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

Benefits, Referrals and Legislative Clout: Your Guild Dollars at Work

by Allen A. Du Mont, President, CSW, BCD

The Office and Professional Employees International Union (OPEIU) of the AFL-CIO has announced that major medical health insurance is now available to all members of the National Guild of Medical Providers who have at least one employee. In addition, they are creating another group medical plan for those of us who are solo practitioners. For Society members not otherwise covered by group insurance, this benefit potentially represents a 20% savings from current rates. As Luba Shagawat, Chair of the Clinical Social Work Federation (CSWF) Guild Committee, points out, "This benefit alone could pay the $85 cost of Guild affiliation several times each month." Medical insurance is the latest of many benefits available to Guild members: discounted dental services, mortgage and real estate programs, low cost loans, free and reduced cost legal services, student scholarships, driver and travel programs, among others. Increased referrals to Guild members are projected. Betty Phillips, Ph.D., Immediate Past President,

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29th Annual Conference

Keynote speakers Carol Tosone, Ph.D. and Bernard Frankel, Ph.D.
Conference report begins on page 6.

EXECUTIVE REPORT

Our Affiliation with OPEIU Guild for Healthcare Providers

by Allen A. Du Mont

As I am writing this message, the Referendum Alert and the By-Laws Referendum enabling us to join the OPEIU Guild for Healthcare Providers is going out. This vote is a first step in a process leading to affiliation with those who can help us to advocate vigorously for our profession, ourselves and our clients and to make an impact on the national and local scene. It is a big step—some would say long overdue—but one fraught with uncertainty, anxiety and some apprehension.

As individuals, each of us risks $85; as a Society, we risk a lot more if a significant portion of our membership decides not to join our effort because they do not want to pay the dues. Some may ask why

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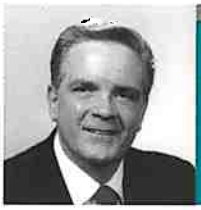

Executive Report

By Allen A. Du Mont, CSW, BCD
Society President

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not make membership in the OPEIU Guild voluntary. The answer is similar to the answer to the question, Why not make taxes voluntary? Without public support, how could we finance police, fire, water, sewage, and education services? Dues for Guild membership go to support lobbying, mailings, administrative costs, legal briefs and other expenses incurred to advocate for clinical social work. Since everyone will benefit, everyone is called upon to share the financial responsibility.

We do not know for certain that our two-year experiment will produce results. We do know, however, that we will be joining a Guild of 20,000 podiatrists, medical doctors, optometrists and clinical social workers who have decided to affiliate and who believe it is worth the risk. It will be up to us, through the CSWF Guild, our own State Society Guild Committee and the State Board to assist, promote, monitor, evaluate and adjust the process to work towards our goals. If we do not succeed, it will not be because we have not tried; and I believe we will succeed. At worst, we will have lost a skirmish, thereby gaining more information to win the war.

Some have raised questions as to why the by-laws change was constructed by the By-Laws Committee as it was. The aim, I think, was to provide a procedure to evaluate a proposal to affiliate (as we have been doing regarding the OPEIU Guild), then to announce the proposal to the membership for comment (as will be done if the by-laws change is passed), following which a three-quarter majority of the eligible vote will be necessary to require membership in another organization (such as the OPEIU Guild) as a requirement for membership in the State Society. The process is meant to combine democratic and republican principles as embodied in our federal government. The third proviso, which says that no member shall have his or her membership terminated solely for not meeting the requirements of "the other organization," ***does not apply to the OPEIU Guild.*** All of our full members qualify. This was written as a protection for members in unforeseen circumstances. I invite your support for these important by-laws changes and invite you to call the numbers listed below with any questions. You are also free to put your questions in writing and to forward them to the State Board. Please be assured that much time and thought and work has gone into the OPEIU Guild proposal on the part of the Clinical Social Work Federation and of members of the State Board, particularly Helen Krackow.

ADDRESS YOUR QUESTIONS TO:
- **HELEN KRACKOW ▸ (212) 683-1780**
- **JUDITH WEISS ▸ (212) 348-4274**
- **AL DU MONT ▸ (718) 224-4886**

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

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Thinking About A Mentorship Program?

By Barbara Bryan, Coordinator of Mentorship Programs

Are you thinking about starting or joining a mentorship program? Or perhaps you have started a program but have encountered problems. Would you like some ideas to improve your current program? The State Mentorship Program, is long on experience with successful programs. It serves as a clearinghouse of ideas and can help solve problems.

If you are not thinking about starting a mentorship program, please contact us to find out what you are missing. If you are thinking about joining, please don't hesitate to call us. If your chapter doesn't have one, call us and we can help you start one. We'll do our best to connect you with a rewarding mentorship program.

CALL, WRITE OR E-MAIL:
- **BARBARA BRYAN ▸ 905 WEST END AVENUE #141, NEW YORK, NY 10025 ▸ (212) 864-5663 ▸ BBRYAN@AOL.COM**

CORRECTION

Two authors were omitted from the article on page 6 in the Spring 1998 ***Clinician: State Society Survey Suggest Members Have Extensive Clinical Training & Experience.*** *The article was written by Joseph Ventimiglia, DSW, BCD, P. Carmichael, PhD, and Jacinta Marschke, PhD.*

New York University
Shirley M. Ehrenkranz
School of Social Work Ph.D. Program
in Clinical Social Work and the
New York State Society
for Clinical Social Work

Announce a Professional Conference

Loneliness, Isolation, and Disillusionment: Creating Hope and Connection in the Therapeutic Relationship

Saturday, November 14, 1998

Keynote Speakers:
Jeffrey Seinfeld, Ph.D.
Roberta Ann Shechter, D.S.W.

Discussant:
Eda G. Goldstein, D.S.W.

Registration and coffee:
8:15-9 a.m.

Morning sessions:
9 a.m.-12 noon

Afternoon workshops led by outstanding clinical practitioners:
1:30-3:30 p.m.

NEW YORK UNIVERSITY
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Eisner and Lubin Auditorium
Loeb Student Center
566 La Guardia Place
New York, New York

For registration and more information, please complete this form; make check payable to *New York University;* and return to Richard Lenert, Shirley M. Ehrenkranz School of Social Work, New York University, 1 Washington Square North, New York, NY 10003-6654.
Telephone (212) 998-5935.
Costs: $45 Advanced Registration
$55 Registration at the Door
$30 Student Advanced Registration
$35 Student Registration at the Door

☐ I would like to register. ☐ I would like more information.

Name

Address

City State Zip Code

( )
Telephone

New York University is an affirmative action/equal opportunity institution.

Licensing Update: Close, But No Cigar!

Yet the future looks promising

By Marsha Wineburgh, CSW, BCD

The New York State Legislature ended its 1998 session without voting on the final version of the social work licensing bill in either house. However, by the time our legislators adjourned, there were many new supporters and a new bill (A11223/S7692), bringing us as close to passing landmark legislation licensing psychotherapy in New York State as we have been in the past 30 years. It could not look more promising for the near future.

The Society thanks our two sponsors, Assemblyman James Gary Pretlow (D-Westchester) and Senator Thomas W. Libous (R-Binghamton), and their staffs for their unwavering commitment to licensing the social work profession and their flexibility in agreeing to accept the concept of licensing psychotherapy in the State.

In the final days before adjournment, Assemblyman Edward C. Sullivan, Chair of the Higher Education Committee, determined that licensing was a serious consumer issue and actively advocated for its passage out of the Assembly Higher Education Committee. That it ultimately did pass unanimously demonstrates the respect Mr. Sullivan has earned from both Democrats and Republicans. Democratic Committee members include Assemblypersons Green, Colman, Pheffer, Gottfried, Tokasz, Luster, Morelle, Magee, Englebright, Perry, Seminiero, Harenberg, Christensen, Ortiz and Stringer. Republican Committee members supporting our legislation include Dinga, McGee, Anderson, Doran, Prentiss, Miller and Ravitz.

Critical support came as well from Senator Kenneth P. LaValle, Chair of the Senate Higher Education Committee. Both he and Assemblyman Sullivan provided strong staff support, including the efforts of Diana Georgia and Stephanie Sorrentino. In the six weeks following the mental health roundtable in Albany on April 30th, the mental health bill was created, introduced and revised, requiring undiscouraged commitment, time and patience by all involved.

In the final weeks of the 1998 session, the Chairmen of the Higher Education Committees and their staffs decided to tackle the three-

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Phone Salons

PSYCHOANALYSIS COMMITTEE REPORT

By Marilyn Schiff, CSW

Having taken a deep breath over the summer, the State COP is trying out new approaches to establishing salons. The perennial difficulty in convening meetings upstate, no matter the profession involved, is the distance which must be travelled to attend even centrally-located events. In an effort to resolve this problem, at its last meeting the State Society's Board of Directors approved an exploration of the concept of telephone conference salons. Subsequent research found that a one-hour eight-person conference call on a weekend would cost about $40—definitely a price which encourages further study. In addition, at this rate, the Committee's budget would cover more than one call per chapter on an exploratory basis.

All the chapters will be contacted shortly to discuss this new type of salon. If you are interested in this new style of convening to explore topics and issues of mutual interest, please call me or your chapter president. Let's see if we can make this work.■

▸ MARILYN SCHIFF ▸ (212) 255-9358

Licensing Update

CONTINUED FROM PAGE 3

decade-old problem of licensing all those who practice psychotherapy in the State. We had understood that scope-of-practice licensing of the social work profession would impact on any non-social workers who considered themselves psychotherapists. If they were not exempt from our legislation, they would not be able to legally practice. Inasmuch as New York State is opposed to interfering with taxpayers who are currently practicing, introducing our licensing bill meant also developing legislative solutions to protect consumers.

Ultimately, the legislative solution was a mega-bill which incorporated our social work legislation as well as several other master degree groups. These include the marriage and family therapists, the mental health counselors, the creative arts therapists and psychoanalysts who do not hold a degree from one of the four core mental health professions. Psychology vacillated, but finally agreed to join at the eleventh hour.

As the mega-bill began to move through the Education Committees, opposition began to arise, primarily from the Medical Society and the Psychiatric Association, who argued that social workers cannot make diagnoses — which is solely a medical practice. With only a few hours left in the session, we simply ran out of time to address these matters before the bill was tabled.

This is the closest we have ever gotten to passing a licensing bill for the social work profession. That it entails licensing of all those who currently practice psychotherapy is a consequence of where the mental health field is today, as well as the long history of licensing efforts upon which we are building. With all its inherent controversies, A11223/S7692 does hold practitioners accountable and protects consumers from untrained and incompetent mental heatth professionals. It is landmark legislation.■

SOCIETY MEMBERS SHOULD CALL OR SEND A NOTE OF THANKS TO SPONSORS OF A11223/S7692:

- **ASSEMBLYMAN JAMES GARY PRETLOW (D-WESTCHESTER)**
- **SENATOR THOMAS W. LIBOUS (R-BINGHAMTON)**
- **ALSO: HIGHER EDUCATION COMMITTEE LEGISLATORS WHO REPRESENT YOUR AREA**

Benefits, Referrals and Legislative Clout

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informs that CSWF is exploring the potential for developing an Independent Practice Association (IPA) which can be utilized by OPEIU as it negotiates with national unions seeking mental health benefits for their members. The State Society is particularly interested in being included in the Employee Assistance Programs of the 2½ million member AFL-CIO in New York State and will be working towards providing therapeutic services for members and their families. Guild members will also have opportunities to participate in a network of mental health professionals providing services for Millennium Health cardholders. (Millennium is a bank card whose members purchase at a discounted rate services not generally covered by traditional health plans.) More than benefits and referrals, Guild affiliation protects our profession through political clout. The CSWF has given the OPEIU a mandate to advocate in Congress for a change in the ERISA (Employee Retirement Income and Security Act) laws which allow self-insured companies to exclude clinical social workers. Says Helen Krackow, Immediate Past President of the State Society, "There is no free lunch. Responsibility to our clients and our profession requires us to support the fight for what is right."

The Quality Health-Care Coalition Act of 1998 (HR 4277), introduced by Rep. Campbell, which provides anti-trust relief for groups of health care professionals who wish to engage in negotiations with a health insurance issuer, is a case in point. The OPEIU-Guild has invited CSWF member states to fax comments on this legislation which will be included in the *Congressional Record*. Members of the State Society may wish to indicate how, analogous to individual workers who have no way to counter the power of their employer on their own and thus have been allowed to organize and bargain collectively, clinical social workers should also be exempted from anti-trust violations in collective negotiations with managed care. Affiliation with organizations that get the attention of big business and Congress seems to provide our best hope for the profession and the clients we serve.■

FAX YOUR COMMENTS ON THIS LEGISLATION TO:

▸ OPEIU-GUILD ▸ FAX (212) 727-3466

Tribute to Kenneth L. Adams, Esquire

Social Work Advocate, Crusader, Protector

By Helen Hinckley Krackow, MSW, BCD, Immediate Past President of the State Society, Treasurer of the Federation

I write to you today to let you know of the retirement this summer of Ken Adams, Esq., champion advocate of the Clinical Social Work Federation and defender of clinical social work. Be assured that his firm will still represent us and that he will always be there in the background. Marsha Wineburgh said to me that without him she believes there would have not been a profession of clinical social work in America. Crayton Rowe, an early President of the Federation, writes much the same thing in his passage below. Much of this article will be quoted from Ken's resignation letter to then-President Betty Phillips, Ph.D., and from the writings of Crayton Rowe, Marsha Wineburgh and Adrienne Lampert. The three prominent New York State clinical social work leaders are all past Presidents of the Clinical Social Work Federation. I quote them because there is no way to improve on their language or their sentiments. Needless to say, my own grief at this parting is only soothed by the knowledge that Ken's firm and the attorney taking his place are superb. In the interest of brevity I have been unable to ask many other past national leaders to join this tribute. I know that they will get their chance elsewhere.

Ken's letter dated June 11,1998 to Betty Phillips begins," I am writing to confirm to you my decision to retire from the clinical social work profession after 25 years as the profession's voice in Washington, D.C. Twenty-five years ago, when Crayton Rowe, Bill Jett, and Arnie Levin and the rest of the Federation's Search Committee interviewed and hired our firm, I was the most junior of the 12 lawyers in the firm, and the only one with Capital Hill experience. Today, I am one of the most senior of the 240 lawyers in our firm, which includes both a Government Affairs group and a Health Law group, each comprised of top notch, experienced lawyers who spend their full time working with those specialized areas on behalf of clients of the firm. I am a member of neither group. As head of the Civil Litigation section of the firm, I spend nearly all my time litigating complex civil cases and supervising the caseloads of dozens of other litigators. As my litigation practice has grown, it has been increasingly difficult for me to commit the time and energy to stay on top of the developments affecting clinical social work, in the health care industry and the government. As I prepare for what Gail Sheehy calls the "second childhood," I accept that I cannot do it all, at least not well enough to suit myself and others to whom I have made commitments. The problem is making the difficult decision to let go, and experiencing the pain that is the unavoidable companion of change."

Crayton Rowe writes as follow, "As you know, I was on the Search Committee with Bill Jett. This was Bill's administration. He was just beginning as a lawyer at the time, but we saw the tremendous capacity to listen and desire to learn about our profession. As Ken learned about our profession, he was able to view our problems objectively within the context of social work as well as within the context of the mental health profession in general. Needless to say, at that time our survival was at stake and Ken took this very seriously. He made it possible for our clinical profession to move forward.

Marsha Wineburgh writes, "For the past 20 years. I have known and worked with Ken Adams on issues pertaining to advocacy for clinical social work primarily on the national level but also on the issues relevant to New York State. As President of the NYSSCSW, President of the National Federation for Clinical Social Work and as Legislative Chair for NYSSCSW, I have been in a position to observe his consistent interest and proactive presence as National Advocate for our national association, now known as the CSWF. To my mind, he is the visionary responsible for the national presence and parity clinical social work now enjoys on the federal level. He has been the strategist and tactician behind the recognition of clinical social workers as providers of mental health services for millions of Americans through Medicare, the Federal Employee Health Benefits Program and CHAMPUS. With his guidance, our national association has been able to withstand national NASW's persistent attempts to derail, overwhelm, dismiss, undercut and, at the very least, minimize our efforts to represent those vital areas which are the discrete interests of clinical social work.

To my mind, he is the visionary responsible for the national presence and parity clinical social work now enjoys on the federal level.

"The road to license clinical social work in New York State has been slow and torturous over many years. The State Society and other groups have written many ver-

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Lies, Lies and More Lies

Report of the Keynote Presentation by Carol Tosone, Ph.D.

By Jim Mac Rae, CSW

Carol Tosone, Ph.D., is Assistant Professor at New York University, Shirley M. Ehrenkrantz School of Social Work.

Carol Tosone, Ph.D., walked to the podium at Mt.Sinai's Guggenheim Pavilion, as over 150 members of the State Society watched and waited for her to begin her keynote speech at the May 16th Annual Conference.

"Good morning," she said. A few voices echoed, "Good morning," back to her.

"No," the speaker replied emphatically, "I really want you to participate.... How are you?"

"Fine!" came the response of the more enlivened audience.

"Some of you have just told your first lie of the day."

The audience was now fully engaged, as Tosone set the stage for her engaging and stimulating topic: *Lies, Lies and More Lies.*

Jim Mac Rae, CSW, is the Director of Children and Family Services at the Mental Health Association of New York City, Inc., and is in private practice. He is a graduate of Hunter College School of Social Work, and he graduated from the Institute for Contemporary Psychotherapy.

Tosone defined a lie as the "conscious or unconscious intention to mislead someone." She stated that lying often occurs in the treatment situation in the form of self-deception or at work or with friends, relatives and partners. Consider the following: one out of three newly-hired employees has altered his or her educational or career credentials in some way; employers often mislead their workers about prospective job opportunities; and it is a common practice for institutions to lie about their statistics in order to justify funding.

In the dating world lies may help people avoid unpleasant situations. Men lie to get sex, while women lie to get a committed relationship, but even in committed relationships, lies are often used as a form of conflict avoidance. Statistics indicate that infidelity exists in 30-50% of all marriages. There is some hope, however. Evidence supports the notion that a "truth bias" begins to occur as the level of intimacy between two people increases. Tosone stated that "trust is the bedrock of the relationship" on a personal level and in a therapeutic relationship.

But how does a person learn to lie? Tosone stated that parents often unwittingly teach their children by example, perhaps trying to enhance their self-esteem or impressing others. Then, there's Santa Claus, the Easter Bunny and the Tooth Fairy. It isn't long before children catch on. When a child becomes a teenager, s/he may lie as a means to greater independence from their parents (or to avoid their control). College students report that 80% of their lies are designed to make themselves appear smarter, kinder or to protect themselves from embarassment.

Who, Me Lie?

Tosone stated that everyone seems to be comfortable with those "white lies," and studies indicate that people lie in one out of every five interactions. But lying is considered unacceptable in our society....especially if the liar is someone else. There is a strong tendency, Tosone stated, in our society, for people to judge other people's lies but to view their own lies as necessary. "We live in a world where mendacity is pervasive." This results in a contradictory self-experience, in which one believes abstractly in the idea of telling the truth, yet in practice often lies. This can pose problems for a profession that is truth-seeking.

Tosone described ways in which psychotherapists and others have come to understand the nature of lying. Freud stated that the cultural superego sets up the need to achieve certain ideals and demands; however, this conflicts with the inclination towards aggression. A lie can resolve the problem. It creates a compromise formation that solves the conflict between the need for affiliation and the desire to express sexual or aggressive impulses. In nature, disguises protect animals from being eaten. In society, coloring one's hair or using makeup may serve a protective function and make the individual appear more attractive and competitive in the arenas of work and society.

Self-lies

Lying can serve as a defensive mechanism to ensure one's psychological survival. Denial, dissociation, isolation of affect, negation, repression and suppression are among the self-lies that might ward off anxiety. Denial,

At the 29th Annual Conference on May 16th, are (left to right) Helen H. Krackow, Past President; Carol Tosone, Keynoter; Bernard Frankel, Keynoter, Dianne Heller Kaminsky, Education Committee Chair; Al Du Mont, President; and Maggie Scarf. A special award went to Ms. Scarf in recognition of her article "Keeping Secrets," a significant contribution in the effort to expose the problem of managed care systems and to affirm the rights of patients to the privacy and confidentiality of their psychotherapy.

for instance, serves a psychic need not to know the truth. One version, the false memory syndrome, might be employed by a person who has been sexually abused. On the other hand, sex offenders may employ denial and minimalization.

In this context, Tosone used Winnicott's notion of the False Self as an example of a defensive function that protects the True Self. While Winnicott's True Self is the inherited disposition of the infant, it must be developed in an atmosphere of acceptance and caring by a "good enough" mother. When this occurs, "Playing becomes the medium for the expression and elaboration of the true self." However, if the mother interferes or impinges in this process, the child withdraws from authenticity and responds to a perceived hostile world with a False Self. This False Self is deceptive, because it appears to be real, but it "has comprised its genuineness by complying with environmental demands as adaption." Lying to one's self, then, becomes an effective communication strategy. This is the reason that so many people mistrust caregivers (and therapists). Treatment, according to Winnicott, must focus on the True Self or the result will be disappointment for both parties.

Tosone described Kohut's theories of intersubjectivity and relationalists. Some relationalists rely upon a theory of constructivism that addresses issues in terms of their narrative truth. From this point of view, "There are no unique realities, only interpretations." There are only "reconstructions from the past." It is the work of the therapist and the patient, together, to create the story. The story will be different from what actually happened, and the approach requires the therapist to be willing to assume a "not knowing" stance as the patient constructs his or her version. "The relational self is a paradox, consisting of contradictory realities that need to be balanced and prioritized but may never be integrated. The therapist, then, must be willing to "stand in the spaces between realities without losing any of them," Tosone said.

The Case of Nancy

When the severity of the paradox is too great for the patient to reconcile, the patient may revert to a defensive posture, such as dissociation. Tosone offered a clinical example that demonstrated how this may manifest. Nancy, a Japanese student, had dropped out of college because she "partied" too much. For two years she continued to tell her parents, who lived in Japan, that she was going to school. Things began to disintegrate when it came time to graduate and her parents planned to attend the graduation. She ingested some pills in an unsuccessful suicide attempt.

When Nancy was a little girl her mother made her kneel backwards with her toes pointed inward when she did not achieve stellar grades. Dr. Tosone came to know the "dutiful daughter who was overwhelmed with shame and grief in having disgraced the family, and the rebellious impish girl who found their views harsh but would consider no other course of action than the one her parents prescribed."

During a session Nancy, overcome with emotion, knelt on the floor before Dr. Tosone and demonstrated the position her mother had imposed on her and repeated a Japanese word (untranslatable in English) that described "shaming generations of ancestors." Dr. Tosone described her own difficulties in sharing that moment with Nancy. "It was a mutative moment, and all I could think to say was, "I understand." Somehow we were 'standing in the spaces' separately and together. Each of her self-states had its reason for existing. Each held a single truth that it tried to tell....which I could not write to suit my preexisting theoretical beliefs."

There is a strong tendency in our society, Tosone stated, for people to judge other people's lies but to view their own lies as necessary. This can pose problems for a profession that is truth-seeking.

Dr. Tosone described the paradox of the psychoanalytic inquiry. "Our profession is founded on truthfulness, yet truth remains an elusive, and in many ways, unknowable concept." In the words of Don Juan, What is a lie? "Tis but the truth in masquerade. I defy historians, heroes, lawyers, priests (and therapists—Dr. Tosone's addition) to put a fact without some leaven of a lie."■

"Seeing is Not Believing"

The Theoretical Concepts of Dr. Bernard Frankel

By Richard Beck, CSW

Bernard Frankel, Ph.D., MSW, BCD, is Clinical Professor of Psychology, Adelphi University, Post Doctoral Program.

Richard Beck, CSW, is on the faculty of the Postgraduate Center for Mental Health, The Training Institute for Mental Health, the EGPS Training Program and is in private practice in New York City.

Dr. Bernard Frankel delivered his keynote presentation in a manner which illustrated his theoretical concepts. He defined, described and illustrated these with clinical vignettes from his practice. Frequent use of adlibs, in addition to his planned presentation spiced his approach. His style reminded me of the introduction to Irvin Yalom's "Existential Psychotherapy." Dr. Yalom described his experience of taking an Armenian cooking class where he followed recipes exactly only to produce mediocre results. He then observed his teacher preparing the same dish, but as it was on the way to the table, she would "add a handful of this and a pinch of that." Dr. Yalom concluded, as did Dr. Frankel, that like this cooking lesson, the healing nature of psychotherapy is in it's human, interpersonal realm.

The audience was touched by the candor, use of humor and humanity of this presenter. Dr. Frankel's use of self in his address paralleled his use of countertransference in his clinical work. He conceptualized his work from both an Object Relations perspective—from the British Middle School of Object Relations, and a Systems approach. This provides for both an intrapsychic and interpersonal focus within an organizational structure.

The presentation began with Dr. Frankel's provocative and timely musing as to how the study of secrets and lies could more easily be "transferred to politics as to its clinical application." The role of spin-doctors, who "reframe" events so meanings became distorted was illustrated. We were reminded that we "practice our craft within a larger society.... and that both we and our patients are effected by social attitudes and values." No longer "is seeing as believing," as we often experience manipulation of perceptions to corroborate a falsification of reality. This is similar to a dysfunctional family, where the Identified Patient often carries the family secret and shame. Today in clinical practice, money has replaced sex as the major secret in therapy. We often collude monetarily with our patients, especially in the area of managed care and insurance claim information.

Secrets and lies are needed to protect self and others from real or imagined injury. The gravest injury is shame, which threatens the cohesiveness and constancy of self and others.... Secrets and lies are maintained to preserve images of a good object or group.

What Dr. Frankel discovered during his 40 years of practice was that in all clinical situations he was "being given an object role assignment to fit him into a dysfunctional systemic grouping." This "suction-induction phenomenon" was part of maintaining a regulatory system in an interpersonal structure. This system functioned to "maintain the reality orientation of its members by making perceptions and behaviors congruent to each other."

Dr. Frankel cautioned us, with respect to conscious secrets and lies, not to confuse a pragmatic view with an amoral one. He formulated the following with respect to interpersonal constructs:

- Object seeking and object attachment is the primary drive.
- This drive requires an interpersonal context for its development and fulfillment.
- Normative development requires a safe internal and external environment where early processes of splitting and transitional space can be absorbed and metabolized.
- Responses between objects become reciprocal exchanges that are systematized by projection and introjection into a corroboration of reality. What is expected follows. What follows is expected. A feedback loop.
- Projective Identification is a normative process of maintaining and expanding boundaries for the expression and containment of the affective life of feelings and emotions.
- We have all been in a captive role assignment as receiver or giver. We have needed to maintain our own internalized object representations and protect our self-organization and the structure of our families.
- Secrets and lies are needed to protect self and others from real or imagined injury. The gravest injury is shame, which threatens the cohesiveness and constancy of self and others.
- Secrets and lies are maintained to preserve images of a good object or group.

Dr. Frankel shared clinical vignettes from family, couples and group therapy which illustrated how conscious secrets and lies induce a captive role assignment, either in the therapist or others, how our being "pulled in" to the system "effects our neutrality" and, most importantly, how our countertransference is..."the experiential data that can unlock and work through the dysfunctional residue and fallout from secrets and lies."

One vignette was illustrative of understanding induced countertransference and its relationship to the "secrets and lies" in the clinical situation. In a family where the presenting problem was the death of the father and the family's "problems with the funeral," Dr. Frankel creatively role-played the father at his funeral and experienced the differentiation between "the mask of death" and the "mask of deadness." The family, a mother and two daughters, recognized that their pact to avoid appropriate grief and mourning deprived them of the life force. In one therapy group, Dr. Frankel was able to recognize that several patients assumed a "reciprocal role assignment to protect parental egos." In that group, a female patient's fear of falling while rollerblading was related to the symptom of premature ejaculation by another patient. The secret each patient carried was related to the maintenance of parents as idealized objects.

Secrets and lies originate and are perpetuated in an interpersonal context and their working through requires an "interpersonal environment."

Dr. Frankel openly demonstrated his struggle to understand his countertransference, to recognize how it shifted in the course of treatment and related this to the shifting of induced role assignment. Secrets and lies originate and are perpetuated in an interpersonal context and their working through requires an "interpersonal environment." We experience the "fallout" of such secrets and lies "via projective identification and captive role assignments." These assignments maintain collusion and impair the affective life and self of all the participants. In therapy, secrets are "to be taken as they are given, unless there is a real threat to life or physical safety." We need be aware of how one's neutrality shifts in the countertransference and in understanding the countertranceference, prevent reciprocal projective identification.

It is no secret that Dr. Frankel's presentation was thought-provoking and intellectually stimulating as he related his unique perspective on conscious secrets and lies.■

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Book Review

Reviewed by Phyllis Mervis, MSW, Chair, Group Psychotherapy Committee

AIDS Trauma and Support Group Therapy: Mutual Aid, Empowerment, Connection

By Martha Gabriel. New York: The Free Press, 1996, 214 pp.

This book review first appeared in ***International Journal of Group Psychotherapy,*** *48(3), 1998. Reprinted with permission of the Guilford Press: New York.*

As someone who has participated in the psychosocial care of cancer patients, witnessing the conversion of cancer from an often acute and fatal illness to one that has become a chronic disease for many, and as one who maintains a passionate belief in the efficacy of group therapy for medically ill people (Mervis, 1977, 1983), I welcomed the opportunity to review this book. I was interested to learn the similarities and differences in the group treatment of AIDS patients, particularly at this point in time. I came away with both more and less than I bargained for.

In her introduction, the author states that she wrote this book "to provide group practitioners and those interested in group practice with people with AIDS some understanding of the special considerations, difficulties, and challenges encountered in facilitating support groups for people traumatized by AIDS." She does much more than that. Herein lies the book's major strength.

In the first chapter, the author chronicles the historical development of the disease's appearance and progression and also familiarizes the reader with many of the medicines, terms, and acronyms used in discussing AIDS. Moreover, references to disease specific information are extensive throughout the book. This chapter also introduces a conceptual framework of trauma for understanding the AIDS experience. Together, this material conveys a profound sense of the disease's inexorable development and numbing physical and emotional toll.

For those who already work with traumatized populations, the book offers an opportunity to review and evaluate their own practice and to expand their theoretical commitments when there is evidence that there might be additional effective explanations and interventions that correspond or resonate with their professional values.

In subsequent chapters, the author outlines important issues such as planning groups with different HIV and AIDS populations, including women, the chemically dependent, and gay men. In the discussion of boundary considerations with these populations, the author emphasizes the need for careful thought into providing group space that is not only accessible to the physically and visually impaired but also well ventilated in terms of health protection from tuberculosis. She also points out the metaphoric aspects of time, absences, and the introduction of new members, and discusses the nature of extragroup contacts.

The third chapter on special issues and considerations in support groups with people with AIDS is particularly relevant for anyone interested in this work. The material covered includes confidentiality, rational suicide, and multiple deaths. While the literature on groups for the medically ill covers many of these topics, the author's knowledge of AIDS related subjects skillfully underscores the ethical as well as clinical complexity of these topics when working with this particular population. Therefore confidentiality must be addressed in light of the Tarasoff Doctrine and the AIDS pandemic, while dementia, TB, and drug resistant TB confront the support group practitioner with emotionally wrenching clinical challenges.

In recognition of the strains imposed on the facilitators working with this population, the author devotes the final two chapters of the book to a discussion of countertransference reactions and "secondary traumatic stress." While these chapters are the weightiest, they also point to the book's major weakness, namely a sense of theoretical indiscrimination. This unbounded discussion includes a cataloging of both recognizable and poorly defined constructs that have the ring of redundancy rather than of empirical truth. The reader is presented with, among others, objective countertransference, subjective countertransference, multiple countertransference, concordant and commentary identification, fundamental transference, stereotyped role, as well as burnout, vicarious traumatization, death imprint, psychic numbing, and counterfeit nurturance. In an effort to be all inclusive, the author also mentions techniques for addressing these reactions through the use of guided imagery, imagery and eye movement desensitization, caregiver support groups, supervision, and personal therapy. This discussion is presented without much commentary even though a lot of the material is anecdotal or descriptive.

Questions about some of these formulations and techniques does not mean that group practitioners cannot learn from studying them. There may be specific ideas that can be integrated into group practice. My concern is that the author's point of view is noticeably absent here as in most of the book. Given her vast experience in the area of AIDS, I miss her clinical impres-

sions and observations in organizing and critically assessing the material. This is particularly important for the beginning practitioner or any clinician wanting to work with this population.

For those who already work with traumatized populations, the book offers an opportunity to review and evaluate their own practice and to expand their theoretical commitments when there is evidence that there might be additional effective explanations and interventions that correspond or resonate with their professional values.

Finally, while the book presents a wealth of references and resources, even including chapter notes that further explicate the text, there are instances of incomplete research and theoretical imprecision. The author states that "a precise definition of support group therapy is lacking in current group literature." Yet an entire 1995 issue of ***Social Work With Groups*** is devoted to articles about these groups. Included is an article by Schopler and Galinsky which is an expansion of their continuing study of support groups (1993). The authors' "open systems model" of support groups is a framework for guiding interventions and for evaluating their impact. The major conceptual dimensions addressed by this model include participant characteristics, environmental conditions, and outcomes.

Additionally, there are many articles which discuss pertinent aspects of support groups that are conspicuously absent in Gabriel's book. The omission of such fundamentals as group dynamics is significant when working with a population which by the author's own acknowledgement demands so much from its group facilitators. Potential leaders would benefit for instance from information about the stages of development in these groups and related leadership functions. It does not feel sufficient to suggest that the leader's skill lies in "framing to provide a safe environment...." How is that done? Likewise, if "central to... reconnection is the activity of narration or storytelling" and the goal in these support groups is "the enhancement of coping skills through mutual aid, empowerment, and reconnection," then how does this come about?

Lastly, while this may be a personal interpretation, it seems that in an effort to develop her model of AIDS as a trauma of disconnection and powerlessness which in turn responds to support group intervention, the author forces a mixture of concepts that leaves a feeling of theoretical ambiguity and incoherence. In developing her premise, the author states that in his seminal paper, Lindemann (1944) was speaking about "trauma as the sudden uncontrolled severance of affective ties." In fact, he was writing specifically about the bereaved's reactions to the death of a significant person. The death of a loved one is a distressing event which is marked by emotional and social upheaval and a process of mourning. Inherent in this process and its resolution is the necessary review of the relationship with all its ambivalence. This kind of tragedy is not the same as the experience of rape and incest where the traumatic event involves the severing of the basic trust the individual has in significant others which in turn often affects emotional development. This in turn is different from the extreme trauma of Holocaust atrocities where the violation of human dignity and human trust was even more profound emotionally and perhaps has longer lasting sequelae.

Nevertheless, the author's extensive attention to the "caregiver's plight" with AIDS patients is an important review of this phenomenon and her depiction of the disease related issues which the group facilitator must attend to also makes for informative reading.

Are these distinctions just a matter of degree? I think not. As mental health professionals we are in a powerful position vis a vis the individuals who are in need of our care and look to us to help them. As the interest in and use of support groups has grown, so too has literature on their potential harm as well as benefit. (Alexander, 1993 and Galinsky and Schopler, 1994). Also, theoretical specificity leads to clinical clarity. All of the recent literature on social support, both empirical and descriptive, points to the importance of stressor-specific sources of support to maximize helpfulness (See Bronstone, 1993, Himle, Et Al, 1991, Mallinckrodt,1989 and Thoit,1983).

Empowerment and reconnection represent the latest reworkings of earlier ideas about how to treat the isolation and alienation of the medically ill and emotionally traumatized. (See Northern's 1989 extensive review "Social Work Practice with Groups in Heath Care"). ***AIDS Trauma and Support Group Therapy: Mutual Aid, Empowerment, Connection*** does not shed any new light on the subjective experience of traumatic states. Nor does the book disentangle the issues on the effectiveness of social support in group therapy for individuals with AIDS in order to refine understanding of how it works to buffer the stresses of this illness and/or trauma, i.e. which sources and types of support are most powerful with this population. Nevertheless, the author's extensive attention to the "caregiver's plight" (Weisman, 1981) with AIDS patients is an important review of this phenomenon and her depiction of the disease related issues which the group facilitator must attend to also makes for informative reading.■

References available upon request.

Kenneth Adams Tribute

CONTINUED FROM PAGE 5

sions of licensing legislation. Throughout this entire process, Ken Adams and his law firm have been available for clarification and advice so we can be assured that the multi-level version we now have better protects our clients from unscrupulous practitioners and adequately represents the clinical social work level of practice."

Adrienne Lampert states, "Ken's interest, availability, and devotion to the clinical social work profession went beyond anything anyone would have expected. He was accessible, returning calls immediately. The fact that he did not talk in a lawyerly way made him a great support. His firm was always a watch-dog looking for health care initiatives in the Congress, state legislatures, newspapers and alerting us to anything that could impact on the mental heath profession and clinical social work."

Finally I think it would be fitting to look at a list of Ken's accomplishments in his own words:

"When I think back, I find it difficult to put in perspective where the profession was in 1974, where it is now in terms of its place in the nation's mental health care delivery system, and how the changes have evolved. Instead, I see a 'highlight' film, a montage of people and events that mark the high points of my experience with the Federation:

- My clinical social work education, initially provided by Eloise Agger, Crayton Rowe and Arnie Levin during the first year we were hired, and continuing over the years through innumerable discussions and meetings and conferences where I saw and heard and felt the shared values and commitment of the profession;
- The distinguished and inspiring leaders of the profession I have had the privilege to know and work with ;
- Inclusion of clinical social workers as providers, alongside psychiatrists and psychologists, in the CHAMPUS program, which covers millions of armed forces families and retirees;
- Active participation by the Federation in the CHAMPUS peer review organization that was a precursor to many of the peer review (and later, managed care) programs designed to solve the dilemma of increasing cost-efficiency without undermining quality of service;
- Inclusion of clinical social workers as providers, alongside psychiatrists and psychologists, in the Federal Employees Health Benefits (FEHB) plans that cover millions of federal employees and their families;
- Inclusion of clinical social workers as providers, alongside psychiatrists and psychologists, in the Medicare and Medicaid programs (though there is

still work to be done to eliminate the price we had to pay, in terms of unfairly low reimbursement levels for clinical social workers);

- Membership in the Non-Physician Liaison Network, a coalition which for years refused to recognize anyone but NASW as the voice of clinical social work in the mental health policy arena;
- Membership and active participation in the Mental Health Liaison Group, the most influential and active coalition in Washington on mental health legislative and policy issues;
- Development of the National Registry's examination program, offering clinical social workers a means of demonstrating clinical competence in states which did not have clinical social work licensing exams;
- Creation of the American Board of Examiners in Clinical Social Work (ABE Board), jointly with NASW (until they resigned);
- Stopping NASW from breaching its contract by going into competition with the new ABE Board during the first five years of its existence;
- Creation of NICSWA, and its eventual merger back into the Federation;
- Creation of the National Membership Committee on Psychoanalysis;
- Challenging the efforts of various groups to lay claim to the exclusive power to accredit educational programs in psychoanalysis;
- Creation of the National Academy of Practice in Clinical Social Work;
- Development of the "Summit Group," a forum where the leadership of the principal mental health organizations (including the Federation) can work together to advance common goals of their members, such as the Patients Bill of Rights;
- Submitting Amicus Curiae briefs to the federal courts that have decided such crucial issues as the right of employers to avoid complying with state laws by disguising their health insurance plans as exempt self-insured programs, and the right of clinical social workers to refuse to disclose to the courts confidential communications from their clients; and
- The current "guild" initiative with OPEIU, to see whether affiliation with an AFL-CIO union offers new opportunities for health care professionals and their patients to form alliances that can effectively curb the abuses of managed care companies.

Were there a clinical social work Hall of Fame, Ken Adams, would be one of the firsts among those honored.

Your analyses, please

News articles, commentary, brief reports or papers, book reviews, meeting notices, photos and your ideas are always needed and welcomed.

CONTACT:
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PHILOSOPHY: Increase recognition by public agencies of importance of parent/child bond in child abuse and neglect cases and importance of reconstituting families. Educate public about clinical social workers' role as psychotherapists. Work legislatively on the state and federal level toward regulation of managed care. Ensure quality mental health care with confidentiality for everyone.

PRIVATE PRACTICE: Group practice, working with a broad range of clients, particularly with abused women and children and issues around parent/child relationships.

PROFESSIONAL TRAINING: M.S.W. from Smith College School for Social Work. Two-year training with Leigh McCullough-Vaillant in short-term dynamic psychotherapy. One year training in family therapy at Philadelphia Child Guidance Clinic. Level II training in EMDR. Intensive weeklong training with Eliana Gil, Ph.D. in treatment of abused children.

OTHER AFFILIATIONS: NASW, Association for Play Therapy, SAST (Sexual Abuse Study and Treatment Team) which is coalition of providers from public and private sectors whose purpose is to ensure best possible treatment for individuals and families affected by child sexual abuse. SAST also provides continuing education for treatment providers.

PERSONAL: Likes to cook. Best dish: latkes. Famous for: homemade chocolate chip cookies she brings to board meetings. Other hobbies: piano lessons and hiking. Judy and her husband recently hiked the Grand Canyon (7 miles down to the river; Bright Angel Trail; 9 days shooting the rapids; camping out a "life-altering experience;" enduring image: "moon glow on side of canyon wall at midnight"). Next trip: sea kayaking out of Vancouver/Alaska-Inland passage.

FAMILY: 23- year-old daughter who teaches in Boston, and 20-year-old daughter going to Skidmore. Husband, a child neurologist.

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