensing, we developed and introduced a series of bills to license clinical social workers. We have spent three decades pressing for state legislation to recognize clinical social workers and we have succeeded.

Over time, I rotated through many different elected positions on the State Board and the Executive Committee, actually serving as all but treasurer. . . a very big job. And now, I am honored to have been elected president once again. We are an important voice in the social work community calling for meaningful standards for clinical education and experience, often alone. Note the recent NASW articles on pursuing students in two year AA programs who are interested in social work (*NASWNews*, Vol. 56, #2, February 2011)!

I welcome your input: ideas, participation in programs, or planning programs. I can be reached at [mwineburgh@aol.com](mailto:mwineburgh@aol.com)."

## **First Vice President Robert S. Berger, Ph.D., MS, LCSW**

Robert S. Berger holds an MS in Social Work from Columbia University School of Social Work; Ph.D. in Clinical Social Work from the New York University Silver School of Social Work (Dissertation: "A Study of the Self-Perceptions of Children with Familial Dysautonomia, the Severity of Their Disorder, and the Childrearing Attitudes of Their Parents"); and a Certificate in Psychoanalytic Psychotherapy from the NYU Psychoanalytic Institute. He is an Adjunct Assistant Professor at NYU Silver School of Social Work (1986–present); and formerly was an Adjunct Lecturer at Hunter College School of Social Work (1986–1996) and Caseworker & Casework Supervisor at JBFC (1979–1988). He also is in private practice.

He is the current State & Met Chapter Listserv Committee chair and the former State & Met Chapter Website Committee chair (2007–2010).

He wrote: "NYSSCSW has worked long and hard to carve out, protect and promote professional social work licensure in New York State, as well as advocate for a high

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# Vendorship and Managed Care Committee

By Helen T. Hoffman, LCSW, Chair

The Vendorship and Managed Care Committee continues to meet by teleconference and communicates by e-mail, gathering and sharing information through the listservs. The committee consists of representatives from the various chapters. Some issues addressed are:

## Medicare Webinar

A seminar on Medicare with teleconference, Power Point presentation and question and answer session took place February 28 at One Liberty Plaza in Manhattan. National Government Services presented an overview of provider enrollment and provider responsibilities and discussed the future direction of Medicare, including the issue of electronic billing. This seminar was tailored for members of the Society.

## Parity Issues

Many clients became subject to the Federal Parity Bill for the first time in January 2011. Since most policies renew in January, this is when changes took effect. Congress has not decided whether all diagnoses will be covered by federal parity. At the moment, we expect that only the biologically

based diagnoses will be covered under parity by most insurance companies, unless an employer decides to be more generous. We advise providers with a new patient to call the insurance company and determine whether the patient's plan falls under parity.


Although under parity laws patients may be told they have "unlimited benefits," providers will still have to show medical necessity for the patient to access these benefits. Providers are advised to familiarize themselves with criteria for showing medical necessity, which are usually posted on the website of the insurer. Often obtaining authorization comes down to demonstrating two points: symptoms and impaired functioning. Plans often distinguish between acute care and maintenance, with less frequent sessions authorized for the latter.

## Some MCOs No Longer Require OTRs

The good news is that more and more plans have discontinued the use of Outpatient Treatment Reports, for example, MHN, some GHI plans and some Value Options plans. However, plans may fall back on telephone reviews to manage the benefit more closely. The Committee has been discussing appropriate responses to requests for in-depth medical information by telephone. Patients and the public are unaware that their personal information can be used in this way and need to be educated by therapists.

## New Vendorship and Managed Care Webpage

With the installation of a new Society website, the Vendorship and Managed Care Committee has been able to mount an improved webpage. For recent informational bulletins, announcements, articles, lists, and alerts go to [clinicalsw.org](http://clinicalsw.org) >About Clinical Social Work>Vendorship and Managed Care Committee.

If you have questions or need information about an insurance issue please contact one of the members of the committee listed here and on our website. 

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\*Medicare Liason; \*\* National Health Insurance Observer

# Chapter Reports

WESTCHESTER ▶ SUFFOLK ▶ STATEN ISLAND ▶ QUEENS ▶ MID-HUDSON ▶ METROPOLITAN

## Westchester Chapter

*Martin J. Lowery, President*

We began the first General Membership Meeting of 2011 by announcing a “Year of Transition,” in which we will have the pleasure of welcoming a new president and vice president. As a first step, a call was made for volunteers to take on some of the non-presidential tasks the president had assumed. The response was encouraging. With more and newer people involved, we hope to see continued chapter vitality.

In response to the Westchester County Executive’s proposed closing of five Community Service Centers under the Department of Mental Health as part of the 2011 county budget, members of the chapter shared their opposition, which resulted in a letter to the county executive signed by both the chapter president and the State president.

The chapter meets on the first Saturday of each month from September to June. The monthly General Membership Meeting consists of a business meeting followed by an invited speaker, who addresses topics of interest to members. Prior to the meeting, the following interest groups gather and share: Group Therapy Practice, Career/Private Practice Building Mentorship, Child and Adolescent Peer Consultation, Peer Consultation, Spirituality and Therapy. In addition, the following committees serve the needs of the chapter: Education, Legislation, Membership, Disaster Preparedness and Vendorship / Managed Care. We keep connected by a well-edited newsletter and listserv.

*Martin J. Lowery, mlowery@maryknoll.org*

## Suffolk Chapter

*Sandra Jo Lane, President*

### Reports of “Demise” Decidedly Premature!

The dissemination of the totally inaccurate news that the Suffolk County Chapter was no longer going to be in existence contributed to our determination that the chapter would, in

fact, thrive! The Three Village Inn was the venue chosen for the First Annual Suffolk County Chapter Brunch. Society members (and a few non-members and yet-to-become members) gathered on the beautifully sunny, but cold, morning of January 16th to share in a delightful and delicious repast. A significant amount of chapter business was undertaken. The chapter now has a membership chair, Sharon Greaney-Watt, a mentorship chair, Charles Greco, a vice president, Diane Freedman, a treasurer, Kathy LaFemina, and we are in the process of filling the positions of secretary and newsletter editor.

We are committed to having fun and learning and have already determined that one of our priorities is including students from Suffolk County’s SUNY at Stony Brook, and welcoming new professionals and prospective members.

We’ve lots of options for meetings, and our group will be delighting in a repeat, but better (!) Three Village Inn gathering, on March 27. The real treat of the day will be our own Sheila Felberbaum making a presentation on “life and connection, separation and death, and all that is between.” In addition to her career in social work, Sheila has experienced life as an R.N. The presentation promises to be educational, informative, and moving.

There will be postings on the Nassau-Suffolk listserv providing additional information about registering. Please look at what you need to do if you have an interest in joining us! Keep your eyes open for other exciting and valuable opportunities you may have through the Suffolk Chapter.

Wishing all warm regards as we slog through the balance of winter and anticipate with pleasure the imminent arrival of a beautiful and productive spring!

*Sandra Jo Lane, 631-586-7429*

## Staten Island Chapter

*Mary FitzPatrick, President*

Our small but dedicated chapter has had a very interesting and successful year.

We continue to strive to keep our chapter thriving, open and relevant to old and new members.

Since fall 2010, we have had several interesting and informative presentations, “Internal Family Systems Theory and Techniques,” Jaime Wasserman, LCSW, “Psychotropic and Clinical Treatment of Attention Deficit Hyperactivity Disorder,” Michael Zampella, LCSW and Christina Vaglica, MD, and “Stroke and Epilepsy: Psychiatric Manifestations and Co-Morbidities,” Aaran Tansy MD.

The ADHD seminar introduced Dr. Vaglia to our community. She is knowledgeable about a problem we all come across, no matter what our practice is, and promises to be a good resource. Dr. Tansy was also very informative about strokes and epilepsy, and made it clear that we can work hand-in-hand. Most stroke patients and patients with epilepsy suffer from depression and need therapy.

We have several interesting presentations to come, including one by Hillel Bodek, LCSW, who will speak on “Ethics and Legal Considerations in Psychotherapy.”

In March we will again host Jaime Wasserman, LCSW, for a half-day conference. She will present “Using Internal Family Systems To Heal the Dissociated States Caused by Trauma.” As we learned in the fall, she is an excellent presenter as well as a gifted therapist.

Other presentations will be: “Understanding Clients and Families of Domestic Violence,” “New York State Evidence-Based Prosecution,” and last but not least, Cristina Casanova, LCSW, will present “Utilizing Somatic Experience Techniques within the Therapeutic Setting.”

All of our members contribute a great deal of time and energy to our chapter. Janice Gross, LCSW, deserves special mention. She is a long-time member who is not only our treasurer, but the voting delegate to the Board. After her weekend trips to Manhattan, she carefully and diligently shares important information with the Executive Committee and the group as a whole. Her dedication is absolute.

*Mary FitzPatrick, fitzrodal@aol.com*

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# Membership Committee

By Shannon Boyle, LMSW, Chair


The State Membership Committee is comprised of membership chairs representing the various chapters of the NYSSCSW. We hold regular meetings via conference calls to coordinate our efforts across the state. Our focus has been twofold: to increase our overall membership, while continuing to ensure that the needs of our current members are met. Over the past few years, our membership numbers have been decreasing for many reasons, including retirement and relocation. The Membership Committee is working to reverse this trend, one that is being experienced by most professional associations.

In November 2010, the Membership Committee put a proposal before the State Board to lower the cost of membership dues for student members. The proposal was approved, and effective December 2010, the new cost for students in an MSW or DSW program is \$48 a year (more specific details are available on the Society website). We know that many social work students would welcome the opportunity to belong to this organization, but the previous fees may have been too prohibitive.

Numerous Society members have connections with students

through direct teaching, on-site internship supervision, or other such settings. We hope that you will take the opportunity to spread the word about the Society and all the benefits social workers have from membership. It is now easier than ever to become a member — applications and payments can be submitted directly through our new Society website at [www.clinicalsw.org](http://www.clinicalsw.org).

Social workers have always been agents of change. The Society is also an agent of change, helping to strengthen clinical social work practice in the state. Strong membership is necessary for us to continue to advocate effectively for clinical social work.

The Membership Committee will hold an in-person workshop to bring together members of our committee along with other representatives of our chapters to coordinate efforts for the continued growth of the Society. We will share the outcome with all members. Please contact your chapter president or membership chair if getting more involved in the work of the Membership Committee interests you. We can certainly use the help and welcome more members to be actively involved in this important work. 

## Licensing Clinical Social Workers

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However in 2002 a quiet revolution occurred. For the first time, individual social work professionals were licensed by New York State as autonomous professionals, increasing consumer protection and furthering our professional identity, public recognition and social prestige by limiting practice to those who could establish their qualifications by education, experience, and examination. Scopes of practice for LMSWs and LCSWs now define our functions, establish our authority over our own work and require each licensed social worker to be responsible for acquiring the knowledge necessary to provide services to the public.

Although the workplace (setting) continues to have administrative authority over social work employees by virtue of employment contracts, LMSWs and LCSWs are now legally granted autonomy by the state. Prior to licensing, the authority to practice was granted to the social worker by a social agency (setting); the final authority rested with the agency. Licensing empowers individual professionals, so that the final authority and responsibility rests with the licensed practitioner who is legally accountable to the State. This is not to diminish the value of consultation, administrative supervision, advanced training, and/or continuing education, but accountability for practice decisions squarely rests with the individual licensed professional.

Recently, in the January/February 2011 issue of *Currents*, the New York City Chapter of NASW raised the question, “What is

clinical practice?” It offered articles reflecting several different settings where clinical social work knowledge is essential for effective interventions. Who would disagree with the premise that the broader one’s professional knowledge base, the less likely it is that one will oversimplify the complex situations facing clients?

The intent of this *Currents* issue is to question again why supervised clinical experience in assessment, diagnosis and treatment is required for the LCSW, the only social work license granting the right to offer psychotherapy services. If one understands the gift of autonomy granted to a social worker licensed to offer these specialized services (LCSW), it is obvious that supervised clinical experience in psychotherapy is an essential ingredient in building necessary clinical expertise. Who would hire a brain surgeon who did not have special training and experience in brain surgery in addition to a medical degree?

Isn’t it time to conclude these discussions about licensing clinical social workers and focus our collaborative efforts on educating licensed social work professionals to be better informed about the advancements in the clinical social work fields where they have chosen to work?

We would welcome ideas for joint educational programming from all parts of our professional community: the institutes, professional associations, social agencies and the unions. Please contact me at [mwineburgh@aol.com](mailto:mwineburgh@aol.com) or call 212-595-6518. 





# BEYOND THE LAST TABOO: *Talking About Money In Psychotherapy*

By Richard Trachtman, Ph.D., LCSW

In 1986 a psychoanalyst, David Krueger, edited a collection of articles, *The Last Taboo: Money as Symbol and Reality in Psychotherapy and Psychoanalysis*. As the first part of its title implied, he considered money a taboo subject which was not being adequately dealt with in our clinical work. He contended that, because of this taboo, patients and therapists were colluding to avoid discussion of money in treatment.

After reading Krueger's book, I became interested the idea of the money taboo and I started paying attention to money as an issue in my work with clients. In fall 1999, in *Clinical Social Work Journal*, I published an article called "The Money Taboo: Its effects in everyday life and in the practice of psychotherapy," in which I claimed that: *A cultural taboo regarding discussion of money affects psychotherapists as well as the lay public. As a result, the psychological literature regarding money is sparse while issues relating to money are seldom addressed in our training, our self-analyses or the treatment of our patients.*

When we do talk or write about money, we focus primarily on the fee we charge for our services and tend to ignore the psychological importance of money in shaping our clients intrapsychic and interpersonal lives. In response to this trend, in 2008 I wrote an article, "Beyond the Fee: Addressing Non-Fee, Money-Related Issues."

A most recent example of avoidance of talking about non-fee based problems occurred during the discussion period after the presentation upon which this paper is based. Although the presentation did not focus on the fee, every question or comment offered by an audience of 26 therapists focused only on issues such as how to set the fee, why so many of us find it difficult to ask for payment, what to do if a client does not pay, or how to raise the fee or respond to requests to lower the fee.

This continued even when I pointed out what was happening. No doubt our ability to earn a good living is of significant importance. But, to focus only on money issues that affect us and not those that affect our clients, represents one type of money based countertransference, characterized by an avoidance which diminishes our ability to truly understand our clients. Other money based countertransferences are

described in my book, *Money and Psychotherapy: A Guide for Mental Health Professionals* (NASW Press, forthcoming).

After completing this article, the reader is asked to take this challenge: think of your own clients and try to identify the role money has played in their identity and character formations, their intrapsychic and interpersonal problems and their adaptations.

## My Work

A large part of my clinical work, as well as the workshops I have run and what I have been writing about, has been aimed at getting us beyond the last taboo, and talking and thinking more freely about money. By "us," I mean us as a profession and us as the whole society. I created MORE Services for MOney and RElationships ([www.monwyworkandlove.com](http://www.monwyworkandlove.com)), which offers clinical services and provides educational and clinical resources including copies of the two articles mentioned above, two bibliographies and a sample of a book published last year, *Money and the Pursuit of Happiness in Good Times and Bad* (which I refer to as a psychologically sophisticated self help book).

## How To Think About Money

Money can be thought of as a blank screen onto which we project our wishes and fears. If we think money is security, we are really hoping it will allow us to provide for ourselves or our families at some time in the future. If we think of money as power, we believe it will allow us to buy favor or to influence events in the future.

But the idea of money is so powerful and pervasive in our culture that we tend to forget that it is only a stand-in for

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**RICHARD TRACHTMAN, PH.D., LCSW**, has been a psychotherapist and social worker, both in private practice and for mental health clinics and social work agencies, since 1964. In addition, he has been an administrator and has supervised and taught social workers, psychologists and students in a variety of schools, training institutes and clinics. This article is based in part on a presentation made to the Metropolitan Branch of the New York State Society of Clinical Social Workers on February 6, 2011.

For more information: [richardtrachtman@aol.com](mailto:richardtrachtman@aol.com) or [www.moneyworkandlove.com](http://www.moneyworkandlove.com)

# Committee on Ethics and Professional Standards

By David G. Phillips, DSW, LCSW, Chair

This January, I was invited to return as Chair of the Society's Committee on Ethics and Professional Standards, a position I had previously held during the decade of the 1980s, when we wrote the Society's original Code of Ethics. My return to the Ethics Committee has led me to think of developments that have taken place over the three decades during which I have been studying, teaching, and writing on legal and ethical issues in professional practice.

When health care professionals are surveyed, they will usually say that the responsibility to maintain confidentiality over information received in a professional context is the most important ethical obligation that they owe to their patients. In recent decades, however, the requirement to maintain confidentiality has been subject to intense debate in a variety of situations in which the welfare of the individual patient was weighed against the needs of the wider society. The general trend has been to limit confidentiality more and more, with the one major exception being the Jaffe vs. Redmond case decided by the United States Supreme Court in the 1990's. This case affirmed the importance of confidentiality in developing the relationship of trust that was basic to effective psychotherapy and favored the recognition of a federal psychotherapist-patient privilege.

This column will serve as an introduction to the topic of growing limitations on confidentiality, and in future columns I will review in more detail the changes that have taken place in this key area of professional responsibility.

The first known official statement on confidentiality was in the original Code of Ethics of NASW, written in 1960. It stated, in total: "I respect the privacy of the people I serve." The dual implication of this precept was both that confidentiality was an absolute right of the client, and that the responsibility to maintain confidentiality arose in the service relationship between the social worker and the client.

When we review current codes of ethics, however, we find that the statements on confidentiality are filled with the many ways in which patient confidentiality might be limited and the conditions under which confidential information might be revealed. These columns will review how we got from there to here, how an absolute right of patients in psychotherapy became a highly limited one.


We will begin by discussing the child abuse reporting laws, which began to be passed by various states in the 1950s, and which now are in effect in all 50 states. This was the first situation in which the rights of individual clients to absolute confidentiality in a psychotherapy relationship was limited because of the concern for the welfare of others.

We will then move on to the well known Tarasoff case from California, which was decided in the 1970s and extended the concept that psychotherapists seeing patients in confidential relationships might have a more powerful responsibility to protect a third party, even though that third party might have nothing to do with the psychotherapy.

We will also discuss the controversy over revealing HIV status that erupted when AIDS became a national crisis in the 1980s. This development raised the question of whether professionals had an obligation to reveal HIV status to possibly endangered third parties, an intense debate in New York, which is one of the national centers of that disease.

We will continue by discussing the impact on patient confidentiality that took place when clinical social workers in New York State first became reimbursable providers for private insurance plans with the passage of the "P" law in 1978 and the "R" law in 1984.

We will finish by talking about the development of modern technology for transmitting and storing data, and the current popularity of social media sites such as Facebook and Twitter.

These latter developments might prove to be the biggest threats to confidentiality of all and perhaps, by the time we're finished, you'll understand why I'm only half joking when I tell my students that, "I'll be glad to teach you something about confidentiality, but it'll have to be from a historical perspective, because in the modern world there is no such thing." 

## The Self-Defeating Private Practitioner

### Part 1: Telephone Behavior

In the course of my years as a teacher, consultant, and supervisor to clinical social workers and other mental health professionals in various stages of their independent practices, I have taught these clinicians everything I know about how to develop and maintain a successful private practice. I have also learned a great deal about why so many of them struggle in their efforts to launch a practice and to succeed.

All of us who see clients privately are likely to hear stories about why some left treatment and came to us, or, why they did not return to the former psychotherapist. We also learn why we were chosen to be their therapist as opposed to others with whom they had consulted.

I believe that there are many ways in which clinicians, unknowingly, self-defeat in the course of their efforts to build and successfully maintain a private practice. Two major areas with which many of us have difficulty were identified and described in the first two articles for this column in *The Clinician*: problems concerning money and fees (Spring, 2010) and marketing issues (Fall, 2010).

There are many other attitudes, beliefs, and behaviors that serve to undermine clinicians who practice independently of an agency or clinic setting. This article will address self-defeating issues having to do with telephone behavior. In Part 2 (Fall 2011) I will discuss ways to avoid self-defeat in relation to your office (clean that bathroom!), communicating with referral sources (do so!), marketing your practice (do so!), and handling termination (with a more flexible approach to the process, if necessary).

#### Telephone Behavior

New clients who were given several names of therapists have reported that one of the reasons they came to see me was that I was the only one who returned their phone calls, or that I returned their calls on the same day rather than two, three, or more days later. I am astonished every time I hear this.

Another set of comments concerns the phone manner of the therapist who does return the call: *Unfriendly; Cold, Abrupt; I felt like I was bothering him; S/he didn't really seem to want to answer my questions; S/he sounded to me like I must sound to the salesperson who calls me at dinnertime*; and more. It seems that some therapists are not any more comfortable talking with strangers than they are talking with us.


Prospective clients who have been referred by a known source may simply be calling to make an appointment. For many prospective

clients, however, it is a fragile moment when they finally make that often-long-delayed call to begin the process of entering therapy. This is the first opportunity to engage the client and establish an initial connection to him or her. Many prospective clients who feel uncomfortable or even put off during the first call will never make it to the first visit with that clinician.

Some potential clients call to arrange an appointment and save their many questions for the first visit. Most of us, undoubtedly, hope for and prefer this caller. However, many prospective clients, especially those who are ambivalent, fearful or seeking help under duress, will require answers to their questions on the phone before ever coming in for a session. How this conversation is handled by the therapist might well make the difference between a new client and a non-client.

If a therapist is uncomfortable or unhappy with a prospective client needing a lot of information during the first phone contact, it is likely to be evident and affect the quality of the encounter. Some callers ask difficult questions that must be handled sensitively, e.g., *What is your fee?; What is your orientation?; How long will it take?; Should I bring my spouse?; Now that I've told you a little about my problem, do you think you can help me?* Many therapists find handling questions about the fee to be quite a dilemma, for there is probably no really safe or "good" answer, at least on the phone.

Some therapists dodge the question by saying they do not discuss fees on the phone and attempt to postpone the fee discussion until the client agrees to come in. The caller may find this answer evasive and permanently end the encounter. With a direct answer, arguably a superior response, the therapist also runs the risk of an abrupt end to the encounter. The prospective client may be comparison-shopping and the stated fee may eliminate a therapist right away, or the client may make an appointment, then not show up.

It is important to remember and utilize well the social work "rules of engagement" we learned those many years ago. The first phone contact is, possibly, the beginning of treatment. Be attentive, receptive, steady, ready to be of service, and generous, so that the person who seeks you out feels recognized and accepted sympathetically as a person in trouble. One approach includes responding directly to the question of fee and also inviting the client to come in to discuss the various parameters of treatment including time and frequency, as well as fee. This conveys an interest in developing a working alliance and a flexible approach which might include a fee reduction, if necessary. 

### *The Artful Brain: Survival through Creativity*

*Presentation by George Hagman, LCSW / Review by Sandra Indig, LCSW-R, LP, ATR-BC, Committee Chair*

On the 9th day of the first month of the New Year, 17 of us attended a lively and highly informative presentation, “The Artful Brain: Survival through Creativity,” by George Hagman, LCSW. To quote from our committee’s Internet posting, “We will explore enhancement of brain functioning and the psychological nature of art, as well as subjective states, including survival through creativity. Art developed to compensate for the limitations of the brain’s capacity for conscious thought, permitting a focused, sustained means to elaborate subjectivity. Through art people represent, elaborate, and perfect subjectivity. This view of art has implications for a new understanding of art and creativity.”

This most memorable presentation was everything you wanted to know about what it means to recognize and develop an artful brain. All appeared to be mesmerized by hearing secrets only known to active artists and neuroscientists. Layer by layer the “veils” fell away as each section of George Hagman’s workshop progressed through a mixture of reading and interactive discussion.

George Hagman (after referred to as GH) proposes a new definition of art. Art is generally seen as a product of certain activities, or a type of discipline or skill. GH argues that the defining feature in art is the psychological processes involved in art creation and appreciation. He doesn’t minimize the art object but regards the defining element as the psychological work that the artist engages in as he creates the artwork. Whenever this particular psychological process occurs, there is art.

The creation of art and the valuing of art is a fundamental human need. This need is supported by recent scholarship in evolutionary theory, neurobiology, and cultural studies. Art’s early adaptive function is linked to basic elements in attachment and self-experience (Dissanayake, 2009, p. 153 – 154).

Art helped communities be more cohesive and therefore more viable. Individuals developed an instinct for art because the function of art in human life increased the probability of survival.

The definition of art which was proposed by GH involves the integration of psychoanalytic with more recent theories for associated fields. He identified the following assumptions in the psychoanalytic perspective: art involves the expression of subjectivity (e.g., fantasies, mental imagery, conscious and unconscious thoughts) into something external, an object that as a result contains subjective elements (e.g., symbols). Simultaneously the externalized subjectivity (the art work) is manipulated according to a dynamic relationship that it has to the artist’s ever changing subjective experience. One crucial aspect, generally overlooked by psychoanalysts is the artist’s perfection of the artwork, and the relationship of the quality of the artwork to the artist’s inner life, especially his aesthetic needs and motivations. He believes that it is the element of “perfecting” that distinguishes art making from other psychological processes such as dreaming, symptom formation, and other psychological defenses and mechanisms.

#### **Art and the Brain**

The speaker noted the remarkable consistency between the psychoanalytic understanding of art and the findings of other sciences. Current research into the biological and evolutionary sources of art were mentioned, notably, the role of brain function and structure in the production and enjoyment of art. Of special note was that the brain actively constructs perception and seeks to organize forms of experience according to some limited set of principles. Several neuroscientists mentioned in this talk were credited with beginning to develop models of art as an activity of the brain and mind that seeks to organize thinking, feeling and experiencing in special ways that enhance adaptation and optimize creativity.

One neurologist, Semir Zeki (1998), argues that the human brain is designed to construct a sense of order in the midst of an ambiguous and ever changing environment. The artful brain develops conceptual ideals, cognitive forms that are felt to capture the essence of certain expectable, familiar experiences. “One of the functions of art is an extension of the major functions of the visual brain.” (Seki, 1998)

Another brain researcher, Erich Harth (1995), offers an explanation for why art developed and its function in the evolution of the human brain. We noted Harth's argument that the origin of art is the same as that of language: the human brain had evolved such an ability and capacity for cognition and various levels of memory that there was a need for thinking to be aided by special symbolizing functions. GH emphasized Harth's observation that the tension between new perceptions and the memory based images that are structured into the brain — in many instances what the brain wants to see, or thinks it should see — powerfully influences what a person believes he or she perceives. In this process internal fantasies and external realities interpenetrate and co-construct.

Harth believes that early Homo sapiens began to engage in making art as a result of the expanded complexity of the frontal lobes. This more powerful neural circuitry had enormous adaptive value. In particular it allowed for the creation of mental imagery (based on perception but elaborated and structured in the mind). However, the features of selectivity and exclusivity of attention, which allows us to focus and understand specific items, also limits the range of cognitive tasks we are able to perform. In other words, flooded with "ghostly and evanescent mental imagery" (Harth, 1995: 75), we also had trouble sustaining our thought processes, or thinking about more than one thing at a time. As a result, people needed to develop a means to sketch ideas and store them externally.

Memory traces, mental images, which are constructed from experience and internalized in working memory, are externalized by means of artistic expression (visual images, language, sound, sculpture). Thus the mental becomes an object of perception and manipulation. As a result internal cognitive processes interact with external meaning and imagery, and both domains are further elaborated and refined.

In other words art is not just a reflection of the functioning mind, it is a way that people think, feel, imagine as well as solve problems, internally and externally. In making art the mind expands beyond the physical brain. Externalized thoughts become the object of the brain's own manipulation, which somewhat paradoxically increases the mind's complexity and efficiency. When this process is communicated and engaged by the brain and its product, the mind, the brain becomes elaborated exponentially. In art we augment our brain power and improve our minds.

Language and art making are linked to the physical structure and operation of the brain. The production of aesthetic experience (the role of line, shape and color recognition in the activation of emotions), and the need to organize and structure perception are both embedded in the design of the brain and the process of adaptation and survival. But more importantly, art expands cognition through the construction of a transitional world of symbols, the manipulation of which allows for an enhanced capacity to think, imagine and problem solve.

### The Evolutionary Origins of Aesthetic Experience and Art

This segment of GH's talk came in the form of a challenging question, "How did art help individuals survive, and how can an evolutionary point of view add to the psychoanalytic and neurobiological understanding of what art is?"

A growing international and interdisciplinary research project into the evolutionary and neurobiological sources of art and experience has resulted in new understandings of what art is and where it came from. Many now recognize that human beings can be called *Homo aestheticus* (Dissanyake, 1992) given the important role of the arts throughout human history, but also more importantly in the central role the arts play in our psychological, social and relational lives.

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**GEORGE HAGMAN, LCSW**, is a psychoanalyst in private and public practice in New York and Connecticut. A graduate and member of NPAP, he is the author of *Aesthetic Experience: Beauty, Creativity and the Search for the Ideal* (Rodopi, 2005) and *The Artist's Mind: Creativity, Modern Art and Modern Artists* (Routledge, 2010).

**SANDRA INDIG, LCSW-R, LP, ATR-BC**, Chair of the Committee for Creativity & Transformation, is an exhibiting painter and Artistic Director of the Abingdon Square Painters, associate of Dances for a Variable Population, and writes for E-Zine, *Manhattan Arts*. She maintains a private practice in New York City.

GH went on to develop this line of thinking by referring to the anthropologist Ellen Dissanayake who suggested that the common denominator for the behavior of art is the quality of “making special” or “elaborating.” Paraphrasing her observations, GH noted how the artist transforms an ordinary experience into something *extra-ordinary*. For example, common behaviors or sensations are exaggerated, patterned, embellished, repeated, or otherwise emphasized and refined. One can see this in the rhythms and rhymes of words turned to poetry, the patterns and repetitions that turn speech to song, the design and color schemes that turn visual display into paintings, etc. In fact Dissanayake argues that making special is the defining characteristic of all art, throughout history. Hagman notes the similarity between the notion of “making special” and the psychoanalytic concept of “Idealization.”

GH paused to again pose a mind expanding question, “What are the sources of this human desire and need to *make things special*?” A number of associations by the group were considered before returning to Dissanayake’s perspective on this question. She argued that at the point in evolution when human beings began to make art, they drew on a “behavioral reservoir” of innate capacities and sensitivities that had evolved originally between adults and their babies. She explained how the special communicative techniques between baby and adult function even to the present day to assist in communication, attachment, heightened emotion, shared awareness of special events and qualities of the world, and help to form the primary psychological bond that becomes the well and template of social and cultural life. Art is the elaboration and expansion of these early proto-aesthetic experiences and art’s function in the adult human world to address and satisfy psychological and emotional needs: to stimulate feelings of belonging, to provide a sense of meaningfulness and cognitive order to individuals.

Given the findings of evolutionary aesthetics we moved on to examine the matrix of art and aesthetic experience in the early attachment relationship, and the way in which the self, the mind, and artistic creation are interrelated.

### The Importance of Attachment: Adaptation and Survival

GH provided us with a most refreshing review of attachment theory from an evolutionary aesthetic perspective. He began with stating that the readiness for an aesthetic response to attachment behaviors is biologically based. Infants are born wanting certain visual, vocal, and movement behavior, commonly known as “baby talk.” In response to the appropriate stimulus the baby spontaneously experiences the interaction according to some specific forms of aesthetic structuring that is built into the brain and evoked and organized in response to interaction with attachment figures. These interactions have formal structure (shape, color, rhythm, line, tone, etc.), which are affectively charged, formalized, repetitious, elaborate, and manipulated for surprise (Dissanayake, 2000). Most importantly protoaesthetic interactions increases excitement and positive feeling between parent and child for each other.

In summary, proto-aesthetic experiences enhance the self and the self-in-relation to the other. They are pleasurable and reinforcing. Over time proto-aesthetic experiences becomes organized and elaborated into more mature forms. Hence these early modes of experiencing do not disappear; rather they continue to make up a set of background, procedural memories that color all subsequent experiences. Thus human life acquires and retains an aesthetic dimension that in general is positively charged.

As the child’s sensibility comes into interaction with the social world, he or she elaborates and organizes higher level forms of aesthetic feeling into what will become mature aesthetic understanding and appreciation. In the experience of mature forms of art proto-aesthetic experience is a dimension of the person’s appreciation of the artwork.

It is clear that art-making has clear adaptive value, given the powerful impact it can have on the quality of self-experience, social relations and communal integrity and vitality. Most importantly art infuses culture with the affective charge of secure attachment — it helps to provide the experience of relationships in a community with a feeling of security and affective resonance. A society that utilizes art making throughout the community and in response to many different events tend to be well functioning and effective. Its members tend to have a greater probability of survival. Relationships that share the enjoyment and/or creation of art tend to be more stable, vital and creative — also enhancing survival. Finally individuals who enjoy making art tend to be better integrated into the community, receive admiration and support from others, and enjoy a higher quality of self-experience.

# Committee for Creativity & Transformation in Clinical Practice

by Sandra Indig, LCSW-R, LP, ATR-BC, Chair

**A**s hoped for, our modified committee name has opened the floodgates to new and returning members. It has been wonderfully energizing and most generative for all to be part of a re-awakening to our well received and very well attended workshops/presentations. Interest in new ideas for ways of expanding our outreach efforts have increased and members from other committees have joined in our activities in unprecedented numbers.

## Events

*From this past October to this past January, the Committee presented three very well received events.*

**On October 10, Dayle Kramer, LCSW, LP presented “Observing and Seeing: The Art of Attunement with Yourself and Your Patient.”** She focused on the similarities between the art of listening, observing the patient, and making art. Through the use of basic drawing exercises and discussion, participants experienced an increased connection to their creative core and the similarities of sitting with a patient.

**Our meeting on November 14 brought us Ann Rose Simon, LCSW on “How Can Neuroscience Inform our Practice: Reclaiming Creativity and the Self.”** This workshop provided us with a brief but extremely well researched overview of the recent findings in neuroscience research which support some of the psychotherapeutic concepts that we utilize in our practices.

**George Hagman, LCSW, on January 9 presented a wonderfully interactive talk on “The Artful Brain: Survival Through Creativity.”** We explored enhancement of brain functioning and the psychological nature of art as well as subjective states including survival through creativity. (Reviewed in this issue.)


**On February 21, Joy E. Sanjek, LCSW hosted “Abstract Expressionist New York”** at the Museum of Modern Art. We saw paintings and sculpture from the 1950s which focused on personal expression above all else. Some of the artists central to that era are Jackson Pollock, Willem de Kooning and Mark Rothko.

## Upcoming Workshops and Presentations

### March 13

**Paul Giorgianni, LCSW, BCD: “Objects in the Psychotherapy Environment”** This workshop will explore the use of displacement and projection by both patient and therapist in the service of communication. Case examples of the use of objects in the therapist’s office will be given.

### May 15

**Helen Hinckley Krackow, LCSW, BCD: “Mirrors of the Soul: Evoking the Unconscious Body Image through Hypnosis”** This workshop will demonstrate the use of clinical hypnosis and psychodynamic theory in working with clients’ unconscious representations of self. The technique for accessing this material will be demonstrated and opportunities to participate will be offered to workshop attendees. 

### WHERE AND WHEN:

Sundays from 11:00 a.m. to 12:30 p.m.

(Registration starts at 10:45 am)

150 Fifth Avenue, Suite 900

(Between 18th and 19th Streets)

*Suggestion:* Please leave 30 minutes for evaluation and networking.

### CONTACT:

Sandra Indig, Chair, to verify address and to reserve a seat: 212-330-6787

## Rockland Chapter

*Beverley Goff, President*

The Rockland Chapter has been trying innovative new additions to our monthly presentations held at St. Thomas Aquinas College.

We have been enjoying film presentations and lunch discussions afterwards, as well as our Clinical Case/Topic Discussions before monthly programs, where colleagues talk about issues and countertransference feelings and feel supported by each other. We are continuing our mentorship groups with advanced social work students from NYU in Rockland.

On March 20, we will offer a Conference/Day Training in two parts: 1) "Treating Self-Injuring and Self-Harming Patients" and 2) "Working with the New DSM V." Please check the Rockland Chapter section the Society website for upcoming events open to all, or feel free to contact our President.

*Beverley Goff, bevgoff@optonline.net*

## Queens Chapter

*Fred Sacklow, President*

The Queens chapter has been busy with monthly Board meetings and monthly educational presentations. Please look for your listserv notices and/or on the website notices for news about our presentations.

We are happy to welcome two new Board members to our ranks. They are husband and wife team Robert Hazelton, LCSW and Nancy Hazelton, LCSW. They lead New Bridge Employees Assistance Services located in Levittown. Beginning as speakers, they became members, and are now active on the board. More information about them is available at [www.eaplifeline.net](http://www.eaplifeline.net).

### Meeting Recap

In September, 2010, Susan Klett, LCSW, spoke about "The Transformative Experience of a Transference Interpretation Viewed Through the Lens of an Object Relational Perspective." In November and December, we heard from Brian Quinn, LCSW, Ph.D. on "Diagnosing and Treating the Bipolar Patient."

In January, our own Jeanne Friedman, LCSW, shared her knowledge about "Dissociative Disorder." For more information visit [www.sidran.org](http://www.sidran.org). In February, Crayton Rowe, MSW, BCD, presented "Undifferentiated Self-Object Transference."

We have more exciting presentations to come on March 20, April 17, May 15, and June 12. As always, we meet at Holliswood Hospital from 11:00 am to 1:00 pm. Light refreshments are served, and there is plenty of parking. Certificates of attendance are provided. Our listserv is active and we have time during every meeting for members to network and share.

*Fred Sacklow, Fred99@aol.com*

## Metropolitan Chapter

*Ariane Sylva, President*

The Met Chapter continues to enjoy robust activity, with events generously offered by and for members.

By popular demand, the Membership Committee has provided encore presentations of three events:

A workshop, offered by Committee Chair Richard Joelson, DSW, on the development of a private practice, has filled up through March. These are intimate gatherings of seven, maximum.

The Food for Thought event, again at Carmine's Restaurant, was a presentation by Kenneth Neumann, Ph.D., on January 25, "Techniques for Working with Your Divorcing Clients," and was delicious and stimulating.

The next Food for Thought presentation will be in April on "Eating Disorders," by Maria Baratta, Ph.D., LCSW. On February 4, had another Member Reception, welcoming new and existing members to mingle and meet at Richard's home.

Looking ahead, there will be two all-day conferences for Met Chapter Members. Both are free except for a \$15 lunch fee for the first conference:

Saturday, March 26: *Expanding and Sustaining a Successful Clinical Practice in the 21st Century*, with Vikram Rajan giving the keynote address, "Essential Marketing Skills to Build Your Practice." There will be six workshops to choose from. This promises to be our largest event of the year. We hope all Met Chapter Members will attend. Please register early.

The second conference, presented by the Met Chapter Clinical Ethics Committee, will be Saturday, April 16: *Professionalism and Ethics in Clinical Social Work*. Presenting will be Hillel Bodek, MSW, LCSW-R, BCD, Chair of the State Society Ethics Committee for over 25 years, and Eileen Ain, Ph.D., LCSW, Chair of the Met Chapter Clinical Ethics Committee. Members are invited to send to the leaders, in advance, ethical issues of their practices as material for the presenters to address.

The Clinical Ethics Committee will meet on the second Friday of each month. The meetings are confidential and collaborative.

The Education Committee Brunch on Sunday, February 6, presented by Richard Trachtman, Ph.D., LCSW, BCD, was "Beyond the Last Taboo: Talking about Money in Psychotherapy." (See page article page 9.) The Family and Couples Practice Committee discussed "Sex and the Older Couple," at their next meeting in February. The second part of the Emotionally Focused Therapy for Couples training, by Elana Katz, LCSW, LMFT, was on Friday, February 25, and will be presented on Friday, March 25, from 9:00 am to 11:00 am.

To find out more about our 14 committees, contact any board or committee member. Find us at the Met Chapter section of the website: [www.clinicalsw.org](http://www.clinicalsw.org)

*Lisa Beth Miller, LCSW, 917-399-6447. ☑*



standard of professional social work practice. As the former Web site Committee chair and the current Listserv Committee chair, I have contributed to the best of my ability to this mission, specifically by increasing the networking and Internet contact between NYSSCSW members through the development of chapter listservs and working on the on-line member directory.

As first vice president, I will continue doing what can be done to support and promote the practice of clinical social work. This is a very important professional and personal agenda for me, an agenda that I have pursued in the Society, and as a clinician, teacher and clinical supervisor. We are an old, essential profession, with a strong commitment to service to others. As first vice president, I will help develop and implement strategies to maintain our standards, bring timely information to our membership, increase our Internet presence and work to promote both the social work profession and our professional specialization as clinical social workers. My devotion and commitment is strong and is focused on helping the collective us."

### **Second Vice President Dore Sheppard, MSW, DSW, LCSW**

Dore Sheppard is currently an Associate Professor for the New York University School of Social Work, teaching courses in human behavior and social work practice. He has a private practice in Nyack and in Manhattan. He is nearing the completion of his psychoanalytic training at the New York University Postdoctoral Program for Psychotherapy and Psychoanalysis. He is a father of three and is lives in Walden, NY.

### **Recording Secretary Elizabeth Ojakian, MSW, LCSW, CASAC, CEAP**

Recording Secretary Ojakian wrote: "I graduated from New York University in 1977 with an MSW after a few years working at the welfare department and in a methadone maintenance program. I had relocated from California to New York.

Over the past 33 years, I have worked at an inpatient psychiatric hospital, various outpatient mental health and substance abuse clinics, and at a supportive apartment program. During 28 of these years, I have maintained a private practice and worked in the employee assistance (EAP) field, which I continue to do today.

Along the way, I attended an institute in individual psychotherapy (MITPP, 1982), a group therapy training program (Postgraduate, 1990), and obtained training and certification as a Credentialed Alcoholism & Substance Abuse Counselor (Adelphi University, 1986). I was an adjunct professor at Adelphi for three years and have taught at NYU since 1995 on a part-time basis.

Although I have been a long time member of both the NYSSCSW and NASW, I never seemed to find time to become active. A book group colleague convinced me to fill the position of secretary for

the Met Chapter two years ago. I went on to become secretary-treasurer of the Met Chapter and secretary of the State Board.

I had been feeling that it was time for me to give back to the profession and help guide it into the future, and my involvement in the Society has provided that avenue. I have also met some wonderful and hard working people along the way, and encourage all of you to join in with whatever time you have to make this a stronger profession."

### **Member-at-Large Monica Olivier, MSW, LMSW**

Monica Olivier holds a B.A. in sociology from Stony Brook University and an MSW from New York University. She worked for 15 years in case management with the Rockland County Department of Social Services and Catholic Charities of Rockland. She is currently a member of the Web site Committee and moderator of the Rockland Chapter listserv. Monica is also a member of the New York State NASW.

### **Member-at-Large Linda Wright, LCSW-R, MSW**

Linda Wright has been a professional social worker for over 15 years. She is currently in private practice in the Holliswood section of Queens. She specializes in marital, family, individual and African American women's issues.

In addition, she has a wealth of experience as a medical social worker. She has worked in several level one trauma centers in the New York City area, dealing with the adjustment issues of acute or chronic medical illnesses along with various levels of crisis situations.

Wright is also an ordained, state-licensed minister and has devoted an additional section of her private practice to working with patients as an interfaith therapist, dealing with the issues and concerns of the Judeo-Christian population.

In 1990, Wright graduated from the Wurzweiler School of Social Work at Yeshiva University. She has also trained at the Albert Ellis Institute and is a member of the NASW. She is an active board member of the Society's Nassau Chapter, where she serves as the recording secretary. 🇺🇸

## **In Memoriam**

**T**he New York State Society for Clinical Social Work mourns the passing of Jeffrey Seinfeld, our beloved friend and colleague at the New York University Silver School of Social Work. A distinguished author of many works on object relations theory and a frequent guest speaker at conferences, he will be sorely missed.

something else. Physical money does not have inherent value, but only represents the value we assign to it. A piece of green paper with a number and a portrait of a dead president on it is still only a piece of paper. Ideas of money are represented with symbols such as dollar signs and certain beliefs are attached to this representation. Then people develop certain attitudes toward the ideas of money and, because of these beliefs and attitudes where money is involved, people act in certain ways. Some of these beliefs, attitudes and behaviors are mal-adaptive and cause problems for which a therapist's help becomes necessary.

On the other hand, there is no denying that money affects not only our psyches, but also our reality. Our economy is based on our faith in this abstract idea of money, which causes it to have powerful effects on our lives. In response to this reality our adaptations, our way of thinking and feeling, our very identities are formed — sometimes in pathological ways.

We also tend to use money as a tool or strategy to deal with other problems, in which case our use of money is our way of trying to adapt to these problems.

Let me offer case studies which highlight differences between a client for whom money was merely a strategy for achieving his ends, and one for whom money itself created a problem.

### **Case Study One: An Entrepreneur**

Sometimes the idea of becoming rich does fuel a client's activity. In this case, it is not the money itself, but his fantasies about what it will do for him, that causes problems. The first chapter of my money and happiness book, "So You Want to Become Rich," provides a case study of a young man who I call Sandy, described briefly here.

Sandy wanted to become rich and famous. In an attempt to do so, he started an entrepreneurial project which so preoccupied him that, outside of his day job, it took up all of his time. He invested all the money he could spare on this project. He was so involved that he lost contact with friends and become socially isolated. He assumed his girlfriend would want to be part of his plan to become rich, and never considered her needs as an individual. So she left him, which was the precipitating reason for his coming to therapy.

One of the things we learned during his treatment was that since childhood he had been very good at thinking up and effecting projects which would make money, and that his initiative in this area had gained him his father's approval. Part of the underlying reason for his wanting to make money was to gain approval (now thought of as fame) as he had in

the past. Another reason was that he came from a family that was less wealthy than those of his cousins and schoolmates, and felt excluded and snubbed by them. So he also wanted to become so much richer and more famous than his cousins that they would have to envy him, as he had envied them. His beliefs about what money would do for him were primary. His attempts to make money were just strategies for gaining approval and for getting revenge for having been snubbed.

### **Case Study Two: Granddaughter of a Rich Man**

A young adult woman was brought to me by her mother, who complained that she was too rebellious. The daughter, a Caucasian, was living with an African American man, which the mother considered a rebellion against the family. Part of the concern was that the daughter's grandfather was quite rich and she could inherit his wealth if she did not displease him. If he knew what she was doing, however, it was likely she would be disinherited. Because the daughter was not the one who asked for therapy, the mother agreed to pay for her sessions and, on this basis, the daughter agreed to try it out.

Although this young woman had a job, she was not financially independent. She had always relied on the family money for things she could not easily afford: help with her rent, a comfortable car, a vacation in Europe. She wanted to believe she could be independent, but was not willing to give up her reliance on her grandfather's largess as a way to live a more affluent life.

What she had not told even her mother was that she not only lived with her African-American "boyfriend," but was actually married to him. Yet she could not bring him with her on visits home for fear of causing problems. And, although he wanted a family, she would not agree to have children for fear of being disinherited. Although she claimed to love her husband, her attachment to the family money was stronger than it was to him. Unlike the case of Sandy, whose problems were caused by fantasies about what money could do for him in the future, in the granddaughter's case, it was the reality of the money itself that was a major cause of her problems. She had grown up with a cushion of wealth that, along with the threats of disinheritance, created in her a dependent character. The best she could do in an attempt to live a relatively independent life was to create a web of lies and deceit to get what she wanted.

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## How To Discuss Money With Clients

How can we best approach the discussion of money with our clients? Given the possibility that, due to the money taboo, clients may be made uncomfortable and resistant to talking about money, how direct or circumspect should we be in asking questions in this area? When and how is it appropriate to ask such questions? Do we need to be any more careful than we are when we ask other kinds of questions? And, are there particular techniques we can use to assist us in addressing money-related questions?

In the book, *New Ways to Have Conversations about Money with Our Clients*, Judith Stern Peck wrote that she believes talking about money is generally problematical. She recommends addressing this problem by first exploring the client's value system in order to lay the groundwork within the context of his values. While I agree that some clients are resistant to talking about it, I do not believe that clients are always so resistant to questions about their relationships to money. I tend to be more direct, and feel comfortable asking most clients about this relationship or pointing out something about how they are relating to money whenever I think it is pertinent and appropriate. I believe that my own comfort in this area allows most clients to talk with me about money without much difficulty.

Your comfort and confidence in your ability to raise money-related questions in a way the client can accept, and to offer clinically appropriate guidance, or even to make judicious use of confrontation, will depend on your having come to terms with your own relationship to money. This is so that you can avoid acting out countertransference having to do with your own beliefs and attitudes about money. It will also depend on having learned to recognize the client's comfort level and to understand the various ways that money can affect a person's development and adaptation. This requires developing self awareness, as well as educating yourself about money as a psychological force. There are a variety of ways to develop your expertise in this area. Reading is one way; a bibliography is offered on my website.

In the money and psychotherapy book, I describe six techniques to help clients be more comfortable discussing money and to help them to gain insight into their "money personalities" and money-related concerns. Briefly, I recommend asking some questions about the client's money history and relationship to money during the intake interview. This is a time when the client expects the clinician to be taking a general history, so these kinds of questions are likely to be understood as being in an appropriate context. By asking such questions at this time, the clinician also sends the message that talking about money is not taboo within the treatment relationship. The client's response to such questions will also


give the clinician a sense of how comfortable the client is about answering money-related questions. Some clients will experience the therapist's questions as a welcome invitation to talk about issues they thought were taboo, and that they may have otherwise avoided.

Where it is evident that the client's relationship to money is problematical and should be a focus of treatment, asking him to write a money autobiography to be shared with the therapist is another useful technique. It can help both of you to become aware of how his money-based beliefs and attitudes were formed and how this affects him in the present. In my book, I include a detailed outline which a client can use as a guide for writing such an autobiography. I also suggest several questions that can be asked or exercises that can be used, when appropriate, to draw out information about the client's wishes or memories having to do with money.

One technique that is often used in child therapy, but which I use with adults as well, is to ask what the client would wish for if a genie suddenly appeared and granted him three magic wishes. In my experience, the client often wishes for money. When this happens, it offers the opportunity to ask follow-up questions such as, *What would you do with the money?* or *What would having the money do for you?* Sometimes the answers can be quite revealing. One client may want money to help someone else, while another may want it to support himself in splendid isolation, and a third may talk about his desire to go to school or start a business. Thus, this question can lead to an understanding of a client's level of relatedness, narcissism or aspirations.

Similarly, asking a client for his earliest memory about money can often reveal a lot about his core concerns. One client told me that her father held a dollar bill in his fist and told her she could have it if she could get it from him. She tried to pry his fingers open and begged him to open his hand, to no avail. When, as a last resort, she tried biting his hand to get him to open it, she was spanked. This told me something about why she always thought of men as withholding.

## Summary

In this article, I discussed the money taboo in the clinical work and writing in our profession, giving particular note to how difficult it is for private practitioners to think or talk about money except in relationship to the fee. I have emphasized the importance of thinking about money as a psychological force affecting our clients' development and adaptations. I have offered suggestions about some techniques we can use to make it easier to talk about money in psychotherapy, and shared some brief case vignettes. 

### What Art Is: An Integration

GH introduced this section by sharing what he had gleaned from his extensive research on art and survival. Namely, that art is a psychological process that a person engages in as part of a special type of interaction with the world. During the initial phase of the creative process artists invest the world with subjectivity — he does this with a particular type of gesture (e.g. a swipe of paint on a canvas, a written phrase, a series of notes, etc). This new element, the artist's externalized subjectivity, becomes the focus of the artist's creative attention and work. Susanne Langer similarly describes how the artist creates “expressive form, or apparent forms expressive of human feeling”. However this process becomes art only when the internal subjectivity of the artist engages the external subjectivity of the new object in dialectic during which inner and outer subjective elements interact and change each other — gesture follows and builds on the previous gesture, the artwork gradually crystallizing as a network of gestures. The direction of change in the artwork is always towards perfecting, or “making special”. As a result of this the artist's subjectivity is expressed, elaborated and refined. The artist who engages in such a psychological process does so by making use of certain types of opportunities to create art. Art making involves the externalization of the artist's subjectivity. He or she accomplishes this transformation through gesture.

Gesture is important to the experience of the self. Our bodies, words, behaviors, ever changing and loaded with emotion and intension, are observed and linked to who we are, and most importantly who we are in the minds of others. In other words, gestures are fundamentally implicit, procedural forms of self-experience, and hence we may not be conscious of the meanings of our gestures, given that gestures are linked to emergent and preconscious expressions of self-in-the-world. Most importantly it is gesture in vocalizations, body movement, and facial expressions that is the means by which we communicate self-states, and influence each other's internal representational worlds.

Throughout life the creative person, the artist, channels his or her unique reparatory of gestures into the disciplines, methods, and contexts of his professional training and practice. The artist brings to that gesture a practice of recognition and selection built on a lifetime of experience. The

deepest sources of gesture are in the spontaneous, physical processes and response to living. They come to reflect who we are in body and mind as they are molded in the crucible of relationships, in education, and are further refined through knowledge, discipline, practice, criticism and appreciation. For the artist gesture is the vehicle of meaning, fully integrated into craft and elaborated by creative effort. At the same time he/she allows her/his body and mind to respond, to react, to make mistakes. This flexibility creates the readiness for new, as yet unseen, gestures, and the creation of conditions which allow for surprise. When we say that art begins with the externalized subjectivity of the artist we are not just talking about feeling, or emotion.

The artist's subjectivity is the personal experience of being. It is the sense of self both in terms of body but also being-in-the-world. In this sense the artist is just like us: all human actions have a subjective signature, the unique quality that each individual life possesses. The artist makes that subjective signature the focus of creative work, and by means of the creative process the artist's being is articulated and refined. In the best of cases, we experience the artwork as an exquisite and powerful aesthetic experience.

A room filled with the sound of applause and the welcome buzz of appreciation pushed us well into the time limit of this wonderful meeting. George promised to answer many unanswered questions and queries about the research only lightly covered in his presentation through electronic mail. We concluded with more applause for the lucky winners of door prizes of current, relevant books in the field and a pass around of the presenter's books in print. 🟩

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- Zeki, S. (1998). Art and the brain. *Daedalus*, Vol. 127.

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*Special thanks to Joy Sanjek, LCSW, for hosting this meeting at her office. She and Sema Gurun, LCSW-R, are Workshop Committee members.*

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### **Training Programs in New York City**

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For more information call  
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### *Invites Applications from Social Workers*

*for our*

### *Certificate Program in Psychoanalysis*

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The **Child and Adolescent Psychotherapy Training Program** is a 3 year program, including coursework and seminars, individual and group supervision, and clinical experience in our Child and Family Center

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Training is available to New York State licensed social workers (both masters- and doctoral-level) whose licensed scope of practice includes psychotherapy and/or psychoanalysis.