NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC

SUMMER 1989 • VOL. XX, NO. 2

Annual Meeting '89

Addiction/Compulsion . . . When You Can't Say No

Report by Selma Samuel, CSW
Conference Reports Coordinator

The Annual Meeting of the NYS Society took place on Saturday, May 13, at the elegant and stately Association of the Bar of the City of New York. The morning session provided the business aspect: Carole Ring, education committee co-chair, welcomed the membership and introduced the topic of the day: *Addiction/ Compulsion . . . When You Can't Say No,* and the workshop leaders (see reports, this issue).

Society President Robert E. Evans reported on the recent board Retreat held in early spring — a working meeting resulting in a statement of refocused objectives and redefined priorities for the Society. (For complete report on the Retreat, see the Spring 1989 Newsletter.)

Public Relations – Committee chair Phyllis LaBella reported a change of PR representation in the effort to enhance the Society's visibility and to define our distinctive presence as clinical social workers and as a unique discipline.

Committee on Psychoanalysis – Rosemarie Gaeta reported for this national committee; training and development was acknowledged, as was the active involvement of the NYC committee in the upcoming second Annual National Conference to be held again in Philadelphia.

Legislative – Chair Marsha Wineburgh reported on activities of the 11-member committee representing all NYS chapters. This year reflects a very active session on the State level. Four major areas include:

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Workshop

Psychoanalytic Treatment of Addictions

Report by Mitchell May, MSW

This workshop on the treatment of addictions focused on the use of psychoanalytic concepts in the treatment of patients who abuse a substance to handle the stresses of life and on the feelings of the therapists involved in that treatment.

The feelings of the therapist may be influenced by a variety of factors, among which are the terms "addiction" and "drug abuse." These are social, legal and political terms with strong derogatory and judgmental bases that cause problems for both the patient and the professional. They encourage patients to deny being a human with problems and to see themselves as "drug addicts" whom the world should pity. For the professional, these tags tend to rob the patient of humanness and to develop counter-transference problems in the therapeutic attitude toward the patient. Rather, the term "preoccupation" serves well. The patient is a human being whose symptom is a preoccupation with the drug,

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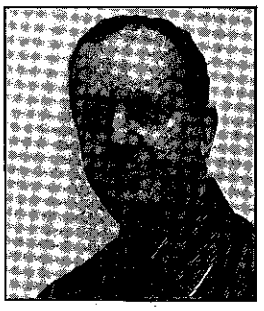
President-Elect

Upon the recent resignation of Marcia Rabinowitz, CSW, as president-elect, the state board met in special session to appoint a replacement. Philip Banner (Brooklyn) is currently president-elect and will assume office as president January 1, 1990, for a two-year term.



Philip Banner, CSW (Diplomate)
President-Elect

Long active on both state and chapter levels (a founding member of the Brooklyn chapter), Phil Banner has "vigorously participated in the workings" of the Society. A member since 1969, he has served as member-at-large, 1986-1987; has coordinated three Annual Meetings (1986, 1987, 1988); and served as nominating and election chair in 1987. In this capacity he has "reached out to membership throughout NYS to broaden participation on the Board." At the chapter level, he has served as treasurer and corresponding secretary (currently, for the second time). He has consistently mounted large-scale membership drives for both state and chapter.

Phil offers "my enthusiasm and the pledge . . . to work hard for the Society and our profession."

Phil is a staff member of Brookdale Hospital Medical Center (Brooklyn), Department of Psychiatry, and is in private practice. An MSW from Wurzweiler School of Social Work, Yeshiva University, New York City was followed by certification in psychoanalytic psychotherapy at the Institute for the Study of Psychotherapy.

EXECUTIVE REPORT

First Priority: Fiscal Planning to Implement New Goals

After a summer hiatus the Society's board will be wrestling with a difficult decision. For at least the last five years the board has been discussing the advisability and feasibility of hiring an executive director to carry out some of the administrative functions which are currently performed by the president along with the executive committee and others who work on a volunteer basis during their terms of office. Whether or not we need to establish a central office for the Society has also been debated.

It is clear that as the Society has grown, it has become more difficult to manage. Past presidents have recognized this and have worked hard to improve the efficiency and effectiveness of our organization. Among the innovations of our immediate past president, Adrienne Lampert, were the development of the "president's letter," which is sent to members after each board meeting; regular meetings of the executive committee; and the establishment of an "ad hoc" chapter presidents' committee. In addition, the office of President-Elect was created to add stability and continuity to the organization. These have been substantial improvements, but they may not be sufficient to meet the challenges of the '90s.

The board Retreat held in March this year provided an opportunity for us to begin to envision our future. The Retreat generated energy and creative ideas. For the past few months the board has been sifting through them trying to separate the wheat from the chaff. An administrative task force has been charged with exploring alternatives to our current organizational structure, defining the possible functions of an executive director, estimating the costs involved in establishing and maintaining this position and a central office. As we consider these alternatives, it has been important to keep our design realistic. Sound fiscal planning is essential.

Robert J. Evans, CSW
President

...Federation Highlights

A meeting of the National Federation of Societies for Clinical Social Work was held from May 4 – 7 in Washington, D.C. Highlights included

— Report from our national advocate John Dill including a Kennedy-Waxman update

— Establishment of Past Presidents' Council and National Task Force on Clinical Social Work

— Update from American Board of Examiners in Clinical Social Work (ABE) and National Institute for Clinical Social Work Advancement (NICSWA)

— Committee Reports

— Plans for 20th Anniversary Celebration

See next issue of the Federation Newsletter for details.

TREATMENT OF ADDICTIONS *(cont.)*

a preoccupation resulting in harmful repetitive behaviors.

The addictive patient uses the addiction as a way of trying to stabilize. Whatever the addiction (drugs, sex, food, gambling), its use is an attempt at self healing — to mask the fear of confronting universal human feelings.

The workshop discussed the underlying unconscious meanings behind the behaviors of such patients: compromise formation; acting out of unconscious wishes and fantasies; defense against psychosis; curative fantasy; oral/anal/phallic development as it relates to drug use as a defense against growth; and use of the drug as a transference. In addition, there is a factor in the use of the drug as a relationship: a way of relating, a transference, i.e., the drug is a non-person but still the real relationship of the patient. Use of the drug is an attempt at self regulation, self medication; but it is a failed attempt at self healing.

In treatment, the patient has the opportunity to begin a new relationship, to shift the relationship from the drug to the therapist. By trying to stay with the pain of the patient and tolerating often overwhelming feelings, the professional can lead the patient to a shift from a harsh infantile super-ego to a more benign super-ego.

The workshop stressed the idea of "becoming friendly" with these resistances. Resistances and defenses are important to the patient for survival; the therapist should develop in-depth understanding of the use of defenses, and respect for the pain and anxiety of the patient and must come to grips with her/his own anxiety.

Staying with the pain of the patient is not easy. The term "burnout" applies here and refers to those responses evoked in the professional by the patient that impede treatment; these responses result from "blind spots" — unanalyzed portions in the professional are triggered that lead away from the pain of the patient. These are the counter-transference and counter-resistance issues at play.

These issues were explored, among which are the unconscious wish to control the patient; the fantasy of saving the patient; fear of one's own aggression and anger; fear of liking the patient; seeing the patient as less than oneself; getting caught in reality issues and patient crises;

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A QUESTION OF ETHICS

No Client Contact Does Not Mean No Liability

Risk in Delegating to Trainees

By David G. Phillips, DSW

Clinical practitioners know that they have certain ethical and legal obligations to their clients, defined as the "standard of care" of the profession, and that they may be held liable for failure to fulfill these responsibilities. In recent teaching on legal and eithical issues, one of the most interesting questions to arise concerns the possible liability of supervisors: What are the responsibilities and risks in situations in which we have no direct contact with the client? This column and the next will discuss some of the answers to this complex question. A major source will be the very valuable book by Ronald Jay Cohen, which is one of the few sources to discuss, or even to recognize, the existence of this issue.

Supervising liability is a "gray area."

Gray Area

Cohen points out that supervisory liability is one of the "gray areas" as it pertains to the mental health professions; there are few actual cases to guide us in understanding how courts will define this concept. There are, however, a number of supervisory liability cases in medicine in which, for instance, a physician is held liable for the actions of a nurse. In the absence of case law, perhaps the best place to start to understand the responsibilities we have as supervisors is to begin with the regulations that define and govern our practice.

The Regulations of the State Education Department in New York prohibit licensed professionals from practicing beyond the scope of their licenses and from performing professional responsibilities for which they are not competent. An extension of this concept is found in another regulation prohibiting licensed professionals from delegating professional responsibilities to another person whom we know, or should know, is not qualified by training, experience or licensure to perform them.

The latter action, sometimes called "lending a license" (in which a non-professional practices under the "cloak" of a licensed professional) can be very serious. Aiding and abetting an unlicensed person in the practice of a profession is, in fact, a felony in New York State. In a recent case, a prominent plastic surgeon not only lost his license but was sentenced to three months in prison for a number of charges, one of which was "aiding and abetting the unauthorized practice of a profession." In this case the physician had staffed his clinics with unlicensed doctors with foreign training and then misrepresented their qualifications in his advertising. In this case, as in many similar, it was the licensed professional — the "supervisor," and *not* the unlicensed "employees" — who was punished.

Do these regulations mean that we endanger ourselves in supervising students or inexperienced professionals who are not yet licensed? Not necessarily, if proper precautions are observed. The State recognizes that training for professional practice must take place and that trainees must be supervised. As Cohen points out, however, it is crucial that the unlicensed person be competent to perform the services that are delegated to him or her, and that the functions of the licensed person not be delegated totally to the unlicensed one. If a reasonable person is not able to distinguish between the unlicensed practitioner and the licensed professional, then the latter may be in danger of being seen as "lending" his or her license. The next column will discuss those aspects of the law that provide a financial incentive for plaintiffs to try to hold supervisors responsible for the actions of their supervisees.

References

Cohen, TJ: Malpractice: A Guide for Mental Health Professionals. The Free Press, 1979.

Social Work Handbook: The University of the State Of New York, The State Education Department, September 1988.

TREATMENT OF ADDICTIONS *(continued)*

use of theoretical concepts to limit observation and understanding of the patient; and guilt and grandiosity of the therapist, which takes from the patient the validation of his/her own feelings. The only solution is for clinicians to understand and analyze these powerful feelings evoked in themselves. □

Workshop

Eating Disorders

Assess, With Patient, Underlying Issues

Report by Selma Samuel, CSW

The workshop attended by this writer was led by Arden H. Greenspan-Goldberg, who provided the participants with a smorgasbord of references, mediation, participatory activities, slides, lecture anecdotes; all in small doses and easy to digest.

The gentle voice of the therapist invited the participants to relax and then to remember and recall one's personal eating memories and to identify the feelings associated with this thought. Next, there was small group sharing and then sharing with the group as a whole. Together we identified not only our own feeling states but those of the individuals we treat.

"If the eating had a voice what would it say?"

Anorexia Nervosa, Bulimia and Compulsive Overeating are major eating disorders. The underlying issues of each individual must be assessed: "If the eating had a voice what would it say? How does a patient feel before a binge (purge), during a binge (purge) and after a binge (purge)? The patient needs to become aware of what he/she feels at the moment of acting out this symptom.

Slides illustrated some of the popular cultural humor and more serious hype to which we are all subjected regarding diet, thinness standards for attractiveness, etc.

There was a bountiful array from which to select. The basic ingredients of successful treatment are concern for the emotional or intrapsychic aspects of the individual, awareness of the impact of cultural determinants of eating disorders and addressing the diet itself.

There was much left unsaid. Another workshop at another time would be a treat.

Tomorrow and Tomorrow and . . .

Doing the laundry. Choosing a college. Writing a thank-you note. Changing your job. Procrastination — the big "P" — is about as certain as death and taxes. Even the most dedicated mover and shaker procrastinates. Many of us put off one specific thing — taking piano lessons, for example — for years, sometimes forever. Some spend their entire lives procrastinating about almost everything. Why do we put things off, especially when it makes us feel so guilty?

Procrastination can be defined as "delaying or postponing some activity that is important to you," according to NYS Society's Crayton E. Rowe, Jr., CSW, a recent guest on WMCA's Carol Ehrlich show. Procrastination can range from moderate to severe, according to its consequences, "If you wait until the last minute to buy Christmas presents, you'll probably just end up being a little pressured. But if you haven't been feeling well and you fail to see a doctor, it could kill you."

Anxiety is the basic cause of procrastination. We tend to put off anything that makes us feel anxious. For example, you might accept an important project at work, but unconsciously you doubt you can handle it. When you think about the project, or actually start to work on it, you may experience what some have described as a vague feeling of anxiety. What procrastinators are really trying to avoid is the uncomfortable feeling associated with a task, not the task itself.

However, a way to stop procrastinating is to allow yourself to "sit with" your anxiety for a while. "When you let yourself experience your anxiety, two things may happen. The anxiety might start to diminish, and you may begin to understand why you're anxious."

. . . a fear of success is a fear of losing identity.

Fear of Success

Part of the fear of success is a fear that we may lose the sense of who we are. Many people find that the possibility of succeeding in their goal makes them uncomfortable — fear of success is really a fear of change. "Success brings with it a new situation. If you complete that big project at work, you may get a promotion. That may mean more responsibilities, longer hours, more travel."

There may be a valid "need for delay."

It's also possible to have a valid reason for procrastinating — a "need for delay." People often find that they aren't ready, either physically or emotionally, to do something that is part of their larger goal. "Accepting a new job might mean selling your house and moving and that might not be feasible for a while. The point is, when they feel they are ready, they are more likely to take action."

Fighting It

A person who lets things pile up really 'puts out of mind' that he's procrastinating. To monitor yourself, keep a diary. If you find yourself consistently setting something aside once or twice a day, you probably have a problem with procrastination.

Two other tips to help fight procrastination: Ask yourself what would happen if you did the thing you want to accomplish. How would you feel? How would your life change? Then ask the opposite question: What are the consequences of *not* doing it? Would the quality of your life suffer? Would you have regrets someday? This is a good way to assess the risks and benefits of your goal, and your true feelings about it.

One final note. While conquering procrastination could make you rich and famous, it doesn't necessarily mean you'll be more popular. Crayton, co-author of the recently published *The Technique of Psychonalytic Self Psychology,* noted that his publisher told him that "everyone wants to write a book. When someone they know actually does it, they feel guilty. They're sure they could do it too — if only they could stop procrastinating." □

Workshop

Erotic Compulsions

Report by
Laura Arens Fuerstein, MSW

The workshop entitled "Erotic Compulsions," led by Laura Arens Fuerstein and Sanda Bragman Lewis, was introduced with a discussion of the conceptualization of "compulsion" in the field. Clinicians think of compulsion as behavior that the subject is obliged to act out without internal control, in order to avoid anxiety. Through the years this concept has most often been placed within the context of overt behavior such as fetishism or Don Juanism. A less familiar application of the term was introduced which is found in the more subtle notion of "compulsive fantasy;" this might be reflected, for example, in a patient's pervasive need for a lover with a specific body type in order to reach orgasm.

The group was prompted to consider the historical evolution of erotic compulsions. Since Freud was largely responsible for the delineation of the term, his early studies call for some review. Early on, he viewed patients' symptomatology as based primarily on real childhood events, traumatic in nature. He later revised this view and focused on the unconscious fantasy attached to the happening. Lewis and Fuerstein related that in recent decades there seems to be a reversion to the earlier perspective with a resultant underemphasis on the patient's fantasy life and a narrower clinical assessment.

Another historical element noted is the evolution in diagnosis of erotically compulsive individuals. In the early years, castration anxiety was considered the primary cause of these disorders; with the incorporation of ego psychology and object relations theory into the clinical framework, however, there has been a shift to a more preoedipal coloring in this area, which at times effaces the value of the concept of castration anxiety. There is a need for a more balanced approach to include both perspectives in treatment.

Note: Due to a death in the family, Sanda Bragman Lewis was unable to submit a report.

ANNUAL MEETING *(continued)*

1) jury exemption for clinical social workers (S.4014), amending judiciary law to exempt psychologists *and* social workers who provide direct psychotherapy services; 2) the issue of confidentiality (A.7319), which protects the confidentiality of information submitted to insurance carriers; 3) provision for social work psychotherapists in private practice to receive direct reimbursement from Medicaid (S.1419/ A.2112); 4) multi-level licensing to clearly define our areas of function and skills of practice as clinical social workers, thereby protecting the consumer and affording the credentialed clinical social worker a clearly defined edge.

On the Federal level, the Kennedy/ Waxman bill (S.1265/ HR.2508), which includes social workers as health insurance providers in its mandatory health care coverage for employees is not likely to be a priority during this administration.

Federation – Adrienne Lampert, National president-elect, spoke of the leadership of the NYS Society on the national level in the establishment of more uniform acceptance of clinical social work practice nationwide. The Federation is also meeting with other regulatory bodies focusing on regulation, education, public relations and research in the constant upgrading of our profession.

For distinguished service in the Society, Diplomate status was awarded to Agnes Giantini and current NYS President Robert E. Evans, both members of the Staten Island chapter.

A buffet lunch was followed by well attended workshops.

IN BRIEF

Diagnosis of Mental Disorders by CSWs: Correct Assessment Crucial for Quality Patient Care

By Hillel Bodek, MSW, CSW

Part 2

Diagnosis of mental disorders as defined in Part I (Spring 1989 *Newsletter)* is the process of integrating biological, psychological and social data regarding an individual into a coherent assessment of mental functioning, and evaluating the factors that have led to and which underlie the current condition. A correct diagnostic assessment is essential to the provision of appropriate and comprehensive treatment planning.

Too often, the training of clinical social workers has neglected to provide the necessary grounding in the role of physical illness in the development of mental symptoms. Additionally, CSWs have not been exposed to patients presenting with a wide range of psychopathology.

Diagnosing Mental Illness

Learning to diagnose mental illness requires a combination of practical/experiential as well as didactic/academic training. It is not sufficient to read about mental disorders and symptoms. To develop diagnostic acumen, one must have the experience of seeing patients who present with various forms of psychopathology and following them as their illness progresses.

The essential diagnostic tools of the mental health professional are taking a relevant history and the performance of a mental status examination. The failure to take an adequate history, particularly with regard to the patient's physical and mental health and in relation to the development of the patient's presenting symptoms, constitutes a gross deviation from acceptable practice. Similarly, the failure to conduct a mental status examination through which all aspects of mental functioning are evaluated either informally, through the interview process, or formally, through direct questioning, constitutes a failure to adhere to basic standards for conducting a proper diagnostic assessment.

When the NYS legislature recognized that properly trained clinical social workers could diagnose mental illness (Chapter 990, New York State Law, 1984), it placed a burden on professionals to make diagnoses based on appropriate assessments and to practice within the scope of their training and experience. More important, it placed a burden on their respective training institutions to assure that clinicians are properly trained and that they are provided with appropriate supervised experience to enable them to diagnose in an effective and responsible manner that enhances the quality of patient care.

Case History

Recently a man who had been seeing a clinical social worker in individual and group therapy was brought to my office by his family. He had a long history of "thinking differently than others," persecutory and somatic delusions, auditory hallucinations, Capgras syndrome and impairment of sleep and activities of daily living. The clinical social worker had not conducted a thorough evaluation of his mental status, was unaware of the severity of his symptoms and was treating him for more than a year for a personality disorder. She had not conferred with his physician nor had she referred him for psychiatric evaluation. The patient was suffering from schizophrenia of the paranoid type, which she had failed to diagnose. I began to see the patient in therapy and referred him for pharmacotherapeutic treatment on an emergency basis. Two weeks after beginning proper treatment resulting from a proper diagnosis, his psychotic symptoms were in significant remission.

This case can serve to illustrate the serious consequences of a failure to conduct appropriate diagnostic assessments. The failure to diagnose a mental disorder in and of itself is not malpractice. However, a clinician's failure to diagnose properly a patient's illness because of the absence of appropriate assessment or because the requisite academic and experiential knowledge was lacking to make a proper diagnosis can lead to significant malpractice liability for the clinician. □

BOOKS

Venus After Forty: Sexual Myths, Men's Fantasies, and Truths About Middle-Aged Women
Rita M. Ransohoff, PhD.
New Horizon Press, Far Hills, NJ
Distr: MacMillan Co., New York,
1987, 276 Pages

From the perspective of a psychotherapist in New York City, Dr. Rita M. Ransohoff has drawn upon her three decades of clinical experience and research to confront and decimate powerful, pejorative myths, men's fantasies and destructive attitudes about the sexuality of women. It is her thesis that older women are viewed by middle-aged men as sexually "over the hill" because of the anxieties experienced by the men themselves in middle age. And it is within the emotional life of men that the answers are to be found in relation to the double standard of aging. To gain access to spontaneous, unguarded male fantasies about older women, the author turns to myths, ancient and modern, fiction, the media and, "best of all," to jokes and cartoons. Sigmund Freud identified humor as a rich source of fantasy — that within the context of the joke, deep-seated fears and anxieties as well as persistent wishes were expressed.

Older women are viewed by men as sexually "over the hill" because of the anxieties of men themselves in middle age.

Myths and Fantasies

Part I looks at a number of myths and fantasies which have resulted in women's thinking about themselves as sexually unattractive. Among the myths that Ransohoff dismantles are:

- the older woman as voracious, sexually greedy and insatiable; as warlike (a "battle ax"), a vampire harridan; as benign, asexual and totally without interest in sex
- instant aging after menopause
- the tight versus the slack vagina
- the "smelly old bag"

Dr. Ransohoff develops her evidence of the power of these myths and their consequent entrenched attitudes with extensive examples from case histories and copious quotes from a variety of publications. The explanatory psychological theory to illuminate the evolution of these fantasies is drawn from developmental theory — with findings from ego psychological thought — and the direct observation of children. This has resulted in new models with enriched Freudian hypotheses. Chapter II, "Out of the Nursery," offers a well-formulated, readily understood summary of the development, especially in males, dealing with the vicissitudes in negotiating their primitive fantasies about mothers, elaborated through the Oedipal period and adolescence into adulthood and the "downside of the curve," middle age.

Realities and Facts

Part II deals with the realities — the facts about the sexuality of middle-aged women which the myths have succeeded in obscuring. The author explores the anxieties men feel about their aging: their worries about the inevitable decline in power and the fears of passivity and dependency — and the reliance on sexuality as their affirmation of masculinity (with vignettes about men who do not fit the stereotype). For men who cannot deal with their anxieties in middle age, the myths once again become emotionally charged and may become the basis for a rationalization to move away from middle-aged women. Otto Kernberg views the awareness of limits as the basis for what is probably the major task of middle life — dealing with a long-term sexual relationship. Whether one can deal with the conflicts within the relationship and resist the temptation to test the limits of sexual potential outside it, is central to the task.

Narcissistically vulnerable middle-aged men who lack an integrated sense of self, require accelerated reassurance and approval. They become grandiose to camouflage feelings of inadequacy. The denial of unacceptable changes in themselves may be projected onto others who are then devalued. Those men most likely to leave marriages in middle age are those who must remain eternally young, labeled by Dan Keley as "the Peter Pan syndrome;" the author views this as a variant of pathological narcissism. And there are stories from older men who deserted their mature wives for younger mates and came to regret it.

Women who buy the myths . . . become obsessed with eternal youth.

Women who buy the myths often become obsessed with eternal youth. Each of the four cases presented represents one of the four types conceptualized by the author. Drawn as composites selected from her practice and acquaintances, each contains sufficient psychological history to affirm the importance of the mother-daughter relationship in the evolution of the self. The women described are unprepared for the second half of life; some respond to the crisis of widowhood or divorce with hypochondriasis, alcoholism and depression. Narcissistic men and women experience aging as a loss or regression rather than as normal development. Each may pursue efforts to forestall the spectre of aging. In our society, however, men have the option of turning to a younger woman, an option that is not open to most women.

It is within the emotional life of men that . . . answers are to be found in relation to [our] double standard of aging.

New Options

As an encouraging contrast, the first Chapter of Part III is about couples for whom mature love is a vital part of their lives. The issue of infidelity is addressed with recognition of its complexity and the double standard in our society. The weight of research supports the desire for monogamy and the pain experienced by the "betrayed" partner. Despite its difficulties, marriage continues to be the most positive option for the possibility of security, a measure of stability and intimacy — if that is one's desire.

New options for middle-aged women, comprising much of the remainder of the book, include the larger number of women

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BOOKS *(continued)*

choosing to remain single, younger men-older women relationships and later first marriages. The women discussed personify dynamic change and growth in middle age — they are too busy to think of the passing years as enemies. Ransohoff's experience indicates that the single women she has known are conducting their lives as if they will remain alone — not, however, shutting the door on the possibiity of finding a partner.

Those who deal well with their single status share a sense of self worth, with their sexuality an integral part of their self concept; they are able to be sensual human beings regardless of age. Among these are such famous women as Jane Digby, Colette, Lou Andrea-Salomé and others chosen by the author as subjects of a final chapter about older women who feel good about themselves, their bodies, and who have gratifying relationships with men. There are examples of men and women in enduring relationships and couples who surmount crises, gaining insights that have enriched their lives.

This is a compassionate, encouraging and potentially enabling book. The appeal, to this reviewer, is primarily to relatively sophisticated middle-class and upper-middle-class women who seek increasingly to take charge of their lives. Clinicians will find this interesting — repetitive perhaps, but with familiar themes. And it can stimulate attention to our own attitudes toward the sexuality of our middle-aged and older clients.

Phyllis Caroff, DSW, is professor emerita, Hunter College School of Social Work. She is currently in private practice specializing in work with adults and couples.

Second Annual Conference

"The Widening Scope of Psychoanalytic Treatment" is the title of this year's national clinical conference sponsored by the Committee on Psychoanalysis. Scheduled for November 16-19 at the Penn Tower Hotel in Philadelphia, the conference will feature presentations by Margaret Frank, MSSW; Judith Mishne, DSW; Joseph Palombo, MA: Herbert Strean, DSW. In addition, papers, workshops and panel discussions with distinguished practitioners will highlight the event.

For details: Crayton E. Rowe, Jr., MSW - Chairman (see NYS Directory).

Two Awarded Diplomate Status

Two Staten Island members have become Society diplomates. Robert J. Evans, CSW, and Agnes Giantini, CSW, were awarded this advanced standing at the Society's Annual Meeting in May.

Robert J. Evans, CSW, currently serves as president of the NYS Society (1988-1989) after his term as president-elect. A Fellow since 1984, he has long been active on the chapter level, serving as treasurer, referral committee chair and president from 1985 to 1987. The first president-elect, he assumed presidential responsibility familiar with its functions and has vigorously pursued solutions to the Society's "growing pains."

Agnes Giantini, CSW, a Fellow, has held various positions at chapter level, including president and education chair. Currently she is vice president and program planning co-chair. She represents the chapter on the Staten Island Mental Health Council. On the state level, she was a member of the 5-Year Planning Committee from 1983-1986. Agnes was active in the drive for parity, working with legislators in Staten Island.

Welcome to New Members

Welcome to the following new members. We hope they will take an active part on both chapter and state levels. All hands are needed!

Brooklyn
Christine Apuzzo
Randy Yudenfriend Glaser
Janice C. Jeffrey
Mercedes Peters
Judith E. Ruiz
Ninette Setton
Teresa M. Testrake
Joy E. Witchel

Metropolitan
Elinor Auslander
Robert Bakst
Judith L. Block
Margaret Boyle
Beth Jan Dolobowsky
Ruth Garbus
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Susan G. Davis
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