

# The CLINICIAN

FALL 2010 | VOL. 41, NO. 2

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

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## PRESIDENT'S MESSAGE

By Jonathan Morgenstern



Jonathan Morgenstern,  
MSW, LCSW

The planning for the Society's Annual Membership Meeting program this year is a model for the importance of infrastructure to the accomplishment of our Society's stated purposes.

A committee had been selected by the State Board to plan our entire annual membership meeting – subject, topics, program, setting and promotion. When the initial (and hastily advertised) program proposal was reviewed and revised, challenges were made both from within and outside the committee to the established process. Ultimately, the original infrastructure was upheld and the result was an excellent program which featured presentations by Dr. David Hamilton, Executive Secretary, State Board for Social Work, and our own Michael Koetting (who chaired the planning committee which also included Beth Pagano and Dore Shepherd) and Dr. David Philips (Society Past President and former Society Ethics Committee Chair, currently serving on the Society's By-Laws

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## LEGISLATIVE COMMITTEE REPORT:

### State Finalizes Social Work Licensing Regulations

*Formal comments were submitted to the State Education Department by NYSSCSW*

By Marsha Wineburgh, DSW, Chair

A Notice of Proposed Rule Making (a change in regulations) was published in the State Register on June 30, 2010. In response to this notice, formal comments were submitted to the State Education Department on behalf of the Clinical Society objecting to, in particular, the change in regulations with regard to supervision requirements for the LCSW. Our comments focused primarily on the inadequacy of group supervision as an acceptable clinical supervisory experience for LMSWs mastering diagnosis, treatment and treatment planning for the mentally ill. Unfortunately, the proposed amendments were revised and continued without our suggested changes by the Board of Regents at the June 2010 meeting. The revised regulations were published in the State Register on September 29, 2010 and may be adopted as permanent regulations by the Board of Regents at the November 2010 meeting.

The following material is from the "Summary" of proposed amendments to the social work licensing regulations prepared by the State Education Department.

#### LCSW Experience Requirements

Section 7704(2) of the Education Law requires an applicant seeking licensure as an LCSW to complete three years of full-time supervised post-graduate clinical social work experience

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## CONFERENCE REPORT: Contemporary Approaches to the Treatment of Trauma



*The 41st Annual Education Conference in May featured outstanding keynote presentations by (photo left) Catherine Lewis and Crayton E. Rowe, Jr.*

SEE PAGE 8.

Photo: Sandra Indig

## State Board Members 2010

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Listserv	Robert Berger <a href="mailto:rsb111@columbia.edu">rsb111@columbia.edu</a>

## President's Message

CONTINUED FROM PAGE 1

Revision Committee). All graciously offered to present on short notice.

The purposes of our Society include strengthening professional identity, building professional networks, promoting professional expertise and advocating for clinical social work. The infrastructure to accomplish these goals includes members who volunteer to make up the state and chapter boards to provide administration and support; members who volunteer on state and chapter committees to provide specific goal-related work; and administrative supports now provided by Sheila Guston and Total Management Solutions, who had made all of the meeting's setting arrangements. Mitzi Mirkin, former Society Consulting Administrative Assistant who retired earlier this year, was honored for her many years of service to the Society.

Volunteerism is the life blood of the Society – everyone volunteers on top of everything else they already do – and this represents both our greatest strength through commitment, and also our greatest limitation.

Our infrastructure also includes our by-laws, which are currently undergoing updating and revision by a committee chaired by Beth Pagano, and our policies and procedures, which were recently compiled into 11 manuals by the Strategic Planning Committee, chaired by Judy Crosley. These anchor and guide all our work on behalf of the Society. Volunteers do not have to struggle with how to do things – our manuals pretty much spell everything out clearly, and make it easier to transition from one leader to the next. It is this infrastructure that supports all that we wish to accomplish. I have spent the last three years of my presidency strengthening this infrastructure through transparent and collaborative communication and leadership. Our future requires nothing less.

### Vision for the future

My vision for the remainder of my presidency includes further clarification of our identity as a society of clinical social workers. Are we a society of private practitioners only, or do we include clinical social workers in all work settings (e.g., agencies, clinics and hospitals)? If we choose to be more inclusive, we should consider offering services of relevance and value, including broader educational offerings and peer supervision – and we will need to engage in outreach. Some chapters are already planning for this.

We should be more involved in the process of establishing more clarity regarding distinctions currently being made between “clinical social work” and “psychotherapy,” since this is causing much division within the social work field.

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in diagnosis, psychotherapy and assessment-based treatment planning, or its part-time equivalent obtained over a period of not more than six years. The law does not require the applicant to complete any other social work experience, although the practice of licensed clinical social work includes other activities, including case management, advocacy, and testing. Such activities are not acceptable toward completion of the experience requirement under the current law. The new regulations adopted in June require an applicant to complete 2,000 client contact hours in diagnosis, psychotherapy, and assessment-based treatment planning over a period of not less than 36 months and not more than 72 months under a qualified supervisor. While this is a 30 percent reduction from the current requirement for 2,880 client contact hours over the same period of time, it is still among the highest requirements for clinical hours in the U.S., and the Department believes 2,000 client contact hours provides sufficient experience to ensure client protection once the applicant is licensed.

Section 74.3 of the Commissioner's regulations was also amended to clarify the experience requirements for licensure as an LCSW in New York. The amendments require an applicant for licensure to complete the required experience as an LMSW or permit holder

**FOR COMPLETE TEXT OF LETTER TO STATE EDUCATION DEPARTMENT ON BEHALF OF SOCIETY SEE PAGE 13.**

in New York, except in certain limited circumstances. For experience completed in another jurisdiction, the experience must be obtained after the applicant completes his or her master's degree. The amendment requires the applicant to complete the experience in an acceptable setting under a qualified supervisor, as defined in section 74.6 of the Commissioner's regulations. The amendment also requires the supervisor to maintain records of the applicant's client contact hours and supervision and to submit verification of the client contact hours and supervision on forms prescribed by the Commissioner.

The regulations also add a new section 74.9 to allow the Department to endorse for practice in New York the license of an LCSW licensed in another jurisdiction. The applicant would have to have at least 10 years of licensed practice during the 15 years immediately preceding the application for licensure in New York. In addition, the applicant must demonstrate: licensure as an LCSW on the basis of a master's degree in social work from an acceptable school, post-degree supervised clinical experience, and the passage of a clinical examination in social work acceptable to the Department. The applicant must also be of good moral character, complete coursework in the identification and reporting of suspected child abuse, and submit the application for licensure and fee established in law and regulation.

Section 74.4 of the Commissioner's regulations was also amended to clarify that limited permit applicants must be of good moral character and that the permit may only be issued for work in an authorized setting under a qualified supervisor. In addition, the amendment strengthens the requirement that the supervisor is responsible for the services provided by the permit holder and limits a licensee to supervising no more than five permit holders at any one time. Since the permit holder is only authorized to practice under supervision, this restriction is appropriate for public protection and consistent with the requirements in other professions. An LMSW or LCSW permit holder who is practicing clinical social work under supervision must be under general supervision as defined in the proposed amendment.

### "R" Requirements

Experience for the insurance privilege, "R," must be obtained after licensure as an LCSW over a period of not less than three years. In addition, the applicant must have no less than 400 client contact hours in any one year in order to qualify for the privilege. In order to clarify the process of meeting the requirements in Insurance Law, the amendment also defined an acceptable setting for the practice of licensed clinical social work and required an LCSW to submit for approval by the State Board for Social Work a plan for appropriate supervision. The amendment also defined acceptable supervision for the privilege as two or more hours per month of individual or group consultation or enrollment in a program in psychotherapy offered by an institution of higher education or by a psychotherapy institute chartered by the Board of Regents. This amendment also eliminated peer supervision, which is not authorized by the Insurance Law, and clarifies the pathway to the insurance privilege.

Certain individuals who started their experience for the insurance privilege prior to January 1, 2011, may submit experience obtained prior to licensure as an LCSW toward the experience requirements for the insurance privilege.

### Supervision requirements for the LCSW

The amendments to section 74.6 of the Regulations of the Commissioner of Education establish the supervision requirements for a licensed master social worker providing clinical social work services. An LMSW who has submitted an application for licensure as an LCSW must maintain registration as a LMSW in New York and may practice only under supervision until licensed as an LCSW. The amendments clarify what constitutes an acceptable setting for the practice of clinical social work and require the supervisor to provide at least 100 hours of individual or group supervision to the LMSW, distributed appropriately over a period of at least 36 months. The LMSW would also be able to submit a plan for supervised experience toward licensure as an LCSW, for review and approval by the State Board for Social Work. By obtaining such approval prior to starting a position, an applicant would be able to avoid working for three years in a position which cannot be accepted toward meeting

# Vendorship and Managed Care Committee

By Helen T. Hoffman, LCSW, Chair

The purpose of the Vendorship and Managed Care Committee is to gather and disseminate information, to provide support to individual members on insurance issues, and to consider how the Society might act to influence external forces affecting the financial health of clinical social workers.

The committee, which consists of 13 members drawn from the various chapters of the Society, meets six to eight times a year by teleconference and in person, and shares information by E-mail. In the last six months the committee has focused on the following areas:

- Responding to the Oxford/UBH transition with a letter to UBH and support for members
- Following the roll-out of the Federal Parity Bill (MHPAEA) as it is interpreted by the insurance industry
- Attempting to understand how the Affordable Care Act will affect patients and providers
- Learning about the realities and possibilities for advocacy from speakers on antitrust and the Clinical Social Work Guild
- Participation in planning for a pilot on depression care by New York Business Group on Health

The Committee recently archived its bulletins of the last two years on the Society website. You are invited to visit [http://clinicalsw.org/committee\\_vendorship.asp](http://clinicalsw.org/committee_vendorship.asp)

*Committee members who may be contacted for information or support on insurance issues:*

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

## Observations on the New Federal Parity Law

By Ruth Washton, LCSW

Optum Health presented a webinar on August 4, 2010 concerning implications and implementation for providers of the new Federal Mental Health Parity Law, which went into effect July 1, 2010. Although I was unable to attend, I did receive a summary, which you may access at [http://go.optumhealth.com/optum-health/presentations/080410\\_nyforum.pdf](http://go.optumhealth.com/optum-health/presentations/080410_nyforum.pdf)

As I find the content of this summary for the most part inscrutable, I would like to share my own current understanding of parity based on a reading of the law in the Federal Register, as well as conversations with the health care representative in Senator Gillibrand's office (a social worker by training) and a UBH Care Advocate who impressed me as having informed herself as much as possible to date about the new law. I do not make any claim to being an authority on this subject, but only wish to share my thoughts and observations on this important topic.

The interpretation of the Federal Parity Law is evolving. While it went into effect 7/1/10, it becomes applicable to a particular policy only when that policy renews on or after 7/1/10. So most policies will not be subject to parity until they renew on January 1, 2011. It is on that date that the final interpretation of the law must be in place. Some of the issues still being grappled with are as follows:

- The Federal Parity Law does not define which diagnoses are covered. Apparently, it is up to an employer to decide which DSM diagnoses to cover. The NY State Empire Plan, which covers NY State employees, has decided to cover all DSM diagnoses, but a Congressional decision has not yet come down to apply to all policies. Therefore, in NY State, Timothy's Law still applies, and right now in New York, only the biologically based diagnoses are covered.

- The New Jersey APA has brought suit against Blue Cross, Horizon and Magellan to challenge managed care's right to intrude on patient confidentiality with their telephone clinical reviews. We are all aware of the stepped up pace with which these reviews are now taking place. APA's basis for its challenge is twofold: the first leg is the breach in confidentiality mandated by HIPAA; and the second leg is the mandate for parity between medical/surgical review practices and behavior health. In other words, if physicians are not called repeatedly to review their treatment of patients, then such review of behavior health providers is not in parity under the law. We will see how this plays out in court.

- To achieve parity between medical/surgical and behavioral health benefits, employers may restrict behavioral health benefits by restricting medical/surgical. For example, a maximum number of visits to a medical provider may be imposed to achieve

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# Chapter Reports

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

## Metropolitan Chapter

*Ariane Sylva, President*

The thriving Met Chapter holds lively planning discussions at the second-Friday-of-the-month board meetings. Members are welcome to attend. Contact our President, Ariane Sylva, to ensure your space, in advance at [drsylva@drsylva.com](mailto:drsylva@drsylva.com).

Our Met Chapter Announcements Listserv has been keeping us all up-to date on the various meetings of the 14 Met Chapter Committees. Our Interactive Listserv has become an online hub for referrals, information and resources. Contact Committee Chairs Robert S. Berger and Lisa Beth Miller at [i.m.c.moderators@gmail.com](mailto:i.m.c.moderators@gmail.com).

The Education Committee held three brunches, as usual: the February Brunch, "Some Like It Not: Why Couples Stop Engaging in Sex with Their Partner," presented by Sari Eckler Cooper; the April Brunch, on "Psychotherapeutic Considerations Specific to the Treatment of the Older Population," presented by Renee Goldman; and recently, another wildly successful, informative and moving brunch, on October 17, "From Soup to Nuts: Effectively Resolving Resistances in Individual and Group Eating Disorder Treatment," led by Joanne Gerr. Contact Committee Chair Susan Appelman at [shrinkga8@aol.com](mailto:shrinkga8@aol.com).

The Membership Committee has been hosting wonderful receptions (four this year) welcoming new, old and potential members. At our upcoming Food for Thought event, members will be meeting for a delicious dinner at Carmine's Restaurant and a professional presentation on Tuesday, October 26, at 7:30 p.m. Dr. Simon Rego will be presenting "Building Your CBT 'Tool Kit' for Anxiety Disorders." Contact Committee Chair Richard B. Joelson at [rbjoelson@aol.com](mailto:rbjoelson@aol.com).

The Clinical Ethics Committee is meeting on October 22. These meetings are closed and confidential, where peers work through an ethical dilemma in their practice or that affects their practice. Contact Committee Chair Eileen Ain at [dreileenain@gmail.com](mailto:dreileenain@gmail.com).

The Committee on Psychoanalysis is holding another rich discussion at the upcoming Movie Night presentation of "Two Lovers," to be held on November 19 at 7:00 pm. Contact Committee Chair Libby Kessman at [libbykessman.lcsw@yahoo.com](mailto:libbykessman.lcsw@yahoo.com).

Save the date for our upcoming Holiday Party: Sunday, December 12, 4:00–7:00 pm.

A great time is had by all at these events.

Our Spring Gathering, usually held in April, will be another great opportunity to meet in person and put faces to the names of the many colleagues interacting on our Listserv.

Rita Gazarik and Phyllis Mervis are planning for our March 26, 2011 Conference: "Creating and Sustaining a Clinical Practice in the 21st Century." Anyone interested in co-leading a workshop about blogs, please contact Rita Gazarik at [ritagazarik@gmail.com](mailto:ritagazarik@gmail.com) or Committee Chair Phyllis Mervis at [pmicsw@aol.com](mailto:pmicsw@aol.com).

Reminder for any colleagues interested in the Society: If you join after September 15, you will be paying the 2011 membership fee and getting the rest of this year at no extra charge. We welcome new participants in our wonderful society, a vibrant professional community.

To contact the leadership of the Met Chapter, go to <http://www.clinicalsw.org/>  
*By Lisa Beth Miller, LCSW, Met Chapter Listserv Committee Co-Chair*

## Mid-Hudson Chapter

*Rosemary Cohen, President*

In collaboration with NASW Hudson Valley Division and the Adelphi University/Hudson Valley Graduate School of Social Work, the Mid-Hudson Chapter is holding its Fall Conference on October 15, with Monica McGoldrick: "Context and Connection: Helping Clients Transform Their Life Narratives." Twenty years ago, in Poughkeepsie, Ms. McGoldrick presented to an overflowing audience a full-day conference on family systems theory and therapy, sponsored also with the NASW Hudson Valley Division and local social work schools and agencies. Since that time several social work conferences have

occurred here in the Hudson Valley through this ongoing collaboration.

On November 13, at the Benedictine Hospital Conference Room in Kingston, Bonnie Kavner Scheer will present her workshop: "Please Don't Treat Alcoholism and Substance Use and Abuse, Unless..."

Ms. Scheer has spent her entire social work career in community service with the Dutchess County Department of Mental Hygiene. In the 1990's she was chosen to be Social Worker of the Year by the NASW Hudson Valley Division.

On January 22, 2011, at Vassar Brothers Medical Center, longtime Society member Alan Spivack of the Family Therapy Center of Poughkeepsie will offer his workshop: "Theraplay: An Attachment Based Family Play Therapy." *Rosemary Cohen, President, [rosemarycohen@gmail.com](mailto:rosemarycohen@gmail.com)*

## Queens Chapter

*Fred Sacklow, President*

The Queens Chapter had a busy year. We had monthly Board meetings and educational presentations from October 2009 until June 2010, meeting at Holliswood Hospital in central Queens. Our presentations included the following topics: Emotional Freedom Technique, practice building, psychosis, distressed marriages, adult ADHD, adult children of alcoholics, overeating, boundary crossings and dreams. It was a very rich year.

Our listserv has been active and we are planning for upcoming meetings and presentations. Please keep the following dates available: 9/19, 10/17, 11/21, 12/19, 1/16/11, 2/13, 3/20, 4/17, 5/15, 6/12. Educational presentations run from 11:30 am until 1:00 pm.

I also want to announce that Lynne O'Donnell, LCSW received a recognition award from the Queensboro Council for Social Welfare in March for her service to the people of Queens and to the social work profession.

For questions please contact *Fred Sacklow, President, at [Freds99@aol.com](mailto:Freds99@aol.com)*.

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# COMMITTEE FOR CREATIVITY & TRANSFORMATION IN CLINICAL PRACTICE

by Sandra Indig, LCSW, ATR-BC, Chair

Almost by way of welcoming this change of season, we will start our Sunday series of presentations/ workshops with a new name. We were The Committee for Arts and Creativity, and we are now The Committee for Creativity & Transformation in Clinical Practice. This new name was perceived to be more inclusive. Perhaps as a result, we will continue to have a long waiting list of fine speakers for the academic calendar year of 2011–12.

## Winter to Spring 2010

The Committee presented three very well received events. On February 26, Sema Gurun, LCSW met us at the Morgan Library for a walk through the exhibit of one of the largest selections of Jane Austen's letters. The exhibit, "A Woman's Wit: Jane Austen's Life and Legacy," was further enhanced by the attendance of its curators and their commentary.

"Source Material of the Writer: Reflections on Jane Austen," an enjoyable presentation by Dr. Roberta Shechter, DSW, LCSW on March 28, used biographical and literary commentaries on Austen and her work to explain the Freudian psychodynamics of learning to love found in the novel *Pride and Prejudice*.

On May 16, Bryan C. Hazelton, LCSW, CASAC, BCD presented experiential exercises to highlight his workshop, "Embracing Empathy Through the Use of Imagination in Treatment."

### WHERE AND WHEN:

Sundays from 11:00 am to 12:30 pm or 1:00 pm.  
150 Fifth Avenue, Suite 900  
(Between 18th and 19th Streets)

### CONTACT:

Sandra Indig, Chair, for more information:  
212-330-6787

## Fall 2010 to Spring 2011

### October 10

Dayle Kramer, LCSW, LP: "Observing and Seeing: The Art of Attunement with Yourself and Your Patient" This workshop will focus on the similarities between the art of listening, observing the patient, and making art. Through the use of basic drawing exercises and discussion, participants will experience an increased connection to their creative core and the similarities of sitting with a patient.

### November 14

Ann Rose Simon, LCSW: "How Can Neuroscience Inform our Practice: Reclaiming Creativity and the Self?" This workshop will give a brief overview of recent findings in neuroscience research which support some of the psychotherapeutic concepts that we utilize in our practices.

### January 9

George Hagman, LCSW: "The Artful Brain: Survival Through Creativity"

We will explore enhancement of brain functioning and the psychological nature of art as well as subjective states including survival through creativity.

### March 13

Paul Giorgianni, LCSW, BCD: "Objects in the Psychotherapy Environment"

This workshop will explore the use of displacement and projection by both patient and therapist in the service of communication. Case examples of the use of objects in the therapist's office will be given.

### April 10

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

## Tips on Cultivating New Referral Sources

**T**oo many clinicians in private practice struggle to maintain an acceptable number of clients in their practices, while others report having more work than they can handle. The causal factors for this disparity may have very little to do with training, years of experience, skill level, or talent. Too often the problem is the absence of effective practice promotion or the absence of practice promotion altogether.

There are many who believe that an excellent education, proper credentials, a lovely office, and a fine reputation in the professional community are—or should be—enough to succeed in private practice. Yet, somehow, the phone is not ringing and there are way too many open hours. Often, these are the very mental health professionals who argue that marketing or practice promotion is “unacceptable,” “unprofessional,” or “undignified.” Comments like these frequently turn out to be camouflage for “I’m not comfortable marketing,” or “I don’t know how to market myself,” or “I don’t want my colleagues to think I’m not doing well,” and more.

A consistent referral flow from a variety of referral sources is vital to a successful practice and marketing your practice is one of the obvious ways to achieve this. I have always seen marketing as an acceptable and enjoyable part of my professional life. I have also observed the extent to which it provides not only opportunities to inform people about my work, but it helps people learn something about what mental health professionals do, how they do it, and what services are available to them as service consumers. It is also an excellent opportunity to help people unsure or unfamiliar with the world of mental health services differentiate between various providers, so that they may be in a better position to make an informed and thoughtful choice.

Marketing to the lay public and to the professional community certainly involves some different approaches and strategies. To the general public, marketing often provides an educational opportunity and helps to demystify what it is we do. Whenever I am in a position to answer questions from prospective clients like, “what exactly is psychotherapy?,” “how long does it take?,” “should I see a psychiatrist, psychologist, or a social worker?,” “will people think I’m crazy if I see a shrink?,” etc. I feel I am helping people pave the way to get the help they might need, as well as promote my own practice if I think it is appropriate to do so.

Marketing to the professional community is different in many ways, but involves quite similar activities. Here are some ideas about how to develop a “marketing mindset” and some “tips” for cultivating new referral sources as well as

making sure that existing sources of referral remain active and interested in you and your practice:

1. Try to remember (and get comfortable with) the fact that your practice is also your business and needs to be handled accordingly.
2. Try to get beyond the idea that your training and competence alone should make marketing strategies unnecessary for successful independent practice.
3. Beware of “narcissistic pitfalls” in the marketing of your practice. Try to make sure that your self-esteem is not at the mercy of such things as the number of open hours in your practice, ebbs and flows in referral activity, some referred clients not working out, etc.
4. Always carry a few business cards with you. Not only is it important to have one on you when someone asks, but carrying them helps to heighten awareness of marketing opportunities.
5. Schedule marketing activity in your professional appointment book the way you would schedule a client. My recommendation is a minimum of three to five hours per week for a practitioner who is seriously interested in generating a solid referral base and in generally attending to the marketing requirements of a successful practice.
6. Figure out a thoughtful way to inform old and new referral sources of changes in your services or in your professional life, e.g., a new specialization, training, publications, degrees, office relocation, honors, etc.
7. Accept responsibility for the outcomes of your marketing efforts. This will help you identify and change attitudes and behaviors that might be interfering with more productive marketing activities.
8. Write an article for either a professional or lay publication on a topic about which you have expertise and that might have marketing value for your practice. If published, send copies to both existing and prospective referral sources. 

**NEXT ISSUE:** The Self-Defeating Private Practitioner: Causes & Cures

# LIVES DISRUPTED:

## **A Theoretically Rich Event**

*By Susan A. Klett, LCSW-R, BCD, Chair*

At the 41st Annual Conference, the keynote presentations by renowned experts Crayton E. Rowe, Jr., MSW, BCD-P, and Catherine Lewis, LCSW, MS, were theoretically rich, creatively reflective and thought-provoking, providing new concepts and approaches in treatment for clinicians working with family and individuals impacted by traumatic experiences.

Thirteen distinguished workshop leaders from across a wide theoretical spectrum, Mary Elbow, PhD, LCSW, Ann Rose Simon, LCSW, Alice Entin, LCSW Aileen Nunan, LCSW, Edith Laufer, PhD Charlotte Kahn, PhD Hillary Grill, LCSW, Louise Kindley, LCSW, Sally W. Clayton, Certified hypnotist, Madelyn Miller, LCSW,CGP, Marc Wayne, LCSW, BCD. Gildo M. Consolini, PhD, LCSW and Tripp Evans, PhD, LCSW, addressed optimal ways to understand and treat patients suffering from multiple dimensions of trauma.

An audience exceeding one hundred people contributed to lively discussions. Groups of up to 20 clinicians participated in dynamic workshops which addressed the educational needs of social workers from diverse backgrounds and settings.

I would like to extend many thanks to the gifted members of the Education Committee — Meryl G. Alster, LCSW-R, Kirk Brewster, LCSW, Gildo M.Consolini, PhD, LCSW, Charlotte Elkin, LCSW, CEAP, Tripp Evans, PhD, LCSW-R, Gail Grace, LCSW-R and Ashanda S. Tarry, LMSW — who gave generously of their time and talents to the success of this extraordinary conference.

I welcome your feedback and encourage you to submit topics for next year's workshops. I invite you to send in a workshop proposal, to share in our community, and to promote your professional growth. You may contact me at [suzanneklett@aol.com](mailto:suzanneklett@aol.com) or by mail at 157 East 57th Street, #6D, New York, N.Y. 10022

## CALL FOR PROPOSALS FOR 2011 CONFERENCE: PAGE 12

## **Extending Kohut's Concept of Selfobject: The Undifferentiated Selfobject: A Case of a Depressed and Potentially Suicidal Woman**

*Keynote Presentation by Crayton E. Rowe, Jr., MSW, BCD-P / Review by Charlotte Elkin, LCSW*

In his presentation, Crayton Rowe examined the concept of trauma as it pertains to first-year-of-life experiences, and extended one aspect therein, interruptions in one's basic undifferentiated selfobject experience, to explain symptoms of psychopathology in adulthood.

The concept of the "undifferentiated selfobject" is an original concept first introduced in 2005 by Rowe, and refers to "the fundamental experience of knowing that there will be unknown, nonspecific happenings that will occur throughout life that will be surprising, challenging, uplifting, and self-enhancing no matter the positive or negative nature of our current circumstances." In that the undifferentiated selfobject is an extension of Kohut's selfobject concept, Rowe began his presentation by first describing Kohut's selfobject. He explained that the selfobject is "the experience of

the functions provided by an object — understanding, attention, and so on." These functions, when present in another, allow us to meet our basic needs for "recognition, twinship... and idealization." Rowe, referencing Kohut, explained that the selfobject is defined by our experience of "what emanates from an object — not from the object itself."

Rowe argued that along with this interpersonal experience of the selfobject, infants universally first experience the more primary phenomena of the undifferentiated selfobject, which does not depend on another to exist. He described the undifferentiated selfobject as the "fundamental experience of knowing that there is more forthcoming to experience." Ultimately, Rowe believes this serves as "the motivating force" throughout life for accomplishments, recognition, the pursuit of satisfying friendships, creativity, discovery, and development.

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**CHARLOTTE ELKIN, LCSW**, has a private practice in Manhattan working with adult individuals and couples. She is also in the CUNY doctoral program in Social Welfare.

### **Illustrations**

To illustrate this experience, Rowe first referenced cultural icons like Sondheim, and his *West Side Story* hit "Something's Coming

## Contemporary Approaches to the Treatment of Trauma

(something good);” Beckett, and the “rewarding” experience of waiting despite the outcome in his *Waiting for Godot*, and Dostoevsky’s observation in *The Idiot* that Columbus’ “highest moment of happiness was, perhaps, exactly three days before the discovery of the New World. . . the point is in life, in life alone — in discovering it, constantly and eternally, and not at all in the discovery itself.” Rowe then went on to share video clips of four infants, two of whom were twins filmed together, from the Child Study Group of The New York Institute for Psychoanalytic Self Psychology. The clips all showed infants at 8 to 9 months, and then again at around 13 months of age. Clearly evident in all three clips of the 8 to 9-month-olds was the “motivational force” to search for and explore that which is new; all four babies enthusiastically reached for or moved towards new objects, and pleasurably examined these objects from a variety of viewpoints. Even the twins, whom one might assume would be more interested in each other, separately exhibited this type of exploratory behavior.

Interestingly, at 13 months, an age by which selfobject experiences have typically evolved, the babies all looked towards their caregivers to share their discoveries, walking to offer a ball, toy or other object for a more interpersonal experience. With one child, the video depicted a mother engaged in a conversation with another adult, and her repeated lack of recognition when her son offered a ball, instead rolling the ball away with little acknowledgement of his discovery. Although subtle, one noticed the child’s enthusiasm diminish and his mood shift as he repeatedly tried to interact and was brushed away. He slowly began to disengage and Rowe referenced Kohut when he later went on to describe experiences like this one, where basic selfobject needs for recognition go unmet, repeatedly and drastically over time, and contribute to subsequent psychopathology.

Of further note, however, is Rowe’s belief that in the first year of life, interruptions in the experience of the undifferentiated selfobject (e.g., an overprotective or germ-phobic parent who continuously curtails a baby’s exploration by jerking away toys, etc.) subsequently affect fulfillment of selfobject needs. When an infant’s search behavior is limited, Rowe argued, their need for recognition is “circumvented” and the “idealizing and twinship needs that are dependent on the child’s feeling recognized will not emerge.” In essence, normal development is disrupted and Rowe, citing others, explained “the traumatizing effects remain as core negative experiences in the unconscious.” Rowe shared that in his analytical practice he has observed that disruptions like these are universally present in “severely emotionally traumatized adults and children.”

In discussing treatment, Rowe explained that while severely traumatized patients may initially present with “compulsive, suicidal,



Photo: Sandra Indig

**Education Conference Committee Members:** (l to r, front) Susan Klett, Chair, LCSW-R, BCD; Charlotte Elkin, LCSW, CEAP; Gail Grace, LCSW-R (back) Gildo Consolini, Ph.D., LCSW; Tripp Evans, Ph.D., LCSW-R; Ashanda S. Tarry, LMSW; and Kirk Brewster, LCSW.

addictive, and attention deficit/hyperactivity behavior,” and tend to focus on the “debilitating effects of their symptoms,” of importance beyond their complaints is their “continuous preoccupation” with “detect[ing] and anticipat[ing] new aspects of their symptoms.” From his perspective, that a developmental need to discover (undifferentiated selfobject) moves an infant towards the development of selfobject needs, Rowe posited that this “pursuit of thinking,” and the resulting worsening of symptoms experienced by these patients, is actually the primary issue, and the symptoms themselves secondary. In other words, individuals whose fundamental motivating force was thwarted early on lack a “template” for motivation, are “fixated on core negative experiences,” and hold onto “more negative views of themselves and the world.”

Because expression of early undifferentiated selfobject needs have been interrupted, Rowe argues that these individuals are pessimistic about new experiences, expecting the reoccurrence of the negative, or the repetition of disturbing symptoms, rather than relief from them. Thus, in treatment, Rowe believes that interventions must focus first on understanding and validating the early “trauma,” or the disruptions in patients’ preverbal, first year experiences, and next offer space in which patients can once again feel free to explore, discover and ultimately resolve unfulfilled selfobject needs. With this approach, Rowe argued, patients can move beyond their fixations to feel recognition, and in turn, success, worthy of contribution, and a need for like-minded friends/partners. Rowe contrasted this to other theories focusing on the nature and persistence of individuals’ symptoms instead. Significantly, in making this purposeful shift, Rowe described his patients as “feel[ing] understood, and [their] symptoms subsid[ing].”

CONTINUED ON PAGE 15

# LIVES DISRUPTED:

## Treating Family Relational Trauma

*Keynote Presentation by Catherine Lewis, LCSW, MS / Review by Susan A. Klett, LCSW-R, BCD*

Catherine Lewis, LCSW, M.S., began her innovative and thought provoking keynote presentation by defining Family Relational Trauma according to Sheinberg & True (2008) “as an event in which a child’s sense of emotional and/or physical safety has been ruptured or violated by the behaviors of adult caregivers. Such situations include, but are not limited to a bitter divorce, the death of a parent, being parented by an alcoholic family member, a child witnessing domestic violence, or a child who has experienced incest. In these clinical situations, the therapist has to explore the relational disruptions that have occurred and the ensuing barriers to fostering re-attachments between family members.”

Lewis engaged the audience by preparing them to enter a live session with her (via video) where she illustrated Ackerman’s Relational Model by sharing the following key concepts which guided her interventions: confidentiality binds, decision dialogue, personal agency, recursive process and relational constraints.

An expert in treating families who have experienced trauma, Catherine Lewis has served in leadership positions at several New York City Social Service Agencies. She is a faculty member of the Ackerman Institute for the Family and the Director of Community and International Training. She is a current member of Ackerman’s Center for Relational Trauma and a past member of the Ackerman Foster Care Project.

Lewis provided a case vignette illustrating a family system approach to the treatment of relational trauma. In her case study, Matthew, an eleven-year-old African American male, has recently been reunited with his biological father after spending two years in foster care during which time he has been diagnosed with ADHD, bipolar and oppositional defiant disorders.

We are invited into a session between Matthew and his father. The audience observes an impasse; Matthew is reluctant to speak to his father who appears sullen, defended and angry. Lewis decides (a choice point in therapy) to meet with Matthew alone with the permission of both Matthew and his father. She carefully explains the family therapeutic process. She creates safety by attending

to a confidentiality bind in assuring Matthew and his father that everything shared in individual sessions will remain private unless the person agrees to share the information or when safety issues emerge which would require a mandated report. Matthew and his father appear committed to improving their relationship; their treatment goal is to strengthen their relationship bond by working toward achieving a meaningful connection to each other.

Lewis’ dedication to the systematic family approach is evident as demonstrated in the following sessions whereby she clearly remains focused on the family relationship while scrutinizing interpersonal dynamics through her precise questions and always exploring relational thoughts and feelings when meeting individually with each family member.

### Matthew’s session

Matthew’s moderately overweight body is slouched in a chair; he lifts his angelic face with full, rounded cheeks, and looks directly at Lewis. Matthew appears overmedicated; yet, despite his drowsiness, Lewis reaches him. She skillfully begins a decision dialogue which leads to uncovering the cause of Matthew’s reluctance. We discover that he is entrenched in a loyalty bind contributing to relational constraints. With sensitivity, attunement and evenly hovering attention, Lewis

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**SUSAN A. KLETT, LCSW-R, BCD**, Faculty, Supervisor, Training Analyst and Director of Continuing Education at Washington Square Institute, Faculty at Postgrad\* The Institute of the Postgraduate Psychoanalytic Society, President of the Postgraduate Society, Chair of the Education Committee of the NYSSCSW. She maintains a private practice in Manhattan.



**Workshop Leaders, Neuroscience Group:** (l to r, front) Edith Laufer, Ph.D.; Aileen Nunan, LCSW (back) Mary Edlow, Ph.D.; Ann Rose Simon, LCSW; and Charlotte Kahn, Ph.D.

# Contemporary Approaches to the Treatment of Trauma

gradually deepens exploration of Matthew's thoughts and feelings. At times she labels a feeling with a questioning tone and at other times repeats a feeling articulated by Matthew to underscore and validate its importance. She attempts to help him connect body, emotions and mind by questioning "how does this feel in your body?" Through this process, Matthew connects to his fear of angering his father, being abandoned, guilt over his attachment to his stepfather, a desire to protect his father from hurt feelings and anxiety regarding addressing these issues with his father. Lewis stays acutely attuned to Matthew; she continues to validate and normalize his competing complex feelings. We witness the expansion of Matthew's awareness and his connection to deep-rooted longings as he expresses his desire for his father to become friends with his stepfather and, for the first time, allows himself to have the hope of keeping both father figures in his life. Lewis prepares Matthew to talk to his father as part of the decision dialogue by helping him to rehearse, modify and edit his articulation of feelings to effectively relate them to his father. Matthew's confidence grows as he experiences a sense of personal agency in being clearly included as an equal participant in family treatment. However, Matthew appears hesitant; Lewis responds and questions whether he would prefer her to speak with his father alone, and he agrees. She listens carefully and transmits his message to his father while he enters the process by viewing them through a two-way mirror.

## Matthew's father

Lewis enters the room with Matthew's father. He appears angry and defensive. In a patient and non-judgmental stance, Lewis stays attuned to his self state, curious about his underlying feelings, his personal history, cultural and organizing relational beliefs.

She informs him that Matthew wants her to let him know how he perceives their relationship and his hopes for their future. His defenses gradually soften; it appears that he can take in this information relayed from Matthew in a way that he would not be able to if requested by Lewis. He begins to open up as he reveals how powerless he has felt dealing with the foster care system and how usurped he felt by Matthew's foster care father, a man caring for his son, who limited and rejected his attempts to contact him. This important expanded relational information provided opportunities for a significant therapeutic intervention.

Lewis meets again with Matthew to discuss his feelings regarding her session with his father. This is known as the recursive process. Lewis came to understand Matthew's father's intersubjective experience, his shame, fear, anger, a sense of hopelessness and competition with the foster parent who has temporarily taken over his parental role contributing to his sense of inadequacy. As she shares this with Matthew in an age-appropriate manner, he realized that his father also

struggles with multiple complex feelings. He was now able to identify with his father and understand his intersubjective experience.

## Matthew joins session with his father

Matthew felt prepared to speak directly with his father, who now appeared non-threatening. Lewis mediated, using expanded relational information to guide an interaction between them, which bridged their former huge communication gap and helped father and son to understand their intersubjectivity, fostering empathy. Both Matthew's and his father's relational constraints were brought into a conversation; both were less defended and able to understand and respond to each other.

Lewis presented a compelling case vignette of a father and son struggling to relate utilizing Ackerman's Relational Model to heal relational trauma. In the paradigm of family therapy, individual work is part of a systemic family therapy approach in which separate sessions are used to enrich family sessions. Lewis skillfully wove concepts of this method throughout her treatment.

Following her presentation, Lewis openly shared the daunting challenges she faced in a lively, thought-provoking and enlightening dialogue with the audience.

In keeping with the theme of this year's conference, Lewis successfully provided clinicians with a new effective approach for healing and reconnecting families, especially children, with caretakers whose lives and relationships have been disrupted by relational trauma. 📺

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Reference: Sheinberg, M. & True, F. (2008). "Treating Family Relational Trauma: A Recursive Process Using a Decision Dialogue." *Family Process*, 47, (2) pp.173-195.



Photo: Sandra Indig

**Workshop Leaders:** (1 to 3, front) Madelyn Miller, LCSW, CGP; Sally W. Clayton, Certified Hypnotist (back) Gildo Consolini, Ph.D., LCSW; Louise Kindley, LCSW; Tripp Evans, Ph.D., LCSW-R; and Marc Wayne, LCSW, BCD

# Call for Proposals

For Workshops and Panels for the 42nd Annual Conference  
of the New York State Society for Clinical Social Work

## ***The Multiple Dimensions of Narcissism and How to Survive Them***

Date of Conference: May 7, 2011

Joan Lachkar, Ph.D. states, "The narcissist is the 'entitlement lover,' the self-proclaimed special child of the universe. Narcissists have excessive entitlement fantasies and an exaggerated sense of self, with which they are entirely preoccupied. They believe the world 'owes them,' are obsessed with perfectionism, and have an internalized, strongly castrating superego. Narcissists are intoxicated by their own power and are unable to use healthy aspects of narcissism because they lack the capacity for empathy and introspection. They strive relentlessly to prove their specialness." [Joan Lachkar, Ph.D. *The Narcissistic/Borderline Couple, New Approaches to Marital Therapy*, Brunner-Routledge, N.Y. (2004) (p.2)]

This conference will address various facets of narcissism and optimal treatment approaches. We are looking for proposals for workshops and panels from all theoretical orientations as well as all modalities that reflect this theme.

### Workshop Suggestions:

- The Narcissistic Generation: Twitter/Facebook: Seductive Outlets for Exhibitionism and Voyeurism (How this affects our patients and their relationships in and out of session)
- Parenting Issues in a Narcissistic Culture
- Working with the Narcissistic Couple
- Containing Narcissistic Rage Evoked in the Transference
- Countertransference toward the Narcissistic Patient
- School Social Work: Clinical and political issues when consulting with the narcissistic parent
- The Unconscious at Work: Navigating politics when dealing with the narcissistic supervisor/boss/colleague
- Attachment: Reaching the narcissistic patient
- Dealing with Narcissism in Groups
- Uncovering the Lost Self: Development disrupted by the narcissistic parent
- Narcissism: Developing a secure professional identity in the hierarchical mental health hospital setting
- How the Therapist's own Narcissistic Needs Influence the Therapeutic Process
- Sexting: Narcissism and the adolescent in the 21st century
- Narcissism as a Defense
- Understanding and Working Effectively with the Narcissistic Character Structure (malignant narcissism, destructive envy and competition, the patient's desire to see the therapist fail)

### Proposals should be from *three to five* typewritten pages, double-spaced, and should include the following:

- 1) Description: purpose, function, and teaching objectives. Include clinical illustrations.
- 2) A workshop or panel outline describing concepts to be developed.
- 3) A bibliography.
- 4) Nine copies of the proposal, one copy of your C.V. (and all other identifying information) on a separate page. Underline one affiliation that you would like listed in the brochure. Private practice is not considered an affiliation.
- 5) On a separate page: A brief paragraph of five lines stating purpose of workshop and listing five to six aims and objectives.

**Deadline for Submission of Proposals: December 15, 2010**

Mail to: **Susan Klett, 157 East 57<sup>th</sup> Street, Apt. 6D, New York, NY 10022**

# Letter from NYSSCSW on Licensing Regulation Sent to State Education Department

New York State Society for Clinical Social Work  
243 Fifth Avenue, Suite 324, New York, NY 10016-8703  
(800) 288-4279  
www.nysscsw.org

Tuesday, August 10, 2010

David Hamilton, PhD, LMSW  
Executive Secretary, State Board for Social Work  
New York State Education Department  
89 Washington Avenue  
Albany, New York 12234-1000

Dear Dr. Hamilton,

We are writing on behalf of the New York State Society for Clinical Social Work, Inc. to provide comments on and disagreement with certain changes in the Regulations of the Commissioner of Education, specifically, §§ 74.3, 74.4, 74.5, 74.6, 74.7 and a new regulation, § 74.9. The Notice of Emergency Action relating to these amended regulations was posted in the State Register on July 14, 2010 and is expected to be on the Regent's Calendar for September, 2010 for permanent adoption.

We have serious concerns about one of the proposed amendments: Section 74.3 – the manner and effectiveness of clinical group supervision for LCSW licensure,

## LCSW Clinical Supervision

Section 74.3 decreased the number of hours of supervised experience LMSWs will be required to meet for the LCSW supervised experience requirement from 2880<sup>1</sup> supervised client hours of diagnosis, psychotherapy and assessment based-treatment planning to 2000 hours. However, we have serious concerns about the manner (group and/or individual) in which supervision is to occur. In this regard, the LMSWs seeking LCSW licensure will have to complete 2,000 client clinical contact hours in diagnosis, psychotherapy, and assessment-based treatment planning over a continuous period of not less than 36 months and not more than 72 months under a qualified supervisor.

The proposed amendment, regarding the provision of this supervision, to section 74.6 provides that "Supervision of the clinical social work services provided by the qualified individual<sup>2</sup> shall consist of contact between the qualified individual and supervisor during which:

- (i) qualified individual apprises the supervisor of the diagnosis and treatment of each client;
- (ii) qualified individual's cases are discussed;
- (iii) the supervisor provides the qualified individual with oversight and guidance in diagnosing and treating clients;
- (iv) the supervisor regularly reviews and evaluates the professional work of the qualified individual;
- (v) the supervisor provides at least one hundred hours of in-person **individual or group clinical supervision**, distributed appropriately over the period of the supervised experience."<sup>3</sup>

We do not believe that clinical group supervision meets the supervisory needs of newly licensed MSWs who wish to learn the specialty practice of psychotherapy nor provides adequate overview by an experienced clinician for the consumer-patient.

Individual supervision is the key to professional development of a health care professional. In the training of a mental health professional in the provision of

psychotherapy services it is particularly essential that the supervisor and the supervisee discuss the interactions that the supervisee has with the patient and how the process unfolded in the psychotherapeutic relationship. Indeed, one of the most important supervisory tools is the treatment process recordings (transcripts of the patient-therapist interaction) by the supervisee which are used for the following: to facilitate the supervisee's assessment and diagnosis of the patient, to recognize and address the supervisee's feelings about the patient, to explain the rationale behind how, why, and when the supervisee intervened in the psychotherapy session, to demonstrate how the supervisee might have intervened in more effective ways, and to encourage the supervisee to reflect on his or her role in the psychotherapeutic process with different patients.

For inexperienced LMSWs to provide mental health services, it is critical that the supervisor and supervisee meet weekly to discuss the supervisee's cases. This is particularly true today, where people do not stay in psychotherapy for years, but, rather, stay in treatment on average for three months to a year. In the past, when patients stayed in longer-term treatment, there was more time to understand the patient's diagnostic needs and plan cogent and meaningful treatment interventions. Today, with shorter term treatments, regular discussions between the supervisor and supervisee on a weekly basis are a necessity to quickly grasp the treatment issues and plan appropriate interventions.

We need to be cognizant that the LMSWs who are seeking to obtain the LCSW are typically recent graduates of MSW programs and may have varying levels of didactic mental health training and have had different field placement experiences in relation to diagnosis, psychotherapy and assessment-based treatment planning. Placing such supervisees in group supervision is too general a supervision experience and would be inappropriate until they have at least been supervised individually. We recommend at least 1000 post-MSW clinical contact hours, and down the line they could then be supervised in individual supervision with a mix of group supervision.

We are very concerned that this regulation amendment allows all of the supervision to be provided as group supervision. Although we can appreciate the monetary benefit of group supervision (fewer supervisors to supervise the treatment of a larger number of supervisees' patients), this does not adequately protect the consumer-patient from well-meaning but inexperienced LMSWs. Once they have had a significant amount of individual supervision, group supervision can be an appropriate method as sharing clinical material with their colleagues under the guidance of an experienced supervisor may be educational.

Given the decrease in patient contact hours of the supervisees, from 20 (960 hours/48 weeks) patients on average per week to 14 (2000 hours/144 weeks) patients on average per week and given the fact that most patients no longer remain in psychotherapy for more than three months to a year, supervisors now have to supervise the treatment of more patients over the course of a year who are in short-term psychotherapeutic treatment. Further, appropriate and effective supervision requires that each patient's treatment be supervised by the same individual. This ensures continuity of treatment for the patient as well as promotes a consistent educational experience for the LMSW.

We suggest the following schedule for supervision:

- 1) During the first half of the supervised clinical experience (defined as having the first 1000 patient clinical contact hours and 60 individual supervision hours) all supervision shall be individual supervision with the same supervisor;
- 2) During the third quarter of the supervised clinical experience (defined as 500 further patient clinical contact hours) the supervision shall be either individual or a mix of individual with the same supervisor during this period and group supervision with the same supervisor during this period;
- 3) During the last quarter of the supervised clinical experience (defined as

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the last 500 further patient clinical contact hours) all supervision may be individual, a mix of individual and group or group supervision.

We have serious concerns about the ability of supervisors to provide individual supervision if they carry more than four supervisees. With regard to group supervision, we have a greater concern since no guidelines have been established for the size of the group and the number of cases the supervisor is responsible for.

For individual supervision, we recommend that the supervisor should not be permitted to carry more than four supervisees during the same time period. Given the fact that under the new regulations a supervisee will see an average of 14 patients/week, that will mean that the supervisor has to be aware of what is happening with 56 patients, if he or she is supervising four supervisees. *See*, footnote 4, *infra*. Also, if a supervisor is providing group supervision, the group should be limited to four supervisees, which would require the supervisor to be aware of what is happening with their supervisees 56 patients. *See*, footnote 4, *infra*.

Further, we are concerned that supervisors be advised of their important role in assuring appropriate care for the patient being treated by their supervisees and their responsibility to those patients whose care and treatment they are supervising. To this end, we believe that the language used in the proposed amendment in § 74.4 (a) (3) (i) and § 74.4 (b) (3) (i), should apply equally to § 74.6 (c) (1) and § 74.6 (d) (1); to wit: “the supervisor shall be responsible for appropriate oversight of all services provided by a permit holder under his or her general supervision.”<sup>4</sup>

Finally, we wish to acknowledge the Department for taking some of our prior suggestions regarding some of these issues raised by these proposed amendments; to wit:

- (1) placing the burden on supervisors, not on the supervisees, by requiring them to maintain records of their supervisee’s client contact hours and supervision hours for the LCSW and provide them to the Office of the Professions;
- (2) requiring each LCSW who is seeking the “R” Psychotherapy Privilege to provide a supervision program for review by the State Board for Social Work;
- (3) changing the wording in the current “R” regulation from “supervision or consultation” to consultation (consistent with the fact that the LCSWs seeking to obtain the “R” are already licensed and do not require further supervision but if they wish to obtain the “R” are required by law to have consultation with more senior clinicians to further develop their professional knowledge and skills);
- (4) allowing LMSWs to submit a plan for supervised experience toward licensure as a LCSW, for review and approval by the State Board for Social Work. [By obtaining such approval prior to starting a position, an applicant would be able to avoid working for three years in a position which cannot be accepted toward meeting the experience requirements for licensure as a LCSW because the setting or supervisor was not authorized by law and/or regulation. The State Board’s review and approval of the voluntary plan would both protect the public and provide assurances to the LMSW that the setting and supervisor are authorized to engage in the practice of clinical social work in New York]; and
- (5) the peer supervision to obtain the “R” Psychotherapy Privilege has been eliminated.

We also support the provisions in the proposed amendment of § 74.7 relating to BSWs. We also support the new § 74.9 which allows the Department to endorse LCSWs from other jurisdictions to become LCSWs in New York.

Thank you for your consideration of these important clinical issues.

Marsha Wineburgh, DSW, LCSW, *Legislative Chair, NYSSCSW*  
Jonathan Morgenstern, MSW, LCSW, *President, NYSSCSW*  
Hillel Bodek, MSW, LCSW, *Past-President, NYSSCSW*

## FOOTNOTES

1. In 1977 the Legislature enacted Chapter 893 of the Laws of 1977 adding sections 162 and 253(8) to the Insurance Law [creating the so-called “P” endorsement on the licenses of certified social workers who must have, inter alia, three years of full-time supervised postgraduate clinical experience in the provision of psychotherapy services]. This law established the basic postgraduate minimum supervised clinical experience requirements that had to be met to assure that certified social workers in New York State had at least the minimum level of necessary clinical competence to provide clinical social work services (diagnosis, psychotherapy and assessment-based treatment planning) independently of supervision.

When the Clinical Social Work license was being drafted, at the suggestion of legislative staff, the supervised clinical experience required for the “P” endorsement was adopted as the supervised clinical experience requirement for the new clinical social work license. By that time, the “P” had been in place for approximately twenty-four years and had become the benchmark for postgraduate minimum supervised clinical experience requirements that had to be met to assure that certified social workers in New York State had at least the minimum level of clinical competence necessary to provide clinical social work services (diagnosis, psychotherapy and assessment-based treatment planning) independent of supervision.

2. “A qualified individual shall mean a licensed master social worker, an individual with a limited permit to practice licensed clinical social work as authorized by section 7705 of the Education Law, or an individual otherwise authorized to provide clinical social work services in a setting acceptable to the department and under appropriate supervision.” § 74.6(2)(a).

3. We note that the prior version of § 74.6 (2)(c)(v) read as follows, “provided that at least two hours per month shall be individual clinical supervision.”

4. In this regard, in *People v. RR*, 12 Misc.3d 161, 807 N.Y.S.2d 516 (Sup Ct, NY County 2005) the court held, that, “this Court further finds, as a matter of law, that licensed master social workers may not make or render diagnoses or prognoses (which of necessity flow from and are intimately related to diagnoses), formulate or develop treatment plans, interpret tests and measures of psychosocial functioning, or provide psychotherapy unless they are doing so under the supervision of a psychiatrist, psychologist or licensed clinical social worker. [FN27] .... Supervision in this context is a legal term. In relation to supervision of a licensed master social worker or a student, extern or intern in a mental health discipline who is providing clinical services under supervision, it means that the patients or clients being served by the supervisee are considered patients or clients of the supervisor, not of the supervisee, that the supervisor is personally professionally responsible and accountable for the evaluation, care and treatment of these patients or clients, that the supervisee is acting under the umbrella of the supervisor’s license, and that the supervisor is personally professionally responsible, accountable and liable under the doctrine of respondeat superior for the professional conduct, misconduct, malpractice and actions of or the failures to act by the supervisee in relation to the patients or clients with regard to whose evaluation, care and treatment he or she is the supervisor.” *Id.* at 12 Misc. 3d, at 179-180, 807 NYS2d at 529. (emphasis supplied) 

## Ms. H

Rowe chose one patient from his practice, "a depressed and potentially suicidal woman," to demonstrate this approach. Ms. H was a 44-year-old single, never married, childless, Caucasian artist whose mother had died one year prior to her presentation in treatment. She sought help initially for "feelings of disinterest in her work as a commercial artist and disinterest in life in general," and cited a history of psychotherapy from elementary through high school which had generally served as a "crutch," helping her to complete school, but never adequately addressing her pervasive feelings of "dissatisfaction and boredom." In describing his impressions and the evolution of their early work together, Rowe highlighted Ms. H's general aggression and annoyance, her preoccupation with death short of actively formulating a plan to kill herself, her tendency to "daydream," withdraw, or stare into space in response to stressful material, her disbelief as to how colleagues could be excited enough to be committed to their work, her apathy towards meeting new people or serious relationships beyond brief affairs, and her overall sense "that she always knew that she was "waiting for life to begin." He related that she spoke of a mother who was a "cleanliness freak" who allowed little room for playing, a family unappreciative of her artistic talent, and a brother two years older who, as a child, would mockingly "take her drawings from her room and hide them." Of note, she described spending much of her childhood alone doing art, only to destroy her creations because they were "not good enough," and of school personnel convinced that her extensive daydreaming was a sign of epilepsy or ADD.

Unlike other treatments, which might have sought primarily to address despairing symptoms, Rowe described focusing instead on the traumatic disruption of Ms. H's undifferentiated selfobject experience. Evidenced in both her life perspective and her personal history, Rowe explained that Ms. H's aforementioned presentation typifies individuals who have sustained such an experience and thus he proceeded in the following manner. While exploring her suicidal ideation, Rowe offered validation, stating, "I think that you have good reason for not wishing to continue the struggle you have had with life." When Ms. H talked of spending hours staring out her apartment window, instead of pathologizing her actions, he esteemed them, commenting, "It's relaxing for you, maybe like the comfort you speak about?" And when she spoke of daydreams organized around death, Rowe

spoke directly to the fixation when he said, "I think that these daydreams were thoughts of how things could be better and they helped you feel sustained through all the rejections you experienced." Finally, Rowe used Ms. H's growing awareness that there had been more to experience in her past, and introduced the possibility of returning to the undifferentiated selfobject phase in therapy, for a reparative experience in her present. Here he stated, "[w]hile this experience of knowing that greater things are yet to be achieved sustained you through the rejections you suffered as a child, it discards the present, as the greater achievements are yet to be. It is a form of waiting for the greater inspiration that prevents you from feeling that your [art]work is good."

Through interventions like these, Rowe helped Ms. H to become more aware of her past deprivations, respond emotionally to their corresponding trauma, and in turn, make sense of why she consistently discounted her work, found peers boring and simple, felt she had little of meaning to offer relationships, and lacked motivation to follow through with various tasks. Over the course of treatment, Rowe reported that Ms. H was promoted within her company, went on to start her own competing company with a colleague, maintained a fulfilling, long-term relationship with a partner, gained like-minded friends, and took pride in her contributions to her community. Freed from her core negative experience, Ms. H was able to recapture the motivating force of the undifferentiated selfobject, develop selfobject needs for idealization, twinship and mirroring and have them recognized, and experience a more positive and hopeful view of herself and of that which she creates.

In acknowledging the pervasive trauma sustained by individuals whose undifferentiated selfobject needs have been disrupted, and in imparting this phenomena with a case illustrative in the therapist's ability to honor and heal this experience in his patient, Rowe conveyed the importance of assessing for, and when present, working with thwarted undifferentiated selfobject needs. Through the lens of self psychology and his own extension of this theory, Rowe raised awareness among conference participants and no doubt influenced how many will heretofore conceptualize their patients' struggles, and treat trauma resulting from unfulfilled, undifferentiated selfobject needs. 

## President's Message

CONTINUED FROM PAGE 2

United we stand, divided we fall; we're all social workers and our specialties should lead to diversification of services, not to competition, division and alienation.

Our Society could become the supportive professional community for all clinical social workers regardless of practice setting. It should offer something of value to every clinical social worker.

And since we are committed to promoting professional expertise, we should also be invested in the next generation of LCSWs. We should reconnect with the social work schools and connect with social service agencies, and with organizations such as the NYS Coalition of Social Workers. We should position ourselves to support those working towards becoming LCSWs, actively exploring ways to maximize our impact by providing qualified supervision and mentorship.

Many of us are upset by our professional status and pay, feeling helpless in relation to managed care. Our Society plays a key role in shaping

the way we would like to be perceived. We provide a service that helps all people lead more effective, productive and happier lives. How did this come to be perceived as unessential!? We must support each other in developing our professional self esteem. Our Managed Care Committee, chaired by Helen Hoffman, provides valuable information and programs to support members in managing their practice from a position of knowledge and strength.

Our power is in our membership that provides support through dues, and through their knowledge, creativity, time and energy. This is an election year for the State Board, so please vote! Your ideas are appreciated; your voluntarism is appreciated more. Please consider becoming involved in our work. Contact your chapter president or me.

And thank you for being a member of the New York State Society for Clinical Social Work. 

## Vendorship Committee Federal Parity Law

CONTINUED FROM PAGE 4

parity with a maximum number of sessions allotted for behavioral health sessions.

• Whatever form or level of clinical reviewing takes place in the future, and whether or not diagnoses covered are expanded beyond the biologically based, the key words to providing continued behavioral health care are “medical necessity”. This will have to be documented in session notes. So far, the rule of thumb that I have gleaned from what I have read and been told is that (1) the patient must have enough symptoms and (2) the patient must have an impaired enough level of functioning to warrant continued treatment. Documentation based on DSM criteria should be made to support your argument.

• It is also important to document progress and improvement in both symptoms and functioning to demonstrate that treatment is effective.

I welcome your thoughts, comments, observations and any experiences that you have and would like to share so that we may all benefit from as much information and experience as possible. Contact me, Ruth Washton, at [rwashon@verizon.net](mailto:rwashon@verizon.net) 

## Legislative Committee Report

CONTINUED FROM PAGE 3

the experience requirements for licensure as an LCSW because the setting or supervisor was not authorized by law and/or regulation. The State Board’s review and approval of the voluntary plan would both protect the public and provide assurances to the LMSW that the setting and supervisor are authorized to engage in the practice of clinical social work in New York. Since an LMSW may provide diagnosis, psychotherapy and assessment-based treatment planning under supervision without seeking licensure as an LCSW, the amendment requires such an LMSW to receive at least two hours per month of in-person individual or group clinical supervision.

The Department received comments from professional associations, state and private agencies and interested individuals. 

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## Chapter Reports

CONTINUED FROM PAGE 5

### Staten Island Chapter

*Mary FitzPatrick, President*

The Staten Island Chapter held monthly Board Meetings and educational presentations from September – June 2010. This year we made a special effort to vary the schedule of our meetings to meet the needs of younger members who found it hard to get to Sunday morning meetings.

We covered a wide range of topics from Domestic Violence with input from the District Attorney's Office and local advocacy groups as well as very interesting topics from our own members on issues ranging from sexual dysfunction to play therapy.

Helen Hoffman was kind enough to take the time on a Sunday morning to try to help us understand the Federal Parity Law, Managed care, and Vendorship Concerns.

We had our usual yearly half day conference. The speaker was Ron Taffel Ph.D on dealing with difficult adolescents and their families and it was extremely well received.

Our education Chair Person Catherine O'Brien is working very hard to ensure that we have an even better year this year. Again she is arranging great speakers as well as different times and locations to keep our small Chapter alive and relevant to all its members.

*For information you may contact President Mary FitzPatrick, at 917-882-9118 or fitzrodal@aol.com.*

### Suffolk Chapter

*Sandra Jo Lane, President*

We take great pleasure in announcing that there is significant interest in reinvigorating the chapter. As a consequence of the terrific work done by Dr. Robert Berger in coordinating

the listserv, and many phone calls from members expressing appreciation for the chapter, we are making plans for new activities. The geographic realities of Suffolk County, and the general "business" of so many members, has made it a challenge to create a viable and vital chapter in the past. We will look for more centrally-located meeting places, and we are planning a meeting to explore new opportunities for the chapter. Your ideas are welcome. *Please contact Sandra Jo Lane, President, at sjlsunshine@aol.com or 631 586 7429.*

### Westchester Chapter

*Martin J. Lowery, President*

We began our first General Membership Meeting of the year on November 11th with a minute of silence to commemorate the tragedy of 9/11. The speaker for the meeting was Nancy Kehoe, RSCJ, Ph.D, who spoke on "Exploring Religion and Spirituality in Clinical Work: The Last Taboo?" The Chapter meets on the first Saturday of each month from September to June. The monthly General Membership Meeting consists of a business meeting followed by an invited speaker who addresses topics of interest to members. Prior to the meeting the following interest groups gather and share: Group Therapy Practice, Career/Private Practice Building Mentorship, Peer Consultation, Creative Process-Therapy-Exercise-Spirituality, Child and Adolescent Peer Consultation. In addition the following Committees serve the needs of the Chapter: Education, Legislation, Membership, Disaster Preparedness and Vendorship-Managed Care. We keep connected by a well-edited newsletter and a list serv. *Contact Martin Lowery, President, mlowery@maryknoll.org* 

## In Memoriam

**O**n August 3rd the Staten Island Chapter lost a dear colleague and friend, Nancy Holzka, our past president, who died after a brief illness. Nancy spent her entire professional career serving the Staten Island community through her work in a children's community mental health center and through her private practice.

When Nancy joined our chapter, she brought a strong sense of commitment and selflessness in sharing knowledge. You always felt accepted when you were with Nancy. She became a role model for so many of our members over the years. Those who knew Nancy will remember her for her generosity in the work she did for our chapter, for her love of clinical work and for her friendship.

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