

# The CLINICIAN

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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

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## PRESIDENT'S MESSAGE

# Enriching Work with Older Clients Providing the Hope of Happier Chapters Ahead

By Karen Kaufman, Ph.D., LCSW-R

The 54th Annual Conference, on the subject of stranger anxiety and the other, was well-received and a relevant prelude to the current issue of *The Clinician*, which focuses on work with the older community. The conference highlighted a wide range of examples, from sibling relationships to the experiences of disabled people, and ethical issues in philosophy, with parallels to the treatment relationship. It was a valuable introduction to examining the marginalized or “othered,” often overlooked client groups, as well as ethical dilemmas in treatment.

The general population can expect greater longevity with ongoing medical and pharmaceutical advances. This is often experienced by elderly people and their families as a mixed blessing; many

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Karen Kaufman

“In our work with older clients, we can bring a powerful, realistic voice of encouragement . . . a reminder of a still-vibrant self.”



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have suffered repeated losses: friends, family members, previously enjoyed work and social/recreational activities, along with diminished cognitive and physical capacities. Many older clients may find themselves more (often unwillingly) dependent on family. Some families lack the time and financial and emotional resources to provide adequate support to their relatives, creating much strain on them.

In my own work with older adults and the grown children of aging parents, I have found a great deal of guilt and depression in the elders for what they perceive as being burdensome and extraneous, as well as guilt and frustration among grown children who feel they can never do enough. Some adult children suffer an added element of fear in their identification with aging parents, viewing what they perceive to be their own futures.

In many cultures, the aging population is shown great respect. They contribute to their families and communities with their life experience and wisdom, and there is more interaction among the generations. As a result, there is a better adjustment to the aging process in which the elderly continue to be valued participants. Research has shown a longer life span and less incidence of depression among many of these individuals.

In cultures that prioritize youth, beauty, and thinness, older people feel less valued. There are meager attempts by advertising campaigns to use older, gray-haired, average-size, or heavier models, and the fashion industry periodically promotes healthier body weight, typically after the deaths of young models from eating disorders. But the message remains loud and clear: *youth, beauty, thinness*.

In our work with older clients and their families, we can bring a powerful and realistic voice that encourages the clients to resume or continue formerly cherished activities, including social and recreational interests,

employment, or volunteering, all according to a realistic assessment of their physical and cognitive capabilities. Over time this can shift the outlook for both client and clinician; as older people are reminded of a still vibrant and highly functioning self; they may reject the views previously assigned to them.

In my own work with clients who started therapy in their 60s or older, one of the first questions was whether it was too late for them. These people went on to work through early trauma: highly dysfunctional early family dynamics and some with the subsequent repetition of these patterns; forced adoption after a teenage pregnancy and finding the grown child decades later; substance abuse; freedom from unhappy or abusive marriages; opportunities to pursue talents and other creative pursuits that were dismissed by parents; and approaching all other life experiences with greater freedom. In the April 30th edition of the *New York Times*, a World War II fighter pilot was profiled; he became symptomatic at age 99, suffering panic and nightmares. His family secured remote therapy services for him, and he came to understand the effects of containing his war experiences for decades.

In my very enriching work with these clients, among my goals was to provide the hope of happier, less burdened chapters ahead. Some went on to try online dating, with index cards for notetaking (lest they forget salient details); others tried new recreational, creative, and volunteer activities from which new friendships developed. The mother of a client told her that her interests in drums and photography were too "male;" she soon gave herself permission to take lessons and courses in both, with great enthusiasm. If we can provide a corrective experience in the lives of older clients who believe in their continued abilities and capacity to learn, we are often providing invaluable support that may supplant the loss of hope.

Another significant element to explore with objectivity and honesty is the older clinician's view of self in regard to the ongoing capacity to engage in clinical work. As Donna Orange pointed out in her presentation at the Annual Conference, we have a great responsibility in the demanding work of caring for others, and it is in all our best interests, clients included, that clinicians are as objective as possible regarding continued practice. As many learn from their clients, retirement for some may be an end, but for others, the opening of new and enriching chapters ahead. 📖

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## The CLINICIAN

THE NEWSLETTER OF THE  
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FOR ADVERTISING INFORMATION:  
SEE PAGE 36

## Inviting NYSSCSW Members Who Practice in an Agency Setting To Join the Agency Practice Committee

### *It is an opportunity to:*

- Be supported by other members who also work in an agency.
- Discuss the benefits and challenges of working for an agency.
- Explore and discuss policies.
- Provide education to other members regarding agency resources.
- Discuss the ways our Society can support social workers who work for an agency.

For more information and/or to receive a link to the next Zoom meeting (on the third Wednesday of the month at 8 pm) please contact:

Patricia Traynor, LCSW-R, Committee Chair:  
[traynorlcsw@gmail.com](mailto:traynorlcsw@gmail.com) or 516 840-1550

### VIDEO: *Conversations with the 2022 MSW Student Scholarship Winners*

If you're looking for some inspiration, try watching the video (link below) of the nine MSW students who won NYSSCSW scholarships in 2022.

To win the \$500 scholarship, each student demonstrated excellence in academics, field placement, research, writing and/or volunteerism. On the video, they give in-depth answers to such questions as: Why did you choose the field of social work? What were the most impactful courses and placements you've had? What surprised you the most? How do you envision the future? Their thoughtfulness and enthusiasm bode well for the future of our profession.

Video of the NYSSCSW 2022 MSW Student Scholarship Awards Ceremony can be found at:



[youtube.com/watch?v=o1SA9iv-j78&ab\\_channel=NewYorkStateSocietyforClinicalSocialWork](https://www.youtube.com/watch?v=o1SA9iv-j78&ab_channel=NewYorkStateSocietyforClinicalSocialWork)

We are delighted to report big doings at the ACE Foundation. On June 24, Bruce Hillowe, J.D., Ph.D. presented our first New York State Education Department-mandated ethics presentation: *Maintaining Professional Boundaries in Psychotherapy*. It has proven so popular we are planning another presentation in December 2023. As a lawyer and psychologist who is psychoanalytically trained, Dr. Hillowe offers relevant and precise guidelines for ethical practice.

The 54th NYSSCSW Annual Education Conference was held on Zoom on two consecutive Saturday mornings in April. Attendance was excellent for our post-pandemic world. If you did not attend, reviews of two of the three presentations are in this issue of *The Clinician*. Both Susan A. Klett, Ph.D., Psy.D., LCSW-R and Desiree Santos, LCSW-R, the former and current ACE Directors of Professional Development, planned this successful program.

Our Board has approved reviewing and upgrading our website to make it even more responsive to our visitors. Work begins in June and will be completed within the next six months.

We are planning to investigate holding weekday lunch-time education programs for the fall. To this end, we are sending out a survey to past attendees to identify their educational needs and convenient times to participate. We need your input, so be sure to respond to our short questionnaire.

Looking forward to offering you quality, intelligent, and up-to-date clinical presentations in the coming years. 🗨️

—Marsha Wineburgh, DSW, President



## SAVE THE DATE

**SUNDAY, OCTOBER 22, 2023**

11:00 AM–3:00 PM

**NYSSCSW ANNUAL MEMBERSHIP MEETING  
RED HAT ON THE RIVER, ONE BRIDGE STREET  
Irvington on Hudson, NY**

**11:00 AM Networking & Cocktails**

**12:00–3:00 PM Luncheon & Meeting**

The Society Board of the NYSSCSW cordially invites you to attend our Annual Membership Meeting on Sunday, October 22, 2023.

This will be a wonderful opportunity to network, socialize, and learn more about your professional organization. You will have an opportunity to mingle with members from all of the chapters in the state and meet the leadership of the Society Board. You will learn about current developments in the organization along with plans for the coming year.

Members from each chapter will be honored for their contributions to the Society.

The Red Hat Restaurant is easily accessible by car and Metro North. Please consider carpooling with other members and get a head start on socializing!

Attendance for members is free of charge. Guests who accompany you will be charged \$25.

**More info available soon at:**

**[www.nysscsw.org](http://www.nysscsw.org) or [info.nysscsw@gmail.com](mailto:info.nysscsw@gmail.com)**

 Photos of 2022 Annual Meeting

## Met Chapter

Helen Hinckley Krackow, LCSW-R, President

### *The Zoomies* Are Alive and Well and Meeting In Person!

It is with great joy that the Met Chapter began its reentry into the world of live, in-person activity this winter. During the pandemic, Chapter members have maintained connection through technology, including the listserv, newsletters, Zoom workshops, and by phone. We lost our in-person conferences, practice committees, Board meetings, and parties.

Our professional efforts over the last several years have produced stellar writing of clinical material for *The Clinician* and for the monthly newsletter of the Committee on Racial Equity. We also developed great skill in presenting successful Zoom courses through the ACE Foundation.

However, being forced to shut down and work at a distance from our clients and our colleagues was very difficult. Our members suffered from the lack of personal contact that the Society had provided in the pre-pandemic years. Many members shared that they have felt isolated and depressed. We are *social* workers, after all!

I found that my work with the Society and my practice helped me stay grounded during these years. We are emerging from the pandemic in stages, I think, and beginning to come alive, thank God!

The Met Chapter has developed new initiatives in response to the political and cultural upheaval in the nation. We are addressing clinical issues related to racial equity, LGBTQIA discrimination, and aging, as well as children and adolescents, who have lost so much to the pandemic and the rise of social media as an influence in their lives.

Our Aging Issues Practice Committee met in person three times since January with great enthusiasm. We spent the first meetings reconnecting. Henni Fisher, LCSW-R, BCD and I are the chairs.

The Committee has a long history; we began meeting in October 2012, on the day before Hurricane Sandy struck New York. Our discussions cover such topics as clinical issues related to the end of life, palliative care, euthanasia, practice wills, practicing ethically as we age and perhaps sicken, handling hospitalizations, dementia, ageism, and many others. We also share information about how to live well as we age.

The Committee serves both older and younger therapists who treat elderly people. At our April meeting, Jane Dorlester, LCSW presented her work on bereavement, including her group work, use of the Alexander Technique to restore balance in patients who are in mourning, and use of visual aids to evoke emotional issues that grieving clients face. (These aids reminded me of the materials used in the TAT projective test.)

It is such a relief to see each other in person after almost three years

apart. Of course, we will continue using Zoom as well. In fact, on July 22, Marsha Wineburgh, DSW, LCSW-R and I will lead a Zoom discussion group on planning for retirement.

In January, a new practice group on fertility began under the leadership of Adam Banks, MA, LCSW, CASAC. In the first two meetings, we discussed the impact of infertility pressures on male partners when infertility or miscarriages occur. Their pain has largely been unrecognized. The next meeting will be about the pressures on couples for grandchildren and other intergenerational problems regarding the bearing of children. A member of the group, Helen Adrienne, LCSW, BCD generously gave all of us a copy of her book, *On Fertile Ground: Healing Infertility*. At our next meeting, Adam will share information gleaned at the Jefferson Infertility Counseling Conference in Philadelphia in April. [The committee's first report is on page 7.]

In another new development, we have reactivated the Gender and Sexuality Practice Committee under the leadership of Kathryn Sedgwick, LCSW and Zoey Peresman, LCSW.

Kathryn worked for eight years at the Ali Forney Center, which treats homeless LGBTQIA youth. She also served as the volunteer Executive Director of Identity House for many years. Zoey was the student representative to the NYSSCSW State Board a few years ago.

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## Infertility and Its Impact on the Family

By Adam S. Banks, MA, LCSW, CASAC, Committee Chair

As we recently celebrated Mother's Day and Father's Day, it is important to consider the impact these holidays have on those facing infertility, as well as their parents, the grandparents-to-be. Infertility is defined as the inability to conceive after one year of unprotected sex, six months if the woman is over 35 years old. In the general public, one in six people will experience infertility. In couples, the ratio of causes for infertility is understood as being 1/3 due to a female factor, 1/3 due to a male factor, 1/3 due to a combination of both male and female factors, and about 10% due to unexplained infertility. Diabetes, sexually transmitted infections, weighing too much or too little, as well as smoking, alcohol and other drugs can also negatively impact fertility. Intended parents may experience difficulty conceiving, repeated pregnancy loss, or find they are unable to have their own biological children and face the choice of using egg/sperm donors, and/or a gestational carrier.

We created the Infertility/Family Building Practice Committee to bring attention to this very important issue through clinical discussion and educational workshops on the causes of infertility, assisted reproductive technology, the impact of infertility on mental health and interpersonal relationships, as well as psychotherapeutic approaches to these challenges. In addition, as the supports for men are few and underutilized, the committee will address the barriers to engaging men in the therapeutic process as well as offer suggestions for improving men's use of these services.

Some common causes of female infertility include polycystic ovarian syndrome (PCOS), endometriosis, and fibroids. In male infertility, the causes include low sperm count (oligospermia), poor sperm motility (asthenospermia), zero sperm count (azoospermia), or an enlarged vein in the testicle (varicocele). Additional factors include diabetes, sexually transmitted infections, weighing too much or too little, and smoking and other drug use.

### The Pressures of Expectations

Individuals facing infertility may experience social, cultural, and religious pressures to get married and have children, leading to both external and internalized stigma. They may feel the disapproval or disappointment from their parents and other significant members of their community who do not understand or accept the difficulties in having children. In some cultures, it is not acceptable to talk about infertility or to use Assisted

Reproductive Technology (ART), such as intrauterine insemination (IUI) and in vitro fertilization (IVF), or third-party reproduction. These pressures can compound their emotional struggles and lead to feelings of shame, guilt, loneliness, and isolation from family and significant others.

Infertility can also be difficult for the grandparents-to-be, who may view grandchildren as their legacy and a means for passing on their familial, religious, and sociocultural values. Having adult children who experience infertility can interfere with what should be a "normal process." As with other emotionally-laden issues in life, it can be difficult for grandparents-to-be to express these feelings effectively (without inducing guilt), which can cause strain or rifts in their relationship with their adult children.

Furthermore, adult children facing infertility may experience their parents' comments as intrusive or as efforts to make decisions for them. Even if well-intentioned, comments or questions about grandchildren can be perceived as pressure, criticism, or disapproval. Statements like "just relax, you're too stressed" or "it will work out" or offering unsolicited advice, such as "it can be worse" or "you can always adopt," can be felt as insensitive or invalidating. This is particularly difficult when adult children have not told their parents about their infertility out of discomfort or expectation of criticism and judgment.

On the other hand, hopeful grandparents-to-be can show their support by being understanding and validating their adult children's feelings and experiences with infertility. For example, I recently spoke to a couple who expressed acceptance of their son and daughter-in-law's decisions as part of their efforts to support them emotionally and financially. They expressed that they "were never anxious about whether or not our son and daughter-in-law would have children; that was not our decision."

We encourage you to explore and learn more about these issues with the Infertility/Family Building Practice Committee. If you have questions or would like information about upcoming meetings, please contact Adam S. Banks at 347-239-9912 or by email at [adambankslcsw@gmail.com](mailto:adambankslcsw@gmail.com).

For more information on the statistics, causes, and treatment of infertility, please visit RESOLVE (<https://resolve.org/>), the American Society for Reproductive Medicine (<https://www.asrm.org/?vs=1>), as well as the ASRM's Mental Health Professional Group (<https://connect.asrm.org/mhpg/home?ssopc=1>), and the Society for Assisted Reproductive Technology (<https://www.sart.org>).

## Mid-Hudson Chapter

Barbara Solomon, LCSW-R, Interim/Acting President

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The Mid-Hudson Chapter is doing well. We have some positive changes to report. A former board member, Crystal Marr, LCSW has returned and has already helped us out tremendously in several areas. She has joined our Membership Committee and has also assisted in sorting out our Zoom account issues. In addition, she has shared her expertise and knowledge in several areas, including the Education Committee, as well as becoming our new liaison to Marist College. She will be holding a meeting with outgoing Marist seniors to inform them of the benefits of joining NYSSCSW.

Rachael Cea, LCSW, a current Board member, has agreed to take on the role of Recording Secretary, a position that has been vacant since the beginning of the year. She has also joined our Education Committee and has offered great ideas so far. Eileen Duffy Traslavina, LCSW-R, has joined the Education Committee, and continues doing fine work on the Membership Committee.

I appreciate all the efforts of each and every person on our Board. We have a wonderful group and we have celebrated engagements, new grandbabies, and retirements together during these past few months. We would really like to have some new members join our Board as the more diverse voices we have, the stronger we can be, and the more we can do for our members. Please contact me at BGS234@gmail.com to discuss the possibility of joining our talented and friendly group.

The Education Committee sponsored a great webinar on April 29, *How to Do Effective Couples Therapy*, presented by Chapter member Keith Jordan, LCSW. It was well attended and informative. We have several webinars lined up, including one on June 11 presented by Leslie G. Nadler, Ph.D., *Emotional Healing from Trauma: How Protectors of Vulnerable Parts Can Relax to Allow Healing to Occur*.

Our Peer Consultation Group, facilitated by former Chapter President Linda Hill, LCSW-R, a very accomplished clinician, continues to be a well-attended and a helpful resource to all of our members. Meetings are held year-round on the second Friday of each month via Zoom.

On a final note, we usually plan a social/networking in-person gathering during the summer. We hope to meet more of our fellow members at future events. Again, please consider getting more involved in taking on leadership positions going forward.

Have a great summer!

✉ Barbara Solomon: [BGS234@gmail.com](mailto:BGS234@gmail.com)

## Nassau Chapter

Barbara Murphy, LCSW, BCD, President

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Since my three-year term as President began in January, two Nassau Chapter Board meetings were held via Zoom. Now that the pandemic is over, we are resuming in-person meetings and events.

The educational conference scheduled for May 7 was cancelled due to a family emergency and will be rescheduled for the fall. Amy Meyers, Ph.D., LCSW, will present *Cultural/Racial Self Identity: Understanding Diversity, Positionality and The Forces of Power, Privilege and Oppression*. Dr. Meyers is a member of NYSSCSW and on the faculty of Molloy University. I had the opportunity to hear her speak recently about the new podcast she hosts for mental health professionals, entitled *What Would Dr. Meyers Do?* We look forward the conference this fall, which will be at an interactive networking event.

Our Book Club will also resume in person this fall at the lovely home of our Board member Susan Kahn, LCSW, BCD. Susan was featured on February 5 in the "Winners" column of *Newsday* as a recipient of a certificate of exemplary service from NYSSCSW.

The Nassau Chapter awarded scholarships to two Long Island University/Post students: Jamie Skurka, in the BSW program and Lauren Barrett, in the MSW program. Board member Faith Kappenberg, Ph.D., LCSW has been working diligently with Long Island University to select one BSW student and one MSW student to receive our scholarship. She is waiting to hear from the Adelphi University social work staff about the selection of an MSW student at that school.

Our membership and budget have remained stable. At our January meeting, Board members were assigned as buddies to new members to orient them to NYSSCSW. This was in response to a recent survey finding that members are not aware of all the benefits of membership.

I am excited to be a member of an ad hoc committee headed by Shannon Boyle, LCSW, the Society's State Secretary and Past President, to work with a public relations firm, The Paige Group, on redesigning our website to be more user friendly and attract new and younger members.

We also need to develop new leadership and increase the members' active engagement in events, programs, and our various committees: aging, diversity, mentorship, programming, and membership. If you are interested in participating, please see the Nassau Chapter section on the NYSSCSW website for contact information for the committee chairs.

Feel free to reach out to me, Barbara Murphy, at [askier@verizon.net](mailto:askier@verizon.net) with any issues or concerns that you would like the Board to address. You can also contact me if you wish to attend the upcoming board meetings, on September 10 or November 12.

**Met Chapter** Continued from page 6

They have organized a panel of five LGBTQIA clinicians to speak to the Met Chapter on May 21 about treating queer people. Kathryn has also put together a CE program on transgender clinical issues under the auspices of ACE, to be held on October 1. Be sure to save the date! The speaker will be Reese Minshew, Ph.D., a non-binary psychologist whose book, *Treating Trauma in Trans People: An Intersectional Phase-Based Approach*, was published in 2023, by the Taylor & Francis division of Routledge. Reese is a skilled and accessible clinician. Our ACE workshop bears the same title as their book.

These presentations will be on Zoom for now, but as the Committee grows we will be able to meet in person. We need all the education we can get in these areas, given the current political climate in this country.

**Save the Date****ACE PROGRAM (CE)****Transgender Clinical Issues****October 1, 2023****Peer Support Groups**

At the suggestion and encouragement of Jane Gold, LCSW, who founded the Riverdale Clinicians Group, the Met Chapter launched a year-long project to create similar peer support groups on the upper West Side, the East Side, lower Manhattan, and Brooklyn. I was touched that a member has already offered her office for meetings of the Upper West Side group.

All of our other Committees are moving forward. These include Mentorship of new professionals, under the leadership of Chris Farhood, LCSW-R; Addictions, under Betsy Spiegel, LCSW; Trauma and Group, under Joe Zagame, LCSW-R, CGP; Psychoanalysis, under Barbara Lidsky, LCSW, BCD and Don Appel, LCSW; the Riverdale Clinicians Group under Jane Gold and Kathy Sommerich, LCSW-R; the Racial Equity Committee, under my leadership; and BIPOC, under Sandra Plummer-Cambridge, LCSW.

I want to thank the Met Chapter Board for their support of our members and each other. I also want to mention that Genie Wing, LCSW-R, BCD has stepped up to become a Member-at-Large. Genie worked on our former Education Committee under Susan Appelman, LCSW. She is a welcome addition. 🍷

✉ Helen Hinckley Krackow: [hhkrackow@gmail.com](mailto:hhkrackow@gmail.com)

*In Memoriam***Elizabeth Ojakian**

**Our colleague and friend**, Elizabeth Ojakian, lost her ten-year battle with ovarian cancer in February. A long-time member and Diplomate of the Society, she served as Secretary and Treasurer for both the Met Chapter and on the State Board. She co-chaired the Met's Addictions Committee and made substantial contributions to its Racial Equity work in recent years.

Liz was an adjunct professor at New York University Silver School of Social Work, where she taught human relations. Over four decades, she used her vast clinical talents in many settings—an inpatient psychiatric hospital, several outpatient mental health and substance abuse clinics, and a supportive apartment program. She was a leader in the employee assistance field (EAP) and maintained a private practice.

Liz was a graduate of two post-master's analytic programs: one in individual psychotherapy from Metropolitan Institute for Training in Psychoanalytic Psychotherapy (MITPP), and one in group therapy from Postgraduate Center for Mental Health. She was a Licensed Clinical Social Worker (LCSW), a Credentialed Alcoholism & Substance Abuse Counselor (CASAC), and a Certified Employee Assistance Professional (CEAP).

Many of her NYU students wrote glowing reviews of Professor Ojakian: "She will provide greater depth and insight as compared with other professors. While this means more is demanded of the student, you will depart feeling your time and tuition were worth it. She is caring and experienced and passionate about her craft. Always open to questions and unpacking cases."

"Her approach is 'old school,' in that foundations of major theories are taught (especially good if you want psychology-type learning and if you're interested in clinical work.) She cares about students' professional development, and she is generous with time outside class. Be ready to read/write a lot."

Helen Hinckley Krackow, President of the Met Chapter, called Liz, "A warrior for humanity. Liz was one of the most humble and low-key human beings I ever knew. After she died, member after member of the Society told me how she had helped them. She never blew her own horn but just showed up whenever she saw a need. Her loss has left a hole in my life and that of many others."

# TASTES LIKE WAR: Grace Cho in Conversation

Reviewed by Helen Hinckley Krackow, LCSW, Diversity Chair

On April 2, 2023, the professional association of The National Institute for the Psychotherapies (NIPPA) presented an illuminating conversation with Grace Cho, author of the acclaimed memoir, *Tastes Like War*, among other books on the South Korean immigrant experience. The workshop touched me deeply and made me proud of my institute for presenting her. I trained at NIPPA from 1986 to 1990.

The book and the conversation with Dr. Cho made me aware of some of the history that impacted our clients of South Korean descent. Over the years, I have had at least four young women as clients whose relationships with their Korean mothers or families were quite troubled. Although I lived through the Korean War, the profound impact it must have had on my clients' histories never occurred to me, and they did not acknowledge it.

Conversely, I have been acutely aware of the impact of the Holocaust, the pogroms, and the two World Wars on my clients of European origin. Perhaps if I had been practicing on the West Coast, the need to study and understand South Korean history would have confronted me sooner. What an eye opener this workshop was!

Dr. Grace Cho is an associate professor of sociology and anthropology at the College of Staten Island, CUNY. She is the author of *Haunting the Korean Diaspora: Shame, Secrecy, and the Forgotten War* (2008) in addition to her memoir. She was interviewed by Patricia Clough, Ph.D., LP, an analyst who was an advisor on her doctoral committee and became her writing mentor and friend.

Grace's doctoral thesis stemmed from an investigation into her mother's life in war-torn Korea, her marriage to an American serviceman, and her life as an immigrant in a provincial American village. The memoir she later wrote was Grace's quest to understand and reconnect with her mother, a brilliant and haunted woman who was lost to schizophrenia when Grace was 15.

Her mother never discussed her early life of extreme hardship in Japanese-occupied Korea, and in the Korean War and in its aftermath. A young refugee, she had lost track of much of her family. To eke out an existence, she sold snacks at an American base and presumably sold sex as well to the soldiers. The secret source of great shame, the fact that she became a prostitute was later confirmed by Grace's American father and Korean uncle.

Americans were seen as saviors of the starving Koreans after the war. Dreaming of delicious meals, instead they received an endless supply of powdered milk that made them sick. Later, when relatives tried to supply Grace's



“Since the Korean War—the forgotten war—more than a million Korean women have acted as sex workers for U.S. servicemen. More than 100,000 women\* married GIs and moved to the United States.”

American marriage nor her mixed race children were accepted there. Soon after, she suffered her schizophrenic break. She began receiving treatment many years later.

In one of the most poignant parts of her conversation, Grace described a symptom of her mother's illness: she would only eat a few American foods, the same ones at every meal. Then, she reluctantly allowed Grace to cook Korean dishes for her. They were reminiscent of those she had eaten at her own mother's table when she was a girl, and an important link was created in her mind between the past and the present.

In spending time with her mother this way, Grace began to understand more about her and the mental illness. It reminded me of the psychotherapeutic cooking group that the out-patient VA ran during my internship year.

There is much here to learn about the mental health issues as they exist in non-Northern European cultures as well as effective treatments other than talk therapy. It also helped me to appreciate that the immigrant mothers of my Korean clients must have been shaped by violent histories, traumas that were never discussed with their daughters. Bravo, NIPPA! 🇺🇸

\*Source: [www.gracemcho.com](http://www.gracemcho.com)

mother with food that would not spoil, they gave her powdered milk. “Tastes like war,” she told them, hence, the title of the memoir in which food is a major theme.

American propaganda sold the Koreans the promise of an idyllic life in America. Unfortunately, the country proved to be quite inhospitable to them. Her mother married an American Merchant Marine and moved to a rural small town in the west. The culture shock was overwhelming. Grace and her mother were often targets of racial slurs.

When she was 45, Grace's mother made a visit to South Korea. As in the U.S., neither her

## Emotional Support Animals and Role Conflicts in Psychotherapy

**Every so often** there is a question posed to one of the Society's listservs about writing a letter in support of a need. The latest was a letter for the purpose of assisting with an immigration problem. Previously the questions have been about accommodation for disability and, most often, in support of a patient having an Emotional Support Animal (ESA.)

In response to each of these requests for information about how to go forward with this ("Does anyone have experience with") we have written that a treating clinician, in our case a clinical social worker, is creating a dual relationship with her/his patient because s/he is stepping outside of the role of a treating professional and into the role of a forensic professional. We have stated that the best position to take is to refer the patient making the request to another professional who will act in the forensic role and who, hopefully, has expertise in the area of request. Considering that we are mandated to be aware of appropriate boundaries by taking three hours of CE, and that dual relationships are one of the ways in which boundaries are blurred/violated, this is a timely topic.

We have located an article that does an excellent job of explaining this concept more fully and well than I have. I've seen it before but did not have an active link that did not involve a paywall. It's written about professional treating psychologists but could actually apply to any

treating professional and certainly applies to clinical social work. Here is the link: <https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC5127627&blobtype=pdf>

Note: we have recently been informed that some airlines are not allowing ESAs to travel inside the cabin in airplanes and must travel with pets. A rule change in December 2020, which went into effect January 2021, limited the animals that will be allowed in the cabin of an airplane to dogs trained to perform a specific function for their owners—in other words, a Service Animal (SA). This is very different from an ESA, which requires no specialized training and could be any animal. ESAs are still allowed in apartments and are protected by federal rules. You can learn more about the requirements for ESAs in apartments/housing at this website: <https://esadoctors.com/hud-housing-rules-emotional-support-animals/>

This does not change the gist of what we are saying, which is that performing an assessment and writing a letter (or completing a form) to request accommodation creates a role conflict and dual relationship which, in turn, can have a negative effect on the therapeutic relationship. The better, safer position is to refer the patient making the request to another clinician who specializes in making those assessments and completing the required documents, especially in cases like accommodations for disability or immigration. 🗣️

## COMMITTEE REPORT | CREATIVITY & NEURO-PSYCHO-EDUCATION

### PRESENTATIONS

- At the 46th Annual Conference of the International Psychohistorical Association, May 2023, *What on Earth is Going On? Psychohistorical Perspectives on a World on the Edge:*

#### Presentations by Inna Rozentsvit:

- What on Earth Is Going On? NeuroPsychoBiology Lens for Psychohistorical Explorations
- From Parenting to Parenthood. (Presentation during Panel on Transgenerational Patterns of Parenthood and Their Effect on the Individual and Societal History)
- When Worlds Collide: The Intrapsychic and Interpersonal Dimensions of Trauma (Panel)
- What Does It Mean to Be Human? (Panel)

**New from Sandra Indig and Inna Rozentsvit:** Our focus is on the visual arts and their implications for Clinical Practice. We pre-reviewed —

- At the Whitney Museum, "Jaune Quick-to-See Smith: Memory Map." Native American artist: drawings, prints, paintings, and sculptures. Smith initiates dialogues around land, racism, and cultural preservation. (through August 13)
- At the Met on Fifth Avenue, "Van Gogh's Cypresses." (through August 27)
- At MoMa, "Georgia O'Keeffe: To See Takes Time." (through August 12)

Please contact Sandra if you are interested in going to the exhibits at the **Whitney, July 16th, 10:30am**, and **MoMa, July 23, 10:30am**. (Dates are subject to change.) E-mail using the subject line: *Museum*. In the body of email: *Your name, phone number, and affiliation*. Thanks for your interest. Suggestions are welcome. 🗣️

Sandra Indig, LCSWR/LP, NCpsyA, ATR-CB, Chair

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Inna Rozentsvit, MD, Ph.D., Co-chair

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# *The Stranger Anxiety: Inside and Out*

## Otherness, the Other, and Subjectivity in Radical Ethics

Presented by Donna Orange, Ph.D., Psy.D. | Reviewed by Karen Kaufman, Ph.D., LCSW-R



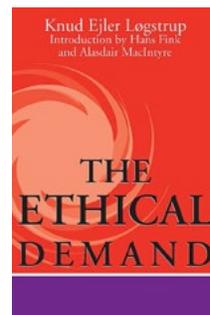
Dr. Orange's presentation on otherness, the other, and subjectivity in radical ethics was a rich, in-depth portrayal of the work of two 20th century philosophers: Knud Ejler Løgstrup (1905-1981) a Danish writer who lived through the Nazi occupation, and Emmanuel Levinas (1906-1995) who was born in Lithuania but whose fami-

ly was uprooted by both world wars and spent years in Ukraine and Europe. Despite different perspectives and religious beliefs, Lutheran and Jewish respectively, both were deeply affected by the Nazi horrors of WWII and the focus of their works was on ethics. Both wrote of the behavior of "othering" which reduces members of devalued groups, typically by race, gender, and sexual orientation. The "other" may also be the orphan, widow, or stranger. The disabled were another group targeted by the Nazis and have long experienced the "other" status in daily life, whether ignored, warehoused or denied basic rights. While both philosophers were immersed in religious text they avoided theologizing in their works. Løgstrup wanted to translate Jesus's message of love thy neighbor into more accessible terms but preferred writing on ethical experiences. Levinas was deeply rooted in Jewish text but his work was interdisciplinary.

“Løgstrup and Levinas were deeply affected by the Nazi horrors of WWII and the focus of their works was on ethics. Both wrote of the behavior of “othering” which reduces members of devalued groups...”

Both men believed that individualism made war possible but that in each person the responsibility for each other exists. They contrasted the roles of bystanders with those who courageously helped the vulnerable during WWII, when coming to the aid of those targeted could lead to imprisonment in concentration camps and death. They considered the habitual styles of responding to others and how these shape the response to vulnerable people in crisis; at the core of an ethical response is hearing the need for help. They opposed colonialism and any form of what they considered murderous violence. It is possible that the atrocities that both philosophers witnessed led to the creation of an unachievable ideal in human interactions, whether by clinician or a neighbor.

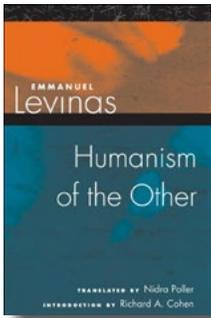
“They contrasted the roles of bystanders with those who courageously helped the vulnerable during WWII ... at the core of an ethical response is hearing the need for help.”



Løgstrup's major work, *The Ethical Demand*, described the command to love one's neighbor. This was understood as: silent, radical, one-sided, and impossible. He believed that human life and trust are gifts, and that individuals have a duty to care for each other. There need be no relationship to god, rather, this caring must be enacted in behavior.

The radical approach requires unselfishness for the sake of the other; this is the unspoken, radical demand: as in our clinical work, the person in the caretaking role must act unselfishly and determine how to take care of the patient. Response requires an acute level of observation and intuition, and the demand is impossible because it does not mean taking charge of the other person's life or responsibilities since this would be an encroachment.

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Levinas wrote an ethical critique of “totalizing;” he viewed the behavior of reducing people to things or categories as violent but natural to western society. His work was haunted by the horrors of the Nazis including the losses of his own family members. He saw the other’s life as coming before his own, the other’s death of greater concern. He

believed in a surrender of self since we are all under the weight of the universe which holds people responsible for each other. For Levinas, subjectivity is a purging of ego centeredness, an emptying of the self to make room for the other. The opposite of this would be self-aggrandizement or narcissism.

“The clinician must be fully present for the patient, and while there may be reciprocity, this was viewed negatively . . . as transactional. While the clinician must expect nothing in return from the client and personal motives must be examined in the interventions we offer, it is the reciprocity in the treatment relationship that provides the foundation of healing and change.”

The philosophical concepts discussed by Dr. Orange may not easily apply to the treatment relationship but there are parallels: the clinician must be fully present for the patient, and while there may be reciprocity, this was viewed negatively in the philosophical writings as transactional. While the clinician must expect nothing in return from the client and personal motives must be examined in the interventions we offer, it is the reciprocity in the treatment relationship that provides the foundation of healing and change. A true emptying of the self in order to be available to the other is impossible, but the clinician’s self awareness may reduce

the need for the client’s admiration or gratitude. When clients feel the safety to expose vulnerability they hope for an attuned response. Løgstrup wrote that failing the other can be irreparable but there are degrees. Kohut wrote of non-traumatic empathic failures, which when minimal, can be worked through in the treatment thereby strengthening the client’s resilience in interactions outside the treatment relationship.

Adding to the impossible nature of a demand is that one never knows if enough has been done for the other or if one’s actions have truly been unselfish. A surprise that many clinicians experience is when a seemingly minor interpretation holds great significance because the client feels heard and understood.

Dr. Orange went on to discuss that as clinicians, we can only engage in radical ethics if we nurture ourselves. Another important task for clinicians is to know our own limitations given the enormous responsibility we take on in the work of caring for others. 🗨️

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**Donna M. Orange, Ph.D., Psy.D.**, is a psychoanalyst and philosopher living in California. She teaches at the NYU Postdoctoral Program and the Institute for the Psychoanalytic Study of Subjectivity, New York. Recent books include *Thinking for Clinicians* (2010), *The Suffering Stranger* (2011), *Nourishing the Inner Life of Clinicians and Humanitarians* (2016) and *Climate Crisis, Psychoanalysis, and Radical Ethics* (2017).

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**Karen Kaufman, Ph.D., LCSW-R**, is President of NYSSCSW. She served as President of the Met Chapter from 2011 to 2019. She works in private practice in Manhattan and Westchester and was Adjunct Associate Professor at Fordham University Graduate School of Social Service from 1998 to 2014.

## FILM: Crip Camp – A Disability Revolution

Discussion Led by Edward Ross, LCSW, BCD | Reviewed by Michael Crocker, DSW, LCSW, and Shaun Peknic, MA



A photo taken at Camp Jened in a scene from “Crip Camp: A Disability Revolution.”  
Credit: Steve Honigsbaum/Netflix

*“From a constructionist perspective, while the person with a disability may not feel ill or be in pain, her or his body is coded as a dysfunctional body. It culturally exists as a transgression, a body that straddles boundaries and therefore is anomalous, ‘matter out of place’ and threatening to the social order.”*

—*Technology, Selfhood and Physical Disability* by Deborah Lupton & Wendy Seymour, citing Douglas, 1966; Thomson, 1997

The World Health Organization has estimated that one out of every six people, 1.3 billion people worldwide, has a significant disability. This makes the disabled population the largest minority group in the world.

If we live long enough, the majority of us will join that community.

On April 22, the NYSSCSW in partnership with the ACE Foundation presented a workshop on the film *Crip Camp – A Disability Revolution* (2020) directed by Nicole Newnham and Jim LeBrecht and produced by President Barack Obama, Michelle Obama, Tonia Davis, Priya Swaminathan, and Howard Gertler. The film documents the lives and evolution of campers who attended Camp Jened, a summer camp in upstate New York for teens with disabilities, and the way it inspired the disability rights movement. As Roger Ebert stated, “This camp changed the world, and nobody knows the story. *Crip Camp* offers something we could all use more of—hope for the future.”

The first few interviews, filmed at the camp in the 1970s, highlight the fragmentation of the disability community and the institutionalized nature of their care. The campers, many with physical disabilities like cerebral palsy or spina bifida, discussed their daily lives of confinement at home with caretakers; they did not attend school. They pointed out how they were set apart from other members of their families and the people in their communities. They longed to be included in the activities of able-bodied people.

Camp Jened showed those campers a way of being in the world they couldn’t imagine at the time. The first half of the film centers on footage that was captured by People’s Video Theater, an experimental filmmaking collective that documented the first women’s liberation march and the first gay pride march, in addition to a couple of summers at Camp Jened. The soundtrack of the film, including Buffalo Springfield’s “For What It’s Worth” helps us understand that:

*“There’s something happening here  
What it is ain’t exactly clear...  
It’s time we stop, children, what’s that sound  
Everybody look what’s going down”*

— *For What It’s Worth* by Buffalo Springfield

The stirrings of a social movement can start in the simplest of ways. Sleepaway summer camp. Playing kickball with friends. A first kiss. *Crip Camp* is about freedom leading to change, the waging of a war against marginalization. Camp Jened was run by young adults who were revolutionary. They chose not to focus on differences. They embraced teens with disabilities. No one was *othered*. In a space of equality, the interactions were healing. This was a utopia for the campers and an escape from the rest of their experience.

At Camp Jened, it didn’t matter if your disability was visible or invisible, everyone was equal. Erving Goffman wrote that people with disabilities are discredited or discreditable. In his theorizing, the discredited are those

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with obvious disabilities/differences. The discreditable are those who could hide their disability. Yet both categories are filled with shame, ostracized, and marginalized due to the way able-bodied people relate to them.

At Camp Jened, these campers found “transitional thinking” similar to Winnicott’s “transitional space,” a mental space in which we do not feel alone. If we do not feel alone, we feel bolstered and able to advocate for ourselves and make changes. This idea was punctuated by the use of the song “Freedom” by Richie Havens as an illustration of the mind-set that resulted from the experience.

The second half of *Crip Camp* focuses on the community of campers who became involved in the disability rights movement throughout the 70s, 80s, and 90s, culminating in a sequence about the 504 Sit-In. This protest related to Section 504 of the Rehabilitation Act which stated that, “No otherwise qualified handicapped individual in the United States shall solely on the basis of his handicap be excluded from the participation, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” The Act was passed in 1973, but without regulations the Act was rarely enforced. Under the co-leadership of former camper Judy Heumann, teacher, and activist for disabled rights, 120 people with disabilities occupied a government building in San Francisco for 25 days. One of the more touching moments in the film is when the Black Panthers start showing up with lunch every day to help support the protest. The intersecting groups both realize that their freedom and equity was braided together.

And yet, there is a glaring absence of diversity in the disabled folks represented in this documentary. There are no BIPOC campers interviewed throughout and there is little representation of those with intellectual disabilities.

The introduction and post-viewing discussion of the film was wonderfully facilitated by Edward Ross, LCSW, BCD a clinician in the fields of behavioral health,

*“Part of the problem is that we tend to think that equality is about treating everyone the same when it’s not. It’s about fairness. It’s about equity of access.”* —Judith Heumann

health, chemical dependence, and social services. He has been the Director of Health and Behavioral Health at Lighthouse Guild International since 2013 and was Director of Behavioral Health at the International Center for the Disabled prior to that.

The lively discussion brought up many significant points. Most importantly the documentary helped us to

understand that the real problem remains with the able bodied, not necessarily people with disabilities. The movie notes that everyone has or will have something “going on” with their bodies.

The movie described how people with disabilities were educated in the basements of schools or other facilities, hidden from the rest of the school and the public. This is the essence of marginalization, not much different from the institutions where people with cognitive and physical disabilities were warehoused.

*“I wish for a world that views disability, mental or physical, not as a hindrance but as unique attributes that can be seen as powerful assets if given the right opportunities.”* —Oliver Sacks

This population has a social hierarchy—those with polio were at a higher point of the ladder, although society was frightened of contagion. As mentioned above, Goffman also provided us with comparisons of those who were “obviously” disabled, different than those who could hide their disabilities.

Camp Jened provided a sense of security and safety, as opposed to the experiences of those who were institutionalized in places like Willowbrook on Staten Island that left people with disabilities in need of care, empathy, and compassion. *Crip Camp* is not just educational, it is a call to action for us to consider our own relationships to people with disabilities.

In conclusion, we believe there are questions we must ask ourselves, those of us in the clinical social work community: How many of us have clients with disabilities in our practices?; Do we work in wheelchair accessible offices?; Do we provide sign language interpreters at CE presentations?; Do we work to elect board members and government representatives who are disabled?; Do we watch movies and TV shows centering on people with disabilities? Representation matters in the fight for equity and inclusion. 🗣️

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**Michael M. Crocker DSW, LCSW, MA, CGT** (He/Him) is the Founder and Director of The Sexuality, Attachment, and Trauma Project, a group practice of clinicians who treat issues related to gender and sexuality. He has published articles on attachment theory, out-of-control sexual behavior, and affect regulation. Michael serves on the board of the ACE Foundation.

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**Shaun Peknic, MA** (He/Him) is the Associate Director of The Sexuality, Attachment, and Trauma Project. He holds a Master’s degree in Industrial and Organizational Psychology with a focus on group processes and organizational behavior, and a BFA in Theater from NYU. Shaun is currently pursuing a degree in clinical social work from Hunter College.

# Aging Vision: How Social Workers Can Help Address Vision Loss

By Lisa Beth Miller, LCSW-R, BCD



**Lisa Beth Miller, LCSW-R, BCD**  
Currently: Outreach and Referral Coordinator at Lighthouse Guild ([www.lighthouseguild.org](http://www.lighthouseguild.org); 800-284-4422) and private practice. Previously: Social Work Manager for Lighthouse Guild's Continuing Day Treatment Program; Board Member of the NY State Society for Clinical Social Work Met Chapter; founder of the Society's online Listserv; inpatient psychiatric unit social worker; outpatient behavioral health clinician in clinic and schools.

## Your client has vision loss. What now?

What happens to someone who wakes up one morning and can no longer see? It could happen to any of us, at any time—clinician or client. Stoic wisdom might suggest that one prepares for loss by imagining it has already happened and resolving to accept the change, to embrace life fully, whatever happens. How do we prepare?

Vision changes are an expected part of aging. The need for reading glasses may be the initial sign of losing elasticity in the eyes when changing focus near or far, adjusting between light and dark, outdoors, and indoors, or day and night. With the expanding aging population, many wonder whether their vision changes are within the range of normal eye aging or a serious eye condition that may significantly worsen vision, possibly requiring medical treatment. Only an eye doctor can determine the difference; early detection and treatment may help maintain vision.

Vision loss often triggers or worsens depression and anxiety, and depression and anxiety may worsen vision. This bi-directionality of physical and mental illness suggests that the approach to wellness and recovery benefits from addressing vision function and emotional function, concurrently, when possible.

## What else do you need to know about vision loss?

Regular comprehensive eye exams are crucial for the early detection of eye disease. During Covid, non-urgent doctor visits were paused. If you or your clients haven't recently had an annual eye exam, now is a good time to set one up. Healthy eating and exercise habits support eye health, too.

When regular glasses, contact lenses, medication or surgery can no longer correct vision problems, referral is made to a low vision optometrist, who prescribes specialized glasses or a magnifier and recommends tools and exercises to help people read, work, socialize, and enjoy other activities. Even those who are totally blind may benefit from a low vision exam and may be prescribed protective sunglasses.

Eye drops or injections may prevent or reduce the progression of vision loss, from some common eye conditions, such as glaucoma and macular degeneration. In February 2023, the first FDA-approved drug treatment for dry macular degeneration was announced<sup>1</sup> and other treatments are in the pipeline, awaiting approval, later this year. Clinical trials provide access to participation in promising new research and can be located online, at the National Eye Institute and [clinicaltrials.gov](http://clinicaltrials.gov). Only an eye doctor can prescribe treatment.

Medical conditions affecting vision include stroke, traumatic brain injury, cataracts, diabetic retinopathy, detached retina, retinitis pigmentosa, Usher Syndrome, optic nerve atrophy, albinism, Stargardt disease and Charles Bonnet syndrome.

Magnifiers and task lighting are low-tech tools for increasing functional vision. Adding lamps that are easy to turn on and changing to LED bulbs may help. Clearing any clutter and cords on the floor at home reduces fall risks. High tech devices include electronic readers, CCTVs, and handheld readers, which enlarge text. Some devices audibly narrate text and describe individuals in the room. Many free phone apps magnify text and read aloud. Computerized sight canes aid with navigation.

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### Who helps?

For direction and guidance, social workers can help sort through negative emotional reactions to the loss of vision and to learn about the resources available. As knowledgeable, supportive listeners and thought partners, social workers can plant seeds for adjustment—de-escalating despair and depression, evaluating overall needs and strengths, connecting people to the path of learning. Optimally, an individual's needs, goals, and priorities are considered, which helps cultivate emotional access to specific, timely support services and inspires hope for improved quality of life. Those struggling with multiple crises benefit from both information and compassion, to help re-direct their focus, from loss to learning.

Since Covid, health insurance coverage has expanded to video calls and phone sessions, increasing access to individual psychotherapy, especially

**"Free, internationally available, virtual support groups for coping with vision loss are available, by phone or Zoom."**

benefiting those with visual impairment. Outreach presentations about programs, services, and resources shifted from in-person to virtual, spreading a wide online information-sharing network to providers at medical centers, and to community liaisons at senior centers, community boards, religious centers, and social service organizations.

Free, internationally available, virtual support groups for coping with vision loss are available, by phone or Zoom. In-person and virtual trainings



provide demonstrations of accessibility features on phones and computers, phone apps, and high-tech vision aids. Additional support and enrichment opportunities include free case management services (NY Connects: 800-342-9871), free audiobook access (Andrew Heiskell Braille and Talking Book Library), escorted running (Achilles Club), InTandem Cycling, Blind Baseball, low-cost refurbished computers (Computers for the Blind), educational videos (YouTube), research participation and clinical trials (NEI and [clinicaltrials.gov](https://clinicaltrials.gov)).

Vision rehabilitation specialists enable individuals with vision loss to attain their goals, training them in skills for navigating their home and community, shopping, going to school, and returning to work. They help people with low vision learn how to best use assistive technology and other tools that help them maintain their independence.

For those deemed “legally blind,” by an eye doctor, the New York State Commission for the Blind provides, for eligible participants, access to independent living skills

training—training in performing household tasks, orientation, and mobility skills, and a low vision examination. Also, vocational rehabilitation is provided for those interested in work, school, or career skills training. In New York City, three vision agencies provide Commission services—Helen Keller Services for the Blind, Visions, and Lighthouse Guild. Every state has its own commission for the blind.

### Where to start?

If you or someone you know has a concern or question about vision changes, now is the time to learn more. Asking for help opens the door to learning. With the help of social workers, people coping with vision loss can learn to take steps towards new ways of functioning, connecting to programs, resources, and individuals that help them emotionally adjust and functionally adapt. 🗨️

1. *Ophthalmology Times*: <https://www.opthalmologytimes.com/view/pegcetacoplan-approved-by-fda-for-geographic-atrophy-secondary-to-amd>.

# Older Women, Body Image, and Eating Disorders

By Mary Anne Cohen, LCSW



Mary Anne Cohen is Director of The New York Center for Eating Disorders and author of three books on this subject. Her latest book, published by NASW Press, is *Treating the Eating Disorder Self*. [www.EmotionalEating.Org](http://www.EmotionalEating.Org)

Paula, age 60, declares during her initial therapy consultation that she hates every part of her body. “Every part?” I ask with dismay. “Well, no,” Paula concedes, “my wrists are okay.”<sup>1</sup>

Paula’s sad lament reminds me of Eve Ensler’s obsession with her “imperfect” stomach in *The Good Body*: “I have bought into the idea that if my stomach were flat, then I would be good . . . I would be accepted, admired, important, loved. Maybe because for most of my life I have felt . . . bad, and my stomach is the pouch for all that self-hatred. Because my stomach has become the repository for my sorrow, my childhood scars, my unfulfilled ambition, my unexpressed rage. Like a toxic dump . . . My stomach has become my tormentor, my distractor, it’s my most serious committed relationship. I’ve tried to sedate it, educate it, embrace it, and most of all, erase it.”<sup>2</sup>

Body image preoccupation and eating disorders are not just the domain of teenage girls. Middle-aged and older women (and men too) worry about their weight, their size, their food, their appearance. Underlying the body image and food despair of older women are struggles around loss and grief, transitions and fear, uncertainty, and the anxious need to be in control. Concerns around menopause, an empty nest, retirement, caregiving or death of older parents, possible divorce, and the illness of one’s self or loved ones can get detoured toward body preoccupation.<sup>3</sup>

**“Old age is no place for sissies.”**

~ BETTE DAVIS

The language of food and fat is symbolic one, a way to express one’s inner emotional battles over feelings of emptiness and fullness, vulnerability and protection, urge and restraint, desire, and despair.

When a person becomes consumed with self-critical thoughts about her body, it can be a symptom of inner conflict or depression. Unable to find relief from deep internal sadness or emptiness, she attempts to comfort herself by trying to alter her outer appearance. Women may recruit their bodies to express what they cannot express in words. Their body and eating problems become a vehicle to communicate matters of the heart that have no other channel. Older women often crystallize their emotional pain into one concrete problem: “I hate my aging body. I need to change it, and change it, and change it some more.”

In *Appetites*, author Caroline Knapp writes, “The state of one’s waistline is easier to contemplate than the state of one’s soul.”<sup>4</sup>

## Eating Disorders and Older Women

Robyn called my office with some anxiety, “I am a 58-year-old woman with bulimia. I know this is supposed to be a problem of high school girls. Is it too late for me to get help?”

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It is true that eating disorders usually affect younger women during their teenage years or early 20s. But these disorders can also begin later in life, for women in their 30s, 40s, 50s, and older. No age (or race or gender or ethnicity) is immune from developing an eating disorder.

Adulthood is filled with developmental challenges which can test one's identity and stress one's coping abilities. Eating disorders are coping strategies in which the person tries to wrest control over their bodies while feeling out of control with life. When forced to deal with such uncomfortable transitions/emotional disruptions, people often begin to obsess about their bodies and translate complicated feelings into the language of fat.

Robyn became bulimic as a teenager and never resolved this, despite the success of a professional career, marriage, and motherhood. It was her private, shameful secret. With the death of her parents, her three grown children leaving home, and her husband struggling with business setbacks, Robyn's bulimia escalated, and she came for help for the first time.

In Robyn's case, we came to understand that she resorted to bingeing, purging, and preoccupation with weight as a way to avoid confronting her sadness and insecure reactions to the losses in her life. Robyn was bulimic in other ways as well: she would go clothes shopping and return the items the next day, she would make quick friends and then drop them at a slight provocation. Attachment issues were at the heart of Robyn's bulimia based on her inner conviction that trusting food is safer than trusting people. Psychotherapy

was so fruitful with her as I often had to manage her wish to "throw up" our relationship. Keeping me and not purging the treatment did help her tolerate keeping her food and uncomfortable feelings as we worked and reworked the traumas, losses, and disruptions of her life.

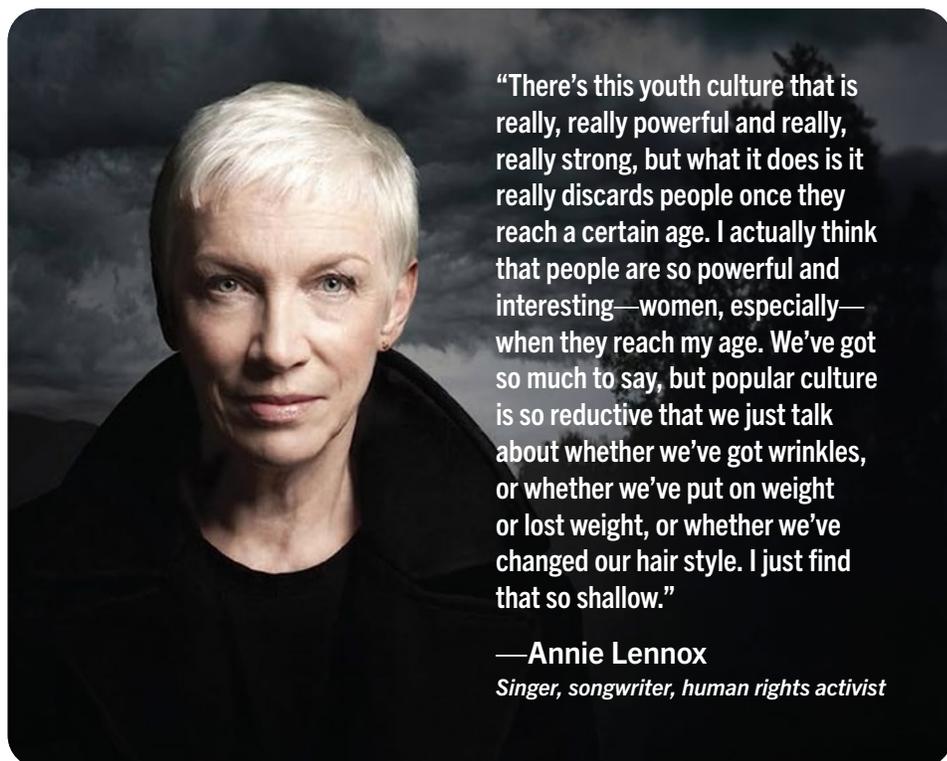
The eating disorders of older women usually occur in one of three possibilities:

**1. A woman develops an eating disorder as a teenager, never resolves it, and it persists through various stages of her life.**

Gail, a 60-year-old woman, was very close to her only son, Jerry. When Jerry and his wife had their first child, the couple became absorbed with the baby. Gail felt left out and jealous of her son's relationship with the baby. When Jerry and his family moved out

of state, Gail's jealousy intensified. She felt guilty and ashamed of her feelings. She began to binge.

In her therapy, we discovered that jealousy had also been an issue for Gail as a teenager. When she did not feel as popular as the other girls in high school and at different junctures in her adult life, she would binge as a way to comfort herself as well as to discharge angry feelings. Making this connection between her teenage struggles and current emotions helped Gail explore her life-long vulnerability to feeling unimportant. She faced her history of feeling left out and neglected. As she identified these emotions and worked through her guilt, she no longer needed to detour her anger through binge eating. Gail also became less ashamed about communicating with her son the genuine need for family connection she was yearning for.



“There’s this youth culture that is really, really powerful and really, really strong, but what it does is it really discards people once they reach a certain age. I actually think that people are so powerful and interesting—women, especially—when they reach my age. We’ve got so much to say, but popular culture is so reductive that we just talk about whether we’ve got wrinkles, or whether we’ve put on weight or lost weight, or whether we’ve changed our hair style. I just find that so shallow.”

—Annie Lennox  
Singer, songwriter, human rights activist

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**2. A woman develops an eating disorder as a teenager, succeeds in resolving it, but relapses as an older woman.**

Sandra discovered that her wife was having an affair. Unable to directly face her anger and grief, Sandra relapsed to anorexia, which she had suffered from periodically at difficult times in her life, starting at age 14 when her parents divorced. Given that Sandra was financially dependent on Tanya, she was particularly scared to voice the full brunt of her fury and hurt. Instead, she diverted her rage into a silent protest by not eating. Sandra recruited her body to express what she could not say in words. She went on a hunger strike. A part of her believed her wife had strayed because she was not thin enough or youthful enough.

Concern for her wife's health and a sincere wish to stay in the marriage prompted Tanya to agree to couple's therapy. Together they began to sort out what had derailed their marriage and how to repair it. Sandra felt nurtured by her wife's interest in saving their relationship. As she began to communicate her pain directly, she no longer had to resort to starving herself as a way of silently venting her anger and despair.

**3. A woman begins suffering from an eating disorder or body image dissatisfaction for the first time as an adult.**

Deena was 42 when she accidentally became pregnant with her sixth child. She had been looking forward to more time for herself now that her children were older, and she was distressed about the arrival of the new

baby and "getting fat all over again." As a religious woman, ending the pregnancy was not an option. Deena began suffering from bulimia for the first time in her life in an attempt to purge her guilt about her "bad" feelings, which she considered "sinful and selfish." Through her therapy, Deena came to understand her regret over this unplanned pregnancy was a natural reaction for someone who thought her days of mothering a baby were over. She felt understood and validated in her therapy and entitled to her feelings of dismay. Deena discussed this ambivalence with her husband who admitted to similar feelings as well. Sharing their reactions with each other increased their closeness and helped them become readier to welcome the new baby to the family.

Although Gail, Sandra, and Deena each developed an eating disorder at different phases of their life cycle, they share certain elements in common: the disorder flares up during periods of exceptional stress, such as any major change that shakes the foundation of how a woman defines herself. Transitions, ruptures, and grief create the perfect storm for eating disorders to take root.

**Eating Problems in the Elderly**

We need to add that as people get older, eating and taking in sufficient nourishment can become more problematic. These difficulties are not diagnosable eating disorders since all eating disorders are defined by the "fear of being fat." The loss of one's appetite for food and for life can lead to eating struggles in the elderly. This may be related to depression,

anxiety or illnesses such as dementia or Parkinson's, all known to cause feeding disorders. Social isolation, GI issues, the loss of smell and taste, dental problems, certain medications, and chronic illness all affect appetite. Refusing food can be a way of trying to regain a sense of control or, in severe cases, a passive means of "solving" one's problems through slow suicide. Financial hardship and limited resources can also cause people to give up on shopping, cooking, and eating. "Food refusal is thought to be distinct from a pure anorexic pattern of behavior and may be a separate psychobehavioral entity of old age."<sup>5</sup>

Both my parents lived 'til 95 and had a different relationship with food as they became elderly. My father continued to eat well—he wanted to keep up his energy for his ballroom dancing and mowing his lawn which he did to the very end. My mother, depressed, no longer ate much and would say, "What's the point?" Not interested even in her previously enjoyed snack of Pepperidge Farm cookies, she required nutritional supplementation as her weight slid under 80 pounds. And, yet, before her death she wrote this poem:

**Regret**

**All strange foods I'll never eat  
All the travelers I'll never meet  
All the books I'll never read.**

**The beckoning signs I did not heed  
The years went by with fearsome speed  
The bloom removed and left the weed.**

**The hill to climb is now too steep  
The only choice—to laugh or weep.**

~ LILY LIFSHUTZ

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## “To lose confidence in one’s body is to lose confidence in oneself.”

~ SIMONE DE BEAUVOIR

### Cultural Pressures

Nowadays, in their anxious quest for youth and perfection, middle-aged women often turn to dieting to help them feel more in control of their aging bodies. Diets do not work but create a vicious cycle of restriction and then result in loss of control with break-out bingeing. Women may also seek out liposuction, breast augmentation, butt lifts in an attempt to “restore” themselves to a younger, firmer self. If you have middle-aged “toe obesity,” doctors offer the “foot facelift.” Plastic surgeons can also enhance your drooping belly button, enlarge your nipples, and even restore your private parts to a tighter, more youthful, rejuvenated appearance. Websites advertise “designer vaginas.”<sup>6</sup>

A former dancer with the New York City Ballet, Toni Bentley, states “At its most extreme, this craze for plastic surgery is more than a display of culturally conditioned self-hatred. It is, rather, a current manifestation of female masochism—a sister compulsion to anorexia, bulimia, cutting, and excessive tattooing and piercing.”<sup>7</sup>

And as Maureen Dowd, *New York Times* columnist, puts it: “Men can look good in many different ways, whereas women are expected to endlessly replicate themselves at twenty-five, à la Goldie Hawn and Heather Locklear until they look like

frozen reproductions of themselves. Our culture is obsessed with freezing the clock—and the face—with lifestyle drugs and medical treatments . . . I worry that women are heading toward one face. Sometimes in affluent settings, you see a bunch of eerily similar women with oddly off-track features—Botox-smoothed, Formica foreheads, collagen-protruding lips, surgically narrowed noses, taut jaws—who look like sisters from another planet.”<sup>8</sup>

Getting rid of a wrinkle here and there may be helpful for self-esteem. But at what point does the desire for plastic surgery turn addictive and become a symptom of body image anxieties and deeper unrest with oneself? At what point does a woman externalize her inner unhappiness in the hope that revamping her outside self will remedy her inner dissatisfaction and emptiness? And, sadly, women discover that plastic surgery may not give them the relief they were looking for since their core body image/self esteem issues have not been resolved.

### The Therapeutic Relationship: Cultivating Hope and Connection

#### *Decoding the Fear of Fat:*

Unconscious and disavowed emotions have been submerged and camouflaged under our patient’s fear of fat and the wish to lose weight. As we try to decode the specific meanings behind each patient’s struggle, we are helping them build a richer vocabulary to express their inner emotional self. The more they can cultivate a rich vocabulary of feelings, the less likely they will speak the language of fat and pain.

#### *The Therapeutic Bridge:*

Patients are fluent in the language of fat and body image distress but not so much in the language of feelings and self-expression. The healing relationship between therapist and client provides the bridge between emotional eating and the road to recovery.

The therapist moves the patient toward self-reflection and curiosity and deepens the treatment into more alive concerns. Emotional eating has frozen our patients’ feelings and pain. Their relationship with us can help them thaw.

“Be bold and love your body. Stop fixing it. It was never broken,” declares Eve Ensler. 

#### FOOTNOTES

1. All cases are true, but names and identifying data have been changed for confidentiality.
2. Eve Ensler. *The Good Body* (Villard, 2005).
3. Men are not exempt from the pressures to be youthful, virile, and in control, and they often do turn to dieting and other attempts to modify their bodies. But women tend to be more self-critical of their bodies than men. As Susan Sontag, the critic and feminist, wrote in “The Double Standard of Aging”: “Most men experience getting older with regret, apprehension. But most women experience it even more painfully: with shame.” Susan Sontag, “The Double Standard of Aging,” *The Saturday Review*, 9/23/1972, 29-38. Joanne Woodward complained that, until he died, actor husband Paul Newman got handsomer every year, while she just got older.
4. Caroline Knapp. *Appetites: Why Women Want*. (Counterpoint, 2003) Pg. 27.
5. <https://www.todayseriatricmedicine.com/archive/070113p18.shtml>  
Elder Eating Disorders: Surprising New Challenge: [https://www.todayseriatricmedicine.com/news/exclusive\\_0409\\_03.shtml](https://www.todayseriatricmedicine.com/news/exclusive_0409_03.shtml)
6. <https://beautybydrat.com/blog/what-is-a-designer-vagina/> In one of the websites on designer vaginas, a woman speaks of wanting this procedure so she could achieve “a top of the line vagina.”
7. Toni Bentley, “Nip and Tuck,” *New York Times* Sunday Book Review, Oct. 22, 2006.
8. Maureen Dowd. *Are Men Necessary: When Sexes Collide* (Berkely Books, 2006).

# The Funny Thing About Grief

By Richard Joelson, DSW, LCSW

**A**side from the fact that it lasts forever, the funny thing about grief is that it has a life of its own. That means that grief episodes occur randomly and often quite unexpectedly and not only when predictable and milestone related. Yes, for many, strong grief reactions are more likely to show up on birthdays, Mother's or Father's Day and anniversaries of the death of a loved one. Other people are more likely to experience intense grief when a memory or a photograph is triggering or when receiving condolences from well-wishers.

My wife, Roz Cohen, a clinical social work psychotherapist and a member of our Society, died in September 2021, after a three-year long battle with cancer. She and I considered ourselves extremely fortunate that this happened in her eighth decade of life and not sooner, that she was minimally symptomatic and pain free until the very end, and that the original six-month prognosis turned out to be three quality years. The love and support from family and friends throughout that period—and still—remains a major component of our, and now my, well-being. I believe that the nature and quality of one's grief experience has a great deal to do with the quality of the care that they were able to provide for their loved one. My complete satisfaction regarding the care Roz received from me and everyone else sustains me to this day. That I have no regrets about her care means everything.

I need no assistance in continually realizing how much I have lost after a glorious 35-year love story. When

I hear family, friends, and countless others describe how much Roz meant to them and their feelings about losing her, my own loss feels that much greater. Not surprisingly, those moments are emotionally mixed. When the sadness and the sense of loss is intensified, it also provides an opportunity to savor the gift of her presence in my life for all those wonderful years together. For me, that is grief at its best.

Joan Didion, in her book, *The Year of Magical Thinking*, spoke of her experience after the sudden death of her husband after 40 years of marriage. One of her reported observations is something that I have experienced countless times. The frequent wish to share information with a departed loved one is ongoing and serves as another reminder of the loss. Didion writes, "I could not count the times during the average day when something would come up that I needed to tell him. This impulse did not end with his death. What ended was the possibility of response." For me, this form of verbal intimacy is one of the greatest losses of all. Most recently, this was captured by the birth our grandson. Born four months after Roz died, he is the first child for our son and the first male grandchild after four granddaughters. Fortunately, she knew about the pregnancy, but not the gender. The impulse to discuss this great event with her occurs frequently and probably always will.

A common fear among those of us grieving a major loss, and one that frequently has worried me, is what I call "memory fading," as well as

other "fades," like the sound of her voice and her laugh, and the way she looked and sounded upon hearing stunning news of any kind. Of course, pictures are wonderful and videos even better, but the details of the interactions of everyday life for over 35 years are sometimes difficult to retain.

David Kessler, one of the foremost experts on healing and loss, says that as a society, we don't know how to talk about death. We are, he

**"Grief is highly personal, and it defies logic and efforts to organize it into categories, timelines, and deadlines."**

suggests, a "grief illiterate society." Grief is highly personal, and it defies logic and efforts to organize it into categories, timelines, and deadlines. Following the attacks on the World Trade Center on September 11, 2001, I conducted a bereavement group for eight widows. The group was scheduled to last for 16 weeks; however, the group remained together for 41 months. That is when they felt their grief work had advanced to the point where the group was no longer necessary, while recognizing that their grief was not over... because it never would be.

J.W. Worden, in his excellent book, *Grief Counseling & Grief Therapy* (1991) describes mourning—the adaptation to loss—as involving four basis tasks:

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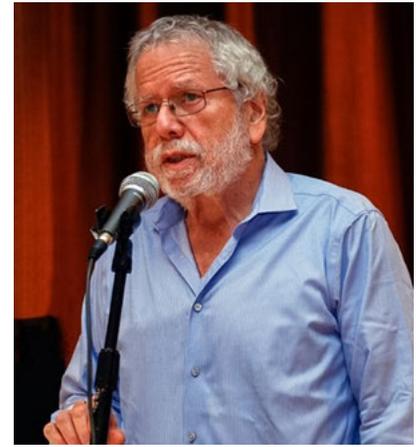
- To accept the reality of loss, which can be extremely difficult when it is sudden, unexpected, and tragic, like the 9/11 deaths
- To work through the pain of grief, as opposed to denying the need to grieve
- To adjust to an environment in which the deceased is missing
- To emotionally relocate the deceased and move on with life

Worden's four tasks suggest an action orientation that I have always found to be useful in my work with grieving clients in my psychotherapy practice as opposed to the more well-known stage or phase schema for bereavement which tend to imply passivity and a lack of action as the mourner passes along a continuum. Worden's approach, which is more consistent with Freud's concept of grief work, encourages activity and implies that the process can be influenced by outside intervention, like a participating clinician.

Clearly, bereavement is not a process that progresses in a sequential manner marked by gradual and identifiable reduction in grief and other indications of a return to normalcy. In many cases, indicators of "progress" are not reassuringly evident. The mourner may appear to be getting worse as months go by, causing needless worry by friends and family. In fact, feeling "worse" is not necessarily a bad sign. It may be an indication that the painful work of grieving is proceeding as it unavoidably must, in fits and starts. The bereavement process may take weeks, months, or years. It is not a path to "recovery," insofar as that means a return to pre-bereavement baselines. Instead, the process leads to the mourner's

increased ability to change, adapt, and alter his or her self-image and role to fit a new status.

Months before she died, Roz urged me to consider the possibility of a new romantic relationship after she was gone. She knew of my unwillingness to even consider such an idea based on two things; one, my high tolerance for independent living, and two, my belief that I had the love of my life for 35 years and could not imagine a second experience with a new "leading lady." Thanks to a serendipitous encounter with a colleague I had never met before, I came to realize that perhaps another romantic adventure at this stage of my life was not entirely out of the question. I had conflict about the fact that this chance meeting—where the mutual attraction was immediately evident—occurred only two months after the Roz's death. Initially, I considered not acting on my desire for more contact, however I also appreciated that I could not ask someone to wait until I achieved the arbitrary one-year milestone that widows and widowers are "supposed to" allow before it is socially acceptable to consider a new partner. Like grief, the heart does not operate in accordance with the calendar. Twenty-one months later, I am glad I seized the opportunity to explore a new relationship however earlier than expected ... especially since this was never expected at all! The important insight for me was that mourning a lost love and embracing a new love were not at all incompatible. The new relationship has served to facilitate the transition from a memorable 35-year marriage to a new partnership that has been similarly meaningful and deeply fulfilling. 



**Richard B. Joelson, DSW, LCSW**, is a psychotherapist in private practice in New York City who has been an administrator, educator, and author in the field of mental health for many years.

#### **A Message To My Colleagues:**

I thought that the postscript to this article would be a good opportunity to announce my retirement (June 1) from private practice and to say a warm farewell to the many friends and colleagues I have made throughout my time in our organization. After 51 years in practice, it felt like the right time to enjoy a different way of life. I will maintain my membership in the Society and will continue blogging for both *Psychology Today* and *Psychotherapy.net*.

I will also maintain my website: [www.richardbjoelsondsw.com](http://www.richardbjoelsondsw.com)  
My e-mail is [rbjoelson@aol.com](mailto:rbjoelson@aol.com)

***My best wishes to all of you!***

## Aging in Place is the Choice of Most Seniors

But what happens when their health declines?

By Susan Birenbaum, LCSW, MBA



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One of the greatest challenges facing the U.S. today is caring for the soaring population of older adults. Most seniors between the ages of 70 to 90 have chosen to remain in their homes as they grow older, with some level of independence. “Aging in place,” the popular term for it, is considered beneficial by policy advisors, health care professionals, elderly people, and their families. It is touted as positive in terms of familiarity, socialization, and cost, as it is usually less expensive than living in a residential care facility. It is perceived as being safer as well.

New York City has a large population of elderly people living in their co-ops and condos. The disadvantages of aging in place become apparent when their health declines and they cannot access the care they need. Aging residents may live alone when their spouses die. They may have no one to rely on for care, as family members may live far away or be unable or unwilling to help. If left unaddressed, deteriorating medical, mental, and physical conditions can put them in distress and in danger. Certain conditions and behaviors, such as dementia, paranoia, hoarding, or addiction, can adversely affect the communal life of the building. It is a common problem, but it does not appear to be addressed in the current literature.

Concerned friends, neighbors, and staff may try to help the individual, but eventually property managers and boards are asked to step in. However, theirs is a fiduciary responsibility—to manage the building and maintain its financial stability—not to intervene in the lives of individual residents.

I became aware of the problem about 10 years ago, when a professor I know at NYU School of Social Work, where I received my MSW, asked me to evaluate an elderly

couple in her building to see if they could continue to live independently in their apartment. I determined that they could do so, with support (more details to follow).

Since then, I have received many referrals from managing agents or attorneys to assist boards with their concerns about infirm elderly residents. I have developed expertise in this unique area. I am a Licensed Clinical Social Worker, a Certified Geriatric Care Manager, a Certified Article 81 NYS Court Evaluator, I hold an MBA and I have served on my own co-op’s board.

### A Brief History

Before World War II, parents and adult children often lived in the same community. When elderly parents could no longer live alone, the adult children took them into their own homes.

After the war, the Greatest Generation experienced a societal shift. Their adult children did not remain in the community, in fact, they often moved far away. The Baby Boomers, born between 1946 and 1964, were not willing or able to care for their parents in old age.

The Greatest Generation is the first to live into their 80s and 90s. Their children, the Boomers, were the largest post-war cohort, estimated at 100 million, or approximately 29% of the population. Now between 60 to 76 years of age, the Boomers often move from the suburbs to the city when they retire.

Beginning in the 1980s, apartment building owners in New York began selling their buildings to residential tenants. It was a very lucrative activity for them and a good opportunity for tenants, who were able to become homeowners for the first time. An enormous number of buildings became co-ops over the next two decades. In the 2000s, new construction changed residential ownership to condominiums.

The people who bought their apartments at the time were generally between 30 and 50 years old; they were healthy, active, independent—working and still raising families. Now, 40 years later, they are between 70 and 90 years of age and still living in the same apartments; New Yorkers do not often move once they are settled.

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### Case examples

I begin each new case with an evaluation of the resident and the situation. I have discussions with the family, if there is one, decide what resources should be brought in, develop a plan, and make recommendations. I communicate with the board, the property manager, and the co-op lawyer, all of whom are stakeholders. I work to achieve a safe outcome for the older person and to resolve the problems in the building. Below are some examples; the names have been changed.

#### Case 1: The Coopers

The Coopers, an older couple in their 80s, had been living in a lovely co-op for a long time and the Board wondered whether they were capable of continuing to live there.

He was a retired professor and she had worked for a non-profit organization. The woman's disabilities had confined her to bed. The couple had nephews who lived in Oregon and were not involved in their lives. They had no attorney to manage their affairs.

I determined that they could continue to live in their apartment with additional support. I arranged for home healthcare aides, activated their long-term care insurance, changed their Medicare plan to a better one, and found new doctors who take the new insurance.

Unfortunately, a young man they considered a friend was taking money out of their account. I managed to have them change their ATM password and stopped him from working with them. They were very pleased with the outcome, as was the building's board.



#### Case 2: Mike

Mike was a long-time and well-liked resident of a co-op. His partner had died and left the apartment to his cousin with the caveat that Mike could live there as long as he paid the maintenance charges. For a while, Mike had a roommate to share the costs, but he left abruptly.

By this time, Mike had developed dementia, began drinking heavily, and his behavior deteriorated. He sat at the kitchen window feeding the pigeons and letting them into the apartment. He walked around the lobby without pants.

I discovered that he had let Medicaid lapse and got him re-certified. I was able to have him admitted to a hospital, and from there to a fine nursing home, where he was well cared for and happy. The Board was pleased with the outcome.

#### Case 3: Sylvia

Some cases, like this one, do not have a satisfactory outcome because the shareholder refuses services and will not communicate.

Sylvia, a woman in her 80s, has lived in her co-op for over 40 years without any problems. Now, she has become malnourished, has paranoia and dementia, and several other disabilities. Her apartment is in shambles. She will only speak to me through a partially opened door.

Sylvia is in arrears for her maintenance by a significant amount. The maintenance accrued during the pandemic because, by law, the co-op could not act to collect it. She will not give me the name of her attorney, if she has one, or any family members.

She is afraid of eviction, and the Board does not want to evict her. They hope to find a safe place for her to live and receive care. Initially, the Board tried to bring in Adult Protective Services (APS), but Sylvia refused to speak with them. After four attempts, they closed the case.

I arranged with a Neighborhood House to assign a case manager who arranged food delivery through Meals on Wheels. But Sylvia will not eat the food because she thinks it is poison. She throws it out and sometimes begs the neighbors for food.

The co-op board, managing agent, and their lawyer understand the situation. The lawyer has petitioned the Court to appoint a guardian ad litem to manage Sylvia's personal and financial affairs; the Court's decision is pending. Hopefully, the guardian will be able to remedy the situation with the support and under the authority of the Court.

Sylvia has not picked up her mail. A Guardian will be authorized to open the mail and communicate with her financial institutions and others. The Guardian also will have the authority to withdraw funds and place them in escrow, and to find Sylvia a safe place to live. 🗳️

# Narcissism, Loss, and Adaptation in Later Years

By Hanna Turken, LPSyA, LCSW, BCD



**Hanna Turken LCSW, BCD, LPSyA**, is a past Board member of the NYSSCSW Queens Chapter; Continuing Education Committee and Senior Member of NPAP; Research Associate at the Psycho-history Forum; and member of many other organizations. A published author, she has presented her clinical papers widely on topics of culture, sexuality, female development, culture, fathers, trauma, and psycho-history, among others. She has maintained a bilingual (Spanish) private practice in Queens and Manhattan.  
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As an adolescent, I made a promise to myself that I would not follow in the footsteps of my mother, who dedicated her life to her children only. Not that she lived an unhappy life, but to me, as an adolescent, to be just a wife and mother did not seem sufficient.

I've been fortunate enough to accomplish most of what I set out to accomplish; I married, had children and I work in a field that has increased my self-esteem and healthy narcissism. I was quite content: I never thought of living my life in any other way—until unexpectedly the lease for the Manhattan office, in which I had practiced for 16 years, was not being renewed. My stability was shaken, and for the first time, the thought of semi-retirement—giving up my practice in Manhattan and continuing to practice in Queens—was up for consideration. But soon that prospect became unpleasant and, to a degree, traumatic. I was no longer simply dealing with the loss of my office but also with the reality of my aging and the aging of important people around me: family, friends, and colleagues. I was also dealing with the possible demise, because of decreased membership through illness or death and the lack of younger members, of the organizations that have been a vital part of my profession

Freud, in *Beyond the Pleasure Principle* (1920), introduces the complex idea that there are forces within us that work to bring the living being back to the inorganic state, the death instincts opposing the living instincts. From biology, we learn that from the moment a cell is born, it is on its way to dying. This natural process of aging is also a belief

in some Eastern philosophies. What I have been speculating about is why, if this is a psychological and a physiological imprint, was I so in denial of the passage of time until it was thrust upon me? It is as if I was young and then not so young anymore; as if I were not the same person that I was the year before. The integrity that I had experienced was disturbed and felt unrestorable.

In my practice, I have three patients older than sixty-five. Each, in different ways, has experienced this disturbance in their sense of integrity. Roy relied on his good looks as a way to seduce and obtain opportunities for himself. The loss of his youthful appearance and the power it provided destabilized his established sense of security, and he presented what can be described as a “melancholic” state in the old Freudian sense as pertaining to older men.

**“The connection between our roles at home, at work, and in society is a clear component of our developmental well-being, but the compounded losses that accompany the aging process make it more difficult to maintain a stable self-identity.”**

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Mary, a divorcee, had depended on the structure of her working week—earning power and socialization—to maintain her emotional stability. Severe arthritis of the knees diminished her ability to get to work in bad weather. At such times, the nature of her job allowed her to work from home, but two months before reaching her retirement age her company “downsized” and her job was eliminated. In this case, lithium has been effective in preventing serious depression, but she is not anxiety free.

Anne, 74, was an aspiring actress married to an actor. She limited her own career in order to give most of her attention to her husband and to her two children. She rationalized that it was better that way since she was not such a good actress. Her symptoms at present are an increasing inability to breathe and she sometimes has severe claustrophobic episodes. These episodes seem to be centered around the fear that something might happen to her husband, who is six years older than she, and that she will be left to face life alone as a non-contributing member of society.

The connection between our roles at home, at work, and in society is a clear component of our developmental well-being, but the compounded losses that accompany the aging process make it more difficult to maintain a stable self-identity. Freud (1917) identified the fear of the loss of the object, the fear of the loss of the object’s love, and the fear of loss of self-esteem as three areas of psychological danger. In aging, as the adaptive defenses become less effective, the dangers become intensified. Erickson (1950) addresses the tasks of this period as identity vs.

despair, where the more developed the individual, the more integrated the sense of identity and the lesser the despair.

As for myself, I recovered my sense of stability. The regression that I experienced in the moment of crisis contributed to a mobilization of my psychological resources and to realistic solutions that, rather than debilitating me, have made me feel stronger. I was able to create what Betty Friedan calls *The Fountain of Aging* (1993). Productivity in the last stage of life in the middle age years leads to a true understanding of the

“Often without our conscious or unconscious intent or knowledge we create concentric circles of influence that may affect others for years and even for generations.”

self. Erickson calls it ego integrity. Hopefully, I have created what Irving Yalom refers to in his book *Staring at the Sun* (2008) as “rippings.” Yalom wrote, “often without our conscious or unconscious intent or knowledge we create concentric circles of influence that may affect others for years and even for generations.”

This has worked for patients as well. Roy found a part-time job at a mental health clinic counseling clients as to how to improve their skills in their fields of work. Being appreciated for the skills and emotional resources he gives

to them has shifted his criteria for self-worth. Mary, who finds driving soothing, has placed her car and her energies into providing her elderly friends and neighbors with needed transportation. Anne has come to the realization that she is a walking “living history;” that in passing on her knowledge of historical, political, and artistic events during her life span to her grandchildren, their friends, or any young person that will listen, she is making a contribution. 🗨️

### **A Moment**

We’ve wound up in hospice  
where there is nowhere to go.

Yet everywhere we are, we are  
surfing in this last hospitality

suite. We dive deep, sweet-sour  
tang, savor even losing our taste.

We swoon shallow, bed ringed  
with prayer and the peculiar

weight of water. The wind  
howls around the building

and though the banshee  
descends we still check

the windows for drafts.

—Margaret Yard, Ph.D.

# A Plea for a Measure of Abnormality:

## Embracing and Celebrating Neurodiversity, One Mind at a Time

By Inna Rozentsvit, M.D., Ph.D.



**Dr. Inna Rozentsvit, M.D., Ph.D., MSciEd, MBA**, is a neurologist, neurorehabilitation specialist, psychoanalyst and neuropsycheducator who is involved in transdisciplinary research on neuro-psycho-biological aspects of health and disease in neurological, mental health, psychosomatic, and neurodevelopmental disorders. She is a founder and medical director of Neurorecovery Solutions, Inc., which serves the neurodiverse community of patients and caregivers.

Dr. Rozentsvit is also the director of programs at the Object Relations Institute for Psychotherapy and Psychoanalysis and the editor-in-chief of the ORI Academic Press. She is co-chair of the Creativity and NeuroPsychoEd Committee of NYSSCSW. [inna.rozentsvit@gmail.com](mailto:inna.rozentsvit@gmail.com)

In 1993, Joyce McDougal wrote a book entitled *Plea for a Measure of Abnormality*, where she challenged what’s “normal” and showed her humaneness and kindness to those of us or our patients, clients, neighbors, or relatives who do not fit into society’s understanding of what’s allowed/ acceptable/ “right” – mostly in relation to the psychoanalytic process in narcissistic pursuits, psychic pain, sexual perversions, and psychosomatic illness, just to name a few.

When we expand this quest for measuring “abnormality” 30 years later, we think more in terms of neurobiological diversity, with all the controversies around it. Controversies arise because of the confusion of (professional) tongues and lack of agreement on how to measure (test) one’s “abnormality.”

If you ask a traditional adult neurologist this question, the abnormality would be measured in the symptoms of neuro-pathological conditions like stroke, multiple sclerosis, Parkinson’s, etc., which also include the neuro-mental symptoms of delusions, delirium, hallucinations, and seizures. A pediatric neurologist would probably recount autism and other neuro-pathological and developmental disorders that show up as abnormal behaviors and developmental delays.

For a neuropsychologist, the abnormality would be measured by testing one’s brain functions: e.g., executive brain functions, which include mainly the working memory (retaining information), cognitive flexibility (thinking in more than one way/direction), and inhibitory control (resisting impulsivity and staying focused).

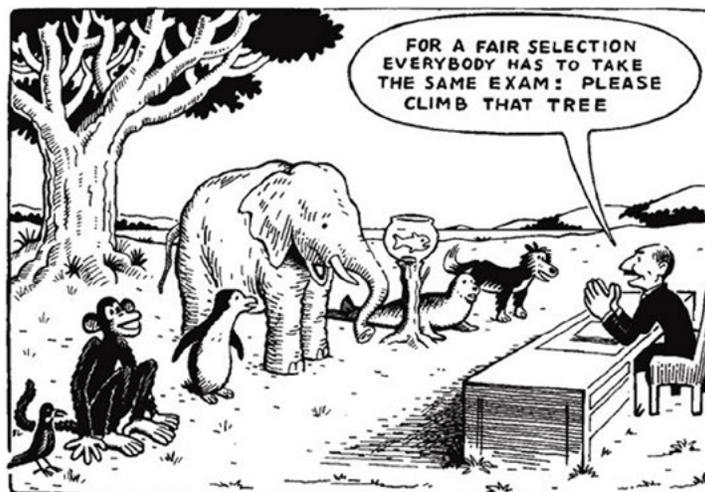
If you ask the same question of a developmental neuroscientist, you will probably hear about “no Theory of Mind” in people with autism spectrum disorders (ASD), which means that people with ASD cannot make inferences about what is in/on the other person’s mind. According to this assumption, people with ASD do not have an idea about other people’s intentions, beliefs, emotions, desires, and thoughts that can be different from their own (Apperly & Butterfill, 2009).

Specialists in speech and language pathology, neurolinguistics, and communication disorders would say that the pathology in neurodiverse people is mainly about severe difficulties in comprehension of spoken language, especially the abstract concepts (adjectives, adverbs, and *wh*-questions), semantic relations and complex syntactic structures (Shane, 2015). They would also say that people with ASD diagnosis are lacking a capacity for empathy (Vollm, 2006) as we know it.



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Some computational neuroscientists and cognitive imaging scientists will say that ASD is a disorder of neural connectivity (Just et al., 2012); others—that there are functional brain asymmetries in three anatomical planes in people with ASD diagnosis v. controls (Desaunay et al., 2023); or that there are abnormalities specifically in corpus callosum (a “bridge” between two hemispheres) connectivity (Loomba et al., 2021); or that facial emotions are accurately encoded in the neural signal (which is new information), and that the problem is possibly in decoding this information (Mayor Torres et al., 2022). The list of problems goes on...



If we ask an educator—she/he will rely on standardized testing to find one’s mind’s “differences” (aka abnormalities), to determine if this student could move to the next class, level, or program. This is reflected in the anecdote which educators in any master’s program learn about: “When asked, ‘What test should you give to a bird, a chimpanzee, a penguin, an elephant, a fish, a seal, and a dog?’—an educator would answer: ‘The tree climbing one, of course.’”

As a neuropsychoe educator, I would say that the problem happens when there is an overload of information for the brain to take in, which causes a breakdown in processing of this information, and the “symptoms” of such a breakdown are socially unacceptable behaviors. When these behaviors are not understood for what they are, there is a further breakdown in inter-personal communications, which cannot be helped by medications or disciplining.

What if we ask parents of neurodiverse children? Responses will vary from feeling shame for “stimming,” abnormal behaviors, low achievement at school—to expressions of pride for their child’s specialness. In her heartfelt poem, “Welcome to Holland,” Emily Kingsley offered a profound

perspective on the experience of raising a child with a developmental disability. She described awaiting her baby as planning a trip to Italy:

“The Coliseum. Michelangelo’s David. Gondolas in Venice...” And then, there is a change in the flight’s plan, and you are not invited to vote on it. And the flight attendant says, “Welcome to Holland.” And that is where you will stay for the rest of your life! It is not a filthy and full of disease place, it’s a different place, even full of beautiful tulips and windmills, but you are not ready to stay, especially when you see other people go to Italy, and they brag about it and all its flashy beauty... But you have to stay here, in Holland! Kingsley says, “And the pain of that will never, ever, ever, ever go away... because the loss of that dream is a very very significant loss... But... if you spend your life mourning the fact that you didn’t get to Italy, you may never be free to enjoy the very special, the very lovely things ... about Holland.”

“The problem happens when there is an overload of information for the brain to take in, which causes a breakdown in processing of this information, and the ‘symptoms’ of such a breakdown are socially unacceptable behaviors.”

So, these parents learn to see the inherent value in the journey (of parenthood) rather than focusing solely on the destination (of fixing their children); and if they don’t—their life is ridden with never-ending

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grief and sorrow. O'Brien (2007) described this phenomenon of mourning the idea of a "normal" (typical) child in mothers of children diagnosed with autism, calling it "ambiguous loss." Ambiguous loss produces all the symptoms of trauma, and if appreciated as such, we, professionals, can become the expert companions in these parents' journeys, which might lead to post-traumatic growth in parents, as well as joyous life for children and families (Grinman, 2020).

“O'Brien described ... [parents] mourning the idea of a 'normal' (typical) child as 'ambiguous loss.' [It] produces all the symptoms of trauma, and if appreciated as such, we, professionals, can become the expert companions in these parents' journeys, which might lead to post-traumatic growth in parents, as well as joyous life for children and families.”

#### Neurodiversity Is...

The concept of "neurodiversity" that is reshaping the way we perceive and understand the human mind was offered in the late 1990s by journalist Harvey Blume and autism advocate Judy Singer. It recognizes and values the inherent diversity in neurological conditions and challenges the notion that there is a single "normal" or "typical" brain. Blume and Singer believed that individuals who are neurologically different deserve recognition as a distinct political category, alongside other established categories such as class, gender, and race. Their aim was to acknowledge the strengths of neurodiverse individuals, to enhance their rights, and to redefine societal perceptions of neurodiversity.

Blume and Singer brought to light the fact that people with dyslexia often possess above-average visual thinking abilities and entrepreneurial skills. Those with ADHD exhibit creative problem-solving skills and imagination, excelling in holistic problem processing based on imagination rather than working memory. Individuals on the

autism spectrum frequently demonstrate an unusual affinity for mathematics and computer programming. Even those who struggle with mental illness often develop unique coping strategies and display heightened creativity.

Today we know that about 15-20% of people who inhabit our planet belong to this neurodiverse group, and this percentage is growing. There was a nearly fourfold increase in parent-reported ASD between 1997-1999 and 2006-2008, as documented by Blumberg et al. (2013) and Boyle et al. (2011). A more recent CDC report showed that children born in 2016 were more likely (56%) to receive an autism diagnosis by age four compared with children born in 2012 (Shaw et al., 2023).

To better conceptualize neurodiversity, we should consider the following key points, offered by the Durham Region Autism Services in Canada: 1) The human brain functions more like a biological ecosystem rather than a computer. 2) Human brains exist along spectrums of ability, and there is a diverse range of mental landscapes. (Many individuals on the autism spectrum may outwardly appear "normal," as cognitive abilities like literacy, sociability, attention, and learning exist on spectrums.) 3) One's abilities are defined subjectively by modern culture, in which the "dis-abled" (neurodiverse) person resides. For example, dyslexia was not a disability until reading became a cultural norm for an average individual (and one of the main accomplishments in school became "reading comprehension"); and the behavior of the person with an autism diagnosis is labeled abnormal because our culture expects adherence to social boundaries and values the innate desire for socialization.

#### Celebrating Neurodiversity Experts and Expert Companions

One of the experts on neurodiversity was Dr. Stanley Greenspan (2000; 2005; 2007), a pediatric psychiatrist, who understood

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that we are all born with so-called individual (processing) differences and that these differences should not be just “fixed” or medicated. Dr. Greenspan believed that “nurturing interactions” based on (body) regulation are the must-have ingredients for one’s social development, as well as learning and intellectual growth. Greenspan (2010) was not concerned with providing diagnostic tags. Instead, his work was about noticing children’s differences in processing sensory information, helping them to regulate and to modulate their emotional responses, to achieve shared attention, engagement, two-way communication, social problem-solving, and continuous flow, and only then—meaningful symbolic communication, logical thinking, and academic skills. (See *Greenspan’s Learning Tree*).

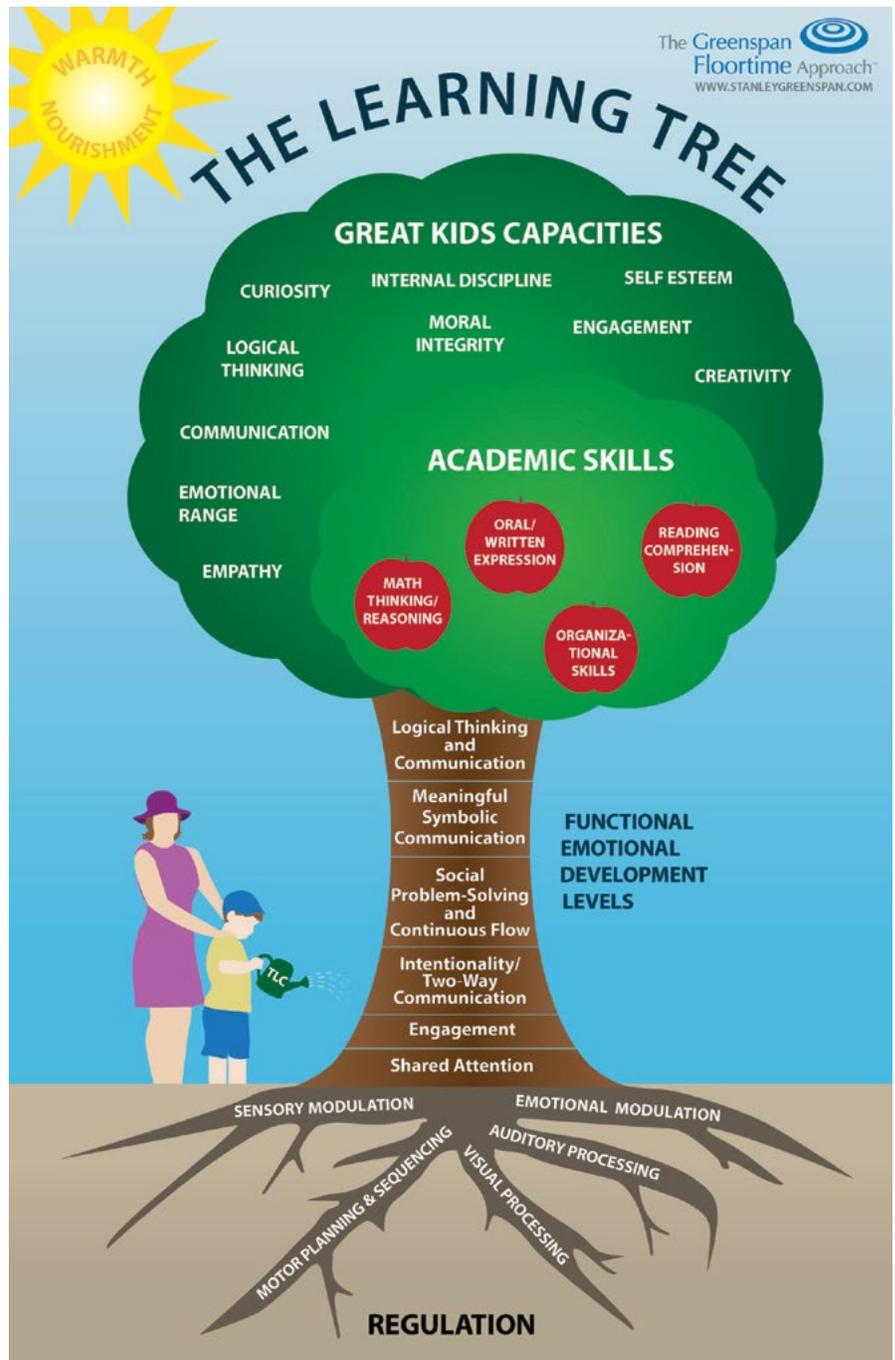
In other words, he was doing the “bottom-up” work with children, so that later in life they could easily exercise the top-down modulation and achieve their highest human potential.

Dr. Eric Kandel, one of the leading neuroscientists and Nobel Prize laureate, as well as the author who popularizes neuroscience, confronted very difficult questions in his lifetime quest to understand the brain-mind dyad: 1) How can the almost 100 billion neurons of our brain communicate to produce the individual Self and consciousness?; and 2) What happens when these connections are miswiring, misfiring, or merely interrupted by physical or psychic trauma? Kandel’s (2007; 2018) work shows how—by studying the disordered brain—we can understand the “ordered” one: studies of ASD illuminate foundations of social instincts; neurological studies of addiction help us understand the relationship of pleasure and willpower; and research on Parkinson’s disease explains the connection of movement, mood, and cognition as a well-orchestrated and well-performed piece of classical music. In his books, Kandel discusses how the diversity in neural processes produces

individual variations (differences) in cognitive functioning, which contribute to the richness of human experiences.

When talking about unusual minds and their contribution to humanity and to the neurodiverse community, we cannot forget Dr. Oliver Sacks, a brilliant neurologist and author. When asked how he would

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like to be remembered in 100 years (during his 1989 interview on “The MacNeil/Lehrer NewsHour”) he said: “I would like it to be thought that I had listened carefully to what patients and others have told me, that I’ve tried to imagine what it was like for them, and that I tried to convey this. And to use a biblical term, the feeling, ‘he bore witness.’” Experiencing neurodiversity himself (he was dealing with the “face blindness” condition), Sacks bore witness to the joys and struggles of various neuro-

“In public talks, Temple Grandin humanizes/normalizes neurodiversity, as she shares how her mind works: it ‘thinks in pictures’ — like ‘Google for pictures,’ it can ‘test-run a piece of equipment. . . just like a virtual reality computer system,’ it attends to details (which a neurotypical mind misses). . .”

diverse populations. In his 1996 book *An Anthropologist on Mars: Seven Paradoxical Tales*, Dr. Sacks offered a fantastic collection of real neuro-pathological case studies, letting us in on some beautiful but complicated human stories and insights that emerge from them.

The title of the book was borrowed from Dr. Temple Grandin, a zoology professor at Colorado State University and an “autistic person” herself. This is how she described her feeling in the world—as a cow or a Martian. The other stories were about remarkable lives of other “different-minded” people: a surgeon with Tourette’s syndrome who exercised a laser-focused precision during operations; an artist who acquired extraordinary skills after traumatic brain injury; and a man with memory area damage, for whom it was always 1968... Sacks (1996) concluded that “defects, disorders, [and] diseases... can play a paradoxical role, by bringing out latent powers, developments, evolutions, forms of life that might never be seen, or even be imaginable, in their absence” (p. xvi).

In her 2010 TED Talk, “The World Needs All Kinds of Minds,” Grandin called for acceptance and appreciation of people “on the spectrum,” asking, “When does a nerd turn into Asperger, which is just mild autism? I mean, Einstein and Mozart and Tesla would all be probably diagnosed as Autistic spectrum today.”

Over the last 25 years, Grandin has become a fierce advocate for the ASD community. In her public talks, she humanizes/normalizes neurodiversity, as she shares how her mind works: it “thinks in pictures”—like “Google for pictures,” it can “test-run a piece of equipment... just like a virtual reality computer system,” it attends to details (which a neurotypical mind misses), collecting them bottom-up (which helps in problem-solving), and it thrives on hands-on activities (like working in the auto-shop, or drafting, or creating art), not on abstract ones; it also tends to be a “specialist” mind—good at one thing and not at others. Grandin calls her type of mind a “photo-realistic visual thinker,” and she describes other neuro-atypical minds as “pattern thinkers” (who become engineers and computer programmers), “music and math” minds, and verbal minds (they “know every fact about everything”). She explains that it is about different wiring: some people are wired to have “cognitive” minds, and some—“social” minds; and that there is a trade-off between these two wiring circuits—that’s all!

Grandin admits that there are some deficiencies in her mind’s operations that she had to deal with, but she feels that people with ASD can adjust to anything they put their minds to. She says that she, like most people on the spectrum, has “sensory issues” (more precisely, sensory processing issues), like touch, light, and sound sensitivity. Still, she learned to give herself more time to process these stimuli. And, she had to train herself to “understand” (feel) time; so, when asked once for some advice about dealing with one student’s poor time perception, she (pragmatically) said, “Just buy her a big clock!”

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**What's Next?**

Dr. Temple Grandin's 2010 TED Talk is a call for appreciation and celebration of neurodiversity. As she lets us in on intricate details of a neuroatypical mind (and a mindset), she also voices a concern: there are not too many young people from this (growing) community appearing in Silicon Valley these days; teachers "do not know what to do with these kids," and the hands-on activities that stimulate these minds to grow are taken out of the K-12 classroom.

As Grandin says, "We need different kinds of minds to work together." To do just that, we need to develop and promote different approaches to stimulating and nurturing neuroatypical minds (not "fixing" them, but letting their abilities unfold—through their mind's "working" rather than following commands) and helping them to integrate into the melting-pot world (rather than providing them with "safe" spaces that do not require either skill building or resilience).

We need to provide them with a healthy, positive, environment that directly modifies the brain (by stimulating the development of complex networks of neuronal connections), furthering its ability to adapt, which leads to one's thriving and success (Durham Region Autism Services, n.d.).

What does it mean practically? As Grandin says, "We've got to show these kids interesting stuff." Also, we need to take these kids out of the "autism sensitivity" bubble and "teach them basic things"—like how to be on time, how to have "table manners," and how to be useful (e.g., to do some work. Grandin recalls being a dressmaker when she was 13, and taking any internship job available when she was in college). As per Grandin, we need to know the pitfalls of neurodiverse minds (like being stuck on one idea) and use those to stimulate some great abilities.

For example, a fixation on cars can be used to motivate a child to do some mathematical calculations related to cars, and a fixation on Legos can be used to build different structures.

Grandin's pragmatic enthusiasm about neuroatypicals is a breath of fresh air: she talks about these people becoming an integral part of the human tribe, and not a protected species, when she describes what kind of jobs neuroatypical minds can do. Visual thinkers can become graphic designers, computer experts, photographers, and industrial designers. The pattern thinkers will be our mathematicians, software engineers, and programmers. The "word minds" will make great journalists and stage actors (as many of them must learn

“We need to develop . . . different approaches to stimulating and nurturing neuroatypical minds (not 'fixing' them, but letting their abilities unfold. . .) and helping them to integrate into the melting-pot world. . .”

social skills as "being in a play"). Grandin also speaks about making changes in the educational system and attracting people from other fields to teach in K-12 classrooms—to "light the spark" (aka to motivate these kids to learn) and to expose them to new things to work on. We also need teachers and mentors to understand that neuroatypical brains need specific tasks rather than general ones and "it is never too late to expand the mind of a person on the autism spectrum" (Grandin, 2010).

As I am celebrating neurodiversity every day of my life, I will finish this article with Temple Grandin's (2006) quote: "If by some magic, autism had been eradicated from the face of the Earth, then men would still be socializing in front of a wood fire at the entrance to a cave." 🗨️

## HEADQUARTERS UPDATE

The first half of 2023 has flown by. We have been working with the Society's Chapters and the ACE Foundation on education programs a few weekends every month. The 54th Annual Education Conference, held in April, was very well received.

We continue to work with the PR Committee and the PR firm on a new website for the Society. The website should have a fresh new look soon!

The 2022 Scholarship awards ceremony was held on Zoom at the end of January. A video of the students was followed by a Zoom after-party. Once again, it was a wonderful event.

The NYSSCSW Board held its first hybrid meeting in March at the Fifth Avenue Presbyterian Church. The Board will use this system again in September and November. The June meeting will be in person.

In March, I represented the Society at the MSW Virtual Job Fair, meeting with graduating social work students virtually and explaining the Society and its benefits to them. There were over 900 students in attendance, all eager to start working and networking.

Looking ahead, the Annual Membership Meeting will be held on Sunday, October 22, 2023, at Red Hat on the River in Irvington. We hope to see you there.

We hope you all enjoy your summer!

*Kristin*

Kristin Kuenzel, Administrator  
Debbie Lebnikoff, Administrative Assistant

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## NEURODIVERSITY Continued from page 33

For some short essays related to neuropsychobiological lenses on various things (aggression, thanks-giving, beholder share) visit [innarozentsvit.com](http://innarozentsvit.com). For more information on neurodiversity, visit one of my web sites "Celebrating Neurodiversity 365™" [CelebratingNeurodiversity365.com](http://CelebratingNeurodiversity365.com).

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## ***As I Grew Older***

by Langston Hughes

It was a long time ago.  
I have almost forgotten my dream.  
But it was there then,  
In front of me,  
Bright like a sun,—  
My dream.  
And then the wall rose,  
Rose slowly,  
Slowly,  
Between me and my dream.  
Rose slowly, slowly,  
Dimming,  
Hiding,  
The light of my dream.  
Rose until it touched the sky,—  
The wall.  
Shadow.  
I am black.  
I lie down in the shadow.  
No longer the light of my dream before me,  
Above me.  
Only the thick wall.  
Only the shadow.  
My hands!  
My dark hands!  
Break through the wall!  
Find my dream!  
Help me to shatter this darkness,  
To smash this night,  
To break this shadow  
Into a thousand lights of sun,  
Into a thousand whirling dreams  
Of sun!

This poem is in the public domain. Published in Poem-a-Day on February 5, 2022, by the Academy of American Poets.

## **NEW MEMBERS OF NYSSCSW**

### **NAME /CHAPTER**

Arens Fuerstein, Laura	MET
Breslow, Mandy, LCSW	NAS
Brody, Heidi, LCSW-R	WES
Bronstein, Lauren, LCSW	MET
Brown-Eisel, Lisa, MSW, LCSW	NAS
Campbell, Robert, LCSW	MET
Canizares, Jaime, J.D.	MET
Chabot, Roger	MET
Cyrus, Ryan, LCSW	MET
Demetri, James Peter, LCSW	MID
Eisenberg, Sheryl, LMSW, MSW	MET
Ellison, Kim, MSW, LCSW	MID
Far, Lida	NAS
Finkel, Genny, LCSW	MET
Foglia, Alissa	MET
Gaetani, Anthony	NAS
Goldfield, Joseph	MET
Gomberg, Cara, LCSW	MET
Gorokhovsky, Helen, LCSW-R	ROC
Griff, Lois, MSW	MET
Haley, Christopher	MET
Harris, Carol, LCSW	MET
Herman, Andrea, LMSW, MBA, MSW	MET
Kanoff, Jennifer, LCSW-R	MET
Lehman, Cheryl, LCSW	MET
Linne, Tara-Marie, ACSW, BCD, DCSW	MET
Maniaci, Cara	WES
Melara, Erin	MET
Monaco, Diana, LMSW	MET
Moses, Kathleen Clark, ACSW	WES
Nelson, J., CSW	QUE
Ocskay, Elizabeth, DCSW	MID
Owens, M. Julius, MBA, MSW, LCSW	MET
Rambeau, Paulina, LMSW	NAS
Robins, Emily	MET
Ryan, Rosemary, MS	NAS
Schnapp, Jonathan, LCSW	MET
Serrano, Corby, LCSW	MET
Teska, Courtney, LCSW	SUF
Tsai, Erica, LMSW, MSW	MET
Vargas, Justin	MET

**CHAPTER KEY:** MET—Metropolitan, MID—Mid-Hudson, NAS—Nassau County, QUE—Queens County, ROC—Rockland County, SI—Staten Island, SUF—Suffolk County, WES—Westchester County.

## From “On Aging”

by Maya Angelou

When you see me sitting quietly,  
Like a sack left on the shelf,  
Don't think I need your chattering.  
I'm listening to myself.  
Hold! Stop! Don't pity me!  
Hold! Stop your sympathy!  
Understanding if you got it,  
Otherwise I'll do without it!

[poemhunter.com/poem/on-aging-2/](http://poemhunter.com/poem/on-aging-2/)

## We Welcome Submissions

We encourage you to submit an original article or review to *The Clinician*. In general, the article should—

- Be of interest to a broad range of clinicians.
- Focus on clinical issues and treatment.
- Be clearly written and jargon-free.
- Use case examples where possible.
- Not exceed 1,000 words. Shorter is better.
- Include your brief professional bio.

Please send a description of your proposed article in advance. We look forward to hearing from you.

**Helen Hinckley Krackow, LCSW-R, Committee Chair**  
[hkrackow@gmail.com](mailto:hkrackow@gmail.com)

**Ivy Miller, Editor**  
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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY  
FOR CLINICAL SOCIAL WORK, INC.

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**Visit us at: [www.clinicalsocialworkassociation.org](http://www.clinicalsocialworkassociation.org)**

### **“Written in a Carefree Mood”**

by Lu Yu, 12th-century Chinese poet

Old man pushing seventy,  
In truth he acts like a little boy,  
Whooping with delight when he spies some mountain fruits,  
Laughing with joy, tagging after village mummings;  
With the others having fun stacking tiles to make a pagoda,  
Standing alone staring at his image in the jardinière pool.  
Tucked under his arm, a battered book to read,  
Just like the time he first set out to school.

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# The NYS Early Intervention Program Needs **YOU!**



The NYS Early Intervention Program serves infants and toddlers with developmental disabilities and delays from birth to age three and their families in their own homes and communities statewide.

## Why our current providers work for NYS Early Intervention (EI):

I consider it an honor to empower EI families to become their child's best role model and advocate."  
 – From a Speech-Language Pathologist.

It is amazing to be a part of our children and families' journey while helping pave the way for a successful future!"  
 – From an Occupational Therapist.

Working with EI children and their families answers our desire to help change the path of a human being immediately, while representing 'what can be' to the families who are desperate for your help and guidance."  
 – From an EI Administrator.

## If you choose to work in NYS Early Intervention, you can:

### HELP CHILDREN AND FAMILIES

- Witness many of the “firsts” that infants and toddlers reach (first steps, first words)
- Help set the educational foundations for lifelong learners
- See the results of your work – sometimes instantly!
- Develop close partnerships with families
- Help parents see the beauty in their child's strengths and possibilities

### JOB PERKS

- Flexible work schedule (part-time/full-time, evenings/weekends, choose your caseload size)
- Many agencies across the state are accepting new providers and you could work with multiple agencies
- Use your imagination and creative skills to plan activities
- Build a large professional network
- Grow and gain professional knowledge by collaborating with families and other professionals

## We currently have a shortage of qualified providers to deliver services to children and families.

We are seeking providers with the following New York State certifications and licenses:

- |                                |                            |  |
|--------------------------------|----------------------------|--|
| • Audiologists                 | • Nutritionists/Dieticians | • Social Workers   |
| • Behavior Analysts (LBA/CBAA) | • Occupational Therapists  | • Speech-Language Pathologists                                       |
| • Mental Health Practitioners  | • Physical Therapists      | • Teachers (special education, vision, hearing, speech and language) |
| • Nurses                       | • Psychologists            |  |

If interested in a job opportunity in The NYS Early Intervention Program, visit our website at <https://health.ny.gov/EINeedsYou> or email us at [provider@health.ny.gov](mailto:provider@health.ny.gov) or by calling 518-473-7016 (Option 1 - Provider Unit).



New York State Society for  
Clinical Social Work, Inc.  
55 Harristown Road, Suite 106  
Glen Rock, NJ 07452



## **Connect → Participate → Grow**

### **Join the New York State Society for Clinical Social Work Today!**

We are a community of highly trained clinicians committed to maintaining standards of professional education and practice in clinical social work psychotherapy. We provide mental health services in a variety of settings including private practice. Join us and network with LCSWs, LMSWs, MSW students, institute candidates, and other mental health professionals.

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- **Advocate for Clinical Social Work** • *Lobbying, Coalitions, Legislation, Practice Management*
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- **Collegiality & Connections** • *State & Chapter Events, Committees, Listservs, Website, Facebook, Newsletters*

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