The CLINICIAN

Fall 1995 Vol. 26 No. 3

The Newsletter of the New York State Society for Clinical Social Work, Inc.

Self Psychology and Clinical Social Work

"Start where the client is," a key social work principle, is also at the heart of self psychology's empathic treatment process.

SPECIAL FEATURE

By
Eda G. Goldstein, DSW, CSW

In today's practice arena, psychodynamically oriented clinicians can draw on four major psychologies to guide their clinical work. Drive theory, ego psychology, American and British object relations theories and self psychology each describe a baby with a different developmental course, distinctive problems and unique treatment needs. As Dr. David Phillips noted in a recent issue of the Clinical Social Work Journal (1993), this is potentially confusing and stressful since unless one is religiously wedded to a single approach, it is difficult to decide when to do what to whom. I am reminded of an old story about a man who visited a psychiatrist and complained of work-related stress. The client reported that his job was to sort the oranges, grapefruits and melons that flowed down a chute and to put each type of fruit in an appropriate carton. The psychiatrist asked, "But what is hard about that? It seems so simple." The client replied, "Doctor, you don't understand. All day long its decisions, decisions, decisions."

In this paper, I shall present the major principles of self psychology — the newest and perhaps least well-known of the four psychologies — and their implications for clinical social work. While self psychology, which was originated by Heinz Kohut, has led to major revisions in how therapists use themselves in the treatment process, it embodies certain ideas that are central to social work. It is a biopsychosocial theory that emphasizes the role of both innate and environmental conditions in the developmental process. Self psychologists see self-actualization in all its forms, rather than conformity, as an important goal of treatment. Being different is not equated with being pathological. They challenge the view that the capacity for total autonomy is the hallmark of health and believe instead that the need for others to provide validation, admiration, support and sustenance continues all through life. Self psychologists argue that treatment must build and strengthen the personality.

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HYPNOSIS CONFERENCE
Sunday, Nov. 19th
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Mental Health Treatment Is Integral

Helen Hinckley Krackow

CSW, BCD,
Society President

Building the Dialogue

These last three months have launched an important phase in the leadership of our State Society. It started in mid-June, when the chapter presidents hired a facilitator to meet with them at the home of Fran Aquino, President of the Rockland Chapter. The meeting was born out of the desire to reassess our mission and become more proactive on the grassroots level. The presidents invited me to attend, an invitation extended as a gift to help me strengthen our Society and accomplish my goals as State President. The meeting was the joyous fruit of democratic problem solving.

"To build more cohesion between the chapters . . . four chapter presidents visited Syracuse."

Sixteen of us met for close to five hours. Fran's daughter had her first paid job helping us with the practical aspects of the meeting, such as computer labels and lunch. The facilitator helped us focus on our concerns for the profession and our Society, formulating these into objectives, analyzing the forces impacting cohesion, and developing an action plan. Many, many thanks are due the presidents of the chapters and Shirley Ross of Rockland County for her assistance in organizing this event.

The immediate results of this meeting were wonderful. The election slate for vacant offices on the Board was filled in under a week. This is a record.

One of the objectives to come out of the meeting was to build more cohesion between the chapters. In a large state with far-flung chapters, that can be difficult. To begin work toward this goal, four presidents agreed to visit the Syracuse Chapter and attend its conference with me in late September — Joan Elkin of Westchester, Karen Whitton of Mid-Hudson, Judith Weiss of Staten Island and Fran Aquino of Rockland. Judy Crosley, President of Syracuse, generously opened her home to us before the conference, giving us time to get to know each other and discuss chapter concerns such as mentoring programs for recent social work graduates.

On Friday morning we attended the best conference on short term dynamic therapy that any of us has ever been to. The presenter was Leigh McCullough-Vaillant, PhD. She is currently at Harvard Medical School and was a former director of Research at Beth Israel Medical Center's Short Term Psychotherapy Research Program in New York. The attendees, drawn from across Western New York and from all the mental health professions, were treated to Leigh's warmth and sensitivity, combined with a clear, organized presentation of techniques that have been thoroughly researched.

She has spent years assessing therapeutic sessions on videotape. Her investigations have yielded data on patients' defenses and conflicts and a unique ability to describe in words what therapists actually do. She has noticed that no matter how clinicians were trained, they instinctively adopt certain methods, some not

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described in the literature. And she has developed techniques for fine tuning interventions; hers are offered with enormous supportiveness and validation. Would that our long-term therapies could mount this type of research demonstrating their effectiveness so clearly. Dr. McCullough-Vaillant has a book due out in June 1996.

Conferences like this one are the best that any professional society can hope to offer — opportunities to learn a variety of therapeutic techniques in a comfortable and collegial atmosphere.

So the winter of '95-'96 is off to a great start. We are building the dialogue about the profession outward to our membership and back again, from our chapter presidents to the larger State Board, to the members and between practitioners of different modalities. Our cooperation and communication will strengthen us all.■

Meeting in Syracuse: L. to r., facing page, (left photo) President Krackow and Chapter Presidents Fran Aquino, Rockland, Judith Weiss, Staten Island and Karen Whitton, Mid-Hudson; (right photo) Judy Crosley, Syracuse Chapter President. Above, (top) Joy Perlow, Founding Past President of Syracuse Chapter and Joan Bornstein; (below) Speaker Dr. Leigh McCullough-Vaillant and Marlana Stabler, Syracuse Chapter Program & Education Chair. Not shown, Joan Elkin, Westchester President.

SPECIAL REPORT

An inside look at the mentoring group experience

By Roxandra Antoniadis, Ph.D., C.S.W.

Editor's Note: This is the second in a series of articles about the many mentoring groups active in the state. Here a protege of the Wednesday night Manhattan group, under the direction of Barbara Bryan, MSW, BCD, Director of the State Society's Mentoring Program, provides a very personal, eloquent insider's view of the process.

I was nervous, all right. This was my first mentor meeting, in late January of this year. After a long and very active career in university teaching, research, and service, I had decided, a few years back, with subsequent processing in my own analysis, to undertake study in social work. It was still a few more weeks before I would graduate from Fordham and earn my New York State certification. I'd seen my two children launch their own careers, and now I, too, was setting off on a new course.

It was daunting. Barbara Bryan's group was small, and its members projected ease and familiarity with one another. I was the only new person in the circle. I had also gathered in advance from conversations with Barbara that the level of social work experience was greater than mine. Although I was a volunteer therapist at the Manhattan Veterans Center following upon my second-year internship there, my current job wasn't even in social work. Members of the group, however, were already full-time in the field. All held agency jobs, and some had a few private clients. In such a gathering, could I really call myself a social worker? Ridiculous. But if not now, when, exactly? I knew my eventual goal was private practice, but how and how soon to get there? If I was in my 50's now, shouldn't I be...oh, 84 for that? After all, that was the age of my best friend's therapist, a rousing woman who had known Jung, and who kept my friend more alert, as he put it, to his professed neuroses than he sometimes cared to be.

And what about my current job? Should I keep it? Having brought up children on my own with few resources, could I now afford a significant cut in salary, as well as potential retirement income, by taking a social work position? Was there a job out there that was worth such a risk? Should I go to an institute? Do fee-for-service? (What was that, anyway?) Build a practice on the side? Maybe options two and four combined could work...or one, three, and five. All of the above? I was chaotic with questions. I needed grounding, a sense of community, people to connect with during this turbulent transition, to share feelings and worries with, both about my immediate and long-term future. Paradoxically, however, I don't speak readily in groups, so I was assaulted equally, like the new kid on the block, by shyness as well as need.

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START A PROGRAM

If you would like information about the program, please contact Barbara Bryan, Director of the Mentoring Program, at (212) 864-5663.

Book Review

by Jeffrey Seinfeld, Ph.D.

Ego Psychology and Social Work Practice.

N.Y. The Free Press. 1995 Second Edition. 368 pages.

by Dr. Eda G. Goldstein

Eda Goldstein has revised and expanded her classical ego psychology text. This is an important event because this new volume addresses many of the important social issues that have arisen since its original publication.

The new volume incorporates new knowledge concerning the effects of the socio-political context and the impact of sexism, homophobia, racial stigma, discrimination, lack of resources and rigid role requirements on clients. Dr. Goldstein disavows those approaches that either discount all theories of personality development and advocate an exclusive focus of changing society or rely exclusively on a personality pathology framework, discounting any effort to change society. Instead, she recommends that the ego practitioner use personality theories selectively and on an individualized basis specific to the facts of the particular case, while helping the client understand him- or herself in relationship to socio-political and cultural forces, as well as those of personal and family history. I might say in my own terms that Dr. Goldstein reminds us that individuals do not only internalize objects but also the socio-political and cultural forces influencing their lives.

In this volume Eda Goldstein applies ego theory to newly considered populations such as women, persons with AIDS, persons subject to trauma, persons of color, persons who have lived with oppression and persons who have suffered from substance abuse. She identifies ten common themes that characterize work with these special and oppressed populations: exercising self awareness; balancing a focus that appreciates the importance of the client's group identity and membership with his or her unique individuality; enhancing and focusing on the client's strengths; building self esteem and personal empowerment; equalizing the power in the therapeutic relationship; maximizing choices and enhancing options; linking the client to needed resources; involving clients in mutual aid and peer support groups; and encouraging political and collective action. Dr. Goldstein devotes a specific section to each of these themes and describes in clear, practical terms their implications for treatment.

This volume offers much in the way of practice wisdom for populations that have, for the most part, been neglected in the traditional literature. It is suggested that practitioners working with Caribbean-Americans, Latinos, Asian-Americans, African-Americans and Native Americans explore the contributions of ethnicity, immigration, race, poverty and oppression to the presenting problem. The practitioner is reminded that the client may be experiencing stress as a result of cultural conflict, loss, unfamiliar surroundings, a different language, new customs and so forth. There is specific knowledge offered about particular populations—for instance, we learn that Chinese-Americans may consider complaining about depression or anxiety a failure and may be more likely to be presenting problems centered around fulfilling role requirements, for instance, at school, work or in the family.

This volume offers much in the way of practice wisdom for populations that have, for the most part, been neglected in the traditional literature.

Dr. Goldstein stresses the importance of focusing on the strengths of these clients and not overly interpreting behavior as pathology. Thus, she points out that in evaluating women and their ego capacities, characteristics such as passivity, lack of assertiveness, difficulty expressing anger, self sacrifice and even self destructiveness may be understood as adaptive solutions to oppressive social conditions or traditional social roles rather than as evidence of innate masochism or pathology. Dr. Goldstein emphasizes that behavioral traits in those populations, sometimes considered pathological, must be reconsidered for their role in aiding psychological survival. Furthermore, in the assessment of women demonstrating clear cut diagnostic disorders, such as anorexia or bulimia, anxiety states or clinical depression, the practitioner must take into account the socialization and environmental factors and the lack of positive outlets and supports and the societal and cultural influences that may contribute to the symptom manifestations.

While devoting much attention to the strengths of special popula-

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Jeffrey Seinfeld, Ph.D., is a full time associate professor of Master's and Doctoral courses at New York University School of Social Work. He is the author of several books, including The Empty Core: Psychotherapy of Schizoid States; The Bad Object: Handling the Negative Therapeutic Reaction; and the forthcoming Interpretation and Holding: The Paternal and Maternal Functions of the Psychotherapist, all published in Northvale, N.J.: Jason Aronson.

FRONTLINES

■ NASSAU CHAPTER

Dr. David Scharff Speaks at Annual Meeting

by Marcia E. Leeds, CSW

On September 17, the Chapter held its annual beginning-of-the-year brunch at the Top of the Commons at C.W. Post College. The guest speaker was David Scharff, M.D., who spoke about *Treating the Family Traumatized by Physical or Sexual Abuse.*

He began with an introduction to the British Object Relations perspective and summarized the work of W.D. Fairbairn. Fairbairn departed from Freud's notion that the basic development of the individual was based on the pleasure principle and put forth the idea that the center of development has to do with the fundamental need for a relationship. According to Fairbairn, the infant, from the first moments of life, is striving for a relationship. As the child grows and develops, the internal objects taken in from his earliest relationships become aspects of the self which form the personality and impact on the individual in all relationships throughout life.

Fairbairn's work represents a reorientation of psychoanalysis with the emphasis on reciprocity between subject and object as being at the core of human striving. In this view, the subject-object relationship contributes to the identity of self, rather than instinctual gratification, as Freud postulated. It expanded Freud's ideas about human capacities and suggested that development of the individual does not occur in isolation, but rather in a process by which the individual experiences an interplay between the external world and the images that are then internalized.

Dr. Scharff spoke about how in his work and writings he has applied Fairbairn's concepts to family and marital therapy. He shared his work with the audience through a videotape of excerpts from several sessions with a family who had experienced a severe trauma . The husband and father had his right arm and shoulder amputated as a result of an infection. The depth of this trauma was uncovered as the history of each member of the couple was revealed and worked with. Each partner had been raised in an abusive family and the object relationships formed were clearly getting in the way of each one's coping mechanisms and ability to manage the rage that was being split off in their relationship. The video illuminated many of the theoretical points raised in Dr. Scharff's presentation. We thank him for an informative and thought-provoking discussion.

■ QUEENS CHAPTER

On Nov. 5, Ira Frankel Will Present Primary Care Evaluation of Mental Disorders

Ira Frankel, Ph.D., BCD, President of the Queens Chapter and Chair of its Research Committee, will present The Primary Care Evaluation of Mental Disorders: The PRIME-MD, at Holliswood Hospital on Sunday, Nov. 5, 1995, between 10:30 a.m. and noon.

The information in this presentation derives from research conducted at the New York State Psychiatric Institute by the people who wrote the diagnostic manuals and who wanted to develop a method of teaching primary care physicians to recognize mental disorders. The material is essential for clinical social workers who must develop reciprocal relationships with the physicians who will serve as gatekeepers and sources of referrals in the evolving health care environment.

As Program Director of the Outpatient Psychiatry Clinic of the New York Hospital Medical Center of Queens, Dr. Frankel has initiated The PRIME-MD Project, where primary care physicians will be taught how to become better diagnosticians of mental disorders.

For additional information, call Dr. Frankel at (718) 544-8821.

■ FAMILY THERAPY COMMITTEE

New Study Groups Formed

by Barbara Feld, Chair

The Family Therapy Committee has spent the past year networking and supporting the heads of the various chapters' family study groups in building and expanding their groups. As a result, a new group was started in Nassau; its first meeting will be held on October 8. Please contact Marcia Leeds at (516) 868-0523 for more information. If you are interested in joining a family study group in Rockland, please contact Irene Falander at (914) 268-9770; Mid-Hudson, contact Yasuko Hatano-Collier at (914) 297-1739; Westchester, contact Susan Gombos at (914) 693-3611; and the Metropolitan chapter, contact Barbara Feld at (212) 410-3680. We are continuing to try to develop study groups in the other chapters. If you are interested in starting one, please contact Barbara Feld at the above number, or your chapter president.

Corrections:

We regret errors in the Spring issue in the article about the induction into the National Academy of Practice of our esteemed colleague Alice Medine King, CSW, RCSW, BCD. She is currently Chairperson of the Legislative Committee of the National Federation. Other posts listed at the National Federation and Coalition of Mental Health Professionals and Consumers are no longer current activities.■

Call for Proposals for Workshops and Panels for

The 27th Annual Conference of The NYS Society for Clinical Social Work, Inc.

The Forgotten Father

Intrapsychic, Familial and Cultural Implications

CALL FOR PROPOSALS:

We are looking for proposals for workshops and panels from all modalities — individual, group, couples, family, etc., as well as from all theoretical orientations. The focus should be on the importance of the father and how it impacts on your work.

Date of Conference: May 18, 1996

Deadline for submission of proposals: November 30, 1995.

Proposals should be a minimum of two typewritten pages, double spaced, and should include the following:

1. Description purpose, function and teaching objectives.
2. A workshop or panel outline and bibliography.
3. Four copies, with biography on a separate page.

Mail to:
Dianne Heller Kaminsky, CSW, BCD
Chair, Education
1192 Park Avenue,4E
New York, New York 10128
(212-369-7104)

VENDORSHIP COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

New Markets Opened to Clinical Social Workers

Aggressive marketing to self-insured companies which prohibit reimbursement to clinical social workers (CSWs) is reaping rewards. Recently we reported that Merrill Lynch will begin to include CSWs as reimburseable providers for its 100,000 plus insureds beginning Jan. 1, 1996. Through marketing efforts begun in New York and carried on by our national marketing consultant, Gary Unruh, the following self-insureds have changed their contracts to include independent CSW's for reimbursement:

AT&T: Eff. 1/1/96 through MEDCO.
Local #851, NY: 4,000 insureds (indemnity plan)
Group Benefit Administration: CSWs now included under their definition of physician (indemnity plan).
Deere and Company: Eff. 1/1/96 through U.S. Behavioral Health.

****MEDCO** will be sending out panel applications in September, so if you don't get one by 10/1/96, call 1-800-999-9772 and request one.

We are ceasing our marketing efforts with the Enquirer/Star (500 employees). They are convinced that including clinical social workers would add to their cost outlay (a false conclusion). We are also ceasing our efforts with the Hotel/ Restaurant Employees International Union (HEREIU). They have over 15 plans and feel they cannot uniformly change their policy. Whether this is a smokescreen or a testament to the necessity of clinical social work to get its international act together, we can't be sure.

There is a national effort spearheaded by the National Federation of Societies for Clinical Social Work's Marketing/PR Committee to identify and market all self-insured/self-funded benefit plans which exclude CSWs from reimbursement for provision of mental health services. The Federation is currently marketing to 71 companies. To this end, one or more point persons have been designated in each Society state to take reports of non-reimbursing companies from their state membership and forward this information to our national committee and salaried marketing consultant for marketing on a national level. The reason for this is that most large self insured companies are interstate and will not respond to an individual state's efforts for them to alter their policies relating to clinical social work exclusion.

We continue to make efforts to persuade the following companies to change their policy of excluding CSWs as reimburseable providers of mental health services: Arrow Electronics, Barnes and Nobel (M.D. supervision), Caldor, Hertz, IBM (indemnity plan), Iron Workers of America, Motorola, Nassau Carpenters Union, Sun Chemical, Unisys Corp., and United Technologies.

If you encounter a plan which excludes CSWs from reimbursement or requires their supervision by an M.D. or Ph.D., please contact your local vendorship/marketing point person.

Managed Care Issues

Value Behavioral Health: Our committee has received many complaints regarding the VBH provider agreement recently sent out. We are not alone. Several respresentative organizations nationwide have received a like outpouring of concern (e.g., NASW, APA). I have forwarded our society's concerns to Federation President Chad Breckenridge, who is meeting with the national heads of managed care companies when the national membership have problems with managed care. He has already met with MCC, HAI and CIGNA, and has been provided with all the information Vendorship has on the New York response to the VBH agreement.

Empire Mental Health Choice

As many of you now know, Empire Mental Health Choice has been taken over by MEDCO. The preliminary feedback from members is not good. Reports of increased MEDCO micro-management, and pressure to limit "medically necessary" care, have begun to trickle in. Vendorship has written to our legislators regarding the numerous provider terminations without cause by EMHC. One must wonder if this is an effort at cost reduction before MEDCO takes over in January. If you are terminated without cause, let your legislators know how you feel and how you'll vote.

Consumer Bill of Rights

Vendorship has sent a letter to members of the NYS Senate Insurance, Health and Mental Health Committees urging the passage of the Health Care Consumers' Bill of Rights. While the Assembly has passed its version of the bill (A 6800), the Senate has not acted on

Continued on facing page

Denied Reimbursement?

Or, do you want to improve press coverage of Social Work Issues?

Call Your Chapter's Vendorship/ Marketing Point Person

Chapter	Contact
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Mid-Hudson	Marilyn Stevens (914) 462-4178
Nassau	Fred Frankel (516) 935-4930
Queens	Shirley Sillekens (718) 527-7742
Rockland	Lenore Green (914) 358-2546
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Syracuse	Pat Demyan (315) 476-4274
Westchester	Anne Gordon (914) 235-5244
Western NYS	Laura Salwen (716) 838-2440

LEGISLATION COMMITTEE REPORT

by Marsha Wineburgh, MSW, BCD, Chair

State Begins to Study Licensing the Practice of Psychotherapy to Protect Consumers

In response to both consumer complaints and the introduction of scope of practice licensing bills for social work (A.5989-A\S.4979), Psychology and the Mental Health Therapists (a group representing marriage and family therapists, mental health counselors, pastoral counselors, creative arts therapists and psychoanalysts without traditional mental health degrees), the Legislature has decided to reassess licensing all mental health practitioners. Because there is no regulation of psychotherapy in New York State, a loophole has been created by which incompetent practitioners can continue to practice after losing their license/certification. In addition, there is a need to balance increasing regulation to protect consumers with consumer access to all competent practitioners. Current licensing legislation, if passed, prevents practitioners outside social work, psychology, nursing and psychiatry from continuing to work in established practices, limiting competition to those groups currently regulated.

With these problems in mind, the Senate Higher Education Committee has requested that all bills dealing with the professions be held in this committee pending review. The good news is the State is again considering the issue of regulating psychotherapy. The bad news is that one can't predict how long it will take to find a resolution which must be agreed on by all parties before any scope of practice legislation can be successfully passed.

Legislative Update

Managed Care Legislation

The NYSSCSW is actively supporting S.4188 (Velella, Hannon)/A. 6800-B (Grannis, Gottfried), an act to amend the Insurance Law and the Public Health Law to establish standards for the quality of care consumers receive from managed care plans, provide consumers with the information they need to make informed decisions or challenge unfair determinations and to set uniform standards for certain problem areas which frequently result in disputes between consumers, providers and managed care plans. There has been an intensive campaign for quality and choice to support these bills, highlighted by a Health Care Bill of Rights.

To date, A. 6800-B, now amended, was passed by the Assembly and sent to the Senate Rules Committee, where it awaited its companion bill in the Senate. S.4188, however, stayed in the Senate Insurance Committee and was not considered. In January, the beginning of an election year, the campaign to pass these two bills will be renewed. Letters pressing for passage have already been requested from our membership.

Jury Service

Lastly, the Judiciary Law has been amended to modify the qualifications for jury service. It essentially eliminates all jury exemptions. Anyone who is a U.S. citizen and county resident, at least 18 years old, without past felony convictions, who understands and communicates in English and has not served on a jury within the past four years, is eligible. Only State and Federal judges are disqualified.■

Chapter Legislative Chairs

Brooklyn	Geri Ness (718) 789-6739
Met (Bx, Man)	John Chiaramonte (212) 535-3839
Albany	Paula Mosher 518 438-2990
Mid-Hudson	Cindy Marschke 914 452-1110
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Suffolk	Dorothy Sokol (516) 493-0918
Syracuse	Jon Ball 315 655-3671
Westchester	Ruth Greer 914 967-1085
Buffalo	Laura Salwen (716) 838-2440

Connecticut Licenses

Effective 10/1/95, Connecticut will license clinical social workers as LCSW, Licensed Clinical Social Workers. Most currently certified independent social workers will automatically become licensed on that date. For an application call (203) 566-1039.

VENDORSHIP, from facing page

its version (S. 4188), sending it back to the Senate Insurance Committee for review. Our letter included the names of those members who were terminated without cause from various managed care plans, as well as a copy of the VBH provider agreement. It is clear that the managed care community does not want to see this legislation pass into law. Here are six of S. 4188's reasons why:

1. Prohibits the use of economic profiling of health care providers.
2. Prohibits termination without cause from the plan of any participating provider.
3. Prohibits payment to a provider or group as an inducement to limit medically necessary services to an enrollee.
4. Creates appeals mechanisms and procedures to challenge credential denials and reductions, or provider terminations.
5. Establishes procedures to protect confidentiality.
6. Offers enrollees choice of obtaining services from non-participating providers (point of service option).

Now is the time to act. Call the New York State Senate at 1-518-455-2800 and find out which senators represent your district. Then call and write them urging that they support bill S-4188. If your representatives don't hear more from you than from managed care, this good bill may not pass into law or pass only in a watered down version.

Be proactive. Call and write today.■

PSYCHOANALYSIS

Social Workers & Psychoanalysis:

The development of advocacy groups

by Richard M. Alperin, DSW, Chair

Although social workers who are properly trained can today legitimately practice psychoanalysis, they could not always do so with such assurance. The doors to psychoanalytic training institutes were first opened to social workers in 1948 by both the National Psychological Association for Psychoanalysis and the Postgraduate Center for Mental Health. However, the practice of psychoanalysis in this country has historically been dominated by the medical profession which has considered it a medical specialty that should only be practiced by physicians.

As a result, social work psychoanalysts received little attention or status. Although psychologists who were practicing psychoanalysis received greater recognition than social workers, they too were considered second-class. Not being content with their status, psychoanalytic psychologists frequently challenged this inequity. This ultimately led to their famous lawsuit in 1985, which opened the doors of the American Psychoanalytic Association to psychologists.

Members of the Board of the State Committee on Psychoanalysis are: **Bonnie Beck** (Met), **Joel Beck** (Met), **Janet Droga**(Rockland), **Laura J. Rothman** (Queens), **Ann Rose Simon** (Westchester), **Ezra Teitelbaum** (Met), **Yaffa Weitzman** (Met) and **Stephan Zemon** (Nassau). They deserve our sincere thanks for their efforts in helping to further psychoanalysis as a viable specialty for those social workers who practice in New York State. If you are interested in being a member of this Board, please call Dr. Alperin at **718-884-5574**.

For a variety of reasons beyond the purview of this report, the number of social workers attending psychoanalytic institutes has rapidly increased since they were first admitted in 1948. In important studies conducted by Crayton Rowe Jr. in 1975 and 1981, it was discovered that at many of the psychoanalytic institutes in the New York metropolitan area, the majority of the students held MSW degrees, while only a small minority of the administration, faculty, training and supervising analysts at these institutes were social workers.

Concerned about this disparity and the inferior status of social work psychoanalysts, Rowe became a strong advocate of clinical social work. In 1980 he formed both the Committee on Psychoanalysis in the New York State Society for Clinical Social Work and the Committee on Psychoanalysis of the National Federation of Societies for Clinical Social Work (later incorporated and renamed the National Membership Committee on Psychoanalysis in Clinical Social Work). It should be noted that these organizations are separate and distinct from each other.

The former, which is one of four practice committees within our State Society (the other practice committees are Group Psychotherapy, Family Practice and Clinical Hypnosis), is open to all members of the State Society, and is designed to keep us informed of the needs of its members who practice psychoanalysis and psychoanalytic psychotherapy so that it can advocate on their behalf and promote the practice of this specialty.

The National Membership Committee on Psychoanalysis in Clinical Social Work (N.M.C.O.P.), on the other hand, is a broad-based, national organization exclusively comprised of practitioners and educators interested in the practice of psychoanalysis and psychoanalytic psychotherapy. Although this organization is affiliated with the National Federation of Societies for Clinical Social Work, it has its own structure, by-laws, and dues requirement, separate from that of the National Federation. The N.M.C.O.P. has 12 area groups throughout the country; ours is the New York-New Jersey Area Group and is currently chaired by David Phillips.

In 1992, Rosemarie Gaeta, the first president of the newly formed N.M.C.O.P., accomplished what seemed like the impossible. She initiated and helped form the Psychoanalytic Consortium, which is comprised of the N.M.C.O.P., the American Psychoanalytic Association, the American Academy of Psychoanalysis, and Division 39 of the American Psychological Association. The Consortium, which has helped further establish social work's rightful place within the psychoanalytic community, continues to meet regularly and has been productive in its efforts toward strengthening the future of psychoanalysis in this country.

The leadership in the N.M.C.O.P. has remained strong. Its second president was Cecily Weintraub. Margaret Frank currently is the third president; and David Phillips the president-elect, will assume the office of president in July 1997.

Recognizing that there is some overlap in the interests of both the Committee on Psychoanalysis of our State Society and the New York/New Jersey Area Group of the N.M.C.O.P., both organizations have worked collaboratively on certain issues and projects. For example, both felt that it was important for psychoanalysis to be listed as a professional activity in our newly proposed state social work licensing bill and jointly asserted their concerns. The Legislative Committee of our State Society was highly receptive and is making efforts in this direction. Likewise, both organizations co-sponsored a brunch on May 21st, where guest speaker Dr. Herbert Strean discussed "Thoughts on the Supervisor's Multiple Counter-transferences."■

Barbara's mentor group devotes the first hour to practical issues of the kind I was shortly to process with them, and the second hour to a focus on the clinical process. Members take responsibility in turn for presenting one or more sessions.

Introductions ensued for my benefit, and I gave a brief sketch of current activities and imminent concerns. Heads nodded, smiles grew pronounced; someone asked for more detail. Had they perhaps been through my "stuff," too? I was beginning to relax. Barbara said, "You haven't mentioned your work with Vietnam veterans." A woman of about 35, at work on her Ph.D. at N.Y.U. and a group member for four years, asked if I wanted to focus on work with persons with PTSD. Another woman, in her late 40's from South Carolina, also a senior member of the group (and "one terrific car mechanic!") announced excitedly she was off in February to a conference on 21st-century traumatology. To heck with whether or not she could afford it. Did I want a copy of the program? We could talk on the telephone about it. "I can't wait to go. It's about research on neuroplasticity and complex adaptive systems theory. I'll be learning a lot, and would like to share it and process it with the group at the next meeting, if people are interested." We were. (And she did. Which led in turn to Barbara's suggesting we might like a colleague specializing in trauma to present aspects of her work to us during our first hour. This was a departure from our usual format, but we were so affected by her discussion that we asked her to return for a second meeting with us.)

A third person, a man in his late 30's, shortly to assume a position with an E.A.P, said, "Maybe you both might want to start a trauma group within the Society? I wonder why there isn't one." The two of us acknowledged interest, but it turned out my new colleague's life, too, was in flux. Should she stay at her present job, where opportunities were by some miracle opening up, or was it time to return home to her roots in the South?

Now a fourth person, apparently in her late 20's, reported she would be moving to Boston in June and knew no one there. Immediately the group dug for their books to search for Boston numbers. Would she stay in touch with us? Was there a mentor group in Boston she could connect with? At this juncture, I was comforted that there were others making transitions and heartened by the group's attentiveness to the conflicts and challenges of each.

Barbara looked at the clock. With so many questions still to discuss, what did we want to focus on during the time remaining? A school social worker, the youngest among us and a '94 Fordham graduate, brought up the subject of pursuing institute studies. This might not be the right time to plunge in since her job and travel time comprised a heavy commitment already, and then, too, she was marrying in late summer. In any case, how did one find out about all the institutes in New York? And how much did institute training really involve in time and money? A volley of information erupted from the group: suggestions, comments, observations about particular institutes, and dates of forthcoming open houses. Since I'd just been scouting for institutes myself, I asked if she'd like me to have her address so I could mail several open house notices to her.

> ***"It was the group that helped both launch and anchor me in this new phase of the rest of my life."***

It was now time for the clinical portion of the meeting, which our Southern colleague, in her third year in inpatient psychiatry at a well-known agency, then took up. She gave a quick review of the case, and began reading the process of her last session. It was a particularly dramatic case in that it pinpointed the issue of boundaries relating to the social worker's responsibility toward the client. I had never heard an actual process critiqued by a group before, and it was fascinating to see how each person grasped each line of it somewhat differently. This had the effect of giving remarkable contour and complexity to the client, quite as though he had joined us in the room. Who was he? And how much of "him" was us? Experienced practitioners already appreciate this, but I could feel how much group process adds to one's sense of reverence before the mystery of being human. When the second hour was up, talk continued animatedly outside the bulding, and loose ends of helpful business were tied up before we dispersed in the night.

There have been seven meetings in as many months since that introductory meeting. During that time, the group has coached me on my first interview in eight years; seen me through the decision to stay with my current job; challenged me to report on steps taken to build a practice evenings and weekends; referred me to a supervisor; cheered me for my first clients; offered suggestions for continuing education; nudged me to follow through on invitations to lead workshops, while dissipating many of my fears of presenting publicly; and, currently, asked for an outline of my upcoming workshop on core images of the self from a Jungian perspective ("I don't know much about Jung," Barbara said. " You can tell us more.") All of this while the group was shifting, with new members added each month as old ones left us for other cities. The circle is now almost entirely reconstituted, and this in itself poses challenges for me as old doubts and fears of revealing myself surface yet again. The extraordinary fact is, though, that I've been able in these months to work through those "necessary losses" of leaving Fordham and the Veterans Center, two communities that parented my beginnings as a social worker, and about which I cared very much. Unmoored (as I was in January), it was the group that helped both launch and anchor me in this new phase of the rest of my life.■

Editor's Note: The Society supports the idea of people working several years in supervised agency practice before starting a private practice. It also places great value on post-agency experience and continued training. However, in the past few years, the economic reality of a very limited job market and fewer clinical jobs has made for new trends, i.e., social workers with little work experience taking on private clients. Mentor leaders can find themselves on the horns of a dilemma: the need to protect standards and the need to support new social workers in gaining clinical experience. Mentor leaders, therefore, take responsibility, on the one hand, for providing awareness of the pitfalls of an inexperienced worker in private practice, and, on the other, doing all they can to ensure such work is performed within the boundaries of the best possible supervision.

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From Page One

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In the treatment process, experience-near-empathy, a phrase reminiscent of the social work principle, "start where the client is," replaces a rigid anonymity, strict abstinence and an objectifying neutrality, since it is argued that the traditional stance is thought to expose highly vulnerable clients to the traumatic or non-responsive conditions of their early life, rather than create the safety and responsiveness that is essential for their growth.

Kohut began by proposing that there was a separate line for self development and espoused a different view of narcissism and its treatment. Later he articulated a new theory of development with the self at the core. The self is more than an amalgam of ego functions or a reflection of what the child has internalized from the outside. The infant's self has organization, motivation and potentialities, but also requires an empathic and responsive selfobject environment in order to unfold optimally.

Selfobjects perform vital functions for the newborn child, such as soothing, that it cannot carry out itself. Kohut identified three main types of selfobject needs in the child's early environment:

1. the need for mirroring that confirms the child's sense of vigor, greatness and perfection;
2. the need for an idealization of others whose strength and calmness soothe the child; and
3. the need for a twin or alter-ego who provides the child with a sense of humanness, likeness to and partnership with others.

Selfobjects perform vital functions for the newborn child, such as soothing, that it cannot carry out itself.

While not all of these selfobject needs may be gratified in a particular child's life, rewarding experiences with at least one type of selfobject give the child a chance to develop a cohesive self. The absence of these experiences or frustrations that are too abrupt, ongoing, ill-timed or characteristic of chronic misattunement or lack of empathy with the child's needs, interfere with self-development.

This article is from a longer paper of the same name delivered in Nov. 1993 at the Frontiers of Psychodynamic Theory, a joint conference of the New York University School of Clinical Social Work Ph.D. program and the New York State Society for Clinical Social Work. Material was drawn from the author's book, Borderline Disorders: Clinical Models and Techniques, New York, Guilford, 1990.

Self psychology views pathology as caused by actual, persistent or acutely traumatic parental empathic failures with respect to the child's emerging needs. Since others are needed for the functions they perform in stabilizing the individual, narcissistic vulnerability can lead to constant demands for affirmation, appreciation and applause. Depression, shame, humiliation, rage and even fragmentation and suicide result from even minor criticisms, lack of appreciation, disapproval, rejection or failure to live up to one's own or others' expectations.

Not all structural defects in the self result in pathology, since the child may be able to acquire compensatory structures that strengthen the self. These structures enable the person to make up for or repair deficits in one aspect of the self through successful development of its other facets.

Individuals with self deficits may either show chronic problems or vulnerability to life situations that lead to crisis proneness. Moreover, many clients who present with problems in their social functioning or with specific disorders according to the DSM-IV have underlying narcissistic vulnerability that is causing, or existing alongside, their symptoms.

Since self psychology sees all psychopathology as reflecting self deficits, that is, gaps, missing or underdeveloped elements in self structure that come about as a result of unattuned or traumatic caretaking, it is argued that treatment must be more empathic, human, experiential and reparative than is characteristic of traditional psychotherapy.

Engaging in experience-near-empathy is crucial to the therapeutic process. The self psychological therapist immerses himself or herself in clients' experiences and intervenes in ways that help them make sense of their own subjective truths. The therapist gives up a one-sided view of what transpires in treatment, recognizing that both therapist and client exist in an intersubjective context in which they exert a mutual impact on one another.

Self psychology moves away from reliance on major classical concepts. For example, it reframes the concept of transference. The selfobject transferences reflect the revival of frustrated early mirroring, idealization and twinship needs in a new, more empathic and non-judgmental context. Despite the exaggerated forms these needs take, they must be seen as understandable, albeit dysfunctional, outcomes of the client's early caretaking experiences. The emergence of these needs in treatment provides narcissistically vulnerable individuals with a second chance to complete their development.

Self psychology reconceptualizes the concept of resistance as the client's efforts to maintain self-cohesion and to avoid disappointment and disillusionment. Likewise, it sees clients' rage reactions as reactive to frustration and narcissistic injury, rather than as expressions of innate aggression. Further, it views what others might label drive-related conflicts as disintegration products caused by environmental failures in meeting selfobject needs.

Self psychology casts aside the interpretation of unconscious instinctual conflict and pathological internalized object relations and expands our view of change processes. Interpretation emphasizes the linkages between clients' dysfunctional traits, personality patterns and defenses to early parental empathic failures and their impact. Empathic interpretations, the identification and acceptance of selfobject needs and disruptions in the treatment relationship and their repair bring about new self structures. Finally, the thrust of countertransference management is self-scrutiny of the therapist's attitudes and behavior that are causing lapses in empathy with the client and disruptions in the treatment.

In employing experience-near-empathy, the therapist tries to understand what it is like to be the client and puts aside his or her own biases about what the client needs, thinks and feels. The therapist must suspend his or her view of external reality in favor of understanding the client's subjective experience and must also be willing to examine his or her contributions to the client's reactions. An atmosphere of acceptance and empathy usually mobilizes many individuals' early frustrated selfobject needs for mirroring, idealization or twinship.

The greater their earlier trauma, however, the more likely it is that clients will have difficulty exposing themselves to disappointment or injury once more. Overcoming their fear of being traumatized is the main therapeutic task in the initial stage of treatment. The therapist conveys empathic understanding of the nature and reasons for the client's fear of involvement and moves at the client's pace. While this approach should be sufficient to engage many clients, some will require more concrete evidence that their needs are understood or the actual experience of having their needs met selectively in order for them to establish a meaningful bond.

In early sessions, Martin, a 34-year-old unemployed actor, alternately boasted of his creative talents, negating the abilities of his more successful peers, or he was non-communicative and disparaging of the treatment.

Martin: I don't feel like talking today. In fact, I really didn't want to come here. I don't think treatment will help.
Therapist: What has happened to make you feel so angry and discouraged?
Martin: Nothing.
Therapist: Perhaps I've upset you.
Martin: You've been okay so far.
Therapist: So far?
Martin: I know you're going to get tired of listening to me.
Therapist: If you feel that way, I can understand your reluctance to be here. But I'm wondering what I'm doing that is giving you that feeling.
Martin: I only know I felt like an idiot after I left the session last week. I was going on about my career and I was thinking that you probably thought I would never amount to anything. I couldn't tell what you were thinking.
Therapist: You seem to feel that my silence meant I was not interested.
Martin: I need to know what you are thinking. I can't take this silent bullshit.
Therapist: I guess that if I don't show that I'm understanding and accepting you, you fear the worst. There haven't been too many people in your life whom you felt were in your corner.
Martin: I never could please my parents, especially my father. (Martin goes on to discuss this for a while.)
Therapist: It's hard to believe, given your past experience, that I will be different.
Martin: But you're not different when you don't let me know what you're thinking.
Therapist: I can see your point. You would feel surer that I really was interested if I gave you more feedback.
Martin: Sometimes I begin to think that you are interested and then I find myself closing down. I don't even know why it happens.
Therapist: It's hard to believe that someone might care and then find out that you were wrong. Who would want to expose himself to that disappointment?
Martin: When you say things like that, I feel you understand me, but I never feel sure.
Therapist: Perhaps feeling understood makes you feel more vulnerable.

Engaging in experience-near-empathy is crucial to the therapeutic process.

Some individuals experience chronic feelings of rage due to the severe and repeated assaults they experienced in early childhood. They can be very provocative and assaultive, taxing the therapist's empathic abilities.

Martin: I had some really great experiences on coke this week. That stuff is better than therapy. It costs a lot though, but at least I get something for my money.
Therapist: You seem to feel that I'm not there for you.
Martin: Of course you're there. You sit in your chair and you listen and sometimes you smile and nod at

Continued on page 12

Interpretation emphasizes the linkages between clients' dysfunctional traits, personality patterns and defenses to early parental empathic failures and their impact.

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the right times. You really have a great technique. You should have gone into acting.

Therapist: Do you feel I'm playing a role with you?

Martin: You are acting! I'm not saying that you have bad motivations. You probably want to help me, but you act as if you are interested and concerned about me and I don't think you are any more interested in me than in any of your other patients.

Therapist: You would like to feel special.

Martin: You got it. You're right on target today. You must have seen your supervisor this week.

Therapist: I've really let you down in some way.

Martin: You're not that important.

Therapist: I think your sarcasm may be your way of protecting yourself from letting me become important to you so that you do not risk being fooled and disappointed. It's easier to rely on coke, even though it can be harmful to you, than to count on me and expose yourself to being hurt again.

Martin: What if that's true?

Therapist: It's a dilemma for you. I think you want to trust me but it feels too dangerous. The more you feel that I understand you, the more you feel at risk and the more you have to protect yourself, even at the price of hurting yourself.

Martin: (Sighs.) I guess you're right. I really want to stop using coke. I feel better when I don't use it.

Repeated disruption-restoration sequences strengthen selfobject connections and are the major pathway for change.

Inevitable transference disruptions occur and must be repaired. These commonly result from the therapist's lack of attunement or failures in living up to the client's expectations. Repeated disruption-restoration sequences strengthen selfobject connections and are the major pathway for change. They usher in transmuting internalizations of the client's archaic needs and self-structures occur in the here and now that did not take place in the there and then of the client's early development.

The necessary repair of the relationship results from the therapist's empathic exploration of the client's perception of what has led to the disruption and of the therapist's possible role in frustrating or disappointing the client. The therapist also explores or interprets how these current incidents repeat the client's earlier experiences with caretakers. The therapist must try to understand and accept the validity of the patient's subjective experience, even if it is at variance with the therapist's perception of reality. There is a difference between trying to understand patients from their point of view and approving of their behavior. Further, empathizing with patients does not prohibit therapists from sharing their own perceptions of the situation or their reasons for certain actions.

Martin: I know I'm 1/2 hour late but it's not my fault and I don't think I should have to pay you. The subway got stuck. I'm sick and tired of rushing here. Why can't you change my time?

Therapist: You are very angry at me today.

Martin: So I'm angry. I had a bad experience with coke that left me feeling terrible. It's all your fault.

Therapist: How so?

Martin: Do you think that I enjoyed watching you sneeze during our session? I'm not paying you to be sick.

Therapist: So you felt that I was not there for you even though I was physically present.

Martin: That's right!

Therapist: Whenever you feel that I'm not interested in you, you feel pretty awful and get into trouble.

Martin: I wanted to feel better. You depressed me. I thought I came in with good news last week about the acting coach who agreed to take me on as a student. Your response was to sneeze.

Therapist: You hoped I would be pleased and I let you down.

Martin: I thought you were more concerned about yourself than me.

Therapist: It's true that I was ill, although I thought I was present for you emotionally. I suppose it's possible that I was less attentive than usual.

Martin: Every time I begin to count on you, you screw up.

Therapist: You have had a lot of experiences in which your parents put your needs on the back-burner in favor of their own. You begin to feel I will be different, but I must prove to you 100% that I'm there for you. If I slip a little, you feel frightened that I'm going to be like everyone else.

Martin: Are you saying that I'm hypersensitive?

Therapist: Perhaps I am, but I was thinking that you need a lot of reassurance that I'm really there for you and you are sensitive to any sign that I'm going to fail you, despite how I've acted in the past.

Martin: I felt very alone when I left here.

Therapist: I guess you turned to coke rather than me.

Martin: I still think you should take better care of yourself.

The therapist focuses on the failures of the client's early selfobject milieu and their impact on later functioning, rather than on instinctual conflicts, the defenses erected against them or object relations pathology.

The self psychological therapist uses interpretation, but its content differs from what is interpreted in treatments based on classical psychoanalytic theory, ego psychology and object relations theory. The therapist focuses on the failures of the client's early selfobject milieu and their impact on later functioning, rather than on instinctual conflicts, the defenses erected against them or object relations pathology. Refraining from using interpretation for a prolonged interval may be necessary with certain clients, however, who experi-

ence even seemingly empathic interpretations as unwanted intrusions.

While some self psychologists might disagree, I believe that selectively providing actual "mirroring" as well as responding in soothing or other need-fulfilling ways are important forms of optimal responsiveness in repairing self deficits. Moreover, the appropriate use of mirroring techniques may increase the client's ability to explore upsetting or traumatic experiences.

Martin: Yesterday I read a poem in class and I was fantastic. I'd like to recite it for you. What do you think?
Therapist: It seems important that I actually hear you read.
Martin: I want you to know how good I can be.
Therapist: I can understand your wanting that, in the light of how little appreciation and encouragement you have had in your life.
Martin: So do you want to hear me or not?
Therapist: I guess it is hard for you to feel sure that you are good if I don't validate your performance.
Martin: I don't know why you're giving me a hard time. All I want to do is read the poem for you. I don't think you're really interested.
Therapist: I am interested.
Martin: Then just listen to me.
(In the next session, the following interchange occurred.)
Martin: I brought the poem in to read to you.
Therapist: Good. Let's hear it.
Martin: I'm a little nervous.
Therapist: What are you concerned about?
Martin: I want you to like it, but I'm afraid you'll be bored.
Therapist: You're not sure you can trust my interest.
Martin: Here goes . . .
Therapist: I enjoyed that.
Martin: I thought you would. I'm a natural.
Therapist: You should be pleased with yourself.
Martin: Damn! I don't know why I'm feeling tearful.
Therapist: What are you feeling?
Martin: I wish I would have had someone to listen to me when I was younger.
Therapist: You should have had more attention and encouragement than you did. Perhaps that's why you feel so hungry for it now and feel so terrible when you don't get as much as you'd like.

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A problem that self psychology has not addressed fully is how to contain impulsiveness and tendencies toward destructive behavior. As Kohut himself acknowledged, more active interventions may be necessary with some clients in order to safeguard the treatment and the client's life. It is possible to use limits and structure and to show concern about the client's behavior as long as the therapist maintains empathy with the client's experience. A problem-solving approach about what might help the client to contain his or her behavior, rather than the imposition of arbitrary rules and contracts, is indicated. The therapist's ability to integrate "empathic confrontations" and the use of external structure into a self psychological treatment may enable such treatment to be successful with the more impulsive-ridden or potentially destructive individuals.

In understanding and managing countertransference, self psychology tends to focus on the therapist's vulnerabilities that may be exacerbated by the client's selfobject needs. Automatically concluding that a client is making the therapist experience certain feelings because of his or her internal pathology is too one-sided a view of the nature of the patient-therapist interaction. It assumes that the therapist has no effect on the client's reactions or that the therapist's vulnerabilities are not at work. What is important clinically is for the therapist to determine what is occurring in the therapeutic dyad with the client's help, since the therapist and client are joint participants in the interaction.

Self psychology has significant implications for crisis intervention and short-term treatment. It alerts practitioners to the fact that narcissistic vulnerability is at the core of many acute disturbances. When clinicians make quick assessments, they must focus on the changes in the client's selfobjects or blows to the self, that is, losses of important sustaining people; disruptions in close relationships; changes in support systems that may deprive clients of mirroring; blows to self-esteem; other narcissistic assaults such as illness, aging, physical injury, emotional problems in the family and disruptions in the use of compensatory structures.

For example, with many depressed individuals who have experienced an important loss, the practitioner should recognize that the lost object (selfobject) may have been providing a certain function for the client, such as admiration or validation. Likewise, with those who abuse their children, it may be important to appreciate a parent's selfobject needs, how these are frustrated and how violence results.

In the interventive process, practitioners must be active in establishing an empathic connection with the client; identifying their selfobject needs and how these are being frustrated in their current lives; enabling them to make connections between present and past experiences; facilitating mourning of the losses to the self; realizing that losses, disappointments or failures do not define them; restoring and enhancing self-esteem; helping clients find new or more responsive selfobjects; and strengthening or developing the client's compensatory structures.

Finally, in dealing with interpersonal problems, it is useful to help clients identify their own needs and what is frustrating them, to expand their empathy for the needs of others close to them and to find ways of establishing more satisfying interactions.■

Self psychology has significant implications for crisis intervention and short-term treatment. It alerts practitioners to the fact that narcissistic vulnerability is at the core of many acute disturbances.

The painting on page 1 is Baby's First Caress by Mary Cassatt; on page 11 the painting is Mother and Child by Mary Cassatt; and on the facing page, the sculpture is Rocking Chair, by Henry Moore.

Using HYPNOSIS in Psychotherapy

by William M. Ballen, CSW

"There are many ways and means of practicing psychotherapy. All that lead to recovery are good. We have developed the technique of hypnotic suggestion, and psychotherapy . . . I despise none of these methods and would use them all under the proper conditions. If I have actually come to confine myself to one form of treatment . . . it is because I have allowed myself to be influenced by purely subjective motives."
Freud, 1939

An honest science of the mind is humble. Categorical claims of objectivity and truth regarding mechanisms of mental functioning are looked upon with skepticism by thinking clinicians today. Hypnosis is a field of study that has unfortunately lent itself to claims of effectiveness and success that go beyond those of other therapeutic modalities. In fact, hypnosis is not a therapeutic modality in itself. So why has there been such sensationalizing with regard to hypnosis? The reasons are multi-determined: certainly the ways in which hypnosis has been portrayed by the media and its abuses by lay "hypnotists" for entertainment have been a problem. But an unrealistic perception of hypnosis, as it is used in psychotherapy, may derive from the highly unusual phenomena that occur in the hypnotic state itself.

The production of hypnotic phenomena such as automatic writing, arm levitation, negative and positive hallucinations, age-regression, dissociation, amnesia, anesthesia and hyperamnesia can easily excite any student of the mind with the mind's own enormous potential to alter experience. Some people have had open heart surgery in hypnosis; others have recalled and spoken languages that were not used since childhood; still others have spontaneously played musical instruments that were not touched for years. Hypnotic anesthesia, aside from its obvious value in treating pain disorders, could be a tool to help researchers explore the mysteries of the mind-body interface and shed light on the fields of psychosomatic medicine and psychoneuroimmunology.

But what is hypnosis and what is its use in psychoanalytic treatment?

What is Hypnosis?

Hypnosis is an altered state of consciousness (ASC) characterized by cognitive, perceptual and psychophysical alterations not present in the waking

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Special Attributes of Hypnosis

- Altered state of consciousness.
- Bridges the gap between neuroscience and psychodynamic science
- Altered information processing mechanisms
- Enhanced memory, attention, focus, absorption, productivity
- Activates ego receptivity and mobility
- Enhances the integrative and synthetic functions of the ego
- Enhances visualization or dissociative mechanisms
- Reduced respiration, heart-beat, blood pressure
- Shift to parasympathetic right-hemispheric functioning

Hypnotic Phenomena

- Dissociation, age regression, age progression, amnesia, hyperamnesia (heightened recall), anesthesia, time distortion, yielding of the generalized reality orientation, perceived involuntarism

Brief Treatment

- Sports performance, forensic hypnosis, childbirth, sleep disturbances, some phobic reactions, post-traumatic stress

Physicians that refer for hypnosis

- Internists – stress reduction, smoking, weight loss, hypertension
- Neurologists – pain management
- Urologists – sexual problems
- Dermatologists – skin diseases
- Pediatricians – enuresis, school phobia, thumb-sucking, nail biting, asthma, tics, test-anxiety
- Dentists – gag reflex, anesthesia
- Psychotherapists – therapeutic impasse

Lay Misconceptions

- Hypnosis is sleep, you "go under" (total amnesia is very rare), deep hypnosis is needed, like stage hypnosis

state. Cognitive changes involve alterations of attention which can be highly focused on internal or external stimuli, heightened absorption and, in deeper states, a shift to primary process thought. Sensory-perceptual changes often include visual-spatial, somatic-kinesthetic and auditory sensory modalities. Psychophysiological alterations that have been noted in hypnosis are reduced respiration and heart rate, lowered blood pressure, with a shift to parasympathetic and right-hemispheric functioning. There is, even in light hypnosis, a heightened ability to shift between the observing and experiencing ego and between conscious and unconscious processes.

William M. Ballen, CSW

At one time, it was erroneously believed that in hypnosis, the subject's ego was bypassed; that he was so regressed that he gave over his ego and superego functioning to the therapist. Today, however, we know that the subject's ego and its defenses are very much involved in hypnosis, albeit differently than in a waking state. It is precisely the increased activity and receptivity of the ego to stimuli from without and within in hypnosis that is at the heart of a contemporary understanding of the therapeutic action of hypnosis in psychotherapy. Patients in hypnosis maintain a capacity to observe, reflect, monitor and direct their experiences if they choose to. For some patients, hypnosis allows them greater access to affective responsiveness and imagery production. Concentration can be either intensely fixed or diffuse. Increased psychic mobility enables vacillation between past and present; conscious and unconscious; ego-activity and ego-receptivity; observation and experience; enhanced memory or amnesia; and mind and body. These are the *sine qua non* characteristics of hypnosis which constitute its usefulness in psychotherapy.

It is probable that, in time, a physiological correlate of hypnosis will be found. Currently there is a great deal of exciting research going on in this area. (Crawford and Gruzelier in Fromm, E. and Nash, M., Eds. 1992. Contemporary Hypnosis Research. N.Y.: The Guilford Press.) Current theories of hypnosis also have not yet fully explained the perceptual and cognitive alterations that take place in the state.

In Psychotherapy

The representation of hypnosis as a modality in itself stems from a fundamental misconception. In ongoing psychotherapy, hypnosis is an ancillary procedure that needs to be introduced within established theoretical guidelines. Historically, hypnosis has been introduced into treatment to recover memories or deal with specific unmanageable symptoms or resistances that could be either dangerous to the patient or to the therapeutic process. These include neutralization of affective intensity, support of specific ego functions, stabilizing transferential reactions that could threaten the treatment, therapeutic impasses and acting-out.

Today, as psychotherapists are seeing increasing numbers of patients with less-than-neurotic character structures, the use of hypnosis has taken on an expanded role. For patients with early developmental arrests, hypnosis is a link to pre-verbal body-memories and an aid in making preverbal reconstructions. The inherent relaxation of the hypnotic state can be utilized to evoke an enhanced holding environment in which early symbiotic needs can be re-experienced with the therapist. The profound comfort of this kind of trance allows borderline and narcissistic patients to share in the sense of oneness and omnipotence they missed. Self-hypnosis encourages self-soothing mechanisms and fosters a sense of self-efficacy, mastery, autonomy and control.

The altered cognitive and perceptual functioning of hypnosis allows for the active use of the hypnotic phenomena in the service of therapeutic goals. For example, the enhanced ability to visualize images in hypnosis can be used by some patients to move towards greater object constancy and secure identity. It can help with the integration of good and bad self and object representations as well as providing cognitive understanding, insight and control where verbal interpretation may cause resistance. Dissociative abilities can be utilized to recover

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It is precisely the increased activity and receptivity of the ego to stimuli from without and within in hypnosis that is at the heart of a contemporary understanding of the therapeutic action of hypnosis in psychotherapy.

Breaking through: *HYPNOSIS as a clinical strategy*

by Susan Dowell, CSW

All of us have felt, in our own analysis as well as in our work with patients, the enormous frustration of reaching an impasse. It was that frustration which inspired my interest in learning more about hypnosis. But what has reinforced this interest was seeing its effectiveness with patients.

Hypnosis is a unique state of consciousness and focused concentration in which some normal human capabilities are heightened while others fade into the background. The effective use of hypnotherapy enables the patient to access resources and insights previously beyond conscious awareness and to get in touch with dissociated memories, affects and ego states. Hypnotherapy has little to do with the TV or stage hypnosis versions. Nor, when utilized in a responsible professional manner, is there a danger of eliciting false memories. Rather, it is a strategy which may be combined with and adapted to a variety of treatment approaches; psychoanalysis, cognitive-behavioral therapy, supportive psychotherapy and many others.

The following two case vignettes illustrate how the use of hypnotic strategies made significant impact on facilitating treatment. In the first case, a hypno-projective strategy was used. This is a technique in which a patient is asked to either have a hypnotic dream or to visualize a play or movie which relates metaphorically to the problem at hand. Hypno-projectives harness the capacity of the unconscious to use metaphor to access material out of conscious awareness. In the following case, the therapist suggested that the patient have a dream which would give more information about the source of his depression. Hypnosis was used to explore the unconscious representations of the dream.

Susan Dowell, C.S.W. is a member of the Hypnosis Practice Committee of NYSSCSW, and is an Approved Consultant for the American Society of Clinical Hypnosis. She has a private practice in hypnotherapy and psychotherapy in New York and Westchester, and has been training and supervising other therapists in hypnosis for a number of years.

Case 1: Alex

Alex, a 33-year-old TV producer, came to therapy because he was feeling very depressed. He said the depression was of long standing, dating back to early childhood, though he could not remember when it began. It became much worse when he and his wife began to discuss having children. He was particularly concerned because he found it interfered with his performance in a very demanding job.

In our discussions, it seemed likely that there was some precipitating event which had occurred in his early life. He carefully interviewed his parents and younger brother regarding historical possibilities of trauma, but they gave him no information. We decided to try hypnosis. I suggested, in hypnosis, that during the next week he have a dream that would give us insight into his concerns. The next session, he came in with the following dream:

"I found myself and my wife in a dungeon-like room with no windows. There was an armed guard at the door. I knew that we were to be executed at some point, but I didn't know why. I kept trying to figure out, in the dream, why we were there, but I couldn't and no one would tell us. I was very upset."

He made very few associations to the dream. Since it had come in response to a hypnotic suggestion, we decided to use hypnosis to explore it further. In trance, Alex went back into the dungeon room, feeling the same fear and bewilderment he had in the dream. I suggested to him that as he looked around the room, a window would appear, and that if he looked out of the window, he would see something or someone who would give him a clue about why he was there. He immediately saw a small barred window and a little girl playing outside. He asked her why she was there. She told him that she was his dead sister and that she was waiting for everyone to say good-bye to her.

As soon as he heard her say this, he began to have a flood of memories. When he was four, his mother had a baby girl who died suddenly. No one told him the truth about what happened. He remembered only that his father picked him up after nursery school and told him that his sister had gone away and wasn't coming back and that his mother had gone out of town for a few days. After that, his mother began crying frequently and became very withdrawn. He soon realized that this was the point at which his parent's marriage became tense. No one ever talked about the sister again. He did not remember a funeral. However, he began to remember that for many years after this, his mother would go up to the attic for hours at a time, telling him that she wanted to be alone.

As he recovered these memories, Alex became increasingly aware of how much his sister's ghost had become a part of his family's life. He decided to call a family meeting to tell his parents and younger brother

what he remembered and the impact it had on his life. He hoped to involve them in a ritual which would allow them to finally bury his sister. The family meeting turned out to be cathartic for everyone. In their own way, all of his family members talked about how his sister's death had affected them. He was surprised to discover that his mother had been visiting his sister's grave on the anniversary of her death for the last 29 years. The family decided to go out to the grave site together and hold a ceremony.

Once Alex had unearthed this secret and had met with his family, therapy proceeded very rapidly. His symptoms of depression soon disappeared. He decided to remain in therapy briefly to work on some relationship issues with his wife and then terminated. He called me several months later to say that his wife was pregnant and that he was feeling wonderful about it.

Case 2. Rhonda

This case illustrates how hypnosis can be used to recapture forgotten events and emotions and enable a schizoid person to convert a brief positive experience into a foundation for transforming her life. Rhonda was a successful historian in her mid thirties who had done a lot of well respected research in her field. Two years prior to entering therapy with me she had completed eight years of analysis.

Although her professional career was moving along well, she felt that, despite her understanding of her problems, she was unable to make close friends or maintain an ongoing relationship with a man. She hoped that hypnotherapy would help her bridge the gap. Rhonda came from a schizoid family where there was little intimate communication of any sort. Her parents, from very different backgrounds, lived side by side in a very separate way and finally divorced when she was a teenager. Rhonda felt she had never gotten any warmth from anyone. The only accolades she received were academic and these came primarily from teachers. She had few close friends and spent much of her adolescence alone or accompanying her mother on errands. Repeatedly, she said she didn't know what it felt like to be close to someone and had no positive connections in her life to use as a reference point for future relationships. This description of her problem became the focus of the hypnosis.

Susan Dowell, CSW

I asked Rhonda, once she was in trance, to review her life experiences and to remember a time when she was able to feel a sense of connection. She identified only one relationship, a summer camp friendship she had as an adolescent. In returning to a scene with this friend, she was able to recapture an awareness of what the feeling of connection was like. We intensified the feeling so that she could get more familiar with it. I taught her how to take this feeling out of the scene and visualize herself feeling this sense of connection in her current relationships. She became aware that she could now interact with others in a more meaningful way. The next step was to teach her self-hypnosis, so that when she was about to participate in a social encounter, she could recreate the feeling of connection. She found the self-hypnosis helpful and practiced it a great deal. Within a short period of time, Rhonda was able to significantly change her social relationships. Her relationships with her office staff improved. She began to develop a close circle of friends and to date more actively. She completed therapy within the year.

Hypnosis is a powerful therapeutic tool. These case vignettes illustrate the use of trance to activate unconscious resources in several ways. Hypnosis can help the patient revive dissociated affects and reconnect them to present-day experiences. Furthermore, it can facilitate the access of forgotten memories and enable the unconscious to provide metaphorical representations of problems. We as clinicians can utilize hypnosis to help our patients make dramatic changes in their lives. For those who are concerned about moving beyond the impasses that impede our work, hypnosis is an exciting and powerful tool.■

by Hillel Bodek, MSW, CSW, BCD, Chair

Clinical Documentation and Recordkeeping, Part I

Clinical documentation and recordkeeping requirements, often viewed as a chore, yet another burden heaped upon health care professionals, are a familiar part of agency practice. However, the importance of clinical documentation and recordkeeping is often overlooked by clinical social workers in private practice. A particular problem is that many clinicians in private practice improperly eschew maintaining legally required adequate clinical records in order to avoid the possibility of having to disclose these confidential records at some later date if a patient requests them or if the patient becomes involved in legal action and places his or her mental state at issue. However, legally mandated clinical documentation and record-keeping serve several important purposes, most of which are equally applicable to agency as well as private practice settings.

The Rules of the Board of Regents defining unprofessional conduct define unprofessional conduct by a health care professional as including, "*failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years,*" 8 NYCRR 29.2(a)(3). In *Suslovich v. New York State Education Department, et. al.*, 571 NYS2d 123 (3rd Dept. 1991), a New York State appellate court affirmed a finding that a psychologist whose patient records consisted of copies of insurance claim forms and the notes he kept in his head, violated this regulation and upheld the suspension of the psychologist's license for professional misconduct. The court noted that, "*[t]he purpose behind the requirements that a proper record be kept for each patient is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable.*" 571 NYS2d at 124. ■

Elements of Good Clinical Documentation

1) provides relevant information in appropriate detail,
2) is organized with appropriate headings and logical progression,
3) is thoughtful, reflecting the application of professional knowledge, skills and judgement in the treatment/services provided,
4) is appropriately concise,
5) serves the purposes of documentation (as outlined above) that are applicable to a given situation,
6) uses relevant direct quotes from the patient and other sources,
7) distinguishes clearly between facts, observations, hard data and opinions,
8) is internally consistent, and
9) is written in the present tense, as appropriate.

In Part II of this series Mr. Bodek will discuss the essential components of an appropriate initial assessment, the key ingredients of a proper progress note and the role of clinical documentation in assuring quality clinical social work services.

7 Key Purposes of Clinical Documentation

1) **to document professional work** – to record what was done, by whom, to whom, when, where, why and with what results; to document diagnosis and assessment, treatment/services provided and the patient's clinical course

2) **to serve as the basis for organization and continuity of care by the practitioner** – to record clinically meaningful information that the practitioner can rely on later to refresh their memory of crucial events in treatment, the patient's response to treatment/services, problems experienced in treatment, key historical facts and collateral contacts; to provide a basis for self-supervision and reflection on the patient's clinical course and progress

3) **to serve as the basis for subsequent continuity of care by other practitioners** – to provide clinically meaningful data regarding the evaluation, treatment, progress in and response to treatment, treatment planning/goals and problems in treatment to practitioners who serve the patient in the future so that they may have sufficient data based upon which they can provide continuity of care/services to the patient

4) **to provide risk management and malpractice protection** – documentation of informed consent for treatment, release of records, etc.; documentation of the nature of the professional relationship and duty owed with regard to the patient; documentation of professional decisionmaking, problems encountered in working with the patient, supervision/consultation obtained, professional response to crisis and other special situations; documentation that will support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan and the application of professional skills and knowledge in the provision of professional services; substantiation of the treatment/services provided and of the results of such treatment/services

5) **to comply with legal, regulatory and institutional requirements** – compliance with recordkeeping requirements of the N.Y.S. Education Department, specific programs (i.e. JCAHO) and third-party payers (i.e. Medicare, Workmen's Compensation, Medicaid, etc.)

6) **to facilitate quality assurance and utilization review** – record professional activities, purposes and results; document appropriateness, necessity and effectiveness of treatment/services provided; documentation of the need for further treatment/services or to support termination of treatment/services; facilitate supervision, consultation and staff development; help improve the quality of services by identifying problems with service delivery and providing data based upon which effective corrective action can be undertaken; provide data for educational planning, policy development, program planning and research

7) **to facilitate coordination of professional efforts** – to facilitate communication between members of the treatment team thereby assuring coordinated rather than fragmented treatment/service delivery.

CLINICIANS, COMPUTERS & CYBERSPACE

Part Two

By Sheila Peck, CSW

Eight years ago Ms. Peck told her husband she was buying a computer and he predicted her interest wouldn't last. But, in Part One of this piece, she listed 15 complex activities made easy by her mastery of the Mac, and encouraged readers to follow suit.

Response to Part One was overwhelming. But if you are one of the many who asked for samples of OTRs or other computer generated formats, please write again to Sheila Peck, CSW, 1010 California Place South, Island Park, NY 11558, and enclose a self addressed stamped envelope.

There are a number of ways you might use your skills along with your computer. For instance, you could offer a workshop for computer teachers on how to improve their communication skills. You could even do it on-line if you had a modem (this means you can "talk" and interact with a number of other people by typing messages at a pre-arranged "meeting together" time via a telephone line through a device called a modem. It's cheap and easy). You might even do a peer supervision group on-line. And the computer will keep a printed log of this for you.

You could advertise your specialties (without cost to you) on one of several computer bulletin boards that allow people to post messages. A number of these are devoted to health or mental health issues.

You can buy reasonably priced computer software which will allow you to keep all your patient records and print out insurance claim forms for you.

You might develop a small newsletter to send out to your clients as a way of advertising; on the computer, it's easy.

These are only a few suggestions. Even if you've never touched a computer, once you learn how, you'll probably enjoy it and wonder how you ever did without it. Your printed work will have more power and authority, too. If you think of yourself as technologically illiterate, remember that once you were really illiterate and you learned how to read because you needed to and because someone taught you.

Almost every high school has adult education courses, reasonably priced, to help you learn the basics; there are a number of consultants, too. If you're concerned about what configuration of computer to buy (this can be a truly overwhelming task) call the Society's resident expert, Fred Mazor, who will help you decide what you need (he's listed in the directory under the Met Chapter). If you think it will be too expensive, you'll be surprised at how much prices are being reduced almost every month. You can probably get an efficient system with all the basics for well under two thousand tax deductible dollars.

Since my first purchase, I've gotten better machines twice. My next acquisition will be a notebook (laptop) computer and/or a color printer. Yes, there is always something new to buy. Nevertheless, besides pantyhose and ball-point pens, computers and other electronics are probably the only consumer items to consistently come down in price (maybe Apple will begin to pay ME to buy their next machine).

Remember, in a few years you'll probably have to get a computer and a modem or a computer billing service because companies will require that you file your claims electronically. Better to do it now and give yourself a chance to learn before real technophobia sets in. Besides, more than one-third of American families already have computers.

Clinicians,computers and cyber-space form a partnership that works. Use yours to expand your creativity and make the trivia of practice more efficient and even more fun. Now that eight years have passed since the advent of computers into my life, my husband has stopped laughing at me. At least about computers. With the aid of my Mac, we now have more time to laugh at other things.■

Sheila Peck, CSW, is a psychotherapist in private practice, chair of the Society's Public Relations Committee and newsletter liaison. She trained in family therapy and sports psychology and served as a mentor at Empire State College. She offers seminars and consultation in public relations and practice-building.■

Ethics and Professional Standards Inquiries

by Hillel Bodek, MSW, CSW, BCD, Chair, Committee on Ethics and Professional Standards

Over the past decade, in my role as chair of the Society's Committee on Ethics and Professional Standards and Forensic Clinical Social Work Committee, I have responded to numerous inquiries regarding ethical, forensic and clinical practice issues relating to social work practice.

Last year, I responded to approximately 600 such inquiries from social workers, patients, practitioners from other disciplines, human service/health care agencies and governmental agencies locally and around the country. The most common issues that are the subject of these inquiries are: confidentiality of patient records, dealing with subpoenas and consents for disclosure of information, dealing with patients' attorneys, addressing the impact of patients' legal problems (i.e.; custody, visitation, lawsuits for injuries), responding to patients who present a danger to others, supervisory responsibilities, fee-splitting issues, insurance and Medicare reimbursement questions, and addressing effectively the needs of multi-problem patients. I realize that when these issues arise they are anxiety provoking and I attempt to respond to each inquiry within 24 hours, although I am not always able to do so. Please be patient. In the more than a decade that I have been responding to such inquiries, I have found that less than ten inquiries each year, no matter how anxiety provoking the problem may be, need to be dealt with on an emergency basis. If I do not reach you within two days, please call back. In order to help me to provide this assistance more efficiently I request that when people call me at my office (212) 753-1355, unless it is an emergency, they do not provide a description of the problem. Please merely indicate your name, that you are a clinical social worker who wishes to speak with me about a practice issue and leave both your work and home phone numbers (since I return most calls in the evenings). If you must reach me in an emergency, you may call me at home, (718) 596-7980, from 9:30 PM until 11:30 PM, or fax me at (718) 596-7982. If there is a particular ethical or legal issue which you would like me to address in my newsletter column, please write to me and let me know.■

BOOK REVIEW

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tions, Dr. Goldstein also stresses that it would be short-changing them not to recognize that individuals can be subject to the full range of problems encountered by the helping professions.

Thus, in discussing gays and lesbians, she points out that homosexuality is not a psychiatric illness and its presence is not indicative of a disease that needs to be treated or cured. Gays and lesbians seek help for dealing with the problems of living: career issues, relationship issues, depression, employment, parenting issues and the like, and not necessarily with their sexual orientation, *per se*. The practitioner should keep in mind that the client's inclusion in an oppressed or stigmatized group has shaped his or her identity and may be playing a role in the presenting problem.

The volume describes specific issues that may arise in the coming-out process and in gay and lesbian relationships and provides practical guidance as to how the therapist may deal with such issues. She also discusses how the client or therapist may internalize societal homophobia, racist and sexist attitudes that interfere with the client's fulfilling his or her fullest potential.

Dr. Goldstein forthrightly acknowledges that indiscriminate use of diagnostic labels stigmatizes gays, people of color and women. While it is possible for individuals of any group to be subject to a clinical syndrome, Dr. Goldstein insists that the use of clinical diagnosis be integrated with an affirmative perspective on people of color, gays, lesbians and women. The sections on the treatment of substance abuse and sexual abuse are among the best for their clinical sensitivity. Dr. Goldstein recommends that practitioners working with substance abusers help the client focus on active abuse but cautions against overly confrontational interventions. She provides guidelines for a psychodynamic approach that also makes use of Alcoholics Anonymous, Narcotics Anonymous and so forth. In discussing the treatment of sexually abused women, Dr. Goldstein illustrates how the practitioner helps the client work through the trauma while supporting the ego.

In conclusion, this revised edition is a timely and important book, highly recommended to practitioners at all levels of experience.■

HYPNOSIS

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traumatic events as well as allowing for increased observing ego, synthetic and rehearsal functioning.

Case Material — Mr. C.

Mr. C., a 36-year-old, soft-spoken and timid man who works as a court clerk, presented for treatment with problems of premature ejaculation and loss of erection. With a flat affect and in a monotone, he explained that he was engaged to be married soon and these problems were causing enormous difficulties for him and his fiance. It was his first sexual relationship, having only recently separated from his mother and taken his first apartment. He had just ended one year of therapy.

During our first session, Mr. C. strongly emphasized his reluctance to get involved in what he considered another long therapy. He said he was more intimate in his relationship with his fiancee, Donna, than he had been before the year of therapy. His remaining sexual problem was his main concern.

It was difficult to obtain much of a history; it was hard for him to talk about his early life and he did not remember a great deal. His father had died nine years earlier of a heart attack on a commuter train. He had trouble elaborating further on his father's death, had not felt much when it happened and thought it strange that he had not cried. He said he knew he spent too much time at home after his father's death, but it was because his mother needed a man around the house. He was able to tell me that he experienced his mother as somewhat controlling and a little overwhelming at times. He was able to connect that he sometimes feels as overwhelmed by Donna.

Week by week his depression and despair seemed to deepen. It was quite difficult to engage him in reflection, and, after three weeks, it seemed as if we had hardly begun. His rigid obsessional style and isolated affect seemed impenetrable and he was not willing to come more often. Ambivalent about the therapy, he asked whether other forms, mainly behaviorally-based sex therapy, would be better for him. I suggested that hypnosis might be helpful to us in our work, that it might help him to have more access to his feelings. He agreed to try it.

At the start of the next session, I asked Mr. C. if he preferred to lie down or sit up for hypnosis. He chose to lie down and I began.

> That's fine. Just allow yourself to adjust to the couch, to not seeing me, to the different position, your head supported on the pillow, your body supported

by the couch. There are different sights and perhaps different sounds. I wonder if you can be aware of your breathing and how you've slowed it down already. *(Ego building; giving him the credit for altering his own physiological response.)* I wonder if you can be aware of your body and how still it is right now. *(Ratifying beginning cataleptic response.)* Maybe you could notice the difference between tension and relaxation in your body or between what it feels like to be warm or cool. *(Focusing and differentiating sensory experience.)* I wonder, with your slower breathing, if you actually feel the sensations of breathing...the feeling of breathing in and breathing out, breathing in and breathing out...*(Pause).* I notice that already you are showing your ability to relax the muscle tone of your face. And I can tell you have lowered your heart rate and your blood pressure, too. You have also altered many internal processes in a short time. If you are feeling comfortable this way, please just nod your head *(He nodded; an ideomotor response.)*

Okay, fine. Now, if you would like to experience this trance state further, please nod your head again. If you are fine the way you are, you can shake your head no. *(He nods yes.)* Okay, now in this hypnosis you have many abilities that you may not often think about. *(A truism and indirect suggestion that he can gain access to feelings.)* One ability is that you can picture things very clearly...sometimes so clearly that you feel as though it's not a picture because you are there and not here. *(Seeding idea for age-regression and revivification of early experiences.)*

Now, I wonder if you see that big movie screen out there? *(Using a question to focus attention; indirect suggestion of visual imagery.) (He nods yes.)* Good, now perhaps an image will come onto the screen that will enable you to experience the hypnosis even more. *(Tying free association to his wish for further trance experience.)* When you see the image...*(pause)*...and when you see the image clearly, please nod again. *(He nods.)* And can you tell me what you're seeing now? *(He said yes.)*

It's a stone wall ten feet high. I'm not sure I can get over it. Wait, there's a ladder. I have to jump from the top though. I can pull the ladder over, but it's a real balancing act. It's a struggle, but it feels good to get to the other side.

And how does it feel on the other side?

It feels much freer. It's less inhibiting. It feels lighter and lighter, more and more carefree. There's less weight on my shoulders. Thoughts can flow easier and I can express myself easier.

Listening to Mr. C., I was feeling lighter and freer myself; his lowered inhibition became mine. Hearing him was effortless and the flow of his words and images began to have somatosensory effects on me.

I see a field with tall brown wheat or grass. It's blowing in the wind. I feel myself running through it. It's a beautiful day running through the wheat, not a care in the world. Now I see Donna in the field. I'm worried about my marriage.

Do you say anything to her? *(Encouraging interpersonal relatedness.)*

I'm saying I love you; I will take care of you. You are the only person for me. I need you very much. We can resolve our differences. We'll always be together. She says she loves me, too. She needs to hear it more often. It feels good to express love. To touch her body freely...without thinking. We're rolling in the grass now. Our clothes are off. We're making love. It's so very natural. I can touch her. I'm touching her legs...her breasts...her face...and she can touch me.

When his hypnotic fantasy ended, I suggested that Mr. C. could return to the waking state, bringing only as much of this experience as he wanted to have consciously available to him and if he wished, he could leave the experience or any part of it deep within his mind. *(Open-ended suggestion for amnesia.)* He returned to an out-of-trance state, and was tired and quiet.

Returning the following week, he began in his slow monotone, relating that he and Donna just had a fight. He said she told him that she never knows how he feels. He said that she had been upset by something her mother did and he related the details of the story for ten minutes.

Feeling that he was removed from the underlying affect, rather than interpreting this, I chose to say, "You know, as you've been talking, part of me has been wondering what you remember about our session last week." Very spontaneously he said, in exasperation:

I'm a procrastinator. I procrastinate with Donna. It's paralyzing and I can't do anything about the situation.

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I see. And I wonder how you felt about the hypnosis.

I liked it, and I was going to ask you when we could do it again.

Do you have something particular in mind right now?

Yes, I want to focus on my mother. My mother makes me feel overwhelmed and non-existent. I think this has something to do with why I procrastinate with Donna.

Mr. C. proceeded to lie down and spontaneously closed his eyes and entered a trance. I provided a few words to help him along, but he didn't require much assistance. I simply asked him to signal when he felt sufficiently in hypnosis. After he signaled, I asked:

Can you tell me what you're feeling?

I'm feeling paralyzed.

Would it be okay to continue to feel that paralysis and to follow it back along a bridge to an earlier time in your life when you felt the same way? *(Affect Bridge Technique.)* In a few moments, I asked:

Where are you now?

At the dinner table.

How old are you?

Ten or eleven. Children should be seen and not heard. My sister is arguing with my father, but I'm just viewing like always, afraid to voice my opinion or make an objection.

Why would that be?

I'm afraid my parents would say I'm wrong...that they wouldn't love me. It is so frustrating to be good.

Would it be okay to go to another memory? This time before the age of six. *(Taking a developmental history.)* After a slight pause, he said:

It was a frightening time to be that young. My mother is so controlling. I need her approval for everything. I have no will of my own. It is so hard to leave my mother to go to first grade. The teacher is so strong-minded...she has a loud voice. I am frightened of her.

Okay, I hear you, and now can you say what the next memory is that comes to mind?

I'm in kindergarten playing. I have a certain freedom to choose things to do. It's not as bad as first grade. Now I'm three years old. Mother is cooking and I am sitting next to her near the stove or between her legs. My sister is jealous of me and is hitting me. But my mother protects me from her.

That must feel good.

Yes, my mother is taking good care of me.

In the following session, hypnosis was used for the third time. In trance, Mr. C. related a dream about his mother that he had 15 years earlier.

I was strangling her. She wasn't listening to me. I didn't kill her. I woke up... it was very scary...a frightening and intense experience.

I'm sure it was.

I remember wanting to play and explore our backyard and my mother would stop me from exploring. She was always holding me back. *(I told him that it might be possible to have another dream in hypnosis that could be either a new dream or an elaboration of the older one.)*

Now my hands are around her neck. I feel resistance to doing it. I feel rage for her not listening to me. "Is this what it takes for you to listen to what I need?" I'm shaking her neck and adding more pressure. She's not saying anything or responding. I have her on the floor and I'm just squeezing and shaking the neck.

Later in the session, Mr. C. spoke out of the trance, with more intensified affect than usual:

My mother stopped listening to me when I was five or six years old. I had forgotten all about how frightened I was to go to first grade. It's like I was there again. I can't believe how much comes back to you...Yeah, that teacher was loud and yelled at me the first day of school. That's why I was afraid to stay. The teacher said, "You have to stay and your mother has to leave. Now go sit down at your desk." Boy, I was angry at my mother for not protecting me.

At the next session, Mr C began by discussing leaving therapy. I asked:

I wonder what you remember about the hypnosis work we did last week?

Not very much at all. Really, I can't remember much at all. I don't think I liked it, though. It made me feel like I was under your power.

Can you explain what you mean?

Well, I feel as though you're watching over me.

I think you are furious with me now for watching over

you like your mother did when you wanted to explore the backyard.

You're right! I am angry at you. I realize it's not exactly fair to you, but I'm very angry at you and I'm glad I can feel the anger, too. This is new for me. I'm really telling you how angry I am at you and I really do feel it. And I'm angry at my mother, too. In fact, I'm even more angry at her than I am at you.

Now, can you remember what happened last week?

Yes, I was strangling my mother. That was very painful to experience.

Very painful. It took a lot of rage to have that dream. Do you think you could be expressing your rage at me by threatening to leave?

Very likely I am. I really was going to quit. But I can see how this works now and I know I have to deal with this anger.

Following this session, Mr. C. became truly committed to working on himself. Subsequently, he has been able to discuss deeper material both in and out of trance. Two years have passed and we have used hypnosis a total of 20 times. Once he became able to discuss difficult material out of trance, I preferred to use hypnosis intermittently to maximize his ego-integration. He is married now and is more empathetic and loving toward his wife. He also no longer has a problem with impotence or premature ejaculation. He is currently discussing conflicts about having children.

In this case, hypnosis was introduced into once-per-week treatment that was at a stalemate. The hypnotic age-regression allowed for a detailed developmental history not previously been possible. Hypnosis helped the patient recover traumatic memories and their attendant affects and integrate them into his conscious ego.

Another important feature of the hypnotic work in this case was that it furthered the development of a transference where one was lacking. It was precisely the formation of a negative transference to me as a controlling, engulfing, over-protective mother-hypnotist that allowed the genetic material which the patient provided in trance into his relationship with me. Once he could see for himself how his conflicts were played out in the here-and-now, the treatment began to move forward.

Behavioral Medicine

Clinical social workers are developing increasing competence in the use of hypnosis not only in psychotherapeutic work, but in the area of behavioral medicine and forensics. Behavioral medicine is a field that emerged in the 1970's in which methods and theories derived from the behavioral sciences are applied to the treatment and prevention of medical illnesses. There has been an explosion of research in the use of hypnosis in the treatment of psychophysiological disorders such as pain, headache, hypertension, asthma, gastrointestinal disorders, skin diseases and immune-related diseases. The hypnotic treatment of habit disorders such as smoking, overeating, substance abuse and alcoholism, sexual dysfunctions and sleep disturbances is on the rise.

Training in Hypnosis

Since the fundamental training in hypnosis is in learning technical procedures for eliciting and using the hypnotic state, the training itself is far less demanding than institute training. For a well-trained psychotherapist, hypnosis is a very understandable skill that can be easily acquired and used within one's existing practice. Most recognized training programs such as those offered by the Society for Clinical and Experimental Hypnosis (SCEH) and the American Society for Clinical Hypnosis (ASCH) provide about 21 hours of instruction (a three-day workshop) as an introduction and another three days later on to learn more techniques and their applications. The American Hypnosis Board for Clinical Social Work is an independent certifying board endorsed by both SCEH and ASCH and authorized to confer diplomate status on clinical social workers in clinical hypnosis. This board is a constituent member of the American Board of Clinical Hypnosis, Inc., which also oversees the hypnosis boards for medicine, psychology and dentistry.

The Hypnosis Practice Committee of NYSSCSW was formed to make hypnosis training compatible and meaningful to clinical social workers. Valuable technical approaches can be learned in the SECH and ASCH workshops, but they do not teach the integration of hypnotic technique into psychoanalytically-oriented treatments. The Committee will fill this void in part at our upcoming November 19 conference and in future programs, as well. An additional route for psychoanalytic practitioners who are interested in learning hypnosis is through case consultation or private supervision with a psychoanalytically-oriented psychotherapist or psychoanalyst who uses hypnosis.■

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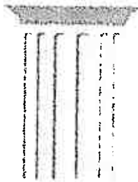

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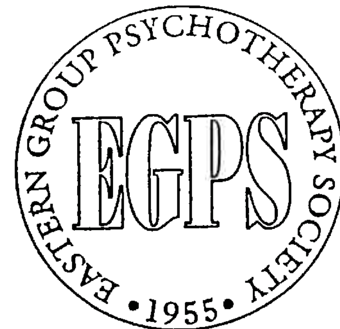

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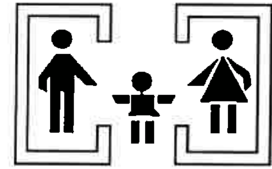

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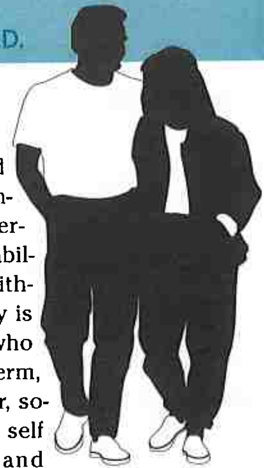
INFERTILITY

by Neil J. Cervera, CSW, Ph.D.

Mental health treatment is integral



At any given moment, 17% of all couples can not conceive a child. Medically, infertility is defined as the inability to conceive or carry a fetus to term after 12 months of repeated intercourse without using birth control. Eventually, 50% of the previously infertile couples will conceive and give birth. Those striving for fertility will spend more than $1 billion each year on medical interventions.

Infertility may stem from many factors: the postponement of child-bearing, which lessens the chances of conception because of the aging process; sexually transmitted diseases, which damage male and female reproductive organs; and environmental pollutants, which may harm childbearing capacities. Another as yet unexplained factor is the documented reduction in men's sperm quality which has occurred since the 1940's. Poverty may contribute to infertility because of the lack of access to reproductive health services. Reproductive medicine is accessed largely by people in the middle and upper middle class.

Neil J. Cevera, CSW, Ph.D.

The Shock of Infertility

Women are more likely to seek reproductive medical services than men. They are socialized to be concerned with childbearing and rearing, they are under reproductive time constraints, and they have usually accepted as prudent a yearly visit to the gynecologist.

Still, the misbelief is widely held by both men and women that reproduction can be easily controlled, that it is simply switched on and off through the use of birth control devices such as the pill. Therefore it comes as quite a shock when conception does not occur easily. A family and personal crisis often follows the diagnosis of infertility. Typically, a grieving reaction sets in.

First, the idea that conception will be easy is shattered. At this point a couple may become immobilized, unsure of whether to get a second opinion, embark upon an long, expensive course of treatment that may prove fruitless, adopt or remain child-free. If they choose a medical solution they face a daunting set of medical choices — medications, surgery, strictly timed intercourse, for example — that lead to more emotional and cognitive challenges. Frequently, infertile persons feel victimized by these procedures. The narrow focus on monthly reproductive processes leads to obsessive thinking about conception, pregnancy and childrearing. Worry, powerlessness, mood shifts, diminished self-esteem and marital stress frequently occur.

Women, often vocal about their personal dilemma, may have partners who remain stoic. The differences in each gender's response can lead to unfortunate miscommunications.

Because a woman's self-image is often tied to her ability to mother a child, a loss of identity and a role failure is experienced with infertility. She may become depressed by the inability to conceive. One attempt at coping is to withdraw from family and friends. This strategy is an attempt to limit interactions with women who are pregnant or have children. In the short term, withdrawal works. However, social isolation leads to more self doubts and to feelings and thoughts of being a failure. For women who have been abused, self-esteem issues can be exacerbated.

Men, in response to their partner's sense of loss, may offer false reassurance, deny their own feelings of loss or overengage in outside activities as a means of coping. Even when the diagnosis is one of male infertility, the woman may be the one to verbalize feelings of hopelessness and failure.

The Role of the Clinician

Unfortunately, too many health care professionals overlook the psycho-social-sexual difficulties that arise. Fatigue, loss of libido, irritability and social withdrawal, all indicators of depression, may be misunderstood. Marital strain and mood disorders lead not only to personal distress, but also may cause difficulties in medical treatment. Happily, more reproductive endocrinologists than ever are referring patients to clinicians. Mental health treatment must be seen by all physicians as an integral part of infertility treatment.

Couples often come to therapy with difficulty communicating their feelings and thoughts to one another. An in-depth assessment of the relationship to determine the meaning of the infertility to the couple, their sources of support, coping and defenses, as well as a developmental and family history, are very helpful. Couples need to grieve, understand one another's thoughts and make decisions about the future of their family. Learning to be informed and assertive during medical treatment is one source of empowerment.

Individual therapy is helpful in dealing with the personal self-esteem issues, such as the idealized self, marriage or wished-for child. Additionally, helping clients with negative thoughts through exploration of feelings and cognitive-behavioral interventions can be helpful. ■

Good sources of information for the clinician beginning a study of the issue of infertility include: Infertility and Pregnancy Loss, Constance Hoenck Shapiro, 1988, Jossey Bass; Infertility, How Couples Can Cope, Linda Salzer, 1986, Hall Publishing; and RESOLVE, INC., of Somerville, Ma., a self-help organization providing publications and referrals, (617) 623-0744.

Neil J. Cervera, C.S.W., Ph.D., received his doctorate from New York University and has been in private practice for more than 15 years. He is an Adjunct Research Assistant Professor at Albany Medical College Department of OB/Gyn and Psychiatry, and also a Research Assistant Professor in the School of Social Welfare at the University of Albany.

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