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

PRESIDENT'S MESSAGE

Clinical Social Work as a Profession and the Society at a Crossroad

by Hillel Bodek, MSW, LCSW, BCD

I am writing the first President's Message of my second term as the Society's President to sum up the state of the accomplishments of the Society over the past two and one half years and my view of the issues, concerns and challenges that we will need to address, as a profession and as a professional organization, in the coming years.

How Well is the Society Carrying out its Missions?

One of the principal ways of measuring an organization's functioning and success is to look at how well it is carrying out its missions. The primary missions of the Society are to establish and maintain high standards of professional education and practice, to promote post-graduate and/or advanced training in clinical social work practice, teaching, administration and research, and to protect the rights of clinical social workers to practice that for which they are trained, all of which relate to our profession. The Society's next mission is an organizational one; to promote clinical social work throughout the state through the formation of local chapters and to coordinate the activities of all the chapters and serve as liaison between them. The Society's final two missions relate to our relationships with other professionals and the public; to collaborate with other professionals and organizations, particularly social work organizations, to further our common interests and goals, and to inform the general public of the specialized skills of clinical social workers.

We have had significant successes in relation to our primary missions. Led by Marsha Wineburgh and our Legislative Committee, we have achieved a clinical social work license with the most comprehensive scope of clinical social work practice in the United States. We have advocated successfully for regulations to implement the new license and, over the past few months, we have defeated attempts by the NASW and the New York State Association of Deans of Schools of Social Work to diminish standards for clinical so cial work education and practice. The Society's Education Committee, under the leadership of Dianne Heller Kaminsky, and the various chapter education committees are conducting annual education conferences and many chapters conduct educa-

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Society Hires Membership Consultant

By Judith Crosley, LCSW, Chair, Strategic Planning Committee

Marian Sroge, CAE, was hired as a membership consultant in the spring 2006 by the State Board at the recommendation of the Strategic Planning Committee (SPC). This was in keeping with the suggestion of John Vogelsang, Ph.D., of the Support Center for Nonprofit Management. The SPC sought his recommendations in April 2005 on ways to help develop a membership recruitment and retention plan and to update our membership materials.

He also recommended that we should consider hiring a part- or full-time executive director in the future to help us follow through with new plans. Inherent in these proposals is the recognition that we can no longer continue to operate as an all volunteer organization if we wish to fulfill our mission and provide appropriate services to our members.

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President's Message

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tion programs as part of their chapter meetings. These high quality programs cover a wide range of topics related to clinical social work practice. We have begun to issue CEU credits for some of these activities and hope to expand that program in the coming year. Under the leadership of Helen Hinckley Krackow, the Society's Mentorship Program is developing and operating mentorship groups for recent MSW graduates to aid them in the transition from student to independent practitioner. Under the leadership of Jonathan Morgenstern, the Society's Vendorship Committee educates and consults with members to help them address managed care and other vendorship issues. The Committees on Ethics and Professional Standards and Forensic Clinical Social Work have aided a number of members in addressing the myriad of ethical, legal and clinical issues that arise in their practices.

Turning to our organizational mission, our chapters are the building blocks of the Society where members can network with colleagues in the same general geographic area, where educational, mentorship and peer consultation programs tailored to the interests and needs of each chapter's members can be developed and implemented, where outreach efforts geared to the needs of local communities can be undertaken for the purpose of helping other professionals and the public learn about and access clinical social work services thereby increasing the recognition and appreciation of clinical social work, and where outreach to local schools of social work and to other clinical social workers to recruit new members can be undertaken. We need to do more to help chapters reach out to more of their members and to bring new members into the Society. Helen Hinckley Krackow, chairperson of our Membership and Chapter Development committees, has been working successfully with some of our existing chapters in this regard. The Strategic Planning Committee, under the leadership of Judith Crosley, and the Membership Committee are in the process of completing the design and issuance of new brochures for use in outreach to social work students, agency social workers and social workers in private practice to encourage them to join the Society.

With regard to the first of the Society's final two missions, the relationship between the Society and the NASW remains problematic. Although we have worked together with NASW on some issues where we have common concerns, we need to continue to seek more opportunities to work together with them. A significant accomplishment was the Society withdrawing from the Clinical Social Work Federation, which since the mid-1980s has failed in its primary mission of providing national level advocacy, the reason the Society helped form the Federation in the early 1970s. In its place, at its September Board meeting, the Society Board voted to affiliate with the Center for Clinical Social Work for the purpose of developing an advocacy program for clinical social work on a national level. We have attempted to work with schools of social work to advance graduate social work education, particularly in the clinical social work area. During the coming year, we will be attempting to work with the State Education Department and the schools of social work to increase the quality of and standards for graduate social work education, field placements and supervision in New York State. The one area to which the Society has not shown adequate attention is informing the general public of the specialized skills of clinical social workers. Hopefully, during the coming year, we will be able to aid chapters to do this in their local communities.

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In Memoriam

Dr. Charles Smith, founder of the New York State Society for Clinical Social Work and its first Vice President, passed away in late July 2006. In October 1968, when Charles was the Assistant Director of Social Work at the Postgraduate Center, both he and his colleague, Dr. Robert Lampert, had become frustrated with NASW's lack of supportiveness toward private practice. They called a meeting of social workers at the center to discuss the problem, and the Society was born, with Robert as its first president.

In recent years, Charles had an active practice in family and couples work as well as psychoanalysis in the Chelsea area of Manhattan. His memorial service was held in August. Donations were made in his name to the American Cancer Society and the Glaucoma Society. We are greatly saddened by his passing.

By Marsha Wineburgh, DSW, Chair

Workers' Compensation – Our Next Challenge

The Society has introduced a bill to amend the workers' compensation law, authorizing the care and treatment of injured employees by licensed clinical social workers. It expands the category of qualified mental health providers available to deliver permitted psychotherapeutic treatment and will afford injured workers greater access to care and more provider options across New York State. Current providers are limited to licensed psychologists and physicians.

The bill was introduced by the Chair of the Senate Labor Committee (S.7379), George Maziarz of Niagara Falls, and Chair of the Assembly Labor Committee (A.11164), Susan John of Rochester. It remains in the Labor Committee of both houses awaiting the overhaul of the entire workers' compensation program. Rumor has it that this project might just be near the top of the soon-to-be Governor Spitzer's wish list.

Other social work organizations have also introduced alternative legislation which sets the qualifications for providers of psychotherapy services at a lower level (LMSWs under supervision and LCSWs) and includes reimbursement for social services. The Society is committed to ensuring all New York State residents have access to those mental health providers who have all the credentials the state offers. The most experienced and supervised LCSWs have earned the "R" insurance designation. This is the group we believe are best qualified to deliver quality psychotherapy and that workers' compensation victims should have access to this group of providers.

Justification for This Legislation

Currently, the only providers under the Workers' Compensation Law that may deliver mental health services to injured workers are physicians and licensed psychologists.

On December 22, 2005, Judge Budd Goodman of the Supreme Court of the State of New York issued a decision that clarified that licensed clinical social workers and licensed psychologists share the same scope of practice and professional functions.

The state has a long history of allowing consumers to choose from qualified health care service providers. At this time, licensed clinical social workers are eligible

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The Society Affiliates with Center for Clinical Social Work

By Hillel Bodek, MSW, LCSW, BCD

On September 9, 2006, the Society's Board voted unanimously to affiliate with the Center for Clinical Social Work and to become a member of its advisory body, the Council of Colleague Organizations. The Center is a new organization that was formed by the American Board of Examiners in Clinical Social Work (ABE) to represent and serve all clinical social workers in an advocacy role on a national basis. ABE will continue to provide its advance practice clinical social work credential, the Board Certified Diplomate in Clinical Social Work (BCD), as a credential that does not require membership in any organization.

By way of background, in the early 1970's, the Society, along with five other state societies for clinical social work, founded the National Federation of Societies for Clinical Social Work. That group, known in recent years as the Clinical Social Work Federation, was developed to provide a national voice for clinical social work and to engage in advocacy primarily to obtain licensure and vendorship for clinical social workers in each state and to include clinical social workers as providers in the three major federal health benefit programs, the Federal Employees Health Benefits Act [FEHBA], the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS, now known as Tricare] and Medicare.

Into the mid-1980's, the Federation was quite successful in carrying out that role and our Society was often in the forefront of those important efforts. After achieving those successes the Federation began to lose focus. A number of its member state societies, which developed primarily to work to attain licensure and vendorship for clinical social workers in their states, diminished in size after they obtained licensure. As it strayed from its primary mission, the Federation made a number of poor decisions. It decided to partner with the Clinical Social Work Guild and marketed the Guild health insurance to clinical social workers. That insurance plan and its replacement plan both dissolved leaving a number of clinical social work policy holders with unpaid health care bills. It decided to develop a

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TREASURER'S MESSAGE

Adoption of Policies Regarding Compensation to Society Members

By Betty Gewirtz, MSW, LCSW, BCD

The Society's Board has unanimously adopted two policies which address the issue of compensation to members of the Society; the first, for services rendered to or on behalf of the Society and, the second, for services rendered as a presenter at educational programs or conferences sponsored by the Society. The policies adopted do not relate to reimbursement for approved expenses actually and necessarily incurred by Society Board members, committee chairs or other Society members on behalf of the Society, for which reimbursement is paid, which are different than compensation for services rendered.

The Society's lawyer and its accountant explained that, unlike for profit corporations which exist to make money for their owners or shareholders, not-for-profit corporations exist to carry out certain functions that are in the public interest, in the case of the Society, advancing a profession which serves the public interests. In a not-for-profit corporation, the directors are called upon to make decisions about how the corporation will carry out its not-for-profit purposes in the public interest and how the corporation's assets will be used to further those public interests; rather than decide how to maximize its profits as in a for-profit corporation. Board members of not-for-profit corporations are typically expected to volunteer their time to advance the public interest purposes and goals of the not-for-profit organization. Additionally, compensating Society members for rendering services to the Society can raise significant conflict of interest concerns.

The Society's attorney advised that, "although there is a strong presumption that not-for-profit corporations should rarely, if ever, compensate members for work they do or for services they perform for the organization, the law does not in all cases prohibit that compensation. When it can be shown clearly that compensating a member is in the interest of the pubic mission of the corporation without any regard to the private interest of the person to be compensated and when appropriate procedural safeguards are instituted to protect from the potential appearance and perception that a compensation decision is being influenced by the private interests of the member, then compensation may be legally permissible. For example, if a member were to possess a necessary skill or expertise that would otherwise be very difficult for the organization to obtain from a non-member, or the cost of obtaining a service would be so prohibitive that it would make it impossible for the Society to obtain that service which is essential to carrying out a crucial function, then compensation would be legally permitted. His view was shared by the accountant.

Thus, the Society has established a multi-step procedure as recommended and approved by the Society's attorney and the Society's accountant by which a request to compensate a member of the Society for services rendered to or on behalf of the Society can be addressed. This procedure is designed around the presumption, enunciated by the Society's attorney and accountant that, payment of compensation to Society members for work provided for or services rendered to or on behalf of the Society, should rarely, if ever occur.

With regard to the issue of paying members to be presenters at Society educational conferences and programs, the accountant and attorney have both stressed that there is no distinction that exists between compensating a member of a professional association for work that is performed related to the association's educational functions as opposed to work performed for the association for other purposes. Thus, as the accountant noted and the attorney concurred, "It would be highly preferable not to compensate association members who present at association sponsored educational activities for doing so. This is the case with most professional associations with which I am familiar. However, I believe that providing a very limited monetary token of appreciation (that is substantially less than what would be paid to an outside speaker who is being hired as a presenter) for a member's contribution of time as a presenter at an educational activity could be done without violating the association's not-for-profit and tax exempt status."

The policy enacted by the Society in this regard follows the guidance provided by our accountant and our attorney; specifically, that the policy (a) place strict limitations on the total of such payments on an annual basis to a very small percentage of the association's annual expenses (two to three percent), (b) assure that no member of the association would make a significant amount of presentations or receive a significant amount of money for making presentations for the association, (c) establish provisions for uniformity of these payments to association members which reflect a token amount that is significantly below what is generally paid to non-members for making similar presentations, and (d) create strong protections against the appearance or existence of a conflict of interest in choosing presenters.

Thus, the Society has established a multi-step procedure as recommended and approved by the Society's

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Vendorship & Managed Care

by Jonathan Morgenstern LCSW, Chair

We are seeking your suggestions for a new name for this committee, "vendorship" being a relatively obscure term. Please forward any ideas to your chapter chair or directly to me as listed below, and thanks.

There have been changes to committee membership: Liz Ruggiero (Westchester) has been replaced by Andrea Gordon, and Peter Smith (Metro) has been replaced by Helen Hoffman. Gary Dunner has also left the committee. We are seeking committee chairs for Brooklyn, Rockland, Suffolk and Mid-Hudson chapters. Your interest is welcome and further information is available from your chapter president or from me.

Our goal is to help membership become efficient and effective in managing practice reimbursement with insurers and managed care organizations. We track relevant trends in the field and report them to the membership. Inquiries to the representatives listed below are welcome.

Members have reported problems in recredentialing with insurers and managed care organizations, including processing delays and lost documentation. Members are encouraged to confirm receipt of information they send.

An inquiry from a member highlighted a very important issue: a Medicare provider cannot enter into a private agreement with a Medicare recipient to not bill Medicare. The following links are resources:

www.ssa.gov/OP_Home/ssact/title18/1866.htm#fn481
- Agreement with providers of services, enrollment processes

www.ssa.gov/OP_Home/ssact/title18/1879.htm
- Limitation on liability of beneficiary where Medicare claims are disallowed 593

www.wpsic.com/medicare/provenroll/monitoring_faq.shtml#q7
- FAQ# 7. Can I choose not to submit claims to Medicare on behalf of my patients?

www.cms.hhs.gov/regulations
- CMS and Related Laws and Regulations.

There has been an increase in practice referrals from EAPs. It was recommended that providers, verify whether there is a no-referral clause, meaning that the referral is for the purpose of assessment only and that the assessing provider cannot self-refer for ongoing psychotherapy should it be recommended. It was also recommended that the provider be clear about the EAP fee. The issue is whether the provider can accept the fee and not become resentful of it later, which would have implications for the treatment provided.

Medicare providers should be aware that when they have not submitted a claim to Medicare for year, their status changes and they have to reapply. Higher deductibles for health care coverage are becoming more and more common – members should thoroughly verify a new client's benefit before the first session.

Tricare is the Defense Department's managed care plan for military dependent and retirees. Interested members may contract through regional companies. The Tricare website is www.tricare.osd.mil and Tricare North is serviced by Health Net Federal Services www.hnfs.net/common/home/.

Members should consider marketing their practice in a broader context – moving away from a pathology based-practice representation to wellness and strength-based.

Members should be mindful of the distinction between benefits verification and session authorization – authorization does not guarantee payment if benefits were not in place at the time the service was provided. Remember to monitor coverage throughout treatment (watch possible changes in benefits, e.g., after a job change). Members may require clients to sign a letter that, in the event that insurance does not cover, the client is responsible. Problems in this area may be referred to the NYS insurance and health departments and to the NYS Attorney.

All members are encouraged to apply for their National Provider Identification number. This may be done online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Save the Date: March 24, 2007, Managed Care Conference (see ad, Page 18).■

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Powerlessness, Aggression and the Body Ego

Mishaps and Adaptations

Keynote by Patsy Turrini, LCSW
Reviewed by Joyce Edward, LCSW, BCD

In her presentation, Patsy Turrini considered the role of the destructive instinct and defenses against it, as well as the effects of a fragile-body-unit in generating intrapsychic and interpersonal conflict. She drew from a wealth of psychoanalytic writings and from her own clinical experience and observations, integrating them in such a way as to demonstrate how these two factors can affect the body, sexuality, and the sense of self.

Turrini is in agreement with Freud (1929) that aggression, destructiveness, and wishes for revenge are normal instincts, which though they have important adaptive value can be the source of serious interpersonal and intrapsychic conflicts. She described research that looked at the biology of the instincts, and reviewed some of the current theories on aggression, and on the revenge motive as a variant of the destructive instinct

Despite the normality of anger, hate, and destructive wishes, acknowledging such feelings is extremely difficult. There is a tendency to deny and repress them in order to defend against the fear, shame and guilt they arouse. In general such denial blocks awareness and often delays indefinitely resolution of the original causes of the hurt and hate, thereby preventing any creative problem solving.

Patsi Turrini

Joyce Edward, LCSW, BCD, is a Distinguished Practitioner, National Academies of Practice; Training Supervisor, New York School for Psychoanalytic Psychotherapy and Psychoanalysis; Coeditor of The Social Work Psychoanalyst's Casebook (1999) Analytic Press; and Contributor to The Inner World of the Mother, (2003) eds. Dale Mendell & Patsy Turrini, Psychosocial Press.

Turrini spoke of a patient who had cause to be very angry at her husband, but who denied any such feelings, and began an affair. Guilty over the affair and her inability to end it, she then started to drink heavily. In time she confessed what she was doing to a sibling, who ostracized her and threatened to tell her employers. As Turrini understood this patient, her underlying guilt had to do, in part, with her unacknowledged rage towards her husband, which became displaced onto guilt over the affair leading to her self punishment. This patient's inability to acknowledge her anger led to a lack of self awareness and a sense of powerlessness. As Turrini, put it, it led to a "silencing of the self."

With some patients, such repressed feelings of hate and anger may lead to interferences in their sexual functioning and/or be channeled into bodily symptoms. Several studies suggest that the stress attendant to the denial of and the warding off of anger and destructive impulses is likely to have detrimental physiological consequences. To the extent that hostility has been thought by some to generate and enhance sexual excitement its repression and denial may also lead to sexual indifference and boredom.

Women appear to have particular problems in acknowledging anger, in part as a result of society's attitudes. Turrini noted how difficult it is for mothers to experience and accept their anger and hatred of their children. Repression of such feelings has been found to be a major source of maternal depression. Though she spoke more about women and anger, Turrini stressed that men also have their own difficulties in accepting anger.

After this consideration of hostility and its denial and repression, Turrini turned her attention to the fragile bodily self. The bodily self representation begins to be formed in earliest infancy and is shaped by countless experiences, including painful ones. It is these painful experiences, expectable and prewired, that become an aspect of the self representation, and foster the development of a fragile bodily self unit. This unit remains in the unconscious side by side with other self images and can be revived throughout the life cycle.

While adverse environmental conditions or inadequate inborn apparatuses are likely to increase this component of the self representation, Turrini emphasized that even under favorable developmental circumstances, this fragile unit develops. Certain common anxieties, traumas and fantasies of childhood foster its

development. Among these are the trauma associated with birth (Grotstein, 2000), stranger anxiety, the discovery of the anatomical differences which leads to the fear of the loss of body parts (and death anxiety); and the "oedipal defeat" which children are apt to attribute to some anatomical inferiority. Also cited were the common fear of dissolution early in life (Gaddini, 1987), and the anxiety during the rapprochement crisis when the child begins to realize that he or she is not part of the mother. Turrini proposed that the experience that many adult mourners report of feeling as if they have lost some part of their body after the death of their parents, may be related to this rapprochement phenomena.

An early sense of the body as fragile is also fostered by an idea, common to young children, of the body as a balloon — as a round, closed circle with things inside and later as a round unit in which things can go in and out (Gaddini,1987). This concept leads to a belief that the body can be punctured and the child will disintegrate and die. Turrini spoke of a patient who became extremely panicked when she thought she had "burst her husband's bubble." He had given her an expensive present which she did not like. She feared telling him. Her overreaction led to an understanding that her actions had been unconsciously experienced as if she had let the air out of his body and had killed him. Here one sees how the patient's anger at her husband for giving her a gift, and her unconscious wish to hurt him, reverberated with an earlier sense of a fragile body self, so that she experienced "deflating him" as if it would destroy him. This case demonstrates how feelings of anger can be equated with murder and therefore must be denied. The thought becomes the deed.

Turrini concluded her discussion by emphasizing how important it is to recognize and work through these two factors in treatment. By enabling individuals to acknowledge their rageful, destructive feelings; to have them recognized, accepted and appreciated by another; and to help a person realize that wishes are not deeds, can free them for more rewarding interpersonal experiences, and in many instances from the need to express these feelings psychosomatically. In helping patients understand and revise their views of bodies as fragile, easily destroyed by their own or others' rage, is to relieve them of a troubling burden.

In closing, let me say that it has been impossible in a summary to do justice to such a rich, original and stimulating paper. One can only hope that at some point the full paper will appear in print.■

FOOTNOTES

Freud, S. (1929) Civilization and its discontents. Standard Edition. 23:59-145.

Gaddini, R. (1987). Early care and roots of internalization. International Review of Psychoanalysis. 14: 321-333.

Grotstein, J. (2000) Some considerations of "Hate" and a reconsideration of the death instinct. Psychoanalytic Inquiry. 20: 462-480.

Comments on Annual Conferences

By Dianne Heller Kaminsky, LCSW, BCD, Education Committee Chair

The 2005 conference, "The Body, Sex, and the Self: Intrapsychic and Interpersonal Explorations," received overwhelmingly positive evaluations both for the keynote presentations, reviewed in this issue, and for the afternoon workshops.

The mandate for the annual conference of the New York State Society for Clinical Social Work has been to promote and educate clinical social workers and to give our society members, and on some occasions, renowned clinic social workers from out of state, an opportunity to present, rather than featuring speakers from other disciplines. We have enormous talent within our own discipline and it is imperative that we tap into it and use it to educate our membership.

Education Conference Committee: Gil Consolini, Jane Stark, Jill Winston, Susan Keett, Loraine Temple, Tripp Evans, Dianne Kaminsky.

The topic for the 2006 conference was "Awakenings: From Despair to Hope in the Clinical Process." The keynote speakers were Judith Kay Nelson from California, who presented a workshop at the 2005 conference, and our own Judith Seigel, who many of you know. This conference will be reviewed in the next issue.

We are in the process of preparing for the 2007 conference, "When Feelings are Split Off: From Dissociation to Integration in the Clinical Process." Please see the Call for Proposals in this issue. Brochures will be in the mail March 1, 2007.

The Impact of a Traumatic Birth Injury on the Internal World of an Adult Patient

A Self Psychological Treatment

Keynote Presentation by Crayton E. Rowe, Jr., MSW, BCD
Reviewed by Gil Consolini, PhD, LCSW

In his exceptionally engaging, theoretically commanding, and clinically rich keynote presentation, Crayton E. Rowe offered a compelling view of the value of a self psychological approach in work with those who come to us for help, in spite of their great discouragement and doubtfulness about what we have to offer. In his case presentation, he discussed how the severe pathology of his patient reflected the development of a disordered sense of self rooted in early traumatic bodily experience. In keeping with the theme of this year's conference, he discussed how intrapsychic conflicts about our bodies and sexuality affect the sense of self.

Rowe, who is the founder of the National Membership Committee on Psychoanalysis in Clinical Social Work and a founding member and training analyst of the New York Institute for Psychoanalytic Self Psychology, used a concept—the undifferentiated selfobject transference—to account for the seemingly intractable nature of the pathology of some individuals who have enormous difficulty getting the help they so desperately require. The concept is elaborated in Rowe's recently published book, *Treating the Basic Self: Understanding Addictive, Suicidal, Compulsive, and Attention-Deficit/Hyperactive (AHDH) Behavior* (Psychoanalytic Publishers, 2005).

In his theoretical overview, Rowe asserted that while other psychoanalytic theories offer a generalized understanding of human motivation, Kohut's theory of the self is based on the view that it is each individual's unique experience of the world that determines his development—for better or worse. He emphasized the importance of understanding the meaning of one patient's behavior and symptomology as distinct from that of other patients, including those who may have similar presenting problems. Rowe pointed out that Kohut, like Freud, considered long-term immersion into the patient's experience necessary to understand how he or she experienced the world. However, Kohut's "experience-near mode" of gathering data about the patient is a departure from the "experience-distant mode" of the classical analyst; it is an approach that provides the analyst with a means of uncovering varieties of "selfobject transferences"—to a large extent, the archaic emotional needs mobilized by the analyst's empathic attunement to his or her patient.

Rowe pointed out that Kohut envisioned selfobject transferences other than those he identified—the "mirroring," "idealizing," and the "twinship"—and discussed his uncovering of a type of selfobject transference he termed the "undifferentiated selfobject transference." Rowe recalled that he first became aware of this type of selfobject transference in work with severely traumatized patients with fixations and repetition compulsions that, according to Freud, were not resolvable and make treatment an interminable endeavor. In addition to the use of theoretical constructs to define this concept, he used the lyrics from the song, "Something's Coming," from West Side Story, to capture what we may all be able to recognize as 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." He suggested that one may be inclined to have "dismissed these uplifting thoughts as child-like, magical, spiritual, or just non-productive flights of fantasy."

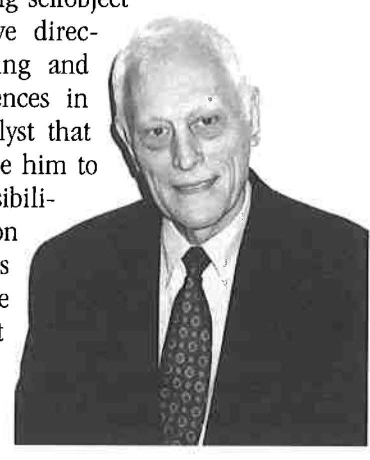
In this manner, Rowe rather beautifully set the stage for his presentation of the treatment of Mr. M. Beginning with his first contact with the patient over the phone, he provided glimpses of his moment-to-moment thinking about what transpired interpersonally and intersubjectively to illustrate the two-person experience-near mode of immersion in the patient's subjective experience, the offering of his conjectures to the patient for mutual consideration, the understanding based on such "intrasubjective" experience that may develop, and the emergence of the much more

Gil Consolini, Ph.D., LCSW, is a New York Center for Psychoanalytic Training training analyst and has published papers in the Journal of Clinical Social Work and Psychoanalytic Social Work. He is in private practice in Manhattan.

resilient self that is made possible as a result of such an analytic process.

In the case of Mr. M, facial disfigurement with lingering neurological impairment suffered during his delivery at birth became a catalyst for repeated rejections that led to a demeaning view of himself, compulsive sexual behavior, and—at the time he entered treatment with Rowe—a preoccupation with suicide. Although Mr. M was profoundly discouraged and aware of the emotional as well as other costs of his compulsive masturbation, use of pornography and prostitutes, and rather sadistic treatment of his employees (he was extremely caught up with undoing his humiliation through the humiliation of others), he began with little hope that treatment would help him. He had had two unsatisfactory experiences with hand-picked therapists—he was a successful executive who could be very selective in making such an important choice—so he decided this time, when his girlfriend insisted he get help, that he would use the yellow pages to find a therapist. He eventually got to Rowe, someone Mr. M could see was interested in how he actually felt, as opposed to how he was supposed to feel. Rowe emphasized the importance of conveying his understanding to the patient of what he had referred to earlier in his presentation as the paradoxical nature of the patient's pathological behavior. That is, from a self psychological perspective, self-destructive behavior may be experienced by the individual who is placing himself at risk as vitally important. Mr. M told Rowe he knew he was "in damn bad shape" when he came to him, yet felt completely incapable of changing his behavior.

Mr. M felt powerfully compelled to use pornography and to engage in other illicit sexual activity to create excitement to offset painful feelings of deadness and the loss of selfcohesiveness. Although life initially seemed quite bland as his use of such activity diminished—so much so that he repeatedly threatened to leave treatment—he eventually became "aware of [his] need to maintain the undifferentiated selfobject experiences through self demeaning sensation states" and could begin "to experience sustaining selfobject experience in non-destructive directions." He developed mirroring and idealizing selfobject transferences in his relationship with his analyst that were worked through to enable him to recognize other rewarding possibilities for his life and to act on them. In the final year of his treatment, Mr. M married the woman who had insisted he get help—he could now regard her as someone capable of offering him something much more than had the many other women with whom he had been engaged sexually. He also pursued doctoral work in a field of great interest, and his professional work improved as a result of his diminished sadism. No longer feeling so vulnerable to being humiliated, he had less need to humiliate others. Thus, what had perhaps seemed to the therapists who had earlier tried to help him as intractable pathology—he had been diagnosed at one point as paranoid schizophrenic—could now be regarded as self-destructive behavior he no longer required for the maintenance of his self cohesion.



Crayton Rowe

Following his presentation, Rowe took many questions and commented further on what sets self psychology apart from drive and object relations theories.■

State Board Members to Meet with Chapters This Fall

Initiative of the Strategic Planning Committee

A team of two State Board members will visit each chapter this fall to meet with chapter members (and lapsed members) about the direction of the Society. This is an initiative of the Strategic Planning Committee (SPC), chaired by Judy Crosley, LCSW, which has grown out of work over the past year with Marian Sroge, CAE, a membership consultant hired by the State Board last spring to work with the SPC on retention and recruitment.

The Board has recognized that declining enrollment, common to all professional organizations, along with the aging of Society members, and member dissatisfaction with some painful but necessary Board decisions, need to be addressed. At the same time, the Society has been grappling with a communications breakdown, which has made it difficult to keep members informed of Board and Society activities. The chapter meetings are intended to open communications between the chapters and the Board.

The Board wants to hear from the members about their needs and expectations and what they think the Society should do to position itself for the future. We also want to let you know what it is doing now and hopes to accomplish in the future. We hope that both current and lapsed members will participate in these meetings and we look forward to frank and open discussions with all of you.■

New Membership Materials Nearing Publication

The Strategic Planning Committee (SPC) of the Society is working with Amy Wolfson, a public relations consultant, and her team to develop new membership materials. These materials are slated to be published in mid-November and will be distributed to all members. We hope they will give every member a sense of pride in the Society and a renewed awareness of its importance to clinical social workers.

The framework for the materials was developed during the summer by the Committee with the assistance of Marian Sroge, our membership consultant, and of some of the chapter membership chairs. This framework is embodied in four "key messages" about what the Society stands for and provides to its members. They are: Builds Professional Networks, Promotes Professional Expertise, Strengthens Professional Identity and Advocates for Clinical Social Work.

The Society builds professional networks by providing an arena for meeting clinical social workers from diverse settings; mentoring for new clinicians; opportunities to build a referral base among clinical social workers; an arena for peer consultation; and, an arena for sharing clinical skills. Much of the networking occurs through chapter activities which are supported by member dues.

The Society promotes professional expertise by providing educational programs and supporting chapter educational programs. It also provides best practices information and informs clinicians about legislation and regulations that impact clinical practice.

To strengthen professional identity, the Society initiates, drafts, and monitors legislation defining clinical social work practice, such as the 2004 licensing bill, enacted after a 15-year struggle. The Society also promotes social workers as providers of mental health services and participates in interdisciplinary coalitions in areas of common interest. In addition, it develops programs in response to member needs, such as the HIPAA training manual and a course on child abuse and neglect reporting regulations.

The Society advocates for clinical social work by retaining a New York State lobbyist who monitors legislative and regulatory issues which impact clinical social work. It also builds and participates in interdisciplinary coalitions on national mental health issues, prepares position papers on key health issues. Additionally, it advocates for utilization of clinical social work services in mental health settings, for strong academic and internship programs in schools of social work and for qualified supervision of students and new clinicians.

The new membership materials will be designed so that they may be used in a variety of settings to communicate the work of the Society, to encourage membership in the society, and to enhance understanding of the clinical social work profession.■

The Society Affiliates

CONTINUED FROM PAGE 3

malpractice insurance plan for clinical social workers which plan eventually dissolved leaving many of its clinical social work policyholders having to pay for expensive tail coverage as a condition of obtaining replacement malpractice insurance. Most important, the Federation ceased to provide an effective program of national level advocacy, the primary mission for which it was formed. Eventually, our Society, along with a number of other state societies of clinical social work, chose to withdraw from the Federation.

The need for effective advocacy for clinical social work on a national level cannot be underestimated, particularly as a renewed national debate over healthcare reform and financing is likely arise over the next few years. Clinical social work cannot rely on NASW, which has to cater to a wide variety of social work interests, to advocate effectively on our behalf and to set, espouse and advocate for high standards for clinical social work practice. Nor can clinical social work rely on the remnants of the Federation, whose track record over the past fifteen years has been marked by a lack of effective national level advocacy and by seriously defective decision making that has led to its likely demise.

Clinical social work is the only major group of health care professionals without a viable national voice. The Center for Clinical Social Work will work to engage in effective advocacy for our profession on a national level in relation to legislation, to set, espouse and advocate for high standards of practice, to obtain appropriate funding for clinical social work education and research on par with that provided to other health care professions and to work to improve graduate education and clinical supervision. Supporting and working with the Center for Clinical Social Work will enable us to have an effective voice for clinical social work on a national level to work toward achieving recognition of the important role of clinical social work as a health care profession.

In the next few months the Center for Clinical Social Work will be reaching out to two hundred thousand licensed clinical social workers in the United States, asking them to join the Center and to provide financial support to this effort. Advocacy is a long process, the important fruits of which are rarely immediately apparent. As an example, it took over a dozen years for our own licensing efforts for clinical social

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President's Message

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The Profession and the Society at a Crossroad

Clinical social work as a part of the larger social work profession and the Society as an organization are at a crossroad and share many of the same challenges. The first challenge is aging membership and declining membership. The age of clinical social workers around the country is increasing and more practitioners are retiring earlier. At the rate of aging of the Society, within the next five years it is expected half of our members will be 65 years of age or older. Also, fewer persons are tending to join professional associations, regardless of their profession.

The second challenge is to recognize that a person is a clinical social worker by virtue of the knowledge and skills he or she has, not by virtue of his or her work setting. The future of the profession and of the Society depends on us recognizing the reality that we are a profession and an organization of clinical social workers. We are not an organization of private practitioners and we will not be able to survive if that is how we are viewed by our clinical social work colleagues who work in agencies. Many years ago, recognizing that psychotherapy is merely one of the many services provided by clinical social workers, the Society changed its name from the New York State Society for Clinical Social Work Psychotherapists to its current name. Regretfully, the Society is perceived by a number of agency clinical social workers as a group of elitist private practitioners who look down on agency practitioners. Accurate or not, perception is critical. We must reach out proactively to the large number of clinical social workers in agencies, many of whom do excellent clinical work with the most difficult patients often in suboptimal environments. We are all part of the same profession and we must view, treat, value and respect these colleagues as the professional equals they are. If the Society is serious about being the organization of clinical social workers in New York State, we must reach out to our esteemed colleagues, fellow clinical social workers in agency practice, who are the heart, soul and heroes of our profession.

The third challenge is to recognize that we are professional social workers. Clinical social workers are professional social workers for whom psychotherapy is one of the clinical services we provide, rather than psychotherapists who happen to be social workers. It is the rich history, heritage, core values and beliefs, commitment to social justice, and particular skills, competencies, perspectives and techniques of intervention in and across the micro, mezzo and macro systems that are unique to the social work profession which add to our effectiveness, underlie our special value as health and mental health professionals, and distinguish us from other mental health practitioners who also provide diagnosis, treatment planning, counseling and psychotherapy. If this is not the case, then why should someone want to seek services from a clinical social worker rather than from a psychiatrist, psychologist, mental health counselor, psychoanalyst, marriage and family therapist or other mental health professional? And, under our license in New York State, licensed clinical social workers are responsible to know and apply the knowledge and skills of generic social work in their practices.

The fourth challenge is to show pride in being a clinical social worker. Those of you who assiduously avoid referring to yourselves as clinical social workers and view that title as pejorative are putting nail after nail into the coffin of clinical social work. How can anyone else be expected to have respect for clinical social work when we, as clinical social workers, are embarrassed to identify ourselves by that title and view and treat it as the professional equivalent of a scarlet letter? Certainly, we must distinguish between ourselves and "social workers" who are not trained professional social workers. But, by not taking active steps to demonstrate proactively our pride in being clinical social workers and by avoiding connecting ourselves to professional social work, we only reinforce, enhance and perpetuate the negative image of our profession and our professional selves from which we are trying to escape.

The fifth challenge is to recognize that each clinical social worker has an ethical obligation to contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. One of the principal ways of doing this is to volunteer in the Society. Not-for-profit corporations such as the Society depend heavily on volunteers. The services and benefits that professional associations such as the Society are able to supply to their members are often highly dependent on the extent to which their members volunteer to take on certain tasks. Without volunteers, these organizations would be severely crippled in carrying out their missions.

The sixth and last challenge is to recognize the limits of what the Society can do for its members and why clinical social workers should join the Society. The Society was formed to carry out the missions set forth above. A number of members have come to expect the Society to aid them in building and maintaining their private practices. The Society, as a not-for-profit membership corporation, is legally prohibited from engaging in activities for the purpose of enhancing or developing its members' professional practices. However, we can and do provide education and training about practice management, consultation about vendorship and managed care issues and advice regarding practice issues. Many of the efforts of the Society do not bear fruits immediately. Most involve a process which takes time and effort, such as obtaining clinical social work licensure, and affect the profession and/or the Society

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Arts and Creativity in Clinical Practice

By Sandra Indig, MSW, CSW-R, ATR-BC

Thank you, valued members, for making this past year's workshops memorable events for all who participated. We owe a debt of gratitude to all our wonderful speaker volunteers and to Marcia Glenn, public relations person and Joy Sanjek for all her support. Their tireless outreach efforts ensured well-attended meetings despite weather conditions and full calendars. The following is a synopsis of the Arts and

Creativity meetings and brief comments for the academic year 2005-2006:

October 2, 2005, Cathy Siebold, DSW, "Female Sexual Agency: Psychodynamics after Separation and Individuation"

The way in which women experience and express sexual passion was the topic of this presentation. Using a Greek myth, it focused on mother and daughter relationships and the vicissitudes of separation while sustaining connection. This myth served as a backdrop for a discussion about female passion and its suppression in western civilization. How we as therapists approach issues of sexual desire with female patients was the subject of discussion among participants.

November 20, 2005, Joy E. Sanjek, MSW, "Healing Through the Art of Collage"

An informative and concise history of collage making preceded this hands-on workshop. Principles of gestalt therapy informed guided experience as well as the casual discussion which weaved in and out of our selecting and gluing together pre-cut pieces of paper. The end result was the experience itself and the creation of images of our own making.

March 12, 2006, Susan Appelman, MSW, CASAC, "Brainstorming Creative Application of Agency Work"

Susan bridged the gap that exists between agency work and private practice, especially the dynamics of dealing with managed care. She culled from a successful history of agency work the intricacies of interpersonal and intra-office politics. We explored the meaning and value of productive supervision and the perhaps, undervalued use of one's personal imagination in surviving and thriving in the agency work culture.

April Outing to the Museum of Modern Art exhibition and film on Edvard Munch, "The Modern Life of the Soul."

Munch, sought to "translate personal trauma into universal terms, to comprehend the fundamental component of human existence: birth, love, and death."

On October 22, 2006, Arleen Bandler, MSW, CASAC, will start this academic year off with "Creative Looking at Sexual Fantasies," from11:00 a.m. to 12:30 p.m. (Leave a half-hour after for questions, answers, and networking.) It will be held at 240 West 4th Street #4-C (confirm address when making your reservation). Please call Marcia Glenn: 718-658-8254 to reserve a seat.

Outreach Announcement

Our call for workshop participants for a citywide sponsored event was very successful.

Sandra Indig, Joy Sanjek and Howard Rossen will present to educators and clinicians "Play, Heal, and Learn" on October 28. Our audience is comprised of members and friends of the New York City Art Teachers Association/United Federation of Teachers. It will be held at The LaGuardia High School of Music and Art. To learn more please call Sandra at (212) 330-6787.

Suggestions and volunteers are always welcome. Please send or call me about your ideas for leading a workshop. Our group flyer explains our purpose and our goals. Anyone with a background or an interest in creative process is invited to attend. Please call (212) 330-6787 and visit us at: www.clinicalsw.org. ■

President's Message

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as a whole, rather than individual members specifically. Membership in the Society is a long-term investment in our profession and in maintaining the infrastructure of the Society. That infrastructure provides a place for networking, where you can benefit from professional education to keep current on changing body of clinical knowledge and skills, where you can obtain mentoring or peer consultation, and from which you can obtain consultation and advice regarding practice, ethical, legal and vendorship issues. Equally important, that infrastructure provides a mechanism for monitoring of policy, legislative and regulatory issues, including but not limited to those relating to the evolving landscape of the provision and financing of health care, which impact on clinical social work practice and to provide both advocacy to address those issues and information and education to aid our members in becoming aware of and adapting to the ongoing evolution of the health care delivery and financing systems.

This is your Society. It can and will only be what each of you makes of it. Please participate in your local chapter, contribute your time and encourage your clinical social work colleagues to join us.■

Treasurer's Message

CONTINUED FROM PAGE 4

attorney and the Society's accountant by which provides that:

1. An honorarium for a presentation that takes up to two and one-half hours (a morning, afternoon or evening presentation) should not exceed $100, an honorarium for a presentation that takes up more than two and one-half hours and up to five hours (a lengthier presentation which may be done in two or more segments, for instance, from morning and through lunchtime with a break in the middle of the presentation) should not exceed $200, and an honorarium for a presentation that takes five hours or more (a full day conference or program in which the presenter's presentation or presentations extend throughout the day) should not exceed $300.

2 . The amount of an honorarium should be wholly independent of the demand for, or the reputation, name recognition, or qualifications of the presenter, or the topic(s) being presented.

3. No presenter who is a member of the Society will be permitted to receive from the Society honoraria for more than three presentations per calendar year or a total of more than $400 per year in honoraria.

4. Society members who are in a decision making position should not give the appearance of being able to influence or participate in decisions that would promote their personal interests over the public interests of the Society. Thus, such members (generally Board members, chapter board members and committee chairs and members) are barred from obtaining from the Society any honoraria for any presentations they make at educational conferences or programs which are sponsored or conducted by the Society, other than as a presenter at the Society's annual education conference where the presenters are selected blindly. Such a bar shall apply for two years after the person leaves the decision making or decision influencing position in question, consistent with New York State's ethics rules regarding conflicts of interest.

These policies, which assure our compliance with applicab le legal requirements, bring into sharp perspective the importance of volunteers to professional associations in general, and to the Society, in particular.

It is important to recognize that professional associations are, by design, highly dependent on members volunteering their time, skills and effort. As a result, the extent of the assistance and service they can provide to members as benefits of membership are largely determined by the extent to which members volunteer. Thus, in the face of decreasing volunteerism, professional associations are often forced to determine and prioritize which projects they can accomplish by using paid staff or outside vendors given the cost of hiring non-members to do so.

The Society's attorney properly called our attention to the fact that, "being a member of a professional association provides professionals with the opportunity to serve their profession and the public. Many professions view contributing time and effort to advancing their profession as being one of the responsibilities of being a member of the profession." In this regard, we should all be aware that the Code of Ethics provides, "Social Workers' Ethical Responsibilities to the Social Work Profession. Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations. (d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences."

The Society is your organization and it can only serve the membership and carry out its public service missions to further clinical social work if its members volunteer to contribute their time to help it do so.■

Workers' Compensation

CONTINUED FROM PAGE 3

to receive reimbursement for the mental health services they provide to persons covered by (1) a variety of federal government health insurance plans, including the federal employees health benefits program (FEHBP) which covers 10 million federal employees, retirees and their dependents, the Civilian Health and Medical Program of the uniform services (CHAMPUS) now called TRICARE, with approximately 5.5 million beneficiaries, and Medicare, which authorized clinical social workers to provide mental health services in July 1990 and (2) essentially all managed behavioral health plans regionally and nationally as well as all group insurance plans in New York State. As such, licensed clinical social workers are currently covered providers of mental health services to federal and state employees, and the dependents of military personnel stationed in New York, as well as to the many citizens of our state whose medial expenses are covered by managed behavioral and group health insurance plans.

This bill would grant the same access to mental health service providers for job-related injuries under the Workers' Compensation Law that is now available for an insured individual's non job-related injuries. Many rural and inner-city areas throughout New York are continuously struggling with a lack of accessible and qualified providers of mental health services. This bill

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Society Hires Membership Consultants

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Ms. Sroge comes highly recommended and brings many years of experience as a consultant to membership organizations, including the Association of Junior Leagues, The Art Directors Club, Transit Museum, The Association of the Bar of the City of New York, and the United States Tennis Association. Having lived in the Bronx for many years, she recently relocated to Sarasota, Florida. This past spring she spoke with many of you in a survey of member satisfaction and expectations. Many members found her to be dynamic, straightforward and enthusiastic.

The survey, along with her review of other materials, identified three areas of the Society's functioning that need review and change: communication with members, relationship of the chapters with the State Board, and board structure and development. It was clear that there has been a lot of dissatisfaction, much of it related to the very painful and difficult decisions the Board has had to make recently.

The SPC subsequently made recommendations to the Board to reestablish our communications, develop membership materials and develop "key messages" that would clearly define the purposes of the Society and what it offered to members (please see accompanying article on new membership materials). In addition, it was recommended that materials be developed to be used by Board members who agreed to participate in "facilitated dialogue training" prior to meeting in teams with the members from each chapter.

Getting our House in Order

The Strategic Planning Committee was appointed in June 2000 in recognition of the growing concerns regarding our need for membership recruitment and retention, leadership development, continuity of operation, and policies and procedures. In the initial phase of work, the committee conducted a survey of members, held focus groups, interviewed leadership, both past and present, and reviewed what other organizations offer to their members. This process identified six areas of concern to be addressed by the SPC or other arms of the Board: membership development and retention, leadership development, board structure, education, advocacy, and fundraising.

Subsequently, the SPC reviewed ten years of minutes and determined that the Board itself needed to "get its house in order." To this end, a number of policies and procedures have been put in place for developing manuals for the Board and chapters that outline our legal, fiduciary, and financial responsibilities as leadership bodies of a not-for-profit 501(c)6 organization, and also to outline the relationship between the state organization and the chapters. Some of the changes made and actions taken have been necessary, but difficult, requiring some retrenchment and ending certain benefits held dear by many. In the past two years, the Board has:

- Balanced the budget and rebuilt reserve funds.
- Developed a Unified Financial System as recommended by our accountant.
- Attended or participated in a series of educational presentations about our legal, financial, and fiduciary responsibilities.
- Adopted "Policy and Procedures Regarding Providing Compensation to Society Members for Work They Do or Services They Render to the Society."
- Adopted "Policy and Procedures Regarding Compensation for Society Members as Presenters at Society Educational Conferences and Programs."

Other areas of interest to the SPC are to see that the Society develops a more comprehensive educational program and to find ways of responding to requests for position statements on the local, state and national level. In addition, we would like to see the development of materials and manuals for the chapters that would ensure continuity and development of leadership and provide guidance for developing programs such as mentoring, educational conferences, and practice groups. Our current members are Judy Crosley, Chair, Helen Hinckley Krackow, Jonathan Morgenstern, Beth Pagano, and Marsha Wineburgh. If you have suggestions, please contact Judy Crosley at crosleyj@yahoo.com. ■

Workers' Compensation

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assists the injured workers in the shortage areas throughout the state by affording them the more accessible healthcare option of a licensed clinical social worker.

This bill would not result in increased costs. The cost of providing services to persons covered under New York's Workers' Compensation system is a function of the number of patients who require such care, not the number of covered professionals who may not provide it.

Licensed clinical social workers have unique skills in providing psychotherapeutic treatment within the context of the patient's environment as well as utilizing community, family and other social resources as an adjunct to treatment. This methodology may reduce workers compensation costs by enhancing the process of rehabilitating persons suffering from work-related illnesses and injuries, and returning them more quickly to work.

- **Timothy's Law** legislation which provides limited parity for health and mental health coverage in New York State has passed the Senate and is expected to pass the Assembly before January, 2007. Whether Governor Pataki will sign it is unclear. ■

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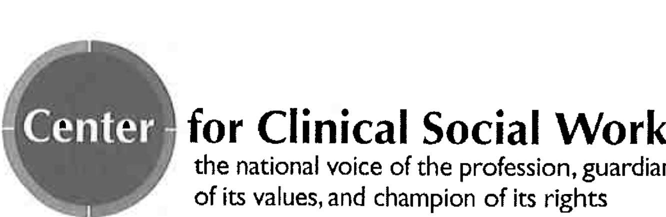

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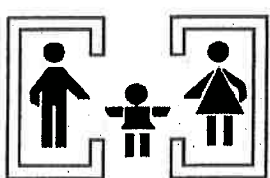

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The Society Affiliates

CONTINUED FROM PAGE 10

work in New York to culminate in the passage of the broadest scope of practice for clinical social work in the United States.

This is your profession. We need all of you to support, to the extent that you are able, the necessary long-term efforts on its behalf. Remember, many of us and members of our families will one day be consumers of some form of clinical social work services - when we develop a chronic illness, when we are older and need to cope with the stresses and losses of being elderly, when we need hospice services, etc.. We need to make sure that there will be future colleagues to be there for us and our families and that they will have the skills and ability to provide us with quality clinical social work services. Supporting the Center for Clinical Social Work is a critical step toward assuring that will happen.■

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Saturday, December 9, 2006, 10 a.m. to 3 p.m.

Paul E. Stepansky, Ph.D.
Clinical Writing: The Good, The Bad and The Ugly
Saturday, January 27, 2007, 10 a.m. to 3 p.m.

Elsa First, Ph.D., Judith Kuspit, Ph.D., Fayek Nakhla, Ph.D., Murray Schwartz, Ph.D.
Making Use of Winnicott: A Roundtable Discussion
Saturday, March 24, 2007, 9:30am to 1:30 p.m.

Kimberlyn Leary, Ph.D.
Continuing the Conversation: Working Effectively with Racial and Cultural Material in Clinical Practice
Saturday, April 28, 2007, 10 a.m. to 3 p.m.

NIP TI's 18th Annual Conference
DIVERSITY IN CLINICAL PRACTICE
Encountering the "Other" in Psychotherapy: Issues of Race, Culture and Ethnicity
Presenting:
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Neil Altman, Ph.D.
Lynne Layton, Ph.D.
Farhad Dalal, Ph.D.

Saturday, February 10, 2007 9 a.m. to 4 p.m.

All workshops take place in Suite 501 on the 5th floor at 250 West 57th Street (between Broadway & 8th Avenues) in New York City

The location of NIP TI's 18th Annual Conference is TBA

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New York State Society for Clinical Social Work Managed Care Conference

- What is managed care, its genesis, purpose and structure?
- How to become a provider and how to disenroll
- Pros and cons of contracting with managed care
- Ethical considerations, confidentiality and HIPAA
- Contractual issues and essentials of reimbursement
- Treatment planning
- Practice marketing implications
- Documentation and practice audit

We welcome your suggestions for topics!

Contact Jonathan Morgenstern
mjonathanm@aol.com

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Call for Proposals for Workshops and Panels

for the 38th Annual Conference of the NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

When Feelings Are Split Off:

From Dissociation to Integration in the Clinical Process

Philip Bromberg states, that "Health is the ability to stand in the spaces between realities without losing any of them."* This conference will define what we mean by dissociation as well as help the clinician to stand in the spaces with his patient and to listen to both his own and his patient's split off states of awareness. We are looking for proposals for workshops and panels from all *theoretical orientations* as well as *all modalities* that reflect this theme.

Suggested topics:

- What are dissociation and dissociative self-states? (how does dissociation differ from repression?)
- The impact of trauma on the organization of the self
- Multiple personality/dissociative identity disorder
- The relationship between dissociation and enactments
- Working with the dissociative patient in the group
- Working with dissociative phenomenon in couple's treatment
- Working with trauma groups: victims of natural disaster, war veterans, terrorist attacks as well as domestic violence and physical and emotional abuse...
- Pornography as a form of dissociation as well as other forms of perversion
- Addictions: alcohol, drugs, food, gambling, compulsive exercise, workaholism...
- The relationship between trauma, particularly childhood sexual and physical abuse and dissociation
- Eating disorders and self mutilation
- The technological generation: the internet, television, cell phones—and it's relation to dissociation
- Dissociation as a social phenomena (e.g. gangs, cults)
- The therapist's dissociation

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

1. Description: purpose, function, and teaching objectives. Include brief **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 about five lines stating purpose of workshop and listing 5 to 6 aims and objectives.

Deadline for submission of proposals: Nov. 28, 2006 Date of conference: May 12, 2007

Mail to: Dianne Heller Kaminsky, LCSW, 1192 Park Avenue, 4E New York, NY 10128

*Philip M. Bromberg, *Standing in the Spaces*, The Analytic Press, 1998, Pg. 186

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