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

Are You Concerned About the Future of Clinical Social Work? Then Don't be Misled. Beware of the CSWA!

Give Your Support to the Center for Clinical Social Work!

Editorial by Helen Hinckley-Krackow, MSW, LCSW, BCD and Hillel Bodek, MSW, LCSW, BCD

Haven't heard of the Clinical Social Work Association (CSWA)? Actually, the CSWA is not a new organization. CSWA is the new name for the Clinical Social Work Federation (CSWF). Same ineffective leadership, same flawed judgment, same failed strategies, new name — as if painting stripes on a cougar can make it into a zebra. The CSWA is marketing itself in New York, California and other states as a national clinical social work membership organization. It misleadingly claims to have "a rich and successful 30-year tradition of service to clinical social workers, our clients and the profession we serve." The truth is that the Clinical Social Work Federation, now CSWA, was formed primarily to bring state societies of clinical social work together to engage in national level advocacy for clinical social work. Our Society was one of its founding members. In its early years, it did so effectively. However, commencing in the mid-1980s the CSWF made a number of policy decisions which led to the downfall of the organization. It went from an organization which had over

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At the Annual Meeting, (l. to r.) President Hillel Bodek, Patricia Blau, and John E. Linville presented Ethical and Legal Issues in Clinical Social Work Practice

IN THIS ISSUE:

Annual Membership Meeting Report

By Betty Gewirtz, MSW, LCSW, BCD

The Society held its 39th Annual Membership Meeting on January 6, 2007. The program began with a welcome and a report by President Hillel Bodek. He outlined several accomplishments this past year: (1) the Society Board has addressed almost all of the concerns expressed by the Strategic Planning Committee in 2003; (2) we have newly designed membership materials; (3) members of the Board have met with each chapter for a facilitated dialogue; (4) our new website has been designed and will be operational in the next few weeks; (5) our membership directory will be placed on line, hopefully by early spring, and available to the public and other professionals to help them locate clinical social workers who can provide them with needed clinical social work services; (6) we have affiliated with the Center for Clinical Social Work to obtain advocacy for clinical social work on a national level; (7) in the coming year we hope to begin a program to provide supervisory training to our experienced members so that they may provide low to moderate cost supervision to

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Diminishing Standards: A Critical Weakness That is Undermining Our Profession

By Hillel Bodek, MSW, LCSW, BCD

I am devoting this President's message to a matter of critical importance to the survival of our profession. The quality of graduate education and training in social work, both in terms of didactic instruction and supervised fieldwork, is steadily declining at an alarming rate. The overall quality of students entering MSW programs is lower than that of students entering other graduate programs. The level of professional knowledge and skills of those graduating from MSW programs is increasingly lacking. A sobering reflection in this regard reveals that nationwide, in 2005, 24.7% of MSW graduates failed the basic MSW level licensing exam the first time they took the exam. In New York, in 2005, the overall fail rate was 51.3%, with 31% of those taking the basic MSW level licensing exam for the first time failing and 81.3% percent of those taking that exam who had previously failed it, failing again. Nationwide, in 2005, 26.3% of MSWs failed the advanced clinical practice examination on their first attempt (no New York State statistics are available for that exam in 2005, because the advanced clinical exam was only beginning to be utilized in 2005 after the LCSW grand-parenting period ended). Indeed, New York State's pass rate for the basic MSW level exam is one of the lowest in the country. This alone, separate and apart from substantial anecdotal information about the quality of social work education and training, the quality of social work students and the knowledge and skills of recent MSW graduates, is cause for serious alarm about the state of graduate education and training in social work and about the future of social work as a profession.

The quality of graduate education and training in social work... is steadily declining at an alarming rate.

A Joint Responsibility

The principal role of a profession is to establish and maintain high standards of professional education, training, practice and ethics. Pursuit and achievement of this goal is particularly important when the members of the profession provide healthcare services to the public. Doing so is the joint responsibility of four entities: the individual members of the profession; the profession's associations; the educational and training institutions which educate and train these professionals, and the accrediting bodies for those institutions; and the governmental agencies which license members of the profession.

Is Social Work a Profession?

In 1910, Abraham Flexner wrote his famous, highly critical assessment of the state of medical education in the United States. His report led to a sweeping reform of the system of training physicians, transforming medical education from an apprenticeship model to a system which provides rigorous uniform professional training in medical science and clinical skills. In 1915, Flexner addressed the National Conference on Charities and Correction. In his speech, he praised the ethical standards, selflessness and dedication of social workers. Yet, he declared that social work was not a profession for two main reasons. One, social workers did not have a great deal of individual responsibility. Two, rather than having a clearly defined and documented unique body of knowledge and skills which could be taught, social work adopted, combined and used parts of the knowledge base of other distinct disciplines — medicine, law, education, economics, etc., and lacked a distinct body of knowledge and skills.

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Annual Membership Meeting Report

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agency social workers; and (8) for chapters and practice committees that request it and agree to follow the required protocol, the Society will be providing CEU credits for all of their educational programs and conferences. In closing, Hillel stressed four points: (1) We must take pride in our profession, appreciate the unique set of knowledge, skills and perspectives we have as clinical social workers, and actively advocate for ourselves. We must refer to ourselves as clinical social workers, not as psychotherapists, psychoanalysts, etc. For, if we are ashamed of what we are and view that title as pejorative, we cannot legitimately expect anyone else to respect us. (2) We must actively assert our critically important role as health care providers and the importance of the unique skills and perspective we bring to the health care team. (3) We must begin to advocate for serious reform in the manner in which graduate social work education is being provided. (4) We must increase membership by reaching out to agency clinical social workers.

Hillel then presented the awards of Diplomate status to Gloria Robbins of the Mid-Hudson Chapter and Judith Crosley of the Syracuse Chapter in recognition of their significant service to the Society at both the State Society and chapter levels. Jonathan Morgenstern, President-Elect of the Society and Chairperson of the Vendorship Committee gave a brief update on committee activities and Marsha Wineburgh, Chairperson of the Legislative Committee, brought us up to date on legislative activities, particularly in the area of Workers' Compensation legislation.

Ethical and Legal Issues Program

A rich educational program titled *Ethical and Legal Issues in Clinical Social Work Practice*, which provided a great deal of important information, followed. We were privileged to have as presenters two outstanding, well-recognized experts in social work ethics; Patricia Blau, MSW, LCSW, and Hillel Bodek, MSW, LCSW, BCD, who have been the Chairpersons of the Committee on Ethics of the NYC Chapter of NASW and of the Committee on Ethics and Professional Standards of the Society, respectively, for over a quarter century, and John E. Linville, the Society's attorney and a well recognized expert in health care law and bioethics. Patricia began the program, addressing the topic *Professional Ethics: Ethical Obligations Inherent in Being a Healthcare Professional.* After reviewing the basic concepts of clinical ethics and the core ethical values of the social work profession, Patricia initially focused on issues relating to patient care, beginning by addressing self determination and informed consent. She cautioned that we must spell out parameters of treatment clearly and discuss them, particularly when informing patients about billing practices, missed sessions, completion of insurance forms, etc. at the beginning of treatment.

Betty Gewirtz, Marsha Wineburgh, and Judith Crosley

Patients also have the right to know the risks, benefits and alternatives in terms of treatment (informed consent). Turning to the issue of clinician competence, Patricia noted that clinical social workers should only practice within the boundaries of their education, training, and license. She stressed that we all need to recognize that we have "blind spots" and make sure to obtain supervision or consultation in problem situations or types of cases where we don't have much experience. Additionally, she stressed that if an issue arises for which you are not trained, you should make an appropriate referral or you can proceed to treat the patient with close supervision or consultation, after obtaining the patient's informed consent.

Patricia then addressed the issue of conflicts of interest. In this regard, she stressed that when working with more than one member of a family or group, clinical social workers must remember that each person is their patient and is entitled to confidentiality. Additionally, she pointed out that material obtained by collateral contacts should be treated as confidential unless the person providing the information agrees otherwise. She then discussed the issue of interruption or termination of service. Social workers should make reasonable efforts to ensure continuity of services and should not abandon their patients. If a patient is not paying his or her bill this should be talked about and worked through before termination.

Diplomate status was awarded to Gloria Robbins of the Mid-Hudson Chapter and Judith Crosley of the Syracuse Chapter in recognition of their service to the Society.

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Legislative Committee

By Marsha Wineburgh, DSW, Legislative Chair

New York State Requires Parity Coverage for Mental Health and Physical Illness

On December 22, 2006, after months of uncertainty, former Gov. George E. Pataki signed into law a bill requiring that commercial insurance policies pay for mental health care in much the same way they cover physical illness. Known as Timothy's Law, it went into effect officially January 1, 2007, although actual implementation will take longer. This legislation is in effect for three years, until 2009, at which time the Legislature will make a decision about continuing the law.

Parity legislation has been has been proposed in some form for the last 20 years. Finally, in June 2006 the Assembly and the Senate reached agreement on the terms of the bill, although they did not complete passage until December, when the bill passed both houses unanimously.

The law requires that commercial insurance policies like those bought by employers provide equivalent coverage, or parity, for mental and physical illness. Co-payments, co-insurances and deductibles for mental health treatment would be comparable to those for physical illnesses. Insurance companies are required to cover 30 inpatient and 20 outpatient days of treatment for mental illnesses.

More specifically, insurers are required to provide coverage comparable to medical coverage provided under the policy for adults and children (under 18 years old) with "certain biologically based mental illnesses." These include: schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia and anorexia.

Comparable coverage is also provided for additional childhood-specific mental health issues, including attention deficit disorders, disruptive behavior disorders or pervasive developmental disorders, and where there is one or more of the following: (1) serious suicidal symptoms or other life-threatening self-destructive behaviors; (2) significant psychotic symptoms; (3) behavior caused by emotional disturbances that places the child at risk of causing personal injury or significant property damage; and, (4) behavior caused by emotional disturbances that places the child at substantial risk of removal from the household.

Despite the widespread attention given to this legislation, the effect of this health care mandate, which may raise insurance premiums, is narrower than it appears. As we know, most people have health insurance through large employers or unions, plans that are usually governed by the federal law, ERISA, which exempts them from state laws. In addition, most commercial policies already cover mental health treatment, as do government programs like Medicare and Medicaid. An employer with fewer than 50 workers could opt out, but the insurer would be required to offer a policy that covered mental illness. The law pledges that the state will develop a method to help small businesses pay for that coverage if they choose to buy it. Lastly, in order to win Senate approval, provisions in the bill mandating coverage for post traumatic stress disorder and for drug and alcohol dependencies were removed from the legislation.

According to a review by the National Conference of State Legislatures, as of early this year, 22 states had parity laws, and the number may have grown since then. Many of them, like New York's law, include exceptions for small businesses and substance abuse treatment. There were at least 17 other states that mandated some kind of mental health coverage, but not full parity with other health benefits.

[Legislative Update: Our Worker's Compensation bill will be reintroduced this year once Governor Spitzer determines whether he will revamp the Worker's Compensation Program any time soon. Our bill allows a LCSW-R to provide mental health services for an injured employee, just as a clinical psychologist and/or psychiatrist can do now.] ■

Timothy's Law

Many legislators and others credited passage of New York's bill to the family of Timothy O'Clair, who campaigned relentlessly for the measure. Timothy committed suicide in 2001 at the age of 12, after the mental health benefits provided by his parents' insurance ran out. Timothy had been in treatment both inpatient and outpatient, since he was eight years old, reportedly for attention deficit problems and aggressive behavior. When his parents could no longer afford treatment, they decided to place him in foster care so he would be eligible for Medicaid benefits. His parents continued to hold shared custody and paid a significant amount of money for statutory child support. Timothy was eventually placed in a residential facility. However, several weeks after his discharge, he killed himself.

Vendorship and Managed Care

by Jonathan Morgenstern, LCSW, Chair

The Committee extends its good wishes for the New Year and its hope that members grow in their understanding of reimbursement processes and how to best position their practices so that the administrative burden is minimized.

There have been more changes in Committee representatives: Andrea Gordon, representing Westchester, has been replaced by Sue Roniger and Ellie Perlman has joined to represent Suffolk. The Committee appreciates both the contributions made and those to come. We continue seeking representatives for Brooklyn, Rockland and Mid-Hudson chapters. Your interest is welcome and more information about what is involved is available from your chapter president or from me.

The Committee continues to function in a supportive role to Society members in their dealings with insurers and managed care organizations. Our goal is to help members become efficient and effective in managing practice reimbursement. We track relevant trends in the field and report them to the membership. Inquiries are welcome and should be made to the representatives listed below.

The Committee wishes to announce its first conference: **Clinical Social Work Practice & Managed Care,** to take place on Saturday, March 24th, 2007, 8:30 am – 1:00 pm, at the Nightingale Bamford School, 20 East 92nd Street in Manhattan. A mailing with more details is in progress. The purpose of the conference parallels the purpose of the Committee — to support Society members and practicing clinicians in managing the reimbursement portion of their practice, being mindful of its relevance to practice development and clinical practice. There will be presentations and workshops by both clinicians and representatives of managed care companies, and the conference is planned to appeal to all levels of practice experience. Suggestions are welcome and may be sent to me at **mjonathanm@aol.com.** At this point, we are seeking a clinician who would like to provide a one-hour workshop on the nuts and bolts of a practice with managed care; if you are interested, please e-mail me.

The Committee is mindful that there may not have been a Society forum for members to express their feelings about the onerous and multidimensional impact of practicing with managed care and we are already thinking in terms of a follow-up conference to consider traditional and more creative responses. To this end, I have joined the New York State NASW Managed Care Committee. Your thoughts and suggestions are welcome.

NYS Society for Clinical Social Work

Clinical Social Work Practice & Managed Care

Saturday, March 24, 2007 | 8:30 - 1:00

The Nightingale Bamford School
20 East 92nd Street, NYC, NY

8:30 Registration & Continental Breakfast
9:00 **Overview: Practice With Managed Care**
9:30 **Keynote: Current Trends in Managed Care**
Fred R. Waxenberg, Ph.D., Chief Clinical Officer – Magellan Behavioral Health
11:00 Break
11:30 **Concurrent Workshops**

- Practice Essentials with Managed Care
- Effective Practice Marketing
- Ethical & Legal Issues in Managed Care
- Evidence-Based Practice

Inquiries to: rwashton@verizon.net
To register mail a check payable to **NYSSCSW** to:
Ruth Washton, 110 Greene Street, Ste 504, NYC,
NY 10012, with your name, address, phone & e-mail.

NYSSCSW Members: by 3/1–$40, by 3/15–$45, at door–$50.
Non-Members: by 3/15–$50, at door–$60.

Participants earn 3.50 Clinical Social Work CEUs.

This bears repeating: members are reminded 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. Members are reminded to monitor coverage throughout treatment (be aware of any possible changes in benefits, e.g., after a job change). Members may consider requiring clients to sign a letter stating 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 General.

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

The following is a quotation from the Center of Medicare and Medicaid Services website at: **http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp**

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Were the Early Clinical Social Workers Ahead of Their Time?

An Exploration of Their Important Contributions to Relational Social Work and Psychoanalytic Theory

By Dore Sheppard, Ph.D.

Throughout the 1990s, I was very fortunate to participate in a long-standing study group led by Stephen A. Mitchell, one of the leading theoreticians of Relational Psychoanalysis in the late 1980s. Through our group discussions, my own research for a dissertation (Sheppard, 2001), and the fruitful dialogues with my dissertation committee members at New York University (including Theresa Aiello, Rosemary Perez Forster, and Jeffrey Seinfeld) I became deeply aware, and appreciative, of how clinical social work theory anticipated many of the ideas of relational psychoanalysis.

Numerous leading clinical social workers, such as Aiello, Bordon, Brandell, Chenot, Goldstein, Horowitz, Kanter, Ornstein and Ganzer, Perez Foster, Ruderman, Saari, Seinfeld, and Tosone, have written about the various ways clinical social work and relational psychoanalysis shared an historical and current relational orientation to theory and practice. Tosone's incisive article, "Relational Social Work: Honoring The Tradition" (Tosone, 2004), introduced the concept of relational social work to demonstrate the ways "social work developed its own definition of relationality." My intention here is to point out the key relational ideas of the leading clinical social work pioneers. First, it is important to note how Greenberg and Mitchell defined the term relational and how relational psychoanalysis and relational social work emerged.

In 1983, Greenberg and Mitchell used the term "relational" to refer to those past psychoanalytic theorists (Sullivan, Fairbairn, Guntrip, etc.) who essentially rejected drive theory (a theory established by Freud positing that the most fundamental aspects of human experience are the sexual and aggressive drives and their derivatives) and who instead placed relationships at the center of their theoretical systems. Relational psychoanalysts throughout the 1980s, such as Benjamin, Chodorow, Ghent, Greenberg, Hoffman, and Mitchell, expanded the meaning and applicability of "relationality" (Mitchell, 2000) by integrating theories such as interpersonal psychoanalysis, British object relations theory, self psychology, intersubjectivity theory, social constructivism, narrative theory, postmodernism, gender/feminist theory and contemporary ego psychology (Aron, 1996; Mitchell and Aron, 1999). Tosone expanded the meaning of relational "as a way to describe the intrinsic relational roots of social work theory and practice":

The term "relational" in a social work context needs to be broadened to include intrapsychic and interpersonal, as well as intra- and inter-systemic dimensions. To be exact, one needs to consider relational not only in terms of internal and actualized object relations, but also in terms of the individual's internalization of, and interface with, the macro systems of the larger society, i.e. cultural, economic, and political institutions and structures. (Tosone, 2004)

Clinical social workers anticipated concepts integral to the three theories that Mitchell identifies (in his earliest writings on relational psychoanalysis) as being the core theories behind relational psychoanalysis — interpersonal psychoanalysis, British object relations theory and self psychology (Mitchell, 1988).

Examples of Relational Theorizing by the Early Clinical Social Work Pioneers

The contributions of Mary Richmond (1861-1928) to relationality are signficant, not only because she was influenced by some the same individuals and movements as Sullivan and Fairbairn (Sheppard, 2001), but because she was the first leading social worker to contribute significantly to clinical social work theory (Turner, 1996). Writing about ten years before Sullivan and 20 years before Fairbairn, Richmond emphasized that the "personality" of a person could not be established, defined or understood outside of his/her relations to others and the social environment (Richmond, 1917; 1922). Although Richmond viewed people as being unique and having individual differences, she emphasized that they require "relatedness" in order to enhance their personalities and develop. Sheffield, who collaborated with Richmond on her monograph, Social Diagnosis, emphasized this by stating:

Social facts should be analyzed in terms of relational grouping the personality is a web-like creation of a self interacting with other selves... we shall talk less of the individual as a solid self-contained unit, moving and acting in an environment of other solid and self-centered units... we shall talk more of... relationships. (Sheffield, 1921, in Nathiel, 1997)

Where Rank and Ferenczi were significant theorists in the formation of relational theorizing, they were also very influential to clinical social workers affiliated with the Functional School. Ferenczi and Rank not only conducted seminars for social workers in New York City, but taught courses at the University of Pennsylvania School of Social Work. Taft, an early pioneer of functional social work theory, was greatly drawn to Rank and Ferenczi because they deepened her already-established object relational thinking as demonstrated in her 1930 view on the centrality and importance

Dore Sheppard, *President of the Rockland Chapter of the State Society,* is an adjunct professor at the NYU School of Social Work and a candidate in the NYU Postdoctoral Program for psychoanalysis and psychotherapy. He earned a Ph.D. in Social Work at NYU and MSW at Fordham University and has a private practice in Nyack and the Bronx.

of identifications and internalizations of objects (note the precursor to Fairbairn):

The child identifies positively or negatively, partially or wholly, not only with parents, but with other members of the family group. (This is when) character begins to be formed. He tries out his will on theirs and, according to what actually happens in those impacts, behavior begins to take on patterns that, with greater or less modification, may last a lifetime... For who can tell what identifications a particular child will take on to his profit or what resistances he will be impelled to feel to his detriment? (In essence,)... the child chooses his own patterns, takes unto himself in his peculiar way identifications both positive and negative which cannot be foreseen or controlled. (Taft, 1930)

Where Palambo, Elson, and Chenot have written poignantly and persuasively on the similarities in values, theory and practice between self psychology and clinical social work, one aspect of Kohut's theory may be amplified by drawing on one of Dexter's contributions. Dexter, an early leading clinical social worker, seems to have anticipated Kohut's concept of "vicarious introspection" by stating:

Human relationships depend upon our ability to identify ourselves with one another. This is the only basis for understanding. We cannot all be delinquent girls nor deserting fathers, but by understanding their motives and recognizing the same motives in ourselves, we can appreciate their problems and understand their behavior. Without identification the case worker cannot get the emotional significance of her client's experiences or reach any real understanding of his problem. (Dexter, 1926)

In terms of conceptualizing theory and practice from a relational perspective, the pioneers of clinical social work were not only ahead of their time, but were important in terms of contributing to relational theory and practice and the field of social work itself. By highlighting their contributions, a meaningful step is being made, hopefully, toward understanding and heeding Eda Goldstein's call to action:

...although the relationship between psychoanalysis and social work has a long and rich history, it continues to show considerable strain to the degree that it is barely visible in most social work academic programs. I wish that there were optimistic signs on the horizon. It is imperative that those of us who are committed to clinical training work together to address this unfortunate state of affairs. (Goldstein, 2002) ■

Note: *A bibliography is available upon request.*

How Private Practitioners Can Make A Difference

By Linda Fleischman, MSW, LCSW, BCD

One of the core values in which the mission of social work is rooted is the pursuit of social justice. The Code of Ethics indicates that, "clinical social workers recognize a responsibility to participate in activities leading toward improved social conditions. They should advocate and work for conditions and resources that give all persons equal access to the services and opportunities required to meet basic needs and to develop to the fullest potential."

Most clinical social workers work in agencies which serve members of the most vulnerable groups in our society—the elderly, those who suffer from chronic or terminal physical illnesses, persons who suffer from developmental disabilities, persons who suffer from chronic addictions and persons who suffer from chronic severe mental illness—many of whom live in poverty and/or who are subject to discrimination and other forms of social injustice. Clinical social workers who are in private practice generally do not serve these populations, but may be able to find a way to play a role in improving the lives of more vulnerable individuals.

One of the ways clinical social workers in private practice can contribute to the effort to achieve social justice is to volunteer to assist their local affiliate of the Mental Health Associations of New York State (MHANYS), which can be located through their website at http://www.mhanys.org/affiliates/index.php. A recent NIMH study found that mental illness affects over 25% of all Americans, yet only 40% of them seek assistance. The 32 local affiliates of the Mental Health Associations of NYS work tirelessly to help those who suffer from chronic severe mental illness and their families.

In Westchester County, the dedicated staff and volunteers of our mental health association, which was founded in 1946, bring vital services to more than 11,000 residents of Westchester County. This year their MHA on the Move 5K Run/Walk & 1 Mile Kids Race will be held on Sunday, May 6, 2007 (rain or shine), from 8:00 AM to Noon, at FDR State Park, 2957 Crompton Road, Yorktown Heights, NY 10598. The goal of this family-centered annual event is more than simply to raise money. It is to raise awareness about and to work to erase the stigma of mental illness, and to help to public realize that we all play a role in protecting and promoting mental health in our respective communities. For further information or to register to participate in this event you may call the Mental Health Association of Westchester County, Special Events Manager at (914) 345-5900, extension 209 or e-mail mccaffeb@mhawestchester.org.

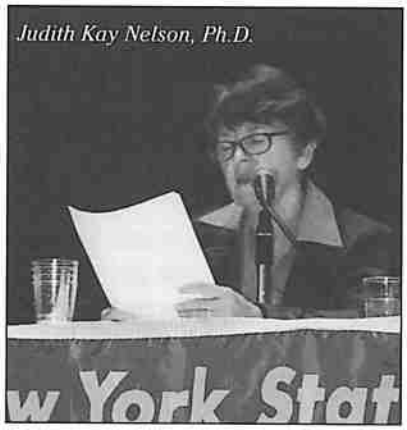
I urge all of you to find a way to participate and to contribute to helping improve the lives of many in need of services in the broader community. ■

Hope is a Thing with Feathers:*

Perseverance and Optimism in Long Term Treatment

Keynote Presentation by Judith Kay Nelson, Ph.D. / Reviewed by Susan Klett, LCSW-R

The keynote presentation of Judith Kay Nelson, Ph.D., was a theoretically rich, creatively reflective and clinically astute discussion of the twinship of hope and despair. Dr. Nelson described how she discovered "the therapist's piece of hope, optimism and its twin, perseverance." She explored psychoanalytic literature, reviewed research, had consultations with colleagues, and let her own courageous and unrelenting determination flower; and eventually she helped a hard to reach patient navigate excruciating intrapsychic pain and paralyzing despair. Dr. Nelson's case study illustrated the practice of two person psychology with a broad canvas. Her work was an effective blend of attachment theory and neuroscience, object relations and psychosocial theories, contemporary relational and interpersonal/intersubjective approaches to the care of a difficult patient.



Dr. Nelson is on the Faculty of the Sanville Institute, which is located in California; and she is the author of *Seeing Through Tears: Crying and Attachment* (Routledge, 2005). She began her presentation with a question: "What role does hope play in the experience and outcome of a therapeutic endeavor?" She led listeners to an answer by pondering the meaning of hope and providing definitions from a dictionary, a thesaurus, recent research studies, psychoanalytic writings, the personal experience of writer Jerome Groopman, and her observations during a long, arduous analytic treatment of a patient whose language was anxiety laden.

An expert on attachment theory, Dr. Nelson reflected on Bowlby and Ainsworth's findings and identified her patient's attachment style as ambivalent/resistant. Understanding the necessity for a connection, she hoped to provide her patient with a secure attachment. Interweaving attachment theory with neuroscience, Dr. Nelson quoted Allan Schore (2003) who discovered that, "Positive affect synchrony between infant and mother contributes to the organization of the infant's right brain and appears to have a positive impact on the mother's brain functioning as well." In agreement with the ideas of Winnicott, Dr. Nelson pointed out that a dyadic relationship between therapist/patient is similar to the parent/infant relationship. When the infant cries it disturbs the caregiver, who then optimally attunes and regulates the infant's negative arousal. Nelson notes that just as a caregiver may, to a degree, become negatively aroused by an infant, soothing the crying internal infant of a patient often soothes both the patient and a negatively aroused therapist as well.

In Nelson's theoretical overview of Klein and Erikson, she noted the importance of early relationships in shaping a patient's expectations in the treatment transference. There is a transferential pull between the patient's mature vs. infantile longings. These longings, which are now expressed in the treatment relationship, were determined by his/her capacity to trust vs. mistrust, in the early mother/infant dyad.

In Dr. Nelson's clinical case study of a 22-year treatment, a female patient said of herself, "I awoke from despair to hope." And it is this change, as a consequence of clinical work, that Dr. Nelson illustrates. Progress was slow, hope and despair co-created. When Dr. Nelson fought against her own despair, she sustained courage by drawing on psychoanalytic literature and the writing/advice of colleagues. She found solace

Susan Klett, LCSW-R is on faculty of the Psychoanalytic Institute of the Postgraduate Center for Mental Health, and on faculty and supervisor at Washington Square Psychoanalytic Institute. She is in private practice.

*Emily Dickinson

From Despair to Hope in the Clinical Process

in the words of Steven Mitchell, "Sometimes, when language itself has proven treacherous and corrupt, the analyst can say nothing; affirmation through continued presence is the only solution. Perseverance in the absence of hope is a way to create it out of despair. (1993)

Dr. Nelson felt validated by the words of Roberta Shechter, who describes how a therapist maintains hope. "There is a dual need for (we) therapist(s) to attune to the negative affect presented by a patient while, at the same time, tolerating the negative affect stirred in us. However, (a patient's) despair, if we let it in, may well taint our hope. The outcome is a delicate balance between hope and hopelessness." (1999)

Building on the ideas of colleagues, when despair rose to the surface in a session, Dr. Nelson consistently and consciously interrupted her patient's narrative. For example, she would raise her finger, as if to change a channel and project a less hopeless view on a matter into the therapy room. Reflecting on her clinical technique, Dr. Nelson said, "I soon realized that this action was not only for my patient but also for myself. We were in this treatment endeavor together. My patient's despair became my despair; I wanted and needed to have hope and in order for me to have it, I had to help her have it too."

Dr. Nelson observed, "I had to get over my preference for non-self disclosure." She cautiously and thoughtfully used anecdotes, and told her patient benign life stories. She shared poetry that related to the patient's need of connection with her. In time, the patient was able to introject Dr. Nelson, and a twinship formed. And, the patient wrote letters as a bridge to her own inner life; she solidified hope and a secure attachment to another human being for the first time in her adult life.

Dr. Nelson presented a beautiful lucid paper. She shared her inner dialogue, which accompanied a creative use of self, which sparked hope during intersubjective moments of a deep treatment. ■

References

Mitchell, S. (1993). *Hope and Dread in Psychoanalysis.* New York: Basic Books.

Shechter, R.A. (1999). "The psychodynamics of a clinicians hope." *Clinical Social Work Journal*, 27, (4). Pp. 371-382.

Schore, A. (2003). *Affect Dysregulation And Disorders Of The Self.* New York: W.W. Norton.

Letter from the Chair of the Education Committee

Dear Members of The New York State Society for Clinical Social Work,

When David Phillips asked me to be Education Committee Chair of the State Society in 1990, I thought it to be a daunting task. I asked, "Dave, do you think I can do it?" He had the utmost confidence in me. I found not only could I do it, but it became a challenging, stimulating and enjoyable endeavor and I learned a lot.

The Education Committee has put on wonderful conferences in the past seventeen years, exploring all aspects of clinical theory and the clinical social work process, beginning with a conference on managed care in 1990, and ranging from topics such as *Countertransference and Self-Disclosure: Uses and Abuses; The Body, Sex, and The Self; Intrapsychic and Interpersonal Explorations: Collaborative Dialogue; The Clinical Process; Awakenings: From Despair to Hope in The Clinical Process;* to this year's conference, *When Feelings are Split Off: From Dissociation to Integration in the Clinical Process.*

I have had a wonderful committee to work with over the years and it is with mixed feelings that I have decided to pass the baton to a new committee chairperson. I will make my goodbyes at the conference on May 12. [See conference information on page 27.]

Sincerely,
Dianne Heller Kaminsky, LCSW, BCD

Education Committee Members: (l. to r.) Susan Klett, Gail Grace, Gil Consolini, Charlotte Elkin, Dianne H. Kaminsky, Tripp Evans, and Justina Kavanagh

Can This Marriage Be Saved?

Reversing the Cycle of Destruction in Troubled Relationships

Keynote Presentation by Judith P. Siegel, Ph.D. / Reviewed by Charlotte Elkin, LCSW, CEAP

In her presentation entitled, "Can this marriage be saved? Reversing the cycle of destruction in troubled relationships," Judith P. Siegel, Ph.D., renowned author, professor and clinical social worker, presented her model for understanding despair, or pessimism, in couples and described the role of the therapist in facilitating a transformation towards hope, or optimism, in romantic relationships. With an engaging, personable style, Dr. Siegel adeptly integrated concepts from object relations and cognitive theories to illustrate her approach to helping the couple who wonders, "Can this marriage be saved?"

Dr. Siegel began her presentation by acknowledging the breadth of attention our society gives to optimistic romantic love, and the lesser extent to which the conflict, distancing, avoidance, isolation and/or loneliness of despair in relationships is truly explored. She explained that when working with a pessimistic or despairing couple, she initially determines whether they have a certain level of commitment to their relationship (often rooted in children, finances, culture, religion, and/or a greater fear of attachment loss than of remaining attached) or whether, in fact, one or both members are interested in separation or divorce. Dr. Siegel will apply her model only with those interested in staying together; with others she implements "divorce therapy" to assist them in humanely ending their relationship.

In essence, Dr. Siegel's model incorporates the following key concepts: from object relations theory, splitting and projective identification, and from cognitive psychology, schema and flooding. The goals of her treatment are for patients 1) to recognize the presence of ambivalence in their relationship — the coexistence of wanting both "out" (despair) and "in" (hope) and, 2) to achieve tolerance for the existence of both extremes. Siegel explained how many couples, at the point at which they seek help, have lost their ability to nourish each other, their capacity for a safe, emotional connection or respect for one another, and ultimately, have replaced their supportive interdependence with isolating self-reliance. Siegel spoke of this negative experience, often triggered by aspects of work, having children, or other stressors, as differing from the "honeymoon stage" in which basic needs of safety, attachment, and well-being are kindled. By helping couples to identify their contrasting perceptions of the "all-good" and later "all-bad" marriage, Dr. Seigel begins to educate them about splitting and the notion of marriage which, like mothering, becomes more hopeful when conceptualized as "good enough."

To reach this "more objective" state, or one in which both individuals can own and merge a range of experiences regarding the relationship, Siegel described a transition from the position of passive acceptance and helplessness to one of observance, ego awareness and the power to choose to do differently. She explained the therapist's roles in this process as examiner, educator, and above all, provider of a "holding environment" for the couple. As examiner, the therapist must understand the level of a couple's ambivalence, the depth of their current destruction or despair, including levels of abuse and/or the presence of affairs, their individual expectations for sex, and the function of pessimism in their relationship (i.e., as a safety net providing distance from being re-injured, etc.). As educator, the therapist applies psychoeducation and vivid metaphor, teaching patients to understand and use theoretical terms and constructs as a way to heighten awareness of their dynamics and decrease the "potency" of their pessimism. And, as provider of a holding environment, the therapist "take[s] a stand against" contempt, thus creating a safe place to learn, experiment and approach change. Dr. Siegel, citing Gottman, explained that contempt leads to emotional abuse and is one of the most evident predictors of divorce. Dr. Siegel's couples must choose between "venting destruction or deferring to pressure" and a "different way to make sense of anger and despair." Only in choosing the latter can they make themselves vulnerable enough to explore their own thoughts, beliefs, and personal history, as well as allow for the "recognition and validation of their partners' experience, whether they agree with them or not."

Charlotte Elkin, LCSW, CEAP has a private practice in Manhattan. She is the senior counselor at the Mount Sinai Employee Assistance program and is on the faculty at the Mount Sinai School of Medicine.

From Despair to Hope in the Clinical Process

With such roles established, Seigel is guided by the following: she understands pessimism as a function of splitting in relationships, and is thus focused on helping patients understand their tendency to split. Cognitive schema, or our systems of organizing beliefs about the world, are likened to folders in a file cabinet, categorized by memories associated with "pride, celebration, self-importance or being respected" in the "good" drawer, and "shame, ...rejection or humiliation" in the "bad" one. She explained that both partners have a schema of the all-bad partner or relationship, and when an aspect of this is triggered, their access to that which is stored in the "good drawer" becomes "sealed off" or inaccessible (in fact, the cabinet locks to prevent two drawers from being opened simultaneously). Furthermore, each file is linked to others in its drawer and thus individuals can be "flooded" by related past experiences, confirming and magnifying the all-good or all-bad state. (Siegel notes that an all-good state can be equally as dangerous as all-bad, in that it leaves "no place for simple problems or the putting out of fires.") Reminding couples that their "experiences are coded in the extreme" and that there is "danger in believing it is the whole truth" rather than a "part-truth," Dr. Siegel redirects couples to the situation at hand, and begins to create opportunity for, and tools with which, nourishment, acceptance and connection can be re-established.

Judith P. Siegel, Ph.D.

In addition, Dr. Siegel addressed the impact of projective identification on splitting, and in particular, flooding. At the point where flooding takes place, or the "Pandora's Box" has been opened, Dr. Siegel informs patients of their choice: to either perpetuate anguish or despair by resorting to their traditional role in the relationship dynamic, or to figure out how to join with their partner in returning to a place of stability, by way of a new approach. Via her case example of a couple called "Amy and Brian," she illustrated the way that early childhood experiences can flood couples' reactions to one another in the moment. Brian, who grew up in a chaotic home with emotionally absent parents, three rough-housing brothers, and "never enough to go around," lacked a sense of safety as well as the ability to hold onto something. Amy, once an artistic, creative child who grew up feeling her academically-oriented parents never understood her, would become enraged when feeling misunderstood. Needless to say, Amy's anger with Brian's inability to commit and "hurtful" responses, and Brian's experience of Amy as controlling, manipulative and dominating, only led Amy to again feel misunderstood and Brian to again feel unsafe. In her work with this couple Dr. Siegel helped them "to define their extreme states, to understand the process of splitting and their experience with flooding, and highlighted the presence of multiple reactive states" in their relationship. In doing this, she reminded them of their ability to access alternative states, and showed them how to conceptualize their "cycle", thus enabling them to live in a position of greater acceptance. There, they were able to solve problems, offer apologies and nourish one another, ending their pattern of an on-again, off-again relationship. As with other cases, Dr. Siegel described her main work with Amy and Brian as "brief," totaling 20 sessions, followed by their return a few years later to brush-up on aspects of the work.

Finally, Dr. Siegel spoke about issues of countertransference when working with couples. She referred to this experience as "trial identification," or the process by which the therapist experiences empathy for the individual and couple. Dr. Siegel's awareness of her own associations to past relationships, stimulated by the couple's content and affect, as well as her own experience of being flooded and splitting within the triangular relationship of couple and therapist, are used to guide her interventions. In sessions, Dr. Siegel will verbalize the sensation of being flooded or of feeling all-good or all-bad about the process, thus modeling crucial techniques for healing.

By taking the normal, defensive reaction of splitting, and focusing on its pathology only when an individual or couple becomes stuck within extreme states, Dr. Siegel clearly depicted an experience common to couples wallowing in despair. She offered an approach which involves assessment, awareness-raising, education, and creation of a space where couples can again nourish and accept one another. Thus, with a fresh, integrated perspective on traditional ideas, Dr. Siegel successfully provided our audience with tools and concepts to assist couples on their pivotal journeys from despair to hope. ■

Disaster Preparedness

By Maureen Buckley-Fox, MSW, LCSW, BCD, Chair

The Disaster Preparedness Committee requests that all Society members who have volunteered and have been trained to participate as responders to disasters under the auspices of the Red Cross, a local Medical Reserve Corps or an institutional/agency group please contact me providing the following information: your name, the name and county of the organization you are affiliated with as a disaster response volunteer, your home and office phone numbers, your e-mail address, the Society chapter to which you belong, what training your received as a disaster response volunteer and from whom you received that training. This information can be sent to me by e-mail at: mbuckleyfox@optonline.net or by phone at 516-662-2263. This will enable the Society's Disaster Preparedness Committee to communicate with you regarding training activities and volunteer opportunities.

Additionally, the New York State Education Department has commenced a program to provide photo ID cards to each licensed health care professional in New York State who desires to obtain one. The cards will indicate the professional's name and the profession in which he or she is licensed. These photo ID cards will be critical in identifying health care professionals who wish to volunteer in a disaster situation. The card costs $20.00 and is valid for the period of the professional's triennial registration, at which point it must be renewed. For further information please go to the NYS Education Department's website at: **http://www.op.nysed.gov/photoid.htm** or call 1-800-567-7704. ■

ALERT: *Misleading Solicitations to Clinical Social Workers*

For the second period of time in the past two years, an organization named Three Rivers Provider Network (TRPN) based in San Diego, California, has been making misleading solicitations to clinical social workers in New York State. In 2005 TRPN staff contacted a number of clinical social workers (LCSWs) by phone indicating to them that TRPN needed them to complete and return to TRPN a W-9 form (an IRS form used to report a provider's social security number to a payor, which payors are required by the IRS to obtain before paying insurance benefits to a provider) so that TRPN could send payments to these LCSWs which were due to them for patients they had seen. The TRPN staff asked the LCSWs for their fax numbers so that they could send the W-9 forms to them to complete. The forms TRPN sent to them had been modified so that when the LCSW completed the form with his or her respective name, address and social security number and then signed it, they were signing an agreement (set forth in small print below the signature line) to join the TRPN network, an independently owned preferred provider organization, and have TRPN bill managed care companies for the patients they were seeing, in return for which the LCSWs would receive a payment of a percentage of the billing directly from TRPN (which would collect the entire fee from the managed care company). TRPN apparently stopped making such solicitations to LCSWs in New York after the Society complained to them about their misleading tactics. The Society has now received several reports over the past few weeks that TRPN is again calling LCSWs asking them to call back and provide their fax numbers, and informing these LCSWs that they must submit a new IRS W-9 form as well as a TRPN application form to obtain a national provider identification (NPI) number, so that they can be paid.

No one needs TRPN's help to get an NPI number. Individual practitioners need to apply for this number on their own. Obtaining this number is easy to do on line through the U.S. Dept. of Health and Human Services' Center for Medicare and Medicaid Services' website, **https://nppes.cms.hhs.gov/NPPES/**. Further, no one should provide a W-9 form (attesting to their social security or tax ID number) to an organization, as a provider of services, unless that organization is one for which they are a provider or that organization is an insurer/payor for services they are rendering to a particular patient. If you are solicited by an organization to do so, ask them to make their request in writing and to supply the name of the patient regarding whom they claim to be seeking to reimburse you for services you rendered, and the dates of those services. They may claim that they cannot provide this information to you because of HIPPA regulations. This is patently false. HIPAA regulations permit them to do so for legitimate payment purposes. When you get any forms they send to you, read them fully and carefully (including all of the small print). Don't sign anything unless you understand it completely.

If you are contacted by TRPN please let the Society's Committee on Ethics and Professional Standards know and forward a copy of any materials you receive from them to the Committee at clinicalswethics@mindspring.com or fax number 718-596-7982, so that this deceptive conduct can be reported to the NYS Department of Law.

Annual Membership Meeting Report

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Patricia then focused on issues of professionalism. She stressed that we must recognize that our private conduct may affect our public image and that of our profession. She then stressed that when a clinical social worker is impaired due to personal problems, substance abuse, legal problems, medical illness, or emotional difficulties, he or she probably needs to take a break from seeing patients, and should make arrangements for continuity of care for them. Additionally, social workers need to be clear about their credentials and to identify themselves using their license — in New York, LMSW or LCSW. Patricia then addressed the area of relationships with colleagues from other professions. She indicated that we should help them understand the competencies of clinical social work and encourage interdisciplinary collaborative practice. We should also cooperate with them for the welfare of patients. Patricia ended by discussing the ethical obligations to the social work profession and its organizations. We must take pride in the social work profession. We should take appropriate measures to discourage, prevent, expose, and correct unethical or incompetent behavior by colleagues, while at the same time defend colleagues who are wrongfully accused. We need to contribute to the education, training and mentoring of social work students and less experienced practitioners and to advancing the social work profession. We must also engage in advocacy to improve the profession and in constructive criticism of its professional organizations.

The Impact of Licensure

Hillel then presented on the topic, *The Impact of Licensure on Ethics and Legal Obligations of LMSWs and LCSWs in New York State.* After explaining the difference between title protection and licensure, Hillel stressed some of the responsibilities placed on LCSWs by virtue of licensure. We must make assessments and devise treatment plans using a biopsychosocial approach. We must gather appropriate healthcare information to do so and must be attuned to symptoms which may have a biological basis and make appropriate referrals to address these. We must have treatment plans which outline goals and objectives and how we intend to achieve these. We must obtain informed consent for treatment, and involve the patient in the treatment planning process, outlining various available treatments they may chose from. We also need to recognize the importance of interdisciplinary collaborative practice in health care, in order to bring a variety of competencies to bear to assist patients. Hillel stressed that by law, all LCSWs are responsible for the various functions listed in the scope of practice for the LMSWs, not just clinical functions.

Hillel stressed that we must all have a strong commitment to competence and lifelong learning. We need to keep abreast of evolving knowledge and new competencies and evidence-based practice. We need to prepare for realities of changes in health care practice as we are called upon to meet the evolving needs of the public, particularly the needs of the elderly, the chronically and terminally ill who require palliative care, crisis intervention, early intervention for children with emotional and developmental difficulties, persons with addictions and those suffering from severe mental illness. We need to meet our ethical obligation to help those who cannot afford treatment by providing pro bono services and/or using sliding fee scales.

We need to contribute to the education, training and mentoring of social work students and less experienced practitioners and to advancing the social work profession. We must also engage in advocacy to improve the profession and in constructive criticism of its professional organizations.

Supervision and Consultation

Turning to issues of supervision and consultation, Hillel explained that supervisors are responsible for the services rendered by and the actions and omissions of the supervisee, because the patient is a patient of the supervisor, not the supervisee. Consultants are responsible to make a sufficient inquiry to provide appropriate advice about the situation for which they are providing consultation (expert advice and guidance) but are not responsible to the conduct of the consultee. Because students and LMSWs are not permitted to diagnose, make treatment plans, provide psychotherapy except under supervision, the LCSW supervisor or another LCSW, clinical psychologist or psychiatrist should conduct a diagnostic assessment of each patient before treatment commences. Additionally, the supervisor is responsible for reviewing and approving the initial treatment plan and

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Are You Concerned About the Future of Clinical Social Work?

12,000 members in approximately forty state societies of clinical social work, to an organization of about fifteen societies with a total of about 15% of its former members. In fact, the Ohio Society for Clinical Social Work, the state society from which the CSWF's immediate past president came, is no longer affiliated with the CSWF/CSWA. The CSWF has had progressively limited financial resources over the past several years as many state societies of clinical social work, particularly the New York, California and Illinois societies, dropped out of what had become a highly disorganized and ineffectual organization that had woefully failed to carry out its primary purpose of national advocacy for clinical social work.

The CSWF's (now CSWA) flawed decision making included:

- urging the state societies and their members to join the Clinical Social Work Guild, and seriously considering compelling them to do so;
- the two medical insurance plan debacles, both of which plans failed, leaving many clinical social workers without reimbursement or payment for healthcare expenses they incurred and for which they paid for coverage;
- the malpractice insurance fiasco, where the company underwriting the plan they developed withdrew from the market leaving many clinical social workers without insurance and having to pay for expensive tail coverage in order to obtain new malpractice insurance;
- taking steps to diminish and to ignore the autonomy of the individual state societies, including New York;
- raising its executive director's salary in the face of a rapidly diminishing number of affiliated state societies and a concomitant significant decrease in annual revenues; and
- its seriously flawed HIPAA education project, touted as a way to earn money to finance the continued operation of the failing CSWF. [Our Society requested the CSWF not to offer this training in our state. We did so because it would provide clinical social workers with seriously flawed instruction by only discussing the federal HIPAA standards without addressing the individual state standards which often supercede the federal standards. CSWF ignored our request and offered the training in New York over our express objection, causing us to incur the expense of a mailing to all of our members about the risk of relying on their flawed and potentially misleading training. Indeed, when the CSWF presented this training in California, a member of the California Society who is an attorney had to interrupt the presentation several times to correct the CSWF speaker by indicating that in certain circumstances California law, which provides greater privacy protections than HIPAA, had to be followed rather than the more limited federal HIPAA regulations].

Mindful of the need for national level advocacy, as noted in the last issue of *The Clinician*, the Society has recently affiliated with the Center for Clinical Social Work (CCSW, "the Center"). The Center was formed by the American Board of Examiners in Clinical Social Work (ABE), the premier competence certifying board for clinical social workers and the only clinical social work competence certifying body which does not require membership in any professional association or organization as a condition for obtaining board certification. Since its inception in 1987, ABE has:

- successfully built and marketed its well-regarded Board Certified Diplomate (BCD) credential;
- conducted outreach to state societies of clinical social work and to a range of professional social work organizations which have clinical social work members;
- worked persistently to develop, advocate for and support high standards for clinical social work education, supervision, practice and research;
- developed and now offers a subspecialty competence certifying credential for clinical social workers practicing psychoanalysis;
- developed a subspecialty competence certifying credential for clinical social workers treating children and their families, which it has begun to offer;
- participated, as a friend of the court, in several cases involving issues relating to clinical social work and clinical social work practice (indeed, in *Jaffe v. Redmond*, it was the attorneys for ABE who were responsible for the final version of the friend of the court brief that was submitted jointly by NASW, CSWF and ABE to the Supreme Court);
- built itself up financially and has maintained a strong financial position; and
- has provided grants and expert/technical assistance to various clinical social work organizations to advance their advocacy on behalf of clinical social work.

When it became clear that the CSWF was no longer a viable source of national level advocacy, the Board of ABE determined that the gap in national level advocacy for clinical social work could not be permitted to continue. It formed the Center for Clinical Social Work (CCSW, "the Center"), "to promote clinical social work as a profession and to advance clinical social work in all settings by developing practice standards and credentials, advocating for practitioners and their clients and enhancing opportunities for research, education and training." While ABE will remain an indepen-

dent competence certifying board, the Center for Clinical Social Work will be able to expand its advocacy efforts on behalf of clinical social work.

The next few years will see a significant effort to reform healthcare delivery in our country. Clinical social work needs a strong national presence which can provide national level advocacy and technical/expert support to local groups of clinical social workers. It also needs an organization which develops, advocates for and supports high standards for clinical social work education, supervision, practice, research. We cannot rely on NASW or the Council on Social Work Education to do so because they have too broad a constituency and have not supported consistently high standards for clinical social work education, supervision and practice. And, after much effort by our Society and other state societies of clinical social work, which regrettably failed in our earnest and repeated attempts to get the Clinical Social Work Federation (now the Clinical Social Work Association) back on track and to prevent its demise, it would be reckless and foolhardy at best, and grossly negligent at worst, to rely on the CSWF (now CSWA) to take a role, let alone to take the lead, in providing national level advocacy for clinical social work.

Unlike the CSWF/CSWA, the Center for Clinical Social Work (CCSW, "the Center"), will build upon the work of ABE, an accomplished, competently run organization which has consistently, successfully carried out its stated missions on behalf of clinical social work over the past twenty years, and is in a financially sound position. It is not seeking economic support from any of the social work organizations it is affiliating with. It has financial reserves to support this effort and has invested fiscal resources toward development of the Center. 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 additional financial support for their advocacy efforts.

As we in New York know from our fifteen-year struggle to obtain clinical social work licensure, advocacy is a long process, the important fruits of which are rarely immediately apparent. Advocacy is expensive, particularly at the national level. We must prepare now for the advocacy that will be necessary after the next presidential election when the provision of healthcare will once again be a significant issue.

The Center for Clinical Social Work (CCSW, "the Center") deserves the support of each and every clinical social worker. Soon, the Center will be sending a mailing to clinical social workers in New York and other states offering them the opportunity to join with the Center in the essential effort to provide national level advocacy for clinical social work and enhance the professional identity of clinical social workers. So, if you are concerned about the future of clinical social work, we encourage you to respond positively when you receive a request from the Center for Clinical Social Work to join with them in this important effort and that you make whatever contribution you can. ■

Vendorship and Managed Care

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Professional paper claim form (CMS-1500)

The CMS-1500 form is the standard claim form used by a non-institutional provider... to bill Medicare carriers... when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies. Please contact your Medicaid State Agency for more details.

Blank forms are not distributed by Medicare. In order to purchase claim forms, you should contact the U.S. Government Printing Office at (202) 512-1800, local printing companies in your area, and/or office supply stores. Each of the vendors above sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc).

The only acceptable claim forms are those printed in Flint Red, J6983, (or exact match) ink. Do not submit photocopied claims. The majority of paper claims sent to carriers and DMERCs are scanned using Optical character recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by all carriers and DMERCs.

You can find basic form completion instructions and print specifications for the CMS-1500 in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04). [Chapter 26 may be found at: **http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf**] ■

Hope to see you at our March conference.

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Early Social Work Education and Practice Standards

The history of professional education and development of practice standards in social work began in New York City, in the late 1800s. As the Charity Organization Society (COS) movement spread from England to America, volunteers, friendly visitors and workers in settlement houses, who began to be referred to as social workers in 1900, worked to help the poor and infirm. A hallmark of their early work was carrying out comprehensive social investigations based upon which service plans were developed and advocacy was provided to support clients in an effort to improve their psychosocial functioning and to help them obtain needed health, mental health and social services. In this regard, social workers were in the forefront of the public health movement and developed what is now referred to as *case management.* Eventually, a series of summer workshops and training programs for these volunteers and friendly visitors was developed. In 1898, The New York School of Philanthropy was founded. It offered a one year educational program in what would later be called social casework. Mary Richmond, the administrator of the COS in New York, who was an instructor in that summer educational program and became a faculty member of this school (which became the New York School of Social Work in 1917 and the Columbia University School of Social Work in 1963), published *Friendly Visiting Among the Poor,* the first textbook of what would eventually be known as *social casework.*

In 1895, the Chicago Commons School opened the School of Social Economics which offered the earliest social work course offerings of any school in the United States. In 1903, the social work program became the Social Science Center for Practical Training in Philanthropic and Social Work and offered a year-long social work educational program. Jane Addams, the co-founder of Hull House, a leader in the Settlement House movement and a recipient of the Nobel Peace Prize in 1931, was one of its faculty. In 1908, it became the Chicago School of Civics and Philanthropy and offered a two-year training program in social work. In 1920, it merged with the University of Chicago as a graduate program in social work and became the University of Chicago School of Social Service Administration.

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In 1905, Richard Cabot, M.D., hired the first social worker at Massachusetts General Hospital (MGH), to provide social services to clinic patients. In 1906, together with Ida Cannon, a visiting nurse, Dr. Cabot established the first *medical social work* program in a hospital to help patients deal with their social problems. In 1907, MGH hired social workers to work with mentally ill patients and, in 1914, the Boston Psychopathic Hospital established a social services department, where the title *psychiatric social worker* was used for the first time. In 1917, responding the Flexner's criticism that social work was not a profession, Mary Richmond wrote *Social Diagnosis*, documenting the unique, clearly defined methodology of psychosocial assessment. In 1918, Smith College established the first training program for psychiatric social workers. Also, in 1918, Ms. Cannon, who had graduated from the Boston School for Social Work (now the Simmons College School of Social Work) in 1907, established the principles of what was then called medical social work. She insisted that social workers in her department have sufficient medical knowledge to know how to work with people suffering from physical ailments.

Organization of Graduate Education in Social Work

By 1919, there were seventeen schools of social work in North America. They formed the Association of Training Schools for Professional Social Work (ATSPSW) which established standards for the education and training of professional social workers. It was renamed the American Association of Schools of Social Work (AASSW) in the 1930s and eventually became the Council on Social Work Education (CSWE) in 1952. In 1937, the AASSW, which had become the accrediting body for schools of social work, mandated that effective in 1939 the two-year masters degree program in social work would be the requirement for becoming a professional social worker.

Defining the Profession and Early Credentialing

In 1958, the NASW Subcommittee on the Working Definition of Social Work Practice chaired by Harriett Bartlett defined the unique professional domain of social work as assessing clients [individuals, couples, families, small groups, agencies and communities] and intervening to assist them in the context of their environment. In 1962, the NASW initiated the Academy of Certified Social Workers (ACSW), for NASW members with the MSW degree and two years of supervised agency experience. This was to serve as a credential for qualified MSW social workers in the widespread absence of regulation of social work practice while the effort to attain social work regulation in each state was pursued.

From Setting High Standards to Abandoning Them

For approximately 75 years, from the 1890s to the late 1960s, social work was making steady progress in its effort to develop, espouse and advance high standards of practice and professional education, the hallmarks of a profession. However, beginning in the late 1960s, with the acceptance of BSW graduates as professional social workers, social work education and practice standards have showed a steady decline, with a resultant decline in the quality of social work practice and service.

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Until 1969, the NASW required that its members have an MSW degree. In 1969, it began to allow persons with the BSW degree to join the association. In 1974, the CSWE lowered the prior standard, enacted in 1937, which required that successful completion of a two year MSW program was necessary in order to be considered as a professional social worker, by allowing BSW graduates to be considered professional social workers. In 1983, the CSWE recognized the BSW as the initial level of professional social work education. This quickly led to the granting of advanced standing to BSW graduates who entered MSW programs, allowing them to enter graduate training in the second year, giving them credit for the first year of MSW training by virtue of having earned the BSW, as if that undergraduate training was the equivalent of the first year of graduate training.

Following the lead of the National Registry of Health Care Providers in Psychology, in 1975, the National Registry of Health Care Providers in Clinical Social Work was created to credential qualified clinical social workers as Board Certified Clinical Social Workers, independent of any membership organization. The NASW also began to issue a clinical social work credential which was limited to NASW members (Diplomate in Clinical Social Work). In 1986, an agreement by the NASW and the National Registry of Health Care Providers in Clinical Social Work resulted in their mutual abandonment of their respective clinical social work credentials and the formation of the American Board of Examiners in Clinical Social Work (ABE) to offer a single board certification to advanced clinical social work practitioners, the Board Certified Diplomate in Clinical Social Work (BCD), *independent of any membership organization.* It issued the first BCD credential in 1987. After a contract dispute between ABE and NASW, the NASW then issued a competing credential which required membership in NASW. ABE commenced litigation to stop NASW from issuing that credential. After the court issued an initial restraining order against NASW, the case was settled. Under the settlement, NASW withdrew its credential and did not resume offering it until February 1992, when they resumed issuing the Diplomate in Clinical Social Work (DCSW), limited to NASW members.

In 1991, the NASW created the Academy of Certified Baccalaureate Social Workers, paralleling its ACSW credential for MSW social workers. In 2005, the NASW began operating the National Social Worker Finder which NASW members can join if they are licensed to practice social work in their state (at either the BSW, MSW or DSW level). They can be listed in this web-based database so that the public can locate them to obtain social work services. As of 2006, the NASW has created seven MSW specialty credentials and three BSW speciality credentials, none of which requires a formal specialty examination or formal specialized training.

The Challenge

Recently, a New York Court wrote, "It is clear to this Court that more needs to be done to prepare psychologists and clinical social workers to meet the evolving needs of the health and mental health systems and of the patient populations they will be called upon to serve. .... This being said, it is clear to this Court that social work and psychology programs need to increase their training in the biological aspects of human functioning .... and the impact of physical illnesses on psychosocial functioning. .... all students should be required to take courses in working with chronically and terminally ill patients and their families, in working with children and adolescents, in working with the elderly, in working with patients who suffer from severe chronic mental illness, in working with substance abusers, in providing crisis and emergency intervention, and in family or group therapy. .... The schools will need to increase significantly their educational efforts to assure that psychologists and clinical social workers are constantly prepared with the wide range of the most up to date

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biopsychosocial knowledge and innovative clinical skills. Only in this way will these professionals be able to meet the significant and growing challenges of providing quality cutting edge health and mental health services based on the constantly developing biopsychosocial knowledge base and evolving set of clinical skills, to a highly diverse group of patients of all ages who have a wide variety of health, mental health and social problems and service needs. *In granting these new licenses which place a significant public trust in the disciplines of psychology and clinical social work, the legislature expected and the people of this State deserve nothing less.*" *People v. RR*, 12 Misc 3d 161, 807 NYS 2d 516 (Sup Ct, NY County 2005)

We, as individual social workers and together as a professional association of clinical social workers, have an ethical obligation to work to remedy this situation which represents a critical weakness that is undermining our profession. We need to hold the schools of social work and the CSWE accountable. One of the major problems is that the CSWE's main constituency is the 458 BSW programs they accredit, not the 181 MSW programs they accredit. As of 2004 there were 28,190 full-time BSW students, but only 22,926 full-time MSW students in the United States. MSW programs need to be overhauled in three areas: admission, coursework, and field instruction, so that they can provide a comprehensive basic education in social work in a rigorous, full-time educational environment.

Overhauling Graduate Education in Social Work

The first step in improving the quality of social work education is to strengthen the admission standards in order to increase the quality of incoming students and their level of preparedness to engage in an intensive, rigorous program of graduate education and training. In this regard, a score in the top 40th percentile on the Graduate Record Examination general test (which measures verbal reasoning, quantitative reasoning, critical thinking, and analytical writing skills that have been acquired over a long period of time and that are not related to any specific field of study) should be required in order to ensure that each applicant has the intellectual capacity and academic skills to complete successfully an intensive, rigorous program of graduate education. Next, students should have a strong foundation of undergraduate coursework in psychology, sociology, biology, chemistry, ethics, statistics, political science and English, as the foundation for graduate study in social work. For example, one cannot expect a student with limited undergraduate education in psychology, sociology and biology to attain the necessary level of knowledge of the behavioral sciences needed by an MSW social worker simply by taking two semester courses in foundations of behavioral science in the first year of an MSW program. Further, BSW students should not receive advanced standing; they should be required to complete the full two-year MSW program as graduate students. Additionally, MSW education and training should be a full-time pursuit, blending a rigorous academic program of didactic coursework with an intensive program of supervised field instruction.

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The second step in improving the quality of social work education is to increase the number of courses to a total of 24 three-credit courses, separate and apart from field instruction. In addition to the traditional two semester long courses in: (1) behavioral sciences, (2) social welfare policy and services, (3) research, (4) generic practice and (5) advanced [microsystem or mezzo/macrosystem] practice; new required generic courses should include semester courses in (a) the biological aspects of behavior, (b) case management, (c) ethics and professional development, (d) supervision and staff development and (e) diversity and social justice. For microsystem majors there should be required semester courses in: (a) psychopathology & diagnosis, (b) family therapy or group therapy, (c) social work practice in healthcare (including palliative and end-of-life care), (d) social work practice with the seriously mentally ill and with substance abusers, (e) social work practice with the elderly, (f) social work practice with children and adolescents, and (g) three electives. For mezzosystem/macrosystem majors there should be required semester courses in: (a) institutional & organizational change, (b) shaping & influencing social policy, (c) community development and change, (d) program development & evaluation, (e) service

systems for children & families, (f) health & mental health service systems, and (g) three electives. Also, classes should continue to be held over the summer.

The third step in improving the quality of social work education is to improve the quality and hours and the fieldwork component of graduate training. Currently, MSW students receive between 900 and 1200 hours of field instruction, depending on the school. The required number of hours of supervised practice required for licensure is: 3500 for psychologists, 3600 hours for licensed mental health counselors, 1800 hours for licensed marriage and family therapists and licensed psychoanalysts and 2000 hours for licensed creative arts therapists. The required number of hours for fieldwork instruction for the MSW should be increased to not less than 2000 hours and should include placement over the summers and during intersessions. Additionally, field placement agencies, fieldwork supervisors and the MSW programs should be required to guarantee that the workload of each fieldwork supervisor will be such that he or she will be able to spend three hours per week of supervising each student supervisee and to spend three hours for preparation and administrative matters relating to the supervisory role for each student supervisee. Further, the student role and the worker role are different. Therefore, students should not receive credit for their prior agency work and should not be permitted to perform fieldwork in an agency for which they have worked or in which they are working.

The Critical Need for Action

For three-quarters of a century the pioneers of our profession worked hard to help social work earn the right to be recognized as a profession, not as simply a group of ethical, selfless, kind, well-intentioned friendly visitors struggling to help the less fortunate members of our society. Currently, approximately one-quarter of graduates of MSW programs nationwide and 31% of those from New York fail the basic MSW level licensing exam the first time they take it. Overall (counting those taking the exam for first time and those repeating the exam) more than one-half of those from New York State who took the basic MSW level exam in 2005 failed, one of the highest fail rates in the United States. The lowering of standards and the decrease in the quality of graduate social work education harms our profession and those we serve. It gives beginning social workers a false sense of competence. It fails to prepare them with an essential background of biopsychosocial knowledge and evidence-based practice skills to meet the significant, rapidly increasing, complex challenges of providing quality health, mental health and social services to a highly varied group of clients/patients of all ages and backgrounds who present with a wide range of health, mental health and social problems and service needs. It places our most vulnerable clients - the chronically ill and disabled, the elderly, the chronically seriously mentally ill — who present with the most complex set of service needs, in the hands of social workers who are unprepared by education, training and supervised experience to meet the challenge of helping them. It renders social work as a profession increasingly unable to compete with other health care providers whose professions embrace higher educational and practice standards. It also increasingly risks the loss to the health care community and those it serves of having the benefit of social work's unique skill set and approach that is so desperately needed, as social workers are replaced by better trained members of other professions with higher standards.

It is up to each and every one of us and our professional associations to work vigorously to renew the climb toward achieving high standards of professional education, practice and ethics for the benefit of our profession, and of the vulnerable populations and larger society we serve.

It is up to each and every one of us and our professional associations to work vigorously to renew the climb toward achieving high standards of professional education, practice and ethics for the benefit of our profession, and of the vulnerable populations and larger society we serve. Finally, remember that many of us will need social work services one day. It is up to us to take the necessary steps now to assure that well-trained, competent, knowledgeable, skilled, professional graduate level social workers will be there to provide these services. ■

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revisions of that plan. Before treatment commences with the supervisee, the supervisor must inform the patient that:

- by law, the supervisee is only permitted to provide clinical services under supervision;
- that the patient is a patient of the supervisor, not of the supervisee;
- the patient has the right to contact the supervisor and how he or she may do so;
- and that no insurance or managed care claims can be filed for treatment by the supervisee (unless the treatment is being provided in a licensed clinic).

The supervisor should regularly review the clinical documentation of the supervisee, and must document each supervisory session in relation to each patient. The supervisor should conduct periodic reviews of the supervisee in writing and provide them to the supervisee, and should have a supervision plan to address the supervisee's learning needs and to track the supervisee's progress. Supervisors need to make sure that the person covering their practice when they are away will also cover their supervision responsibilities or obtain other supervision for the supervisee for those periods (if the supervision is in an agency, the agency would have to assure appropriate coverage). If a supervisor terminates the supervision of a supervisee or a supervisee terminates supervision, the supervisor is responsible for the continuation of treatment to the patients who were being seen by the supervisee under his or her supervision (in an agency the agency would be responsible to assign appropriate staff to see those patients). LCSWs who are not employed by the agency to do so, should not provide supervision to agency LMSWs and students with regard to patients the LMSW or student is seeing at an agency, unless they have a specific contractual agreement with the agency to do so, even if the supervisee wants to obtain outside supervision. Supervisees should not be caught between two competing supervisors, the agency supervisor and an outside supervisor retained by the supervisee. Supervisors should seriously consider requiring that supervisees include them as other insureds under their malpractice insurance and they should seriously consider naming their supervisees as other insureds under their malpractice insurance.

Other Ethical Issues in Practice

Hillel ended his presentation with a discussion of several ethical issues that arise in practice. First, he indicated that clinical social workers should terminate services after an appropriate termination process when they are no longer required. Clinical social workers cannot terminate patients who are unable to pay for continued treatment and who require continued treatment until they can effectively transfer their care to another professional. Simply providing the patient with a list of potential clinics/professionals is insufficient. The patient must have had an appointment with the new treating practitioner, after which he or she has been accepted for ongoing treatment by that practitioner. Second, he related that when a clinical social worker provides services to two or more persons who have a relationship with each other, he or she must clarify with all parties the nature of his or her professional responsibilities to each of them and the ways in which appropriate boundaries and confidentiality will be maintained. Special care should be taken when treating a couple and one person withdraws from treatment. In such cases, it is usually best to have a termination period with the remaining person and refer that person for additional treatment to another practitioner if he or she wishes to continue treatment. Third, clinical social workers need to comply with the terms of employment, managed care and other contracts or agreements. Fourth, clinical social workers must provide truthful information to insurance companies regarding preexisting conditions, diagnoses, type of treatment being provided (i.e., not claiming to provide group therapy when he or she is providing family therapy). Failing to do so conveys to patients that it's OK to engage in anti-social behavior (lying and fraud). Fifth, clinical social workers must maintain contemporaneous records of the services they render. A byproduct of compliance with this legal requirement is that the practitioner must think about and reflect on what is happening in treatment, a form of self-supervision. Finally, as social workers we have an ethical obligation to further social justice and to work for conditions and availability of resources that give all persons equal access to the needed services.

Professional Discipline Process Advice

John Linville, Esq. then explained in detail the professional discipline process in New York. After doing so, he gave some practical advice on what to do if a professional discipline complaint is filed against you. First, do whatever you can to avoid being caught up in this process, especially, keep good records. Often they will be critical in resolving the complaint favorably at the investigation stage. Second, consult a lawyer as soon as you are advised that a complaint has been made against you. Three, be very careful about pleading guilty to criminal violations or professional misconduct in New York or in another jurisdiction. Such pleas may automatically constitute professional misconduct in New York, where you will not be permitted to challenge those prior findings in New York professional discipline proceedings, which will then move directly to the penalty phase. ■

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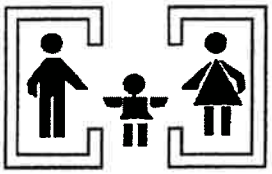

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