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

Clinical Social Work Is Now Licensed!

By Marsha Wineburgh, DSW, Legislative Committee Chair

On July 27, 2004, Governor George E. Pataki signed into law Chapter #230, the final version of our social work licensing bill (S7613/A9102). This law creates two licenses for the social work profession: the Licensed Master Social Worker (LMSW) and the Licensed Clinical Social Worker (LCSW). As of September 1, 2004, all CSWs have been converted into LMSWs and all CSWs with P/R Insurance status have been issued a clinical social work license. By now, most of the 69,000 certified social workers (CSWs) have received their new registration certificate. Be sure to sign it!

Eleven years after the Society for Clinical Social Work (NYSSCSW) introduced a bill to license clinical social work in New York State, we have finally succeeded. Was this effort worth it? You bet! The scope of practice for Licensed Clinical Social Work (LCSW) which describes and legally sanctions what we do in clinical practice is comprehensive. We have been

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(Above) Marsha Wineburgh was honored for her years of service in the licensing effort. (Below) At the licensing celebration, Bobba Jean Moody (left) with Mitzi Mirkin, Society Executive Secretary and her husband, Ed Mirkin.

Society Celebrates Licensing Victory

On Saturday, May 15, 2004, after its annual education conference, the Society held a dinner party at the Harmonie Club, in New York City to mark the passage of the new law licensing clinical social work. The party celebrated the 15-year effort by the Society's Legislative Committee led by Chairperson Marsha Wineburgh to achieve licensure for clinical social work in New York.

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PRESIDENT'S MESSAGE

New Challenges And Opportunities

By Hillel Bodek, MSW, LCSW, BCD

I am pleased and honored to write to you as I complete the first nine months of my term as President of the Society. This is an exceedingly important time in the history of clinical social work in New York, a time filled with challenges and opportunities. I hope that each of you will work with the Society as we move forward to meet these challenges and to take advantage of the opportunities for advancing clinical social work.

Our New License

As you read this letter, you will have recently received the registration certificate for your new license as either a licensed master social worker (LMSW) or licensed clinical social worker (LCSW).

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The new LCSW license is the result of legislative effort led by Marsha Wineburgh and the Legislative Committee that has taken almost 15 years. Throughout this effort, the Society persistently worked to inform the various participants in the legislative and regulatory processes about the skills of clinical social workers and the important role we play as one of the core mental health disciplines. More important, we did not waiver as we struggled to assure that the requirements for licensing as an LCSW would be consistent with the high standards of clinical education and clinical supervised experience that are needed to engage independently in clinical practice at an advanced practice level. The result of this effort is that we have achieved one of the most comprehensive scopes of practice for clinical social work in the country. We have maintained our professional independence by not being required to have either physician supervision or consultation. We also achieved enactment of a strong core clinical educational requirement for the LCSW, "completion of a core curriculum which includes at least twelve credit hours of clinical courses."

Become involved in your chapter. Join a committee. Volunteer to help the Society in one of its important projects — continuing education, supervision, mentorship, community outreach, outreach to agencies, outreach to schools of social work or outreach of other professionals.

The LCSW license provides, for the first time in New York, a clear legal definition of clinical social work, who we are and what we do. The reason for licensing health care professionals is to assure that only those who are competent professionals are entrusted with the responsibility to provide health services. By enacting the new clinical social work license effective September 1, 2004, the legislature and the Governor, as representatives of the people of our State, have placed trust and confidence in the skills, knowledge, ability and expertise of clinical social workers to provide high quality health (including mental health) services. We must not violate that trust.

The LCSW license imposes important challenges and responsibilities on the social work profession and its professional organizations, as well as on each social worker. The Society is prepared to do its share to meet these challenges and responsibilities, and seeks your input and efforts to work with us to do so.

Clinical Education

Social workers are ethically obligated to attain and maintain the knowledge, skills, abilities and expertise that are required to provide competently professional clinical social work services. With an ever expanding base of knowledge and new diagnostic and treatment techniques, clinical social workers, as health care professionals, must be aware of these clinical trends and advances and know how to integrate them into their practices. Further, the changing demographics of American society make it clear that there are a rapidly expanding number of persons who suffer from chronic illnesses, who are elderly, or who are terminally ill. Also, a steady increase in work-related mental and physical symptoms and disorders is being noted as the nature of the workplace becomes far more stressful and economic instability is increasing. Thus, developing competence in working with such patients and their families will steadily become a necessary educational goal for clinical social work over the next decade and beyond.

Among the main purposes of the Society are, "to establish and maintain high standards of professional education and practice," and, "to promote post-graduate and/or advanced training in clinical social work practice, teaching, administration and research." To this end, the Society's practice committees and its chapters provide ongoing continuing education opportunities. This coming year, the Society plans to increase these educational offerings. In order to do so, we are asking that our more experienced members to help us in this effort to provide more continuing education to help individual LMSWs and LCSWs increase their clinical knowledge and skills, and to offer clinical

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Clinical Social Work Licensed!

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given the right to provide mental health services without mandated physician referral, supervision or consultation. With this all-inclusive license comes the professional responsibility to be trained in any of the areas in which a LCSW chooses to practice. (For updates on the law, regulations and applications, see this website: www.op.nysed.gov/swcounts.htm.)

Why This License is Significant

This new license for clinical social workers legally establishes our credentials as one of the core mental health professions in New York State. Along with psychiatry and clinical psychology, LCSWs have the right to diagnose, develop and implement assessment-base treatment plans, and treat mental illness.

REASON ONE

For the first time, *clinical education* is required by law. Twelve credit hours of clinical courses must be completed either in an MSW program or after completing an MSW in order to sit for the LCSW examination. The course work must be relevant to diagnosis, treatment planning, treatment techniques and special populations.

REASON TWO

Supervised experience duplicates the current "P" Insurance Law. A candidate must have three years of full-time/six year's part-time supervised experience delivering psychotherapy services which includes practicing diagnoses and planning treatment. Supervision must be obtained from a licensed mental health professional, specifically an LCSW, licensed psychologist or psychiatrist. All *LMSWs* who are providing psychotherapy services must be supervised in accordance with the regulations developed by the State Board for Social Work.

REASON THREE

All qualifying *supervised experience* must be in either facility-based or private practice settings. As with the "P" insurance law, these settings cannot be combined.

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Society Celebrates Licensing Victory

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Many members of the committee were present for this celebration. *(See sidebar for committee.)* There are many other past Legislative Committee members, too numerous to mention, to whom acknowledgment is due, who worked with Marsha on this Herculean legislative effort over many years.

The highlight of the evening was the presentation of a plaque to Marsha honoring her years of devoted service to the Society during which she shepherded the licensing effort along the long, difficult road to fruition. Before that, she led the successful effort to achieve vendorship for clinical social workers, by enactment of the "P" law in 1977, and the "R" law in 1984. In presenting the plaque, Hillel Bodek, Society President, noted that few people have contributed as much to the Society and to clinical social work as Marsha has during her many years in the profession and as a member of the Society. The outpouring of gratitude for Marsha's years of effort to achieve the most extensive scope of practice for the profession of clinical social work was enormous. Our lobbyist, Mary Ann McLean Esq., was also honored, as was Diana Georgia Esq., former legal counsel to the State Senate Higher Education Committee.

Mary Ann McLean delivered the keynote address, recounting many anecdotes about various events that occurred during the long struggle toward achieving licensure for clinical social work. Helen Hinckley Krackow, Past-President of the Society, and Hillel, who drafted dozens of versions of the licensing law as a consultant to the Legislative Committee, also addressed the gathered members of the Society. Mitzi Mirkin, who has contributed so much to the Society, above and beyond the call of duty, over her long and continuing tenure as the Society's Executive Secretary, and her husband, Ed, who has designed the covers of many of the Society's membership directories, were the Society's guests at this celebration. The evening's festivities ended with concert given by the jazz group, Uptown Sound, two of whose members, Helen Hinckley Krackow and Dorothy Buzawa, are members of the Society.

LEGISLATIVE COMMITTEE	
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Vendorship & Managed Care

by Jonathan Morgenstern, CSW-R, ACSW, Chair

As the incoming committee chair, I offer appreciation and thanks to Alice Garfinkel, the outgoing chair, who has been supportive during the transition. She continues to be helpful, in addition to all the excellent work I've been told she has done.

The committee will continue to function in a supportive role to Society members in their dealings with insurers and managed care organizations. Inquiries are welcome and should be made to the representatives listed below. Hillel Bodek, the Society President, has made himself available to help with ethical issues related to managed care.

One recent interesting inquiry was from a member who initially contracted for private payment and, mid-treatment, found out that the client had managed benefits, that she was on the panel and the MCO was requiring her to reimburse the balance between the amount she contracted for with the client and the amount she was contracted for with the MCO. The provider is in fact so liable. To avoid this situation, it is the responsibility of the provider to make thorough and ongoing inquiry as to changing coverage, and to document contemporaneously in the record of the sessions in which the inquiries occur the results of such inquiries.

Society members who are contracted with MCOs are strongly encouraged to read contracts prior to signing them. While this may seem obvious to some, many inquiries reflect ignorance as to contract content. Signing a contract makes one responsible to conduct oneself in line with what has been agreed upon – your word is your bond. Doing otherwise leads to consequences clearly stipulated within the contract. "If you can't do the time, don't do the crime." An important aspect of clinical treatment is responsibility, and nowhere is this more evident than in the manner we manage the business dimension of providing psychotherapy and other clinical social work services.

Many private practitioners are in fact small business owners, requiring an additional body of knowledge for success. The Society's Independent Practice Committee offers support in this area, and members are advised of an upcoming conference — "Clinical Entrepreneurship in Changing Times: Building Your Practice With or Without Managed Care" on October 2nd. Another relevant resource is the publication Psychotherapy Finances (http://www.psyfin.com/default.htm).

Updates and News

Recent news includes the reduced fees announced by ValueOptions for the GHI-BMP contract. I have received copies of a couple of well-written letters by members to the MCO, eloquently pointing out that the fee reduction comes at a time that providing treatment to covered members involves more (unreimbursed administrative) work while business expenses have increased; that this act is perceived as the company devaluing its provider panel. Hillel Bodek wrote a letter on behalf of the Society, ending with: "In summary, we believe that ValueOptions' and GHI's fee reductions for clinical social workers (and clinical psychologists) have regretfully conveyed a message that they are not provider friendly, are not concerned with the needs of their clinical social work (and clinical psychology) providers, do not truly value them and the services they provide, and do not appreciate them as the asset they are to their health plan." The letter was responded to by the Vice President of the NYC Service Center. He wrote that, "There is a large supply of social workers and Ph.D.s and not enough corresponding demand to keep prices (fees) as high as providers want. ValueOptions is obligated, professionally and morally, to help its clients get the most value from their investment. If the market determines that we can save money in one area, we must do so." In other words, the fee reduction was a business decision. I think it is important that we understand that clinicians and managed care have completely different

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VMCC REPRESENTATIVES

Metropolitan	Peter Smith	(212) 744-6428
Queens	Shirley Sillenkens	(718) 527-7742
Staten Island	Colleen Downs	(718) 816-0712
Nassau	Fred Frankel	(516) 935-4930
Suffolk	Ellie Perlman	(631) 368-9221
Westcheser	Liz Ruggiero	(914) 321-1170
Rockland	Beth Pagao	(845) 353-2933
Syracuse	Gary Dunner	(315) 488-1884
Statewide	Jonathan Morgenstern	(914) 967-4567

By Hillel Bodek, MSW, LCSW, BCD

Comprehensive Training Offered

In 2001, the Society created its newest practice committee, the Palliative and End-of-Life Care Committee. During the 2002-2003 academic year, the Society presented a 32-hour *Comprehensive Training Program in Palliative and End-of-Life Care: Working with Chronically Ill and Terminally Ill Patients* to two separate groups of Society members, one in the fall of 2002 and another in the spring of 2003.

What is Palliative Care?

There is a widely held misconception that palliative care is synonymous with end-of-life ("EOL") care. Initially, EOL care was the primary focus of palliative care. This was due to the fact that, commencing in the early 1990's, there were large infusions of funding (particularly through the Project on Death in America that was supported by the Open Society Institute and the Soros Foundations Network) for palliative care services, education and research in relation to terminally ill patients. Also, the National Public Radio series, "The End of Life: Exploring Death in America," (1997-1999) and the four-part series, "On Our Own Terms: Moyers on Dying," that aired on PBS in 2000, brought greater public attention to the issue of death and dying.

Palliative care is the treatment of pain and suffering. Dame Cicely Saunders, the founder of the modern hospice movement, was a British nurse who, after sustaining a back injury, became a medical social worker. After observing the problems in the provision of pain management to dying patients, she decided to become a physician so that she would be able to improve the treatment of pain. She wrote about "total pain"— physical, emotional, social and spiritual — all of which are interrelated and must be properly addressed in order to provide appropriate holistic patient care.

Palliative care is a state of mind. It is a patient-centered rather than illness-centered way of viewing, conceptualizing and approaching the provision of healthcare in a holistic manner that considers and addresses the physical, psychological, social and spiritual dimensions of the experience of injury, illness and disability. Although palliative care may become the primary treatment being rendered when curative care has failed or is no longer viable, it is never the absence of care. It is a technically sophisticated area of expertise in the evaluation and treatment of the range of symptoms — physical, psychosocial and spiritual — which may accompany physical injury, illness and disability, one that is more powerful than ever in the history of healthcare. It is based on whole patient assessment and ongoing reassessment of goals and priorities of care. It seeks to empower patients to make informed treatment decisions based on their clinical status and their particular beliefs, values, priorities, feelings and concerns regarding life, illness, disability, mortality, death. In doing so, it respects and seeks to foster the autonomy of each patient, to be a partner with each patient in the provision of care to them, and to enhance each patient's dignity.

Because addressing the range of bio-psychosocial-spiritual issues involves a wide range of knowledge and skills, palliative care requires interdisciplinary and transdisciplinary collaborative practice bringing together the expertise of professionals from different health care disciplines. More than any other area of healthcare, quality palliative care depends to a significant degree on the clinician's use of self. Thus, it requires a high level of clinicians' self-awareness of their beliefs, values, priorities, feelings and concerns regarding life, illness, disability, mortality, death and quality of life. It requires a careful balancing of the need for empathic closeness with the need to maintain appropriate professional boundaries and clinical objectivity. It necessitates a respect for, understanding of and close attention to a wide range of beliefs systems, values, religions and cultures. Palliative care addresses not only the needs and concerns of patients but attends to the needs and concerns of the patient's family, friends, significant others and caregivers.

The Role of Clinical Social Work in Palliative Care

Clinical social workers are uniquely qualified to provide palliative care services. Among the health care professionals, we are the best trained to assess and address the psychosocial-spiritual problems of patients within a

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The Many Faces of Love

Pathways and Barriers to Intimacy

Each year the annual conference for the New York State Society receives rave reviews; however, this year's conference was superb. Congratulations to Dianne Heller Kaminsky, Chair, and the entire Education Committee for an outstanding job. Both Valerie Tate Angel's paper on "Love Lost and Then permitted" and Denise Zelman's paper on "The Good Enough Intimacy: Intersubjectivity and Couple Therapy" were beautifully presented and make an original contribution to the field of psychoanalytic psychotherapy and couple therapy. The two papers are reviewed here. The afternoon workshops received excellent evaluations as well and it is only because of limited space that they are not reviewed as well.

PRESENTATION BY VALERIE TATE ANGEL, CSW

Love Lost and Then Permitted

Reviewed by Lorraine R. Tempel, PhD, CSW

Lorraine R. Tempel is in private practice in Manhattan and is an Adjunct Assistant Professor at Columbia University School of Social Work.

Valerie Tate Angel's informative presentation crystallized and illuminated the kaleidoscopic terrain encountered when considering the complicated topic of love. Melding together the psychoanalytic works of Freud, Bergmann, Stolorow, Mitchell and Davies with citations from philosophy, biology and mythology, Angel illustrated how the progression from infantile to mature love is inextricably linked to the development of the self, a process throughout which mourning the loss of the Oedipal love object plays a crucial role and is thus central to all future love relationships.

Warming us up for the rocky road to achieving intimacy, Angel stimulated us with Schopenhauer's fable (as cited by Freud in 1921) about a group of porcupines hanging out in the cold who attempt to find warmth by moving closer to each other. As they move together, their quills cause them to recoil, but the need for warmth sends them back together, only to repeat the whole cycle again. Angel used this as a metaphor to help us begin thinking about the antithetical forces which operate in the psyche when the human animal sets out to find a love object. She also gave us a flavor of the biochemical aspects of love and cited recent research advances about the intricate biological mechanisms operating in the brain's release of neurotransmitting chemicals in the regulation of sexual desire. Citing a study by Pfizer in which a group of women were physiologically aroused when administered Viagra, Angel reported that these participants needed "exquisite timing and a perception of intimacy" in order to connect their arousal with desire. Thus, Angel painted the contextual picture for beginning to understand the importance of a loving relationship in this process.

She presented the "cautionary tale" of "Cupid & Psyche" (Apuleus) which she used to illustrate the extreme dangers which the individual may face when setting out to attract a mate. She interspersed the story with her own comments about the behaviors and emotions encountered in matters oedipal, including extreme envy, deception, distrust, retaliation (and fear of it), mortality and the wish for immortality. Angel emphasized that in our work with patients, we view the unfolding of these emotions both through our patients' recounting of them and through the transference. She reminded us that the child's competitive feelings with

the same sex parent and desire for the opposite sex parent are "rooted in a quest for exclusivity, not incest," and that "love lost and then permitted" involves "giving up and working through the accompanying disappointment" at not achieving this exclusivity.

Angel's discussion theoretically expanded Freud's idea that "all love is refinding" with Bergman's commentary that the quest to find a love object has as its' aim the "refinding of a lost ego state." Angel put forth that love may be a means toward expansion of the self. She asked us to consider that the quest for the love object incorporates and captures (for better or worse) the attunement and misattunement that the self experienced in the early mother/infant relationship. She offered to us that an individual may love someone who can heal or rescue them from these early wounds. This reviewer would like to emphasize Angel's implication that when the relationship with the original love object is fraught with trauma, the mourning process is impeded and mature love is thwarted. We so often find that severely traumatized individuals who are desperate to find healing often make inappropriate choices because they are emotionally blinded by their own neediness.

Valerie Tate Angel, CSW

Incorporating Davies' writings, Angel presented a relational approach to understanding the "revitalization" of the oedipal complex which zeroed in on the mutual influences of the original child/parent relationship in determining the quality of the child's future love relationships. Angel posited that monogamy is rooted in early wishes for exclusivity with the parent. She stated that it is not only the child's wish for exclusivity--but also the parent's wish—that may prevent the necessary resolution to take place. Angel emphasized that parents must be able to "untie their own feelings about being replaced" with "an empathic identification of the child's assertive and affectionate self" and reminded us that Freud (1914) originally referred to the oedipal complex as the "parental complex." The clinical case material that Angel presented supported her conviction that treatment can move the individual who is unable to find a satisfactory love relationship due to early oedipal trauma. It is also interesting to ponder how early family interventions, particularly work with parents when their children are young, might preventively preclude some of the suffering which we observe with the individuals in our practices.

On the Nature of Love

Angel also discussed the philosopher Irwin Singer's (1987) conceptual categories on the nature of love. As Angel described them, Singer posited a developmental progression beginning with "falling in love" to "being in love," to "staying in love." Falling in love generally involves emotions described as "earth shaking" or being "crazily in love." Many of the individuals we see in treatment never move out of this phase; instead, they repeatedly move in and out of relationships and re-experience the "falling in love" feeling. Angel brought in Bergmann's writings about the development of transference love (and although not explicitly stated, the clinician's management of it) as an opportunity to work through "love lost," particularly because the structure of the patient/clinician relationship does not allow for acting on libidinous feelings.

"Being in love" involves a more sustained "special bond" and what Angel (citing Freud, 1912) described as "the union of affectionate and sensual currents into one object." In "staying in love," the special bond aspect of "being in love" is able to sustain itself even when there are extra-relational, co-occurring circumstances acting upon the love relationship. According to Angel, the power of "staying in love" is a "culmination of self cohesion...because...the self can suspend its need without the feeling of being lost." Thus, the self is able to be there for the other. This is a reciprocal, looping kind of process because it requires that the other then be there to supply the necessary nutrients when needed by the original self, with the process continuously recycling.

Angel highlighted that these three categories are somewhat fluid so that earlier phases of the progression may be called upon further down the line. For example, she explained that the memories of "being in love" can help the couple overcome hardships which may threaten their capacity to sustain the relationship. This reviewer would like to emphasize that the latter point can be particularly useful to call upon when working with couples who present with despair about their relationship in the treatment room. Encouraging couples to recall what drew them together in the first place — their first feelings of "being in love"— may prove to be of assistance in helping them to regain their grounding. The latter illustration is just one of numerous examples of how Angel's richly theoretical presentation held a wealth of practical applications for daily practice.

PRESENTATION BY DENISE ZALMAN, MSW, BCD

The Good Enough Intimacy

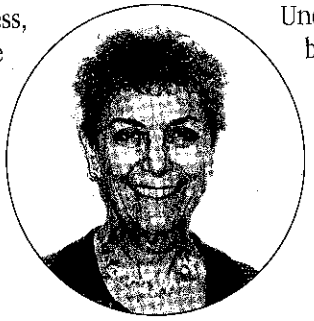
Intersubjectivity and Couple Therapy

Reviewed by Gil Consolini, MSW

Gil Consolini, MSW, is in private practice in Manhattan. He is a training analyst with The New York Center for Psychoanalytic Training and a doctoral candidate at New York University School of Social Work.

In her exceptionally engaging, theoretically rich, and clinically savvy keynote presentation, Denise Zalman offered a view of the attainment of an intimacy in the long-term treatment of couples that is "good enough." Zalman, who is a training analyst, senior supervisor and faculty member with The Postgraduate Center for Mental Health Psychoanalytic Institute, as well as an Institute for Contemporary Psychotherapy faculty member and supervisor, used intersubjective theory to do so.

Individuals coming for help with their marital problems today, Zalman stated, have to rely on each other in an unprecedented way. Once primarily social, political and economic arrangements, marriages and other similar adult partnerships are now the "primary holding environment for adults." Since traditions and laws are no longer enough to preserve the marital relationship, the "issues of trust, openness, authenticity, and mutuality have become especially important in preserving the goodness of the relationship and preventing its dissolution."



Denise Zalman, MSW, BCD

For the therapist treating a couple, helping partners become more intimate with each other is much harder than simply getting them to get along with each other. As Zalman indicated, the psychoanalytically-oriented therapist who has traditionally relied on object relations theories and self psychology recognizes that the individual's developmental history has a great deal to do with how he or she perceives his or her partner. Inevitably, fears of being disappointed and re-traumatized as well as hopes of getting one's needs met are transferred on to the spouse.

However, as Zalman argued, a developmental arrest model does not provide enough of a theoretical framework for the understanding of how adults interact. Traditionally, psychoanalytic theory has understood difficulties in the development of intimacy in the couple from the perspective of the individual rather than the perspective of the dyad. To correct what Stephen Mitchell has called this "developmental tilt" in psychoanalytic thinking, intersubjective theorists have emphasized that intrapsychic and interpersonal development cannot be viewed separately from the properties of the interactional system.

Intimacy for Zalman is a "one-person experience in a co-created two person field." She believes that we feel intimate when we are able to be one with ourselves while we are securely connected to someone we trust who cares deeply about our personal fulfillment. Understanding what makes one capable of becoming intimate from a developmental perspective is necessary but not sufficient to understand and foster the experience of intimacy in marriage. Individual experiences of intimacy are created within a unique co-created intersubjective context that is both enhancing and limiting at the same time—an intimacy that is "good enough."

Zalman offered various conceptualizations from intersubjective theory that she has found to be helpful in the understanding of couples, including the distinction between implicit and explicit levels of relating and the contrast of moments of similarity or complementarity with moments of difference and opposition—in both their positive and negative effects. After she pointed out that different authors have addressed different aspects of intersubjectivity, she commented that Jessica Benjamin's views are particularly relevant to the treatment of couples who are unable to negotiate differences.

People are attracted to each other because their similarities make them feel intimate without effort. With time, they discover their differences, something that offers them the opportunity for greater intimacy or threatens them as individuals with increased isolation and depletion. With treatment, partners become less

Education Committee members (from left) Gil Consolini, Lorraine Temple, Jill Winston, Tripp Evans, Dianne Heller Kaminsky, Committee Chair, Roxandra Antoniadis and Charlotte Elkin.

excessively reactive to each other in relation to their differences and gradually are prepared to work in therapy to become more intimate with each other.

Zalman described how the therapist uses his or her subjectivity to support the expression of each partner's subjective experience—of the therapist as well as of each other—and progressively uncovers and addresses fantasies of "instant intimacy as the hallmark of a good marriage." The fostering of the understanding and acceptance of the other as a subject rather than an object is an especially important aspect of their work together. As a result of this work, partners become better able to tolerate the "otherness of the other they can neither share nor understand, and they begin to experience pain and loss where they originally felt defeat and rage." The relinquishment of lost illusions helps them appreciate what they actually have together and enables them to more easily offer each other solace.

The fostering of the understanding and acceptance of the other as a subject rather than an object is especially important... Partners become better able to tolerate the otherness of the other that they can neither share nor understand, and they begin to experience pain and loss where they originally felt defeat and rage. The relinquishment of lost illusions helps them appreciate what they actually have together and enables them to more easily offer each other solace.

Zalman ended with three vignettes of her work with couples, informed by intersubjective theory. In the first, the use of the therapist's subjectivity to engage a couple in finding a non-judgmental collaborative way to help the husband express himself more freely was illustrated. Zalman shared her subjective experience of the attempt by Paul, the husband, to communicate with his spouse, Linda, and with Zalman herself to show them the subjective nature of each of their responses and the benefit of turning their implicit experience of each other into explicit knowledge.

In the second, Zalman demonstrated how she helped a couple recognize the circularity of their interactions while creating a space for reflection, empathy and negotiation. As a result of their work together, each learned to insist less upon regulation by the other. In the third, Zalman illustrated the value of stressing intersubjective relatedness in work with couples. As a result of her long-term engagement with Steve and Ellen, they were able to confront their differences without suffering profound alienation. In fact, as she indicated to them, they had found that their levels of animation and conviction could at times be more alike than they had ever expected.

Zalman was thus able to demonstrate quite convincingly that treatment of the couple consists of work with "minds in contact" rather than "isolated minds trying to make contact." The thoughtful questions and comments from the audience following her presentation also indicated that she had made a very good case for the value of treatment planning that recognizes the inevitability of intersubjectivity in long-term, in depth clinical work with couples.

PRESIDENT'S MESSAGE

New Challenges And Opportunities

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education services to health, mental health and social service agencies to increase the skills of their staffs. For those experienced LCSWs who are hesitant to teach because teaching is not a skill they have developed, we intend to offer training to help them develop clinical teaching skills.

Supervision and Mentoring

The new licensing law requires supervision for master's level social workers who are providing clinical social work services. And, LMSW's will be required to have three years of full time or its part-time equivalent obtained over not more than six years of supervised experience in providing clinical social work services in order to qualify for LCSW licensure. In addition to its mentoring program for social work students and recent graduates, the Society hopes to begin to offer low-to-moderate fee supervision, both in cooperation with agencies for agency LMSWs and LCSWs, and for LMSWs and LCSWs in other practice settings. In order to do so, we are asking that our more experienced members to help us in this effort to provide low-to-moderate fee supervision to LMSWs and LCSWs in cooperation with agencies and for LMSWs and LCSWs in other practice settings. For those experienced clinical social workers who are hesitant to supervise because supervision is not a skill they have developed, we intend to offer training to help them develop clinical supervision skills.

Community Outreach

Now that there is a clear legal definition of clinical social work practice in New York State, this is an appropriate time to renew our efforts to inform the general public and to educate our professional colleagues from other disciplines about clinical social work. We also need to work with social work students to interest them in pursuing careers in clinical social work.

Among the main purposes of the Society is, "to inform the general public of the specialized skills of clinical social workers." In this regard the Society will attempt to increase our outreach to the public through chapter-based activities geared to working with their unique local communities. Additionally, we are planning to commence a program to reach out to other health care professionals, groups and agencies, both to educate them about clinical social work and offer presentations that can meet their training needs. Community outreach not only benefits clinical social work and the Society, it also provides a vehicle for members who participate in this effort, and their practices, to become known in their communities.

Professional Pride

We must be proud and clear that we are social workers. What makes clinical social work so unique and valuable is the rich heritage, history, values, beliefs and framework of social work. We assess, treat and serve our patients/clients holistically in a bio-psycho-social-spiritual framework. We view our patients/clients and address their needs in the context of their environment -- from their intrapsychic self, to their family, various group and other relationships, to their communities and the larger social systems and policies which affect their lives. This is what makes us unique and valuable as health care professionals. If we abandon or fail to take pride in our social work heritage, clinical social work will lose its soul, and we will tragically become just one other group of people who practice psychotherapy.

Membership Recruitment

Among the main purposes of the Society is, "to collaborate with other social work and clinical social work organizations in order to address issues of mutual concern, to further our common goals and to provide a voice for clinical social work." We must reach out to our colleagues in other areas of social work, to work with them on issues that concern our profession, as several of our chapters having been doing successfully for some time, particularly in the area of continuing education. In relation to clinical social work, we must recognize that the Society is not a group devoted to private practice. It is a group devoted to clinical social work without regard to the setting in which it is practiced. We need to attract to the Society more of our clinical social work colleagues who work in agencies, where the largest number of clinical social workers practice and where the largest amount of clinical social work services are provided. Over the next year we will be asking members who work in or who have regular contacts with agencies to assist us in this effort.

Revitalizing the Society Website

By the end of 2004, the Society hopes to complete the overhaul of its website. The new website will have links to all chapters and committees. It will be much easier to navigate. It will also provide on-line access to the Society's membership directory. Society members will be able to update their membership information and to determine which parts of that information they want to have in the public view. Members of the public and other professionals will be able to search the public portion of the Society's membership database to locate clinical social workers who can meet their needs for

Monthly Mentorship Groups

The Society offers monthly Mentorship Groups to students and recent graduates of masters level graduate programs. They provide a continuation of the professional support by peers that is lost at graduation. The groups, led by our experienced members, offer help in clinical social work career planning, provide information and support for job searches, ethical guidance and information about further training. As groups develop, opportunities for case discussion are provided. A five dollar fee is charged to non-members of the Society. If you are professor teaching clinical social work students, we would be happy to provide you with fliers for distribution to them prior to graduation in December and May. Please contact Helen Hinckley Krackow at (212) 683-1780 with the number of fliers needed, your name and address.

CHAPTER MENTORSHIP CONTACTS		
Brooklyn Chapter	Donna Arking, LCSW	(718) 434-2801
Metropolitan Chapter	Helen Hinckley Krackow, LCSW	(212) 683-1780
Nassau Chapter	Fran Slater, LCSW	(516) 481-9772
Staten Island Chapter	Dennis Guttman, LCSW	(718) 442-2078
	Donna Rothestein, LCSW	(718) 982-6480
Suffolk Chapter	Terry Greenberg, LCSW	(516)736-1173
Westchester Chapter	Nan Miller, PhD, LCSW	(914) 273-3261
	Judith Stone, LCSW	(914) 941-4173

CONTINUED FROM PAGE 10

clinical social work services. Also, we will be requesting that each member of the Society who has e-mail, provide their e-mail address when they update their membership information. E-mail addresses will not be available for public view. But, this e-mail address will be used by the Society to communicate with members at a significant cost savings.

Participate in the Society

Finally, the Society is your Society. Like other professional organizations, our members look to the Society for various types of assistance, some of which we can provide and others which we can't. Yet, it is easy for members to forget that they are the Society. Without their participation and assistance, the Society's ability to serve its members and accomplish its goals will be limited to some extent.

Social workers have an ethical obligation to contribute their time and energy to help advance the profession. In 1960, President Kennedy indicated that Americans needed to ask what they could do for America, rather than what America could do for them. But, alas, this is no longer the Kennedy era and society has changed. The Society asks that you not only to seek our assistance, but that you participate in the Society and increase through your contribution of time and energy its ability to serve the clinical social work profession, the public and all members of the Society. It is all too easy to expect another of your colleagues to devote his or her time and energy to the Society while you reap the benefits of those efforts without contributing your own. Become involved in your chapter. Join a committee. Volunteer to help the Society in one of its important projects — continuing education, supervision, mentorship, community outreach, outreach to agencies, outreach to schools of social work or outreach of other professionals. This is your Society. In the end result, it will reflect the extent which you, individually and as a group, participate in it and contribute your time and energy to it. We cannot do it without you.

If you need to contact me on Society business please e-mail me at nysscsw@mindspring.com and, in addition to your message, please leave your day and evening phone numbers. I continue to chair the Society's Committee on Ethics & Professional Standards. If you need to get in touch with me in that regard please e-mail me at clinicalswethics@mindspring.com and, in addition to your message, please leave your day and evening phone numbers so that I can call you back if I need to.

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Vendorship & Managed Care

CONTINUED FROM PAGE 4

agendas; to the extent that we want to challenge managed care decisions, we must understand such issues as market forces and be prepared to interact relevantly.

Another piece of news is a recent mailing from Magellan – a bulky compilation of contracts, the signature pages of which must be signed and returned by providers by December 17, 2004 in order to maintain their status as in-network providers. Society members are encouraged to read all contracts thoroughly and make a business decision of whether to sign or not.

Members are advised that Medicare is conducting practice audits and are strongly advised to maintain adequate records and case notes. Standards for Clinical Documentation and Record Keeping constitute Appendix One of the NYSSCSW HIPAA Compliance Manual, and members are referred to this publication in order to comply with professional standards and safeguard their practices

Please contact me at 914-967-4567 with suggestions for this column and copy me with relevant correspondence.

Clinical Social Work Licensed!

CONTINUED FROM PAGE 3

As a point of interest, the private practice setting has again been recognized by New York as a legitimate arena for social workers delivering mental health services. (Insurance laws were the first to recognized private practice). As noted earlier, the *LCSW* can work autonomously (without supervision) in any setting including private practice; LMSWs *with qualified supervision* may practice in all settings, including private practice.

Private practice has historically been a controversial area for the social work establishment. It is still devalued by some as a betrayal of traditional social work's commitment social justice and environmental change.

The new LCSW statute introduces a different perspective. In the past, private practitioners have usually been seasoned clinical social workers who had many years of agency experience as well as advanced clinical education. Private practice was often used interchangeably with independent practice, i.e., practicing outside of supervision. Our LCSW legislation allows for LMSWs to be in private practice providing they are supervised in accordance with the regulations of the State Board for Work. In fact, *no LMSW in New York State may practice clinical social work without supervision no matter what setting they are in – agency, mental health clinic, hospital, or private practice.* This is because the licensed supervisor is responsible for the work of the LMSW, both what is done and what is not done.

The National Association of Social workers has long favored a minimum of two years of agency experience before entering the *independent (unsupervised)* private practice. Many of us would agree with this standard, remembering our own early social work experiences when there were many agencies offering well-supervised clinical jobs, in-service training and the luxury of staff meetings. But clinical social work services and the agencies or institutions that delivered them have changed. Financial restraints and time commitments required by increased accountability (paperwork) have cut into staff training. Adequate supervision of clinical practice is often spotty; in non-urban areas, qualified supervision is often only from outside the agency. Finding agency-based employment to gain experience delivering psychotherapy services is challenging. With the passage of this law, the state saw fit to recognize the private practice setting as appropriate for psychotherapy services and the need to provide oversight of clinical services provided by LMSWs through supervision by licensed mental health professionals.

REASON FOUR

Insurance reimbursement laws have not been changed. We continue to be able to qualify for insurance coverage for mental health services. The qualifications for the "P" or the optional insurance reimbursement law are identical to those for LCSW. However, one must apply for the "R" level which requires 3 additional years of supervised psychotherapy experience.

Bottom line for LCSWs

This licensing law, like all social policy legislation, will have an unforeseen impact as it begins to take on a life of its own. We can only speculate on what influence licensing may have on the social work profession or what licensing psychotherapists in New York State will have the larger community of coaches, body workers and rehabilitation counselors. This we know for sure: we have legal recognition for the specialty of clinical social work as a mental health profession. Licensed Clinical Social Work has parity with clinical psychology and psychiatry. We can practice autonomously, i.e. without mandated physician consultation, referral or supervision. We have insurance reimbursement privileges. We are competitive with the new mental health professionals about to be licensed in January 2005. These are the licensed marriage and family therapists, the licensed mental health counselors, the licensed creative arts therapists and the licensed psychoanalysts.

Was licensing clinical social work worth the effort? Absolutely!

Warning to LCSWs

Our license as an LCSW is stronger and more comprehensive that any of the newly recognized mental health professionals mentioned above. We can do everything they do, with proper education, without the requirement of physician supervision. They have no insurance laws requiring reimbursement for their services in New York State. Think carefully before applying for any of these other licenses. The risk is that you will be held to the standards of the most restrictive license in all of your professional work. For example, you will lose the all the privileges associated with Licensed Clinical Social Work if you become a Licensed Marriage and Family Therapist or a Licensed Psychoanalyst.

Palliative and End-of-Life Care

CONTINUED FROM PAGE 5

bio-psychosocial-spiritual framework. The use of self and the development of self-awareness are skills and traits that have historically been viewed as essential to the provision of clinical social work services and a core part of our training. Respect for, understanding of and paying close attention to a patient's beliefs systems, values, religions and cultures are, too, a core value and core competence of ours.

Clinical social workers are often the professionals who coordinate the provision of services to chronic patients, particularly in outpatient settings. Our practice is grounded in the recognition of and respect for the autonomy of each patient, and on the importance of maintaining and enhancing each patient's dignity. Another of our important well-established professional roles is empowering patients by helping them to participate fully in the planning for and implementation of the clinical services rendered to them. We are the health care professionals who have traditionally had the responsibility to address the needs and concerns of the patient's family, friends, significant others and caregivers, and have been specifically trained to do so.

The changing demographics of American society make it clear that there are a rapidly expanding number of persons who suffer from chronic illnesses, who are elderly, or who are terminally ill. Those who are chronically ill are living longer with their illnesses because new treatments are helping to slow the progress or achieve remission of their disease, enabling them to maintain longer their quality of life. Many of these people will need and can benefit from clinical social work services to address the psychosocial-spiritual issues arising as a result of their medical problems. Most physicians have little, if any, training in palliative care, and do not have the time to spend with patients that it takes to begin to address their psychosocial-spiritual problems. Working together with physicians by providing palliative care services to their chronically/terminally ill patients is a good way to partner with these physicians to provide comprehensive care for such patients and to maximize their ability to maintain good quality of life as long as they can. Even for those clinical social workers who do not work with the chronically/terminally ill or elderly, other patients they see in their practices are likely to have concerns and stress relating to their personal experience dealing with a chronically/terminally ill patient or elderly person in their family. And, eventually, all of us are likely to have such personal experiences and concerns.

Palliative Care Education from the Society

The Society provides a Comprehensive Training Program in Palliative and End-of-Life Care: Working with Chronically Ill and Terminally Ill Patients. This training program provides thirty-two hours of instruction. It is designed to provide clinical social workers with the core knowledge and skills that will enable them to assess and address appropriately and adequately the needs of patients who suffer from chronic and/or terminal illnesses and their families. This training program covers the major topics related to palliative care for chronically/terminally ill patients: (i) Gaps in Palliative and End-of-life Care, (ii) Psychosocial Aspects of Chronic Illness and Terminal Illness: Taking Care of Our Patients and Ourselves, (iii) Advance Care Planning, (iv) Communicating Bad News, (v) Whole Patient Assessment from a Palliative Care Perspective, (vi) Elements of and Models of Palliative and End-of-life Care, (vii) Pain Management, (viii) Suicidality including Physician-Assisted Suicide, (ix) Anxiety, Delirium and Depression, (x) Goals of Palliative and End-of-Life Care, (xi) Legal Issues in End-of-life Care, (xii) Sudden Illness, (xiii) Medical Futility, (xiv) Common Physical Symptoms, (xv) Withholding and Withdrawing Treatment, (xvi) Last Hours of Living, (xvii) Spirituality in Chronic and Terminal Illness, (xviii) Teamwork and Interdisciplinary Collaborative Practice, and (xix) Grief, Bereavement and Mourning.

This program can be provided: (i) on six consecutive Saturdays from 9:00 AM – 2:30 PM (with snack breaks), (ii) on four consecutive Saturdays from 9:00 AM – 7:00 PM (with lunch and snack breaks), or (iii) on two consecutive or (iv) alternate weekends from 9:00 AM – 7:00 PM each day with lunch and snack breaks. The base fee for this program will be approximately $250.00 (which covers the cost of the training participant manual and other training materials and the Society's actual costs for this program), plus an additional sum (probably $75.00 to $100.00) to cover the cost of lunch, snacks and space rental, and speaker travel that is yet to be determined. The speakers all volunteer their time. We had attempted to conduct this training in the Hudson Valley Region and on Long Island this year, but there was insufficient registration in each area to conduct the program. Thus, we are going to offer the program once next year, in the spring, either in Westchester or New York City, for the entire Society.

If you are interested in this training, please e-mail Hillel Bodek at palliative-care.csw@mindspring.com, with your name, address and day and evening phone numbers.

ANNOUNCEMENT

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New Bi-annual Publishing Schedule

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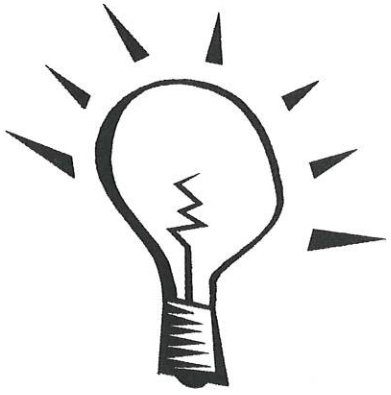

Your ideas are always welcome.

Send news items and articles (in digital format only, please) as well as photos and captions for **THE CLINICIAN** to

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Continuity and Freedom: Core Elements in the Analyst's Work
Saturday, December 4, 2004, 10 a.m. to 3 p.m.

Estelle Shane, Ph.D.
Transforming Aggression Through the Analysis of Shame
Wednesday, January 19, 2005, 7 p.m. to 10 p.m.

Polly Young - Eisendrath, Ph.D.
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Saturday, January 29, 2005, 10 a.m. to 3 p.m.

Gilbert W. Cole, Ph.D. and
Christopher B. Eldredge, C.S.W.
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Saturday, March 12, 2005, 10 a.m. to 3 p.m.

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