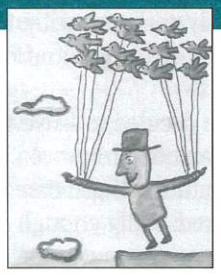
The CLINICIAN

FALL 2003 ▪ VOL. 34, NO. 3

The Newsletter of the New York State Society for Clinical Social Work, Inc. • A Founding Member of the Clinical Social Work Federation

34TH ANNUAL CONFERENCE REVIEW

Creativity and Play In the Clinical Hour



We are proud to announce that of the many clinical conferences held in the metropolitan area over the years, our Society's annual conferences have always ranked among the best, as reflected in the evaluations of those who have attended.

The 2003 conference, Creativity and Play in the Clinical Hour, was no exception, receiving outstanding reviews for both the morning keynote presentations as well as the afternoon workshops.

The two morning keynotes are reviewed in this issue. Unfortunately, due to limited space, we are unable to review the afternoon workshops, which were of equal merit. Of particular note were presentations by Judith Mishne, "Working with Patient's Play, Dreams, Humor, and Wit," and Harriet Pappenheim, "Playing With Fire: A Psychoanalytic Model for Helping Couples in Crisis, Integrating Self Psychology, Object Relations, and Attachment Theory."

The Education Committee, chaired by Dianne Heller Kaminsky, is busy working on the 2004 conference, The Many Faces of Love: Pathways/Barriers to Intimacy.

KEYNOTE REVIEWS PAGE 8

PHOTO BY SANDRA INDIG

Jill Winston, Carol Silverman, Richard Beck, Karen D'Amore (speaker), Dianne Heller Kaminsky, Jeffrey Seinfeld (speaker), Roxandra Antoniadas, Tripp Evans.

All MSWs *Are Not* The Same

We strongly disagree with the proposed educational preparation for the LCSW level

By Marsha Wineburgh, DSW, Legislative Chair

The State Society is actively participating in the development of regulations by the State Board for Social Work for implementing Chapter 420 of the Laws of 2002, the Social Work Licensing statute. This is a long and tedious process that requires interpreting the Legislature's intent as it is reflected in the actual wording of the new licensing law. This procedure has been complicated by the fact that the final version of the legislation has not been amended to reflect last minute changes agreed to by all parties as the bill made its way though the legislative process and to the Governor's desk. Consequently, some of the draft regulations may not be relevant.

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IN THIS ISSUE:

President's Message

By Helen Hinckley Krackow, CSW, BCD, Society President

I am writing this final Executive Message to you on the anniversary of 9/11. This fall marks the 35th anniversary of the New York State Society for Clinical Social Work. And, these are the last months of my third term of service as your President.

These certainly have been eventful years. I was privileged to be President during passage of licensing legislation that includes a very strong scope of clinical practice. This achievement was heavily influenced by the work of Hillel Bodek, Dr. Marsha Wineburgh, and our Legislative Committee.

Also, during my presidency, we decided to leave the Guild. Our foray into Guild membership was an attempt to gain enough clout to fight managed care on a national legislative level. It proved, sadly enough, to have been misguided. We have, however, continued to work with other professional groups, particularly the New York State Psychological Association, to meet with managed care companies to improve reimbursement rates and correct other hardships managed care imposes on practitioners.

This year we accomplished the task of preparing our members for HIPAA, largely through the efforts of Hillel Bodek. He digested massive amounts of HIPAA requirements, merged them with New York State laws regarding privacy, and prepared the impressive manual and forms which appear on our website.

It was during my tenure that the Society was faced with the catastrophe of 9/11. Our members worked long hours for months afterward to help New Yorkers recover, and we will continue to deal with 9/11's effects for years to come, both clinically and personally. All of you can be proud of your contributions to the healing of New York. The crisis called for the acquisition of new skills in short order. We did this through intensive education, which we got from our own Society, our institutes, the American Red Cross, the Green Cross, and our Society-sponsored Mitchell trainings. We have consequently established the Crisis Response Committee under the leadership of our former President-elect, Mark Maginn. We also formed relationships with other groups such as Project Liberty through the efforts of our referral service Therapy Resources. We are working with the Mental Health Association of New York to prepare for future disasters.

In the next years, our plans call for helping our members be grandfathered into licensure and otherwise prepared for the LCSW. The work will take place sometime in 2004 as the regulations are published. We also will be focusing more than ever on the provision of affordable clinical social work education for and by clinical social workers. We hope to model some courses along the lines of the Treating the End-of-Life Patient and Palliative Care Course, which has been provided by Hillel Bodek for only the cost of the course materials. On the books this was a 27-hour course, but it probably came closer to 36 hours of training. The idea of making education the primary focus of the Society is Hillel's.

As for me, I will continue to Chair the Newsletter Committee. In addition, I will assume the Chairmanship of the State Mentorship Program in the coming year. This is because we feel a deep commitment to beginning practitioners. We have been unable to find a replacement for the eminent founder of the program, Barbara Bryan. Her work and vision were invaluable to the profession. I would appreciate any assistance you can offer regarding contacts at the universities for distribution of materials and opportunities to address student groups.

I want to take this opportunity to thank the State Board for all its support during these two last years. As you know, we are all volunteers. It gives all of us great satisfaction to serve you and to shape the course of our profession. ■

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

The Clinician

The Clinician is published three times each year by The New York State Society for Clinical Social Work, Inc.

www.clinicalsw.org

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All MSWs *Are Not* the Same

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Our State Society endorses the statute's three criteria for advanced clinical practice: an examination on the clinical level, three years of supervised post-master's experience delivering psychotherapy services, and clinical course work either from an accredited social work school or obtained after graduating from an MSW program.

The interpretation of these last criteria, clinical course content, is of considerable concern for us. The State Board for Social Work intends to propose regulations which support the MSW curriculum accredited by the Council of Social Work Education (CSWE) as offering sufficient clinical course work to meet the statutory requirements for the LCSW level. A student could select enough clinical courses to meet minimum requirements for advanced and autonomous practice. But it is also possible for a student to select alternative tracks in research, administration or community organization that do not contain advanced clinical material essential for understanding the complexities of diagnosis and/or the treatment of mental illness.

Worst case—the first year of an MSW program, which informs basic social work practice, would be deemed sufficient for clinical work on an advanced level. Further, this would mean that BSW graduates who exempt their first year of social work school in advanced placement programs could have no graduate courses to inform clinical work. These non-clinical MSW degrees will not contain the basic coursework necessary for minimum competence in advanced autonomous practice for the LCSW level.

Consequently, the State Society strongly disagrees with the Board's proposed recommendation for educational preparation for the Licensed Clinical Social Work (LCSW) level and finds that it fails to meet the standard for adequate public protection.

Sample Curricula

All graduate MSW programs in New York State offer the possibility of clinical course work, but there is no guarantee students will select those courses as part of their MSW program. As a result, the course work completed by one MSW student may encompass a significantly different amount of relevant clinical course work than the MSW work completed by another student. Examples are:

- **Columbia University School of Social Work** offers five tracks, including social administration, social research, and advanced clinical social work practice. In the four semesters of an MSW program, social administration seems to offer three possible practice courses. In the four semesters of the social research track, there are three possible practice courses. In contrast, in the advanced clinical social work practice track, there are nine practice courses. All students, however, graduate with a generic MSW degree.
- **Wurzweiler School for Social Work** offers a year-long generalist practice course as a foundation in the first two semesters of their MSW program. In the third and fourth semesters, students select from three "social work method concentrations as a specialization": group work, casework and community social work. In the foundation year, there is the possibility of taking as many as six clinically-oriented practice courses or as few as four. In semesters three and four, more clinical courses can be elected, or none, if the student selects either the track in community organization or administration. No course in psychopathology is required. Two semesters are available as electives. All students, however, graduate with a generic MSW degree.

Possible Solutions

The State Society is calling for specific relevant guidelines to ensure that LCSWs have adequate educational preparation for practice in the complex specialties of assessment, diagnosis and treatment of mental, emotional, addictive and developmental disorders. This is in keeping with the Legislature's intent to require clinical course content at the LCSW level. Precedent has been established in the regulations governing licensure of New York State psychologists. These specify course work and hours of graduate work required in seven substantive content areas to qualify for clinical licensing (8 NYSCRR, Sections 52.10 and 72.1).

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WE ARE HISTORY!

The Board has approved the State Society's affiliation with the M.E. Grenander Department of Special Collections and Archives, housed in the New Library Building of the University at Albany, SUNY. This is a repository for the papers of individuals and records of political interest groups and associations concerned with New York State public policy issues, particularly since 1950. It is a source for original research papers dealing with social action, public advocacy and, for our Society, our work in mental health social policy. All of the Society's papers and activities including, but not limited to, advocacy for expanded mental health benefits, vendorship, licensing, advanced clinical education, and so forth can be sent to the archives for posterity. If you have material five years old or older that you would like to contribute, please contact Marsha Wineburgh, (212) 879-9025.

Joint NMCOP/State Society Workshops

By Marilyn Schiff, CSW

The first year of workshops co-sponsored by the National Membership Committee on Psychoanalysis (NMCOP) and the State Society proved the popularity of this type of meeting. Whether in Manhattan, Brooklyn, or Sparkill (Rockland County); whether in rain, sun, or fog and snow, the attendance at each of these workshops approximated our goal of 25. Enthusiasm and participation were all we could have hoped for.

Building on last year's work, we will present Patsy Turrini in Nassau County on November 2, 2003; a March 2004 meeting in Staten Island; and a final, June 2004 workshop in Syracuse. We hope you will be with us.

In November 2002 Diana Siskind presented "Some Observations on the Current Nature of Parental Permissiveness and Its Impact on Child Development, the Parental Ego Ideal, and the Treatment Situation." This excellent workshop, hosted in Manhattan by Roberta Shechter, explored, among other features, behaviors so many of us are faced with in patients who arrive in adult treatment with little or no impulse control or, in some cases, socialization.

In March 2003, our Rockland Chapter, led by President Beth Pagano and Chapter COP Chair Susan Sobel, hosted Beverley Goff's presentation, "Lesbians in Psychoanalytic Theory and Practice." This intimate workshop dealt equally well with the historic and literary treatment of lesbianism, and with Beverley's and workshop participants' own experiences. We were additionally grateful that this workshop was supported by the Rockland Branch Campus of the Shirley M. Ehrenkranz School of Social Work of New York University.

Our third meeting, in June 2003, was held in Brooklyn, hosted by Chapter President Ethel Barber. John Bliss spoke on "Psychoanalysis of Addiction," an outstanding presentation which was followed by many searching and informed questions from the workshop participants.

All three of these workshops benefited greatly from the presence of Helen Krackow, State Society President. All told, they represented the best efforts of Helen, Judy Ann Kaplan, President-Elect of the NMCOP, Marilyn Schiff, New York State Area Chair for the NMCOP and New York State COP Chair, together with the three sets of hosts and presenters, to develop an educational experience in casual settings conducive to rich interaction.■

2004 NMCOP Conference to Explore Change

By Richard M. Alperin, DSW, Public Relations Chair, 2004 NMCOP Conference

The ninth biennial conference, Psychoanalysis: Changing in a Changing World, sponsored by the National Membership Committee on Psychoanalysis in Clinical Social Work (NMCOP) will be held at the Marriott Financial Center Hotel, March 11-14, 2004 in New York City. Presentations will explore the interplay of changes in psychoanalytic theory with changes in our world and family life and the impact of these evolving forces on practice. Cutting edge topics such as complex adoptions, technologically assisted births, transgenderism, and war and terrorism will be discussed by distinguished psychoanalysts and psychoanalytic therapists, most of whom are clinical social workers.

The conference will begin with a daylong pre-conference seminar entitled, "Relational Social Work and Supervision: Reclaiming Our Contribution to the Analytic Process," presented by the NMCOP National Study Group. Gerald Schamess, Carol Tosone and guest, Lewis Aron, will explore current relational ideas and their connection to social work's traditional emphasis on the treatment relationship. To further demonstrate these ideas, they will discuss a supervisory session conducted by Roberta Shechter.

The conference will formally open with the NMCOP National Study Group's presentation of its highly acclaimed video, "Why Am I Here? Engaging the Reluctant Client," which will be followed by a discussion by Carolyn Saari, Caroline Rosenthal and Carol Tosone. The NMCOP Study Group made the video in collaboration with NYU's Shirley M. Ehrenkranz School of Social Work and the Council on Social Work Education (CSWE).

Keynote speakers for this conference are Judith Wallerstein, who will discuss "What About the Kids: Raising Children Before, During, and After Divorce"; Patrick Casement, who will present his paper, "Using Analytic Space: A Challenge to Contemporary Psychoanalysis," and Francine Cournos, who will discuss "Psychoanalysis and Traumatic Childhood Loss: A Personal and Professional Perspective."

Please join us. We look forward to seeing you there. For more information see our website: www.nmcop.org or call 718-398-9516 or email catbkny@earthlink.net■

The Loss of a Sibling

By Joyce Edward, CSW, BCD

Clinicians of all persuasions have long been aware that the loss of a sibling is likely to have a significant impact on the development and lives of the surviving siblings. In the early days of psychoanalysis, psychoanalytically oriented therapists tended to view the surviving sibling's guilt over their past rivalry, hatred and death wishes as playing a major role in determining their responses. This was a time when issues of sibling rivalry tended to dominate psychoanalytic thinking.

This preoccupation with sibling rivalry and its effects on the loss of a sibling can be traced in part to Freud's own sibling experience. At the age of 19 months, his eight-month-old brother, Julius, died. In a letter written in 1897 (Jones, 1963), Freud recalled his hostile wishes against his little brother, and attributed his lifelong tendency to self reproach to the fulfillment of these wishes when Julius died.

Observational researchers are noting the many ways siblings relate and contribute to each other's development. While continuing to recognize the role of rivalry, including its constructive aspects, contemporary findings affirm the importance of the positive attachment between siblings (Bowlby, 1973). One investigator, Leichman (1985), has suggested that siblings experience a form of symbiosis and separation-individuation from one another, albeit different from the progression they negotiate with their parents. Sharpe and Rosenblatt (1994) have described what they consider to be a normative oedipal-like attraction between siblings, which exists in its own right. These sequences are thought to promote development even as they may serve as the source of conflict.

In the last 50 years or so, psychoanalysts have begun to explore the sibling relationship more fully, and to appreciate that there is much more than rivalry involved.

Thus, in considering the impact of the death of a sibling on the surviving child, today's clinician is concerned with discovering the unique interpersonal and intrapsychic meaning of the lost child for the surviving child, including the child's fantasies about the deceased brother or sister. At the same time, work with surviving children must take into account the impact on them of their parent's reactions to the tragic loss they have suffered. Not only must these children contend with their parents' painful grief, which often means some withdrawal, at least temporarily, from them, but they are likely to have to deal with certain efforts that their parents make to deal with their loss, some of which can be deleterious for the surviving child. Among such efforts is an attempt on the part of some families to mold one of their surviving children into the image of the lost child or in some situations to conceive another child to replace the child who has died.

Case Vignette

In the interest of furthering our understanding of the impact of sibling loss in the light of our growing understanding of the sibling relationship I should like to offer a brief case vignette. The patient, Mrs. Carter, a 75-year-old, attractive, articulate and engaging woman, sought treatment when she felt "mired" in her grief following the sudden death of her husband two years earlier. Medication given her by her physician, grief counseling shortly after the death, as well as an interval of elapsed time, had lessened her dysphoria. Yet she continued to be preoccupied with the idea that she had failed her husband in some inexplicable way.

This feeling of having failed him was not in accord with what she knew of their actual life together. Mrs. Carter felt it was preventing her from going about her life as well as she might. She emphasized the vagueness

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Joyce Edward, CSW, BCD, is a psychotherapist in private practice. Distinguished Practitioner, National Academies of Practice; co-author of "Separation Individuation Theory and Application"; co-editor of "Fostering Healing and Growth"; and co-editor: The Social Work Psychoanalyst's Casebook: Essays in Honor of Jean Sanville."

This is a fourth in a series of six articles provided for The Clinician by The National Membership Committee on Psychoanalysis (NMCOP) in cooperation with the New York State Society for Clinical Social Work. Earlier articles were written by Jane Hall, Diana Siskind and Miriam Pierce.

By Rosemary Lavinski, CSW, Co-chair

Developing a Niche Market

As co-chair of the Independent Practice Committee, I have had the pleasure of being a presenter at numerous chapters throughout the state on "The Clinical Entrepreneur: Business Skills for Successful Practice." I have observed that clinicians are now acutely aware that the days when they could sit in their offices and wait for the phone to ring are over.

In past years, most referrals came from former clients or other psychotherapists. Today these sources are not as reliable. With the depressed economy, many clients seek therapists within their managed care plans. Consumers are also experimenting with new ways to address their mental health needs. Coaching, training seminars such as "Landmark," psychics and other kinds of alternative helping models are becoming both popular and fashionable.

In this competitive market, it is essential to have a clear marketing plan. How do you begin to develop such a plan? First, know your clinical strengths and weaknesses. People will value and respond to individuals who are "masters of their trade" and clearly love their work. This takes time, energy, and hard work. Do not identify yourself as a specialist in an area unless you have the skills, experience and advanced training to back it up. In developing a specialty, it is important to choose a population and a work style that you enjoy and in which you excel. It is easy to stay motivated in your pursuit of mastery if you have chosen a specialty that reflects your core values and interests.

Many therapists identify their "target market" as clients who, immediately after service is rendered, can pay out of pocket without the assistance of managed care. This criterion is not sufficient.

Clinicians often confuse a "niche" with a "specialty," but they are not the same. A good niche has two elements: 1. You define and target a narrow group of people to market. 2. You repeatedly sell a program to one group, or you modify it to reach out to new markets.

For example, focusing on stress reduction would be considered a specialty. You could develop this specialty into a niche market if you developed a program and marketed it repeatedly. An example of a niche might be the formation of six session groups for new parents that focused on stress reduction. Having a specialty and developing a niche will make you unique in the marketplace.

All clinicians need to be aware of the business trends in psychological services. It is necessary to realistically assess what is happening from a global perspective in the industry and to develop an innovative, creative business plan. Clinicians need to explore whether there is a need in the marketplace that is not being met. This involves doing both a market and consumer analysis.

You need to be more specific. For example, how did you make contact with your present self pay clients? Where did the referrals come from? What is the education level of your target group? Where do they live and what are their interests? Where do they go and what do they do for entertainment? Where do they spend their leisure time? What are their learning needs? What kinds of wellness activities would they participate in? What professional organizations do they participate in? What type of client is most receptive to what you have to offer and is a good fit with you? What kinds of advertising program development can you do to reach this market?

In summary, how can you develop a marketing plan that targets self-pays? Be a master of your craft! Find a specialty that is truly representative of who you are. Finally, create awareness of your niche through repetitive advertising. Decide whether to advertise with a newsletter, brochure, pitch letter, web page, or through seminars and presentations. You can also send targeted mailings advertising your niche. Be aware that whatever way you choose to market yourself, it must be frequent and consistent.

Rosemary Lavinski is in private practice in Brooklyn and Manhattan with a niche in short-term career coaching groups for helping professionals. Visit Rlavinski.com or Northeastcoachinginstitute.com■

Arts and Creativity in Clinical Practice

By Sandra Indig, MSW, ICSW, R-AT, ATR-BC

Freud himself was heavily invested in the phenomenon of creativity and considered creative work the one thing which made his life worthwhile. The Arts and Creativity Committee endeavors to explore and help define the meaning of creativity and the creative process as both experienced and understood by individual clinicians and applied in practice.

Today, we welcome practitioners with an interest or background in the arts and in the creative process. Our wish is to provide both seasoned therapist and newcomer alike with a safe, supportive place to meet, to be part of a community of like-minded people who are willing to nurture needs to grow and expand; to experience connection en vitro. Diana List Cullen, Metropolitan Chapter leader, encouraged me to form a committee focused on the arts. The Chapter later voted to give us, as Murray Itzkowitz called it, "seed money" to get the Committee off the ground. If not for this support, we might have missed the opportunity to represent the arts in clinical practice as other professional societies were already doing. Because of our commitment and belief in the transformative power of accessing unconscious, implicit, non-verbal communication, particularly in the transference and counter-transference process, we felt both personally and professionally that absence of this dynamic knowledge base would be a grievous loss to both present and future members.

Why This Committee?

What better way to amplify and enrich our grasp of the transference and counter-transference phenomena than to view it through the soma/body and mind of the nonverbal therapies/therapists? What better way to refresh one's understanding of these phenomena than through viewing it as a dynamic aesthetic experience? Our monthly meetings allow for the possibility of the expansion of language, dialogue, and ideas with energetic and knowledgeable leaders.

Despite the difficulty in spelling out what is meant by creativity and the creative process in clinical practice, it is worth the effort to try. Rudolph Arnheim, Ph.D., psychologist and author of many classics in the field of visual perception, maintains that the brain participates but language begins with the eyes — the senses.

Goals

The inner dialogue like the inner life or unconscious is never easily accessible. Passion, belief, faith, often fear, but always much courage is requisite to the inquiry. Suspicion and skepticism, sometimes mixed with awe has historically been associated with the arts and creativity. There is also the issue of "splitting" on the same subject; there is a: mind/body schism; a cognitive/affective schism; legitimacy of the seen versus the unseen; the declarative and concrete versus the abstract metaphor. We tend to overvalue the intellect, look for descriptions and often demand understandable, concrete forms. Much to our profession's credit, a highly esteemed training institute is offering a seminar on aging where original poetry will be presented for discussion, and only then supplemented by clinical papers.

Our first meeting was January 1997. Helen Hinckley Krackow, president of the State Society, showed up to participate and lend support despite a deluge of rain. A few months later, during one of our worst snow storms, she was there to lead a wonderful and informative workshop, "Mirrors of the Soul: The Hallucinated, Unconscious Body Image." Helen helped to set a professional standard and deeply human example of personal caring and commitment for all the well-attended and well-led workshops we have had since then.

Take Action

The committee flyer explains, in some detail, what we are about and gives our schedule of meetings. Sheila Peck posts this information on the Internet at http://www.clinicalsw.org.

It is member's passion and curiosity combined with their willingness to share that provides the energy which motivates us to meet and talk season after season. Please call with your questions and ideas. To quote our flyer, "The unfinished, rough, and unpolished idea is as welcome as the publishable case study; we value meaning and relevancy. Process is as important as product. I can be reached at: 212-243-2861 or psych4arts@hotmail.com. ■

2003-2004 Calendar

Meetings held Sundays
11 am – 12:30 pm
For a reservation, call
Sandra Indig 212-330-6787

Oct 12	Alice Garfinkel, CSW Creative Partnering With Managed Care
Nov 16	Karen D' Amore, CSW, BCD Using the Group to Develop Members' Creative Goals
Jan 25	Susan Bady, CSW, BCD Pets in Psychotherapy/Hypnotherapy
Feb 22	Jane Wilson Cathcart, CSW, ADTR, CMA Using Dance Therapy for Therapists' Self Care
Mar 14	Sema Gurun, CSW Creative Approaches to Trauma: The International Community
April 25	Sandra Plummer-Cambridge, CSW, CDT Creating a Safe Place Using Drama Therapy

The Therapeutic Playground

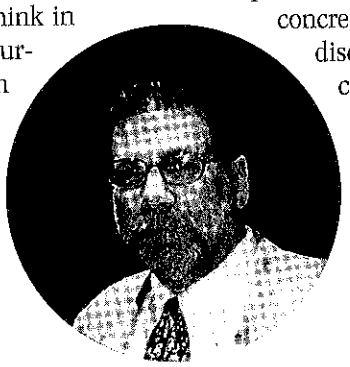
From the Paranoid-Schizoid to the Depressive Position

Keynote by Jeffrey Seinfeld, PhD • Reviewed by Charlotte Elkin, CSW

In his keynote presentation Jeffrey Seinfeld, PhD, spoke on the subject of "The Therapeutic Playground: from the Paranoid-Schizoid to the Depressive Position." Using an object relations perspective, Dr. Seinfeld addressed issues of play, loss and separation as they pertain to the paranoid-schizoid and depressive experiences.

Jeffery Seinfeld, PhD, Professor, New York University Shirley M. Ehrenkranz School of Social Work; Author, The Bad Object, New York, Jason Aronson, among others.

Building from Freud's notion that "in order to engage in a transferential relationship [the patient] has to play at [the therapist's] being like something," Dr. Seinfeld presented multiple examples from his own practice of adults and children who were initially unable "to play," and/or evoked an inability "to play" on the part of the therapist. He spoke of these individuals as being unable to symbolize, or to think in terms of metaphor, and posited that encouraging the use of play in their treatment, in particular within the transference, facilitates transition from a paranoid-schizoid position, in which they are "not too connected to others," to a depressive position, in which they have the capacity to connect.



Jeffrey Seinfeld, PhD

Dr. Seinfeld explained this experience in terms of the therapist preparing the patient to have the capacity to play, and that this capacity enables individuals to internalize and to relate to external objects in a manner in which they were previously unable. Through the integration of artfully described pivotal moments in treatment and theories from American and British object relations, attachment theory, and concepts from self psychology, Dr. Seinfield was able to clearly convey the mutative significance of connecting via play in the therapeutic relationship.

[He described] a client who for months would proclaim "I'm an adding machine." Accordingly, their treatment consisted of the client being an adding machine with Dr. Seinfeld, along side him, doing the same.

Dr. Seinfeld began his presentation by clarifying differences between concrete and symbolic perceptions in the transference. For the psychotic client, the therapist is someone, as opposed to "like" someone and Dr. Seinfeld illustrated this by describing a client who for months would proclaim "I'm an adding machine." Accordingly, their treatment consisted of the client being an adding machine with Dr. Seinfeld, along side him, doing the same. One day, prior to Dr. Seinfeld's termination from the clinic the client proclaimed, "You know, you're just like an adding machine. All you social workers add me up and then you leave." With this example, Dr. Seinfeld explained the transition from concretization to symbolization and went on to discuss how this client's previous concretization had served to defend against his feelings of loss and separation, subsequently brought out through play.

In other examples, Dr. Seinfeld explained a similar transition for the client in the paranoid-schizoid position. For one such individual, a heterosexual male client, the presenting issue was his inability to connect to and to sustain a relationship with a female partner. In his case, two significant areas of concrete thinking included ending a relationship because it had reached the "next step" and thus he had accomplished a personal goal, and considering evaluating future partners by filling out the equivalent of psychosocial assessments on them. Another concrete, more personal issue for this client was that when choosing partners, a determining factor was the woman's "ass," in particular its "shape." To this concretization, Dr. Seinfeld replied, "draw it" and described a series of sessions in which aspects of "the ass" were drawn and analyzed by client and therapist, alike. In turn, Dr. Seinfeld reported that the client came in and talked about thinking he had seen his ex-girlfriend on the street, and of his disappointment to discover that it

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Charlotte Elkin, CSW is in private practice in Manhattan and Brooklyn. She is a candidate in ICP's two year program in contemporary psychodynamic psychotherapy. She is also the senior counselor at the Mount Sinai NYU Health Employee Assistance Program.

The Transformational Power of Group Psychotherapy:

Journey into Transitional Potential and Creative Space

Keynote by Karen D'Amore, MSW • Reviewed by Richard Beck, RCSW, BCD, CGP

Karen D'Amore's creative and thought provoking presentation illustrated how group therapy can be "the agent of transformation: finding congruence with others, which facilitates kinship and identification." Participating in a group, she said, can produce a sense of belonging and create "a potential space within the group itself" that can translate into an environment of "safety and security." Ms. D'Amore considers the group to be a "home base" where "regression in the service of the ego" and "playing" that is essential for change can take place. The group becomes the transitional object that represents the safe emotional space in which members can become "alive, authentic and creative" people.

Karen D'Amore

Ms. D'Amore used a group creatively to describe how the process of group therapy can create a place in which members feel safe enough to become their authentic selves. She used a metaphor as she reframed patients' material to reflect a group as a whole phenomenon. Patients' references to a trip through a maze in the dark at a science museum were reframed as "joining the group seems like you are going through a maze in the dark. You don't know where you're going. It's exciting but maybe scary, too. You need some solid ground to stand upon."

Anxiety and anticipation, according to Ms. D'Amore, are typical of a new group, where members talk about their experiences in terms of metaphors, allowing the group to become their transitional space "in which the boundaries between the internal and external are always shifting and frequently blurred."

The theoretical lens through which Ms. D'Amore views the group is focused via Winnicott's developmental schema, which focuses on the "interaction between the mother's and child's need for affirmation of the child's existence separate from the mother – to be held both physically and emotionally." The "gaps in this holding pattern," according to Winnicott, "including the experience of loss" opens "a potential space between mother and child, where interactions, fantasies, illusions, and most of all, play, can occur." According to Winnicott, creativity is linked inextricably with play, with creativity meaning to "live fully and authentically." Winnicott's approach, as was Ms. D'Amore's, is "to respond to the immediacy and uniqueness of each clinical encounter to develop theory and take action immediately." Play, then, was the essential "work" of childhood and creativity the medium for the expression of one's true self.

Ms. D'Amore reflected that "play" in a group "merges the real objects – members and therapist – with members' internal objects and other affectively colored relationships." Play allows for "the setting aside of harsh and punitive superegos reactions." It "provides opportunities for trial identifications, for processing and healing past injuries and mediating withdrawals... Play allows group members to address issues symbolically, preventing destructive reenactments both within and outside the group." It is quite a playful, emotional crucible that Ms. D'Amore describes, a transitional space that is both emotionally tender yet strong, flexible and containing without being restricting.

Metaphors can be used, both by the leader and the group members, to address sensitive issues in a playful way, a way less painful and injurious than directly confronting. These metaphors, allusions and symbols "are powerful components of the creative or transitional space."

Ms. D'Amore beautifully illustrated these concepts as she described one of her groups, whose composition was relatively homogeneous, with further exploration yielding an important similarity among members. Each member had at least one parent who was actively alcoholic, mentally ill or highly narcissistic. As a result, the need of each member to respond to the disturbed parent "dominated his or her early life." These members suffered from "diffuse and impaired identities, extreme fluctuation in self esteem and distortions in their perceptions of others."

How the group was able to contain and detoxify the members' shame was illustrated by Ms. D'Amore. As group members began to both trust and risk sharing historical and current experiences, a form of "vicarious detoxification" was taking place within the group.

Several vignettes from this and another group illustrated how the modality of group treatment can be used in conjunction with individual treatment to provide a therapeutic space for growth and change.■

Karen D'Amore, MSW, is on the faculty and a supervisor at the Psychoanalytic Institute, Postgraduate Center for Mental Health and a faculty member and supervisor for the Group and Couples Programs at the Training Institute for Mental Health.

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The Therapeutic Playground

CONTINUED FROM PAGE 8

had not been her. This was followed by a session in which the client spoke of dreaming about the well-being of his ex. Both reports, Dr. Seinfeld explained, are early signs of the client transitioning from the detached, schizoid position to the concerned depressive position, in that aspects of object constancy, symbolic thought, and feelings related to loss, like guilt, had all evolved.

Dr. Seinfeld explained this evolution for the paranoid-schizoid patient with the following psychodynamic theories. He began by citing Freud's belief that "the shadow of the object falls upon the ego." Dr. Seinfeld interpreted this in terms of the negative or ambivalent feelings that one has towards a lost object, which get turned inwards once the object has been internalized, and thus, from a depressive position, are experienced as self-hatred. He went on to speak of Abraham, analyst to Melanie Klein, and his belief that by the time the depressed patient has incorporated the lost object, the lost object and its related fantasy have already been "destroyed" or "expelled." Often, Abraham recognized, this expulsion gets played out in bodily processes. With the example of enuresis in children following loss or separation from their parents, Dr. Seinfeld used Abraham's theory to again exemplify a prevalent form of concretization – that of "relationships to people get[ting] played out in bodily functions."

From this notion, Dr. Seinfeld related premises of object-relations put forth by Melanie Klein. He explained Klein's belief that infants interpret all bodily sensations as rooted in external objects. Thus, if an infant experiences something pleasurable, it is because a positive object is causing this; something uncomfortable is attributed to a negative object. In this way, Dr. Seinfeld noted, "things are happening to the baby" and the baby is an object of its experiences. He explained that henceforth, we remain "something of an object in our experience and something of a subject.

Dr. Seinfeld clarified this concept when explaining aspects of subject and object in the paranoid-schizoid and depressive positions. Relating an element of Bowlby's attachment theory that via evolution, we are predetermined to understand the world in terms of predator and prey, Dr. Seinfeld spoke of our instinctual need to connect to others so as to decrease our own vulnerability. In this sense, paranoia is the "normal equipment" we possess to protect ourselves from real danger, or the fear of others as predator. Dr. Seinfeld explained that for the paranoid-schizoid, this innate reaction is coupled with a lack of connections to others, and thus the individual "feels like prey." In other words, s/he is "the object of their experience versus the subject" and other people are responsible for what s/he feels. (Dr. Seinfeld noted that in self psychology, this concept is explained via the term "self-object," and in British object relations, "part-object.")

He contrasted this with the position of the depressive, who alternatively sees his/herself as the predator, or the subject of their experience, and "responsible for everything."Associated with this responsibility is the capacity to feel guilt and concern for others and subsequently, "the wish to restore others affected by [one's] actions." While Dr. Seinfeld did not advocate promotion of either extreme along the paranoid-schizoid-depressive continuum, he did lend significance to the capacity for "appropriate" guilt, concern, mirroring, and empathy when engaging in on-going relationships.

For clients unfamiliar with or unskilled at these experiences, whose perspectives are one of object versus subject, Dr. Seinfeld argued that play serves as a means by which a more connected view can be introduced, experimented with and encouraged. By presenting 1) his regard for the transference as the therapeutic playground, 2) his personal ability to cultivate moments of symbolization, like active play, metaphor, dream and art, and, 3) theory outlining the paranoid-schizoid and depressive positions, Dr. Seinfeld demonstrated how he perceives play, and the development of a capacity for such, as integral to clients' progress. In a presentation itself rich with theatrical play, Dr. Seinfeld clearly connected with the audience and imparted a deeper understanding of the detached or schizoid client, the depressed or more connected client, their respective challenges to resolving issues of loss and separation, and the therapist's role in enabling transition, or in preparing the client to have the capacity to play.■

All MSWs *Are Not* the Same

CONTINUED FROM PAGE 3

Since MSW students may or may not select clinical practice courses in the third and fourth semesters of their graduate program, we recommend further regulations be instituted to specify clinical content requirements. Some states have required a minimum number of clinical course hours for the LCSW level; Florida, Maryland, Wisconsin, and New Jersey all require a number of clinical courses ranging from 12 to 24 hours. Alternatively, a clinical track in the second year could be required for LCSW licensure. We believe there is enough variation in the CSWE-approved MSW programs to require the NYS Education Department to review the educational background of each candidate for licensure at the LCSW level to ensure basic clinical education for advanced autonomous practice.■

Vendorship & Managed Care

By Alice Garfinkel, ACSW/DCSW, Chair

The Vendorship & Managed Care Committee (VMCC) continues to function as a support for Society members in their dealings with managed care and third party payers. We assist members with difficulties in payment, non-payment or delayed payment of authorized sessions. We also help members obtain continued authorizations for patients, enroll or disenroll from panels, resolve dilemmas about confidentiality, and answer Medicare questions.

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The VMCC also markets to self-insured companies that do not recognize clinical social workers for independent reimbursement for mental health services. We continue to market The Mark Hotels, Bedford School District, Nova Care, IIT Research Company and Chemed Corporation.

Recent News:

• Providers on Empire Blue Cross Blue Shield – Magellan: There are two provider fees (in-network). The $50.00 provider rate is for local accounts and the $80.00 provider rate is for national accounts. When you take a new patient on Magellan (Empire Plan), you should find out if the account is local or national. As a rule, local accounts have claims mailed to a post office box in NYC, and national accounts have claims mailed to a post office box in Middletown, NY.

• UBH has a new claims mailing address:

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Some UBH contracts still use the Houston, TX address or Atlanta, GA address, so it is best to check the address for each specific employer contract.

• New legislation effective 7/1/03 reduces the Medicaid payment for Medicare coinsurance amount in instances where the Medicare paid amount is higher than the Medicaid fee. The State Society Legislative Committee and our committee are looking into this further and will provide more information in the future. Social workers in agencies are not affected. Clinical social workers in private practice, who work with Medicare/Medicaid patients, where Medicare is the primary payer and Medicaid is the secondary payer with no Medicaid surplus, are those affected. We believe there are a small number of therapists who work with these patients, but we need to know who you are. If this affects you, please call Alice Garfinkel at (917) 424-3545 or Marsha Wineburgh at (212) 595-6518.■

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The League of Woman Voters for Members of Congress	212-677-5050
Senator Charles E. Schumer	212-486-4430
Senator Hillary Clinton	212-666-5150

CONTINUED FROM PAGE 5

of this feeling, noting that she could not connect it to events. In earlier counseling, she had dealt with the fact that, in not being able to keep her husband alive, she felt herself to be a failure. But this was not, she believed, the core of the current overwhelming feeling.

It had been the second marriage for both partners. Her husband had lost his first wife after nursing her through a long, terminal illness. He had been widowed for six years, and Mrs. Carter had been divorced for some eight years, at the time they married. They each brought married children and grandchildren to their union, and from her account, the families had blended well. She was grateful for the rich life she, her husband and their respective families had shared together.

It became clear by the end of the first session that despite the fact that Mrs. Carter enjoyed the love and admiration of her family and many friends, and had achieved distinction in her career and in other areas of endeavor, she had struggled with a vague sense of inadequacy since childhood. Feelings of failure were familiar, but had been greatly exacerbated after her husband's death.

It was when Mrs. Carter referred to herself as a "replacement" wife in the second session, that we began to gain some understanding of one of the factors that contributed to her limited self esteem and was now complicating her mourning. While she knew intellectually that she occupied a different place in her husband's heart and mind than had his first wife, and understood that he could and had loved each of them, there was something about this idea that she was a "replacement" for his first wife, that had begun to preoccupy her after his death. It seemed to have something to do with her feeling she had failed him. She then added that she thought it was not so much that she failed him as that she had disappointed him, though she knew that, were he alive, he would say that was not so. It is as if, she noted, the reality has little to do with "what is in my head."

As she explored the idea of disappointing someone, I learned for the first time that Mrs. Carter had lost a nine-year-old brother when she was two and her sister was four. She had no memories of him, but she had heard much about him from her father. He was apparently outstanding in every way and her father's pride. She believed that her father never recovered from his loss. As much as she felt he had loved her and her older sister, she was convinced that he never derived the satisfaction from them that he did from her brother.

As we considered this together, we came to see that her husband's death and the fact that Mrs. Carter was her husband's second wife had revived life long feelings of being a failed replacement child—one who could never really fill the place of the idealized lost son of her father.

As we considered this together, we came to see that her husband's death and the fact that Mrs. Carter was her husband's second wife had revived life long feelings of being a failed replacement child—one who could never really fill the place of the idealized lost son of her father. While not conceived to replace her brother, she nonetheless believed her father wanted her to take his place, and she could not. Although during the years she shared with her husband she had not felt as if she were a disappointment to him, after his death she had come to feel that, just as she had failed her father in some inexplicable way as a child, so had she failed her husband.

As one might expect, this was not the only way the loss of her brother had influenced Mrs. Carter's current response to the death of her husband. In some sense, her feelings of having failed her husband represented an identification with her father, who she thought always saw himself as a failure for not having been able to save her brother. At some level she also felt her husband's death was a punishment for an oedipal victory. She had the vague sense that she had "won out" over his first wife.

As we considered these and other issues, Mrs. Carter's concerns about having failed or disappointed her husband lessened. She began to feel freer to go on about her life and we agreed, after four months of weekly sessions, that it was time to conclude our efforts together.

While such a brief presentation can hardly do justice to such a critical event as the loss of a sibling, hopefully it can serve as a reminder of the importance of the sibling relationship and the profound and long term impact the loss of a brother or sister can have on the mind and life of the surviving sibling.■

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Public Relations Committee & Website Report

By Sheila Peck, LCSW, Chair

Have you been to the Web lately? Have you seen the State Society's site, www.clinicalsw.org? You may be unaware of what's there.

As of this writing in late August, almost 6,000 hits have been recorded — this without much PR or linking with other sites (that's our next project). The site serves as an effective vehicle for recruiting potential members — we now get several inquiries a week that are forwarded to Membership Chair Adrienne Lampert.

You can download the latest copy of our HIPAA manual, along with sample forms and documentation information. Each Society chapter has a page of its own, with upcoming events and programs. If you search Google.com or other search engines, a link to our site appears on the first page of results.

We've added other bells and whistles, too — a search link with Google, a site search button, announcements, links to sites of interest in New York and lots of resource links.

And, most recently, we've started accepting advertising on the site. As of now, there are ads for several social work university programs, office space, employment, etc. Besides providing another effective venue for advertisers, this also serves as a source of revenue to help support the site. Please do take a look - click on the flashing button at the upper left of our homepage and support our advertisers.

We are contemplating putting a membership directory online (voluntary for members) into which, after the computer refers to an electronic database to make sure you belong, you will input your own information and update it as necessary. All members will have a page of their own. We've been researching ways of doing this and found that the American Board of Examiners and the APA already have such a feature. We'll let you know more as plans develop.

We'd like readers to send in suggestions for Web sites that we can link with. The policy is that for now we will link only with not-for-profit groups.

We've also been using our e-mail list to send out announcements of interest to members (like the HIPAA manual). If you're not on the list, let me know and you'll be added. Don't miss out. Send your ideas or address to Sheila2688@aol.com.

So if you haven't been to our site lately, you might want to take a peek now. And let us know if there's anything you'd like to see added to the site.■

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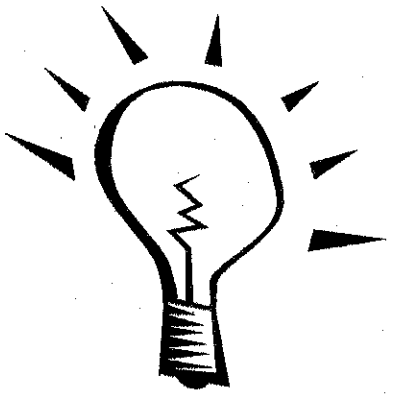

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