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

Regulations To Implement Social Work Licensing In Final Form

By Marsha Wineburgh, DSW, Legislative Committee Chair

On July 27, 2004, Governor George E. Pataki signed into law the final version of amendments to the social work licensing statute, Article 154 of the New York State Education Law.

These amendments further clarified the intent of the statute to license clinical social workers. A number of requirements for the clinical social work license (LCSW) were changed and the insurance reimbursement statutes for licensed clinical social workers were integrated into the new education law.

These changes clarified the education and experience requirements for the LCSW and the program requirements for social work schools which choose to offer qualified clinical courses in their MSW programs.

To meet the criteria, at least 12 credit hours of clinical courses must be offered and courses must address the areas assessment and diagnosis, treatment planning or treatment techniques for general and special populations. As of December, 2004, The State Education Department (SED) has approved programs at five universities as "registered programs." Both the LMSW and LCSW programs have been approved at Adelphi, Fordham, Robert Wesleyan and Yeshiva. The LCSW program was approved at CW Post. Transcripts from students graduating from these programs will not have to be reviewed by SED when they apply for licensing.

Prior to the Governor's action, however, the Board of Regents, pressured by the imminent effective date of the social work legislation (September 1, 2004), had adopted regulations to implement the licensure laws using an interim form of the bill. Consequently, new regulations needed to be developed for the amended version of the social work laws.

On December 23, 2004, the SED proposed new regulations addressing these recent legislative revisions. The Board of Regents intended to act on these recommendations at its next meeting in March 2005. (For updates on the law, regulations and applications, see this website: www.op.nysed.gov/lcsw.htm.

Changes in LCSW Regulations

As we know, this new license for clinical social work **legally** establishes our credentials as one of the three core mental health professions in New York State. Along with psychiatry and clinical psychology, LCSWs have the right to diagnose, develop and implement assessment-base treatment plans, and treat mental illness.

CONTINUED ON PAGE 5

PRESIDENT'S MESSAGE

Accomplishments and Challenges

by Hillel Bodek, MSW, LCSW, BCD

As I start my second year as President of the Society, I look back over the Society's major efforts and accomplishments over the past year, some of which will be coming to fruition fully during the current year. I also look at the challenges that the Society and the clinical social work profession will have to face.

Efforts and Accomplishments

First and foremost, the new clinical social work license, the product of an almost fifteen year herculean effort by Marsha Wineburgh and the Legislative Committee, which provides clinical social workers in New York State with one of the broadest scopes of practice in the country (substantively the same scope of practice that is provided for psychologists in New York State) and protects our professional autonomy by continuing to not require

CONTINUED ON PAGE 2

IN THIS ISSUE:

President's Message

CONTINUED FROM PAGE 1

physician referral, consultation or supervision, took effect on September 1, 2004.

Second, based on the observations and recommendations of the Society's Strategic Planning Committee, chaired since its inception in 2001 by Judith Crosley of the Syracuse Chapter who is currently also the Society's Recording Secretary, and on the strong recommendation of the Society's accountant and its attorney, last November the Board voted to implement a Unified Financial Management System for the Society. This system centralizes the Society's fiscal operations, alleviating the need for the Society to rely on a number of volunteers in the chapters with varying knowledge and skills of bookkeeping and accounting to carry out fiscal operations in a timely and uniform manner. It also allows for more contemporaneous oversight of the Society's fiscal operations by the Society's Board, consistent with the evolving stricter standards of corporate fiduciary responsibility and financial accounting. Since its implementation, it has assumed the burden of legally required record keeping from the chapters, who retain decision making authority over the spending of funds allotted to the chapters within the limits of each chapter's annual budget, which is approved by the Society's Board as required by law.

Third, the Society reviewed the operation and functioning of the Therapy Resource Committee ("TR") from its inception in mid-1998 through the summer of 2004. The new licensing law which took effect on September 1, 2005, created for the first time in New York scopes of practice of licensed master social work and licensed clinical social work. That law impacted legally on the manner in which TR could function. Membership corporations such as the Society are forbidden by law from engaging in the practice of a profession. Thus, according to the Society's attorney and regulatory authorities, TR could no longer function in the way it had. In making referrals after September 1, 2004, TR would only be able to gather limited demographic information, information about the service being sought and accept the problem as presented by the caller with limited clarification. It could no longer explore the caller's history and symptoms, explore various treatment options with the caller or attempt to clarify what therapeutic options might be best for the caller. Additionally, over the years, there has been persistent substantial concern by the Society's Board that all qualified members of the Society should have equal opportunity to receive referrals if they desired to do so without having to join TR. **The Society owes a debt of gratitude to Joanna Strauss of the Westchester Chapter for her work as Chairperson of the TR Committee and to the members of the TR Committee who volunteered to coordinate TR on a regional level, handle the phone calls, make presentations to the community and otherwise support this public service effort.**

In place of TR, once the dues renewal season is over,

CONTINUED ON PAGE 7

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National Academies of Practice Elects Society Members

At a gala membership banquet on November 6, 2004, in Alexandria, Virginia, the National Academies of Practice inducted 11 new members into the Social Work Practice Academy. Among the distinguished social work practitioners elected to the Academy were our President, Hillel Bodek, MSW, LCSW, BCD; Westchester Chapter member Dr. Sharon K. Farber, PhD, BCD; and Metropolitan Chapter member Susan B Sherman, DSW, MSS. Congratulations!

The National Academies of Practice was founded in 1981 in recognition of the need for interdisciplinary collaboration in health care. It is comprised of distinguished practitioners and scholars from all of the primary health professions now including ten disciplines, each in their own Academy: Social Work, Dentistry, Nursing, Optometry, Osteopathic Medicine, Medicine, Pharmacy, Psychology, Podiatric Medicine, and Veterinary Medicine. Only 150 distinguished members can be elected to membership in each Academy, so selection is an honor. Each year, the NAP sponsors a forum on an aspect of interdisciplinary collaboration. This year's meeting addressed the health professions' role in promoting public policies to protect the nation's heath and supporting interdisciplinary care.

Annual Meeting Review

by Betty Gewirtz, MSW, LCSW, BCD

On January 8, approximately 150 Society members attended the Society's annual membership meeting that was held at Fordham University at Lincoln Center. The day's events began with a brief report from the Society's President, Hillel Bodek. He spoke of the need for increased volunteerism by Society members and encouraged members to participate in chapter and committee activities.

Helen Krackow, Immediate Past-President and current Chairperson of the Mentorship Committee, then presented an award to Barbara Bryan, the founder of the Mentorship Program. That program provides mentoring to social work graduate students, recent MSW graduates and clinical social workers in their first years of practice. In honor of Barbara's significant enduring contributions in this vital area, the Board voted to name the Mentorship Program the *Barbara Bryan Mentorship Program.* Hillel then presented an award to Alice Garfinkel, the former Chairperson of the Vendorship and Managed Care Committee for her years of dedicated service in that position.

(L. to r.) Henni Fisher, Brooklyn Chapter member and Board Member-at-Large; Hillel Bodek, Society President; and Julie K. Simonson, Pharm D., Pfizer.

Committee reports were then presented. Jonathan Morgenstern, the current Chairperson of the Vendorship and Managed Care Committee, provided a brief report on current issues and concerns relating to managed care. Helen Krackow who reported for Diane Heller Kaminsky, Chairperson of the Education Committee, who was unable to attend, provided information about the Annual Educational Conference that will be held on May 14, entitled *The Body, Sex and the Self: Intrapsychic and Interpersonal Explorations.*

Marsha Wineburgh, Chairperson of the Legislative Committee, then spoke about the progress of the implementation of the new clinical social work licensing law. She noted that the practice of psychoanalysis, mental health counseling, marriage and family therapy and creative arts therapies is within the scope of practice of licensed clinical social work. Thus, licensed clinical social workers do not need to be licensed under the new mental health practitioner law which licenses licensed mental health counselors, licensed marriage and family therapists, licensed psychoanalysts and licensed creative arts therapists. Marsha stressed that if a licensed clinical social worker obtains one of these other new licenses, he or she will be required to obtain physician consultation when treating persons with serious mental illness, something that licensed clinical social workers are not mandated to do.

After these reports, Marsha introduced Julie K. Simonson, Pharm D., a Clinical Pharmacist from Pfizer who presented an educational program, *Update on Psychotropic Medications Most Commonly Used in Out-patient Treatment.* She reviewed the various psychopharmacologic medications in use today from various pharmaceutical companies, the pharmacologic properties of these medications, as well as the indications for their use, contraindications and side-effects. A question and answer period completed her highly informative presentation.

After lunch, Hillel, in his role as Chairperson of the Forensic Clinical Social Work Committee, presented the two-hour New York State Mandated Training Program in Child Abuse and Maltreatment Identification and Reporting. This training, which was attended by almost 250 social workers, is now a prerequisite for new licensure as a licensed master social worker or as a licensed clinical social worker in New York State. Those already licensed must have completed this training by the time of their next triennial license registration.■

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Vendorship & Managed Care

by Jonathan Morgenstern LCSW, Chair

At the Society's Annual Meeting on January 8th, Alice Garfinkel was presented with a plaque to honor her for her significant contribution to the Society over a period of several years as chairperson of the Vendorship and Managed Care Committee (VMCC).

The Committee continues to function in a supportive role to Society members in their dealings with insurers and managed care organizations. Inquiries are welcome and should be made to the representatives listed below. President Hillel Bodek has made himself available to help with ethical issues related to managed care.

Magellan Contracts

Last June, Magellan providers received a rather imposing three ring binder with recontracting materials. The cover letter stated: "In order to be eligible to participate in the Magellan provider network going forward, you must *complete, sign and return all the enclosed contracts, addenda, amendments and the form W-9 within two weeks of the postmarked date on this packet...If Magellan does not receive your signed documents by December 17, 2004, you will no longer be eligible to provide services as an in-network provider to any members whose care is managed by Magellan, effective January 1, 2005."*

Members who had ignored these instructions and sent in the signature sheets only will find that their provider status has been suspended pending Magellan receiving the balance of all contracting materials as specified above. It is strongly recommended that you do not wait to discover that your provider status is suspended when you call in for session authorization – send in the balance of all contracting materials ASAP and keep a copy of everything for your records.

Society members are reminded that payors expect that practices be run in a business-like manner. For example, while it may make sense to save on paperwork by just sending in the Magellan signature sheets, the reason Magellan requested that the entire package be returned is likely related to the fact that the documents in the binder were contracts which, being legal documents, and being bar coded (see bar codes on bottom of sheets) needed to be returned in their entirety. Taking umbrage at Magellan is not advised – their instructions were clear and should have been followed by all providers wishing to remain in their network.

Online Billing

Another business aspect of running a practice is online billing. It should be expected that MCO's increasingly encourage providers to bill online. While this decreases the MCO's overhead it is also to our advantage – information provided online is immediately checked by the software program which cuts down on mistakes and payment time is decreased. Members are reminded that there are HIPAA issues involved in online billing and OTR submissions and that practices must by HIPAA compliant before they begin to bill, submit OTRs, or seek ore-authorizations online.

In-House Behavioral Health Services

Recent news includes the increasing practice by health insurers to provide in-house behavioral health services rather than refer to outside practitioners, e.g. Aetna Inc., Cigna Corp. and UnitedHealth Group (source: Managed Care Week). Another example of this is a service by CIGNA Behavioral Health – an online coaching series called Emotional Well Being. This service is reported to provide anytime access to a licensed behavioral health expert to help with emotional problems and to provide coaching with written and oral skills, manage chronic pain and build stronger intimate relationships (Source: Cigna Behavioral Health release).

Competition from Mental Health Counselors

Our members are faced with impending competition from Licensed Mental Health Counselors who will begin to be licensed in New York State in 2005. They are being recruited as behavioral health providers by Oxford and, once licensed will be eligible for credentialing by Oxford as members of their behavioral health providers panel. Members are encouraged to take these developments into account when marketing their practice, and advertise their practice in line with our special skills and niche areas as clinical social workers. Social workers have a considerably broader scope of practice under our license. Also, unlike licensed mental health counselors, licensed marriage and family therapists, licensed psychoanalysts and licensed creative arts therapists, clinical social workers are not required by law to obtain physician consultation or supervision unless we determine it to be clinically indicated.

New York Business Group on Health

Finally, the State Society has been a member of The New York Business Group on Health, an organization comprised of Insurers, MCO's and other services providing health coverage. The VMCC provides representation at NYBGH's meetings and to its Mental Health Committee which is currently planning for a series of three conferences on mental health services to employees, focusing on effectiveness and coverage. It is important that there be representation from the providers of clinical services.

I encourage members to contact me with suggestions for this column or related issues.■

Licensing Regulations in Final Form

CONTINUED FROM PAGE 1

The first notable change in the regulations pertains to qualifying experience for the LCSW:

- All qualifying supervised experience in clinical social work shall be obtained in a **facility setting or a non-facility setting** (private practice) or a combination of the two. Note that this supersedes the "P" insurance law, which does not allow facility and non-facility settings to be combined.
- A candidate for the clinical social work license must have three years of full-time/six years part-time supervised experience providing psychotherapy services. **The experience must be completed within six consecutive years.**
- Qualifying supervision must be from an LCSW, a licensed psychologist or a psychiatrist. All **LMSWs** who are providing psychotherapy services must be supervised in accordance with the regulations developed by the State Education Department.
- If you are planning to be **grandfathered in for the LCSW**, be sure to get your application in before **August 31, 2005**.
- An MSW graduate, who is not a LMSW, must apply for a limited permit to practice licensed master social work. Those practicing under a limited permit do NOT have a license. Therefore, they must, by law, be under the general supervision of an LMSW or an LCSW. **They cannot be in a private practice setting**.
- Optional insurance reimbursement for mental health services in group policies ("P" vendorship law) is automatic for all LCSWs. However, three years of additional psychotherapy experience, post LCSW, is required to qualify for mandatory insurance reimbursement in group policies, the "R" Insurance level. The required **supervised experience** for the LCSW is the same as the experience requirement for the "P" insurance law, except that facility and non-facility settings can be combined.
- Every LMSW and LCSW is required to pass one SED-approved training program in ***Identification and Reporting of Child Abuse and Maltreatment*** prior to their next registration (License) renewal which is done every three years. Documentation must accompany renewal application.

Legislative Updates

State Board for mental Health Practitioners As of January 1, 2005, no one can legally provide psychotherapy services in New York State who is not a licensed mental health professional or exempt from one of the licensing statutes. Regulations have been rewritten for Article 163 of the Education Law which licenses marriage and family therapists (MFTs), mental health counselors, creative arts therapist and psychoanalysts with no academic degrees in the traditional mental health disciplines.

During July and August of 2004, an uproar was created by the State Board for Mental Health Practitioners, which developed regulations that sought to disenfranchise the established mental health professions (MDs, PhDs and LCSWs) from supervising their candidates for licensing. This concept was initiated by the MFTs who have endorsed the national MFT agenda to establish themselves as a separate profession that recognizes only MFTs as qualified supervisors for their trainees and requiring all supervision be from approved MFTs. The State Society and the National Membership Committee on Psychoanalysis in Clinical Social Work (NMCOP) joined with the traditional mental health community in New York to successfully defeat this regulation.

Training standards for "licensed psychoanalysts" created another problem. An e-mail campaign was conducted this fall to support a higher standard for psychoanalytic training for these "licensed psychoanalysts" who do not have advanced degrees in the mental health field. There was concern that the candidates' health care educational background was insufficient and the training standards for the frequency of control analyses (supervised analyses) and personal analysis were not comparable to the "community standard" adopted by the traditional psychoanalytic organizations. In the final regulations addressing this issue, educational requirements were increased but specific training standards were left to the registered/ chartered individual institutes where candidates are trained.

NOTE that the LCSW scope of practice, the job description for clinical social work, is extremely comprehensive and includes all of those modalities practiced by the new mental health professions. The LCSW is also free of physician consultation as a legal requirement. If you elect to obtain one of the new professional licenses, you will be obliged to follow the regulations for the more restrictive license. Therefore, you will be required to follow the provision for the new professions which stipulates that, in the case of treatment of any serious mental illness, you must have a medical evaluation of the illness and consultation with a physician who will determine and advise whether medical care is indicated.

Workers' Compensation Legislation The Legislative Committee is studying the possibility of reintroducing a bill to have LCSWs included as Workers' Compensation providers. Currently, only physicians and psychologists are legally members of the panel.

Timothy's Law The Legislative Committee is following this legislation, which creates parity in insurance coverage for physical and mental illness. The issue is the definition of mental illness. The Medical Society prefers a narrow biological definition of mental illness, while non-medical practitioners support a broader definition.■

Independent Practice Committee Conference Report

By Iris Lipner, Conference Chair, Helen Hinckley Krackow, Rosemary Lavinski, and Sheila Peck

One hundred eager practice-builders attended the Independent Practice Committee conference, Clinical Entrepreneurship in Changing Times: Building Your Practice With or Without Managed Care, on Saturday, December 11, 2004 at the NY Blood Center in Manhattan

Iris Lipner, Chair and founder of the committee, and Lynne Morris, Co-President of the Metropolitan Chapter, delivered opening remarks. Iris described how satisfying it was to see so many clinicians in the audience, in view of the fact that the conference date had been changed.

During Iris' presentation, "The Inner Game of Money," she asked participants to consider if they conceive of themselves as business persons or as helpers, coaches, social workers, teachers or clinicians. She raised the issues of family history, gender, and inner dynamics that often interfere with our desire to make money. She emphasized the need to consider our obstacles and how they hold us back from becoming more entrepreneurial and creating a profitable business. Some of these are old habits, excuses, lack of vision, negativity, lack of confidence, fear of change and lack of business skills. She proposed that clinicians determine the value of their services and the beneficial difference they can make in the lives of potential clients. Earning potential and how many hours you can work were also discussed, as well as strategies for change—working smarter, not harder.

Helen Krackow's talk, "Creative Connections for Love & Money," discussed networking skills that all clinicians need. Creativity in making connections is a natural extension of our clinical social work skills in building relationships. Clinicians need to think about their own personal styles of building relationships and not be afraid to use them in building business relationships. We need to be prepared to market our practice with every person we meet in every setting. It is a natural part of making a connection. We can be prepared to ask people for their business cards and to write notes on them to remind us who they are and what they do. We can also ask for referrals and ask what would make a good referral for them.

Other skills of networking were covered, such as remembering names better, paying attention and following up by calling and continuing the contact. Joining specialty-practice online chat groups and list servs also helps in networking. This section of the conference ended with an exercise in networking with other conference attendees.

Rosemary Lavinski spoke about how to choose a specialty and the development of a niche. Her talk, "What's Your Niche?" emphasized the importance of having a focused, targeted marketing plan. She recommended that your target market should reflect the kinds of clients you enjoy treating in a modality in which you have exceptional skills and interest. She noted that clinicians frequently confuse a "niche" and a "specialty." A niche is a program you repeatedly sell to a particular group. For example, a niche would be a short-term group for parents of gay and lesbian people. A specialty might be working with the gay and lesbian population.

Your "specialty" and "niche" identify "what makes you unique" in the mental health market and are primary components of your marketing plan. Rosemary had the audience consider a list of 100 niches and to find ones that they would like. This exercise was the basis for a lively discussion among the participants.

Sheila Peck spoke about the "Nuts & Bolts of Practice Building: How-to and Hands-on." She worked with members of the audience to identify specific practice niches and pointed out the importance of developing a "30-second verbal logo" so that they and their work would be recognizable and easily remembered. She compared building a practice to the way a chain reaction occurs in a nuclear reactor.

She also introduced the "OLT.OGT" method of practice building: start with a commitment to do "One Little Thing" and do it. This will give you the confidence to carry out "One Gutsy Thing," which is probably more difficult. Then go back to another "OLT" and another "OGT" and so on.

Finally, Sheila presented a wealth of material about getting known and publicizing your work via the Internet and included a handout for future reference.

On feedback sheets, conference participants registered a positive reaction and a wish for more of the same. For the presenters and members of the Independent Practice Committee, it was a constructive learning experience as well. We believe it could have been an all-day conference and added quite positively to the way the Society is perceived.■

The New York State Society for Clinical Social Work, Inc. would like to acknowledge the generosity of the Association for Autonomous Psychoanalytic Institutes and several of its members who contributed several hundred dollars to help the Society offset its costs for the Independent Practice Committee (IPC) Conference. The costs were incurred because The NY Blood Center inadvertently double-booked the IPC Conference with one run by the AAPI in October 2004. The contributors were James Fosshage, Ph.D., Judith Kaufman, LCSW, Estelle Shane, Ph.D., and Sandra Hershberg, M.D. AAPI is the first international interdisciplinary and multitheoretical psychoanalytic association of 22 autonomous psychoanalytic institutes which offers membership to individual analysts and candidates. For more information, visit www.aapionline.org.

President's Message

CONTINUED FROM PAGE 1

the Society will be able to implement its new program to transfer the Society's membership directory online with a search engine that will enable members of the community and professionals to obtain referrals online. Additionally, Mitzi Mirkin, the Society's Executive Secretary, will continue to use the Society's membership directory to make referrals in response to telephone inquiries as she had prior to the time TR was operating. **In this way, all LCSW members of the Society who wish to receive referrals will be able to have their practice information available online and to update that information online, without having to join a special committee. This section of the new website will replace the printed biennial membership directory at a savings of approximately $200,000, over the next decade.** I note that the Society, as a not-for-profit membership corporation, is legally prohibited from engaging in activities for the purpose of helping members develop or build their practices. The Society will place on our website the practice information of our LCSW members who desire us to do so as a service to the public and professionals, just as TR was designed to be, to help them locate clinical social workers who may be able to meet their professional needs. Although some LCSW members may obtain one or more referrals as a result, the experience with TR and other referral services, makes it clear that it is not likely that more than a small portion of our approximately 1600 LCSW members is likely to receive referrals in this manner.

Fourth, the community outreach efforts made by the TR Committee will now be integrated into each local chapter and will be provided with economic support from the Society. **Members who are interested in reaching out to agencies and groups in the community to make them aware of clinical social work and the services LCSWs provide and to provide public education and continuing professional education on health and mental health related topics and issues should contact their chapter presidents.** Community outreach to the public, our fellow health care professionals and to agencies is an important role of the Society and its members. It is also a good way for members to increase the visibility of their practices and their agencies (if they are in agency practice) in their communities and to develop linkages with health care colleagues with whom they can work together professionally. So, volunteering to help in this effort can be beneficial to all of those involved, to the clinical social workers who volunteer, to the Society, to the public and to our colleagues from other disciplines.

Fifth, the Society has a long history of providing continuing professional education through its Education Committee, its various practice and other committees and through its local chapters. However, largely because continuing education credits are not required for licensure in New York, it has not regularly offered such credits. However, the American Board of Examiners in Clinical Social Work ("ABE") which offers the Board Certified Diplomate in Clinical Social Work credential (the "BCD"), an increasing number of managed care companies, and the State of New Jersey where a number of our members are licensed and practice, require evidence of continuing education for board certification, managed care panel participation and continued licensure, respectively. The Society is currently finalizing a mechanism to provide, regularly, certification of continuing professional education credits for educational programs it conducts and to certify credits of continuing education programs provided by others of which it approves.

The Challenges We Face

First, the Society is aging. The average age of our approximately 2000 members is 58 and the median age is 59. One percent of our members are in their twenties, five percent are in their thirties and eleven percent are in their forties. Eighty-four percent of our members are age fifty and above, forty-six percent are age sixty and above, and eleven percent are age seventy and above. We can expect approximately forty percent of our current membership to cease active practice within the next ten years to twelve years.

If the Society is to survive over time, we need to attract younger members. Helen Krackow, our past president, has been chairing the Mentorship Committee for the past several years. With the assistance of the team of active mentors, we are attracting more beginning social workers to the Society. However, we must do more. **We need to establish more mentoring groups. We need to expand significantly our outreach to social work graduate students, many of whom wish eventually to become LCSWs, and to recently graduated social workers who are beginning or are early on in their careers in agencies. We ask that each of you who has any affiliation with a school of social work (field instructor, faculty, adjunct faculty, agency liaison, alumni association member, etc.) or a post-graduate psychotherapy training program assist us in this effort. If you are interested in doing so, please e-mail Helen Krackow at hhkrackow@aol.com.**

Second, the legal requirements for licensure as an LCSW in New York have been established by a separate clinical social work license. **By establishing in the law high qualifications for engaging in social work practice at the advanced clinical level and defining a specific and distinct advanced scope of practice for clinical social work which clearly distinguishes clinical social work practice from generic social work practice and non-clinical direct practice, our legislature has acted to provide crucial, long-needed protections for the public.**

CONTINUED ON PAGE 8

President's Message

CONTINUED FROM PAGE 7

To advance public protection the legislature enacted certain legal requirements:

- One, it requires that those seeking to engage in the practice of clinical social work demonstrate advanced clinical competence by undergoing advanced clinical education, completing a period of supervised clinical practice and by passing an advanced clinical practice examination.
- Two, it clearly defines a broad scope of clinical social work practice which does not differ in any substantive manner from the scope of practice of psychology and sets forth the core clinical services rendered by clinical social workers - diagnosis (as distinguished from psychosocial assessment), psychotherapy (as distinguished from counseling), assessment-based treatment planning (as distinguished from preparation of a service plan), and interpretation of tests and measures of psychosocial functioning (as opposed to the mere administration of the tests themselves).
- Three, it requires (with very limited exceptions) that LMSWs who provide clinical services may only do so under supervision of an LCSW, psychologist qualified to perform clinical work or a psychiatrist.

By enacting the new LCSW licensing statute, the legislature, representing the people of our State, placed an important public trust in the social work profession and in those social workers who will become licensed clinical social workers; the trust that they will satisfy their obligation to provide high quality clinical social work services to meet the health, mental health and psychosocial needs of the people of our State. Quality clinical social work services require setting and adhering to high standards of practice, rigorous education and supervised clinical experience leading up to LCSW licensure, continuous professional education throughout one's career, engaging as indicated in interdisciplinary and transdisciplinary collaborative practice that brings together the competencies of various disciplines to address holistically the health, mental health and psychosocial needs or each patient, and maintaining high ethical standards of practice. The challenge of satisfying this important public trust will not fall only on each **individual licensed clinical social worker, but upon the social work profession, its professional organizations and the graduate schools of social work. Social work cannot survive as a house divided. The futures of social work, clinical social work, our professional organizations and our graduate schools are inextricably linked. We must all work together collaboratively to assure that LCSWs are properly prepared to meet this important challenge.**

Third, the nature of health and mental health care is changing. Practice is increasingly being shaped by evidence-based practice standards. Health care practice is becoming more dependent on holistic evaluation and treatment that addresses the biological, psychosocial and spiritual elements of each person, through interdisciplinary collaborative practice which brings together practitioners with various, at times overlapping competencies, to work collaboratively to evaluate and treat the patient (and, at times, group or family). Along with the aging of our population, the rapid expansion of bio-medical knowledge that has led to treatments that prolong the lives of many persons with chronic illnesses who would have died earlier in life in the past, has made the treatment of patients with chronic illnesses and the elderly a significant and rapidly growing arena of healthcare practice. Indeed, many studies have now demonstrated conclusively that the provision of psychosocial-spiritual services along with medical services improves quality of life of persons suffering from chronic illnesses while resulting concurrently in significant decreases in overall health care utilization and spending, making such care both cost-effective and beneficial to patients without limiting care.

In the mental health arena, psychoanalytic theory, informed by advances in neuroscience during the ***decade of the brain*** and beyond, some of which were hypothesized by Freud, a neurologist and neuropathologist, in his 1895 work, ***The Project for Scientific Psychology***, remains the most widely used basis for understanding of psychosocial functioning and behavior. Psychoanalytic principles provide the underpinnings of theories of psychosocial (including group and family) development and function that have evolved since that time and which to this day are the linchpin and gold standard of psychosocial assessment and diagnosis.

On the other hand, many new psychotherapeutic treatment techniques that are informed and shaped by psychoanalytic understanding of human development and functioning and newer ideas about human development and function that have evolved from psychoanalytic theory, but which do not use psychoanalytic treatment techniques, have developed over the years. The evidence for the efficacy of a number of these techniques, along with concurrent psychopharmacotherapy when indicated, has shown them to be highly effective for many patients. Thus, future psychotherapeutic practice will increasingly require practitioners to have a broad eclectic armamentarium of therapeutic techniques, including psychoanalytically-based techniques, readily at their disposal to shape and provide individualized assessment-based treatment to meet the different and unique combinations of needs of each patient in

CONTINUED ON PAGE 9

President's Message

CONTINUED FROM PAGE 8

different circumstances.

The clinical social worker of the future will need to have a sound grounding in psychoanalytic theory, group and family dynamics, the biological basis of psychosocial functioning, and the core values, historical framework and techniques of intervention in the micro, mezzo, and macro spheres that are unique to social work. The clinical social worker of the future will have to abandon approximation of theoretical purity, and develop knowledge and skills in a wide repertoire of treatment techniques to meet creatively the varied treatment needs of different patients. The clinical social worker of the future will have to be skilled in engaging in interdisciplinary and transdisciplinary collaborative practice with physicians and other health and mental health practitioners. The clinical social worker of the future will need to know how to address the increasingly complex ethical issues that arise in healthcare and mental healthcare, along with the changing nature of society, the family and other social structures. **In summary, the clinical social worker of the future will have to be better and more broadly trained, have a much more comprehensive knowledge base upon which his or her practice is based, possess a more varied and eclectic set of skills, be dedicated to a career of constant learning, questioning and revising his or her professional practice, be more sensitive to and be able to deal with complex ethical issues in practice, and be prepared for a career marked by working collaboratively with a range of health and mental health professional colleagues in a variety of systems.**

The Society must work with schools of social work to encourage them to enhance significantly the training of future clinical social workers so that they will be able to meet the challenges and demands of clinical social work practice of the future. **The Society, through the continuing education programs provided by the chapters, the Society's practice committees and Society's education committee needs to broaden the focus of training to help prepare clinical social workers with the knowledge and skills they will need to meet the evolving clinical needs of patients of the future.** For if we stay rooted in the past and do not grow and evolve professionally, clinical social work will be left behind as other healthcare professions advance and adapt to meet the evolving health, mental health and psychosocial needs of a changing population and society.

Fourth, the nature of how health and mental health care is provided and funded is changing in many ways and will continue to do so. These changes are a result of a combination of the aging of our population, the promises, hopes and expectations stemming from biomedical advances, changes in societal structures, a changing economy, and increasing globalization. Changing values of health care providers and a decreasing willingness of a number of them to put aside to a great extent their personal lives in order to serve their patients (which is a positive step toward needed self-care for health and mental health professionals) are also impacting on the provision of health care. Further, the demands on health care providers to do more, accept less compensation, accept limits on their professional autonomy and meet productivity demands that decrease their ability to spend the time they need with patients, further fuels the changing health care environment.

Additionally, for the first time in New York, it is inevitable that, as has happened in other states where they are licensed, licensed mental health counselors and licensed marriage and family therapists will be competing with LMSWs, LCSWs and psychologists for jobs in health and mental health institutions and will be starting part-time private practices. Indeed, some managed care firms have already indicated that they will offer membership on their panels to these practitioners once they are licensed in New York, which should begin to happen before the end of this summer.

Currently, the United States spends approximately 17% of its gross national product on healthcare. Some form of national health insurance and some form of rationing of care is inevitable if the current health care system is to remain viable and solvent as the population ages and the demand for health care increases. Under such a system, which is likely to be put in place within the next decade, payment for mental health services will, as it has been for some time in most countries, be limited to treatment of the chronically severely mentally ill, crisis intervention, provision of mental health services to address the psychosocial needs of those suffering from chronic physical illness and their families, short-term psychotherapy to address emotional problems which interfere with employment or functioning in the workplace or impact significantly on psychosocial functioning, and services to address significant substance abuse. Some of the psychotherapy being provided today in private practice will have to be paid for privately and is not likely to be covered by any form of national health insurance, just as it was prior to our obtaining vendorship legislation in the 1980's.

The Society must help prepare clinical social workers to be ready for and to adapt to the inevitable changes in the way health care is provided and funded. As solo private practice has been decreasing throughout the country in the various health care professions, we must work toward the legal and other changes necessary to facilitate the development of multidisciplinary practices which include clinical social workers as partners rather

CONTINUED ON PAGE 10

President's Message

CONTINUED FROM PAGE 9

than as employees. We need to work with other health care organizations to assure that mental health and clinical social work services are fully recognized and included in any new plans for delivery and funding of health care. Our Legislative Committee is attentive to ways of increasing participation of clinical social workers as health and mental health care providers, and to protect legally and through regulations the high standards for clinical social work practice that we have achieved. Our Vendorship Committee will continue to address managed care issues and the inclusion of clinical social workers as providers of mental health services.

The Society needs to educate the public, health and mental health institutions, the administrators of payor systems, and other professionals about the special skills and competencies of clinical social work. And, we must take pride in our noble profession. We are not merely psychotherapists who have a social work degree. We are professional social workers with advanced clinical skills who provide psychotherapy and other clinical services informed by the culture, values, special knowledge and experiences of social work, and the unique perspectives that brings to our work.

In practical terms, what distinguishes us from other health and mental health professionals is that our core focus is on people as part of the larger social systems in which they live and with which they interact, and our ability to work within all of those systems to effect change. This translates into our particular skills in developing and coordinating interdisciplinary treatment and service plans which address the many aspects of people's presenting problems in a holistic manner in the context of the many levels of their interaction with their environment – from their intrapsychic relationships within themselves as individual people, to their relationships with other individuals and groups, to their relationships with multiple large social systems. Through the services we provide we strive to reduce our patients' suffering, to enhance our patients' bio-psycho-social-spiritual capacity to function optimally as social beings in their environment, to maximize their ability to live in harmony within themselves and in the greater world around them, and to access in a coordinated and meaningful way the range of multidisciplinary services they may require to enable them to do so.

It is crucial that we work harder to enhance the appreciation of those clinical social workers who work in institutions, providing clinical social work services which constitute the majority of mental health and clinical social work services provided in the United States, dealing under difficult circumstances with some of the most problematic and complex challenging clinical cases. We must reach out to them and welcome them into the Society.

In the early 1990s the Society changed its name from the NYS Society for Clinical Social Work Psychotherapists to its present name in recognition that clinical social work is not merely psychotherapy. It is psychotherapy and other clinical services provided within the context of the core values, historical framework and techniques of intervention in the micro, mezzo, and macro spheres that are unique to social work which add to our effectiveness and to our unique value as health and mental health clinicians. Additionally, the Society, which began as a organization of primarily psychoanalytically trained therapists predominantly in private practice, recognized that we needed to reach out to our clinical social work colleagues in agencies. For clinical social work is defined by its core values, mission, knowledge base, skills set and unique perspectives, not by where it is practiced. And, we are the Society for Clinical Social Work.

Although some clinical social workers are in full time private practice, the majority work in agencies and may or may not engage in part-time private practice. We need to reach out more vigorously to our clinical social work colleagues whose primary workplace is in agency practice, who are the majority of the approximately 16,000 currently registered licensed clinical social workers working in this State. We need each of our members who either works in, consults with or is otherwise involved with an agency which employs clinical social workers to encourage our clinical social work colleagues to join their local chapter, to come to a chapter monthly meeting or educational workshop, to view the Society as their professional home and to contribute their efforts, as part of the Society, to advance clinical social work.

Fifth, clinical social work is facing the prospect of workforce shortages in the future. This results from several factors.

- One, we have finally achieved the establishment of legally well-defined high standards for clinical social work practice and strict limits on the provision of clinical social work services by LMSWs who, in virtually all situations, may not do so unless they are functioning under approved supervision.
- Two, we have finally achieved the establishment of high standards of clinical education, supervised clinical experience and advanced clinical practice examination that must be met in order to qualify to become an LCSW, which standards are being strictly enforced.
- Three, the number of agency jobs in which LMSWs can provide clinical services (as opposed to traditional social work direct practice activities) under what is now legally required supervision is too small to afford each LMSW who wishes to become an LCSW the ability to obtain the necessary hours of supervised clinical practice.

CONTINUED ON PAGE 11

President's Message

CONTINUED FROM PAGE 10

The law requires that this supervised experience be obtained in **full time practice** [20 patient contact hours of psychotherapy per week, each contact hour being at least 45 minutes of psychotherapy with individuals, families, or groups, for a total of 960 hours per year based on a 48 weeks of work per year, for three years], or in **part-time practice** [no less than 10 patient contact hours per week of psychotherapy with individuals, families or groups, each contact hour being at least 45 minutes in duration] **or a combination of these**, over a period not to exceed six consecutive years.

- Four, because LMSWs are not eligible for mandatory insurance and other reimbursements and cannot provide clinical services in private practice except under approved supervision which they will have to pay for, it is unlikely that they, too, will be able to obtain the necessary hours of supervised clinical practice to qualify for the LCSW within the mandated time frame of not more than six consecutive years.

The Society, together with other social work organizations and the graduate schools of social work needs to work with health and mental health agencies which provide services within the scope of practice of licensed clinical social work, to assist them in obtaining qualified LCSW supervisors who are willing to come to these agencies to provide low to moderate fee supervision. This could ease the supervisory burden placed upon these agencies by the new law in relation to the supervision of LMSWs providing clinical social work services. In doing so, this would enable these agencies to retain LMSW staff to provide under appropriate supervision clinical social work services. This would help meet the needs of the agency to have supervised staff to treat patients, of the LMSWs to be obtain the supervised experiences needed for them to become LCSWs, of the social work profession to maintain a career pathway for those who wish to become LCSWs, and of the community by helping assure an adequate supply of LCSWs for the future.

Sixth, an increasingly critical challenge that is impacting on most professional associations including the Society is the issue of decreasing volunteerism. The Society has been able to accomplish all that it has accomplished over the years: vendorship legislation; licensing legislation and regulations; providing stimulating Society annual educational conferences and educational programs by the chapters and by various practice committees which enrich the knowledge and skills of our members; helping members and other social workers address appropriately ethical issues that arise in their practices; developing various chapters from what was originally a non-chapter organization; implementing a highly successful mentoring program for social work students and new graduates; helping our members deal with the intricacies of HIPAA and the new licensing statute; helping members learn how to operate their practices more effectively and to address vendorship and managed care issues; and speaking out for clinical social work and guaranteeing our right to practice that for which we are trained.

As we turn to meet new challenges, we need you, our members, to volunteer – to provide your time to assist us in serving you, our profession and the public. As professional social workers you each have an ethical obligation to contribute your time and energy to the profession. Become involved in your chapter. Join a committee. Volunteer to help the Society in one of its important projects – continuing education, supervision, mentorship, community outreach, outreach to agencies, outreach to schools of social work or outreach of other professionals. This is your Society. In the end result, it will reflect the extent to which each of you, individually and as a group, participate in it and contribute your time and energy to it. We cannot do it without you.

Special Thanks

In closing, I note that the social work profession in this State owes a great debt of gratitude to David Hamilton, Ph.D., LMSW, the Executive Secretary of the State Board for Social Work and the State Board for Mental Health Practitioners, and his colleagues in the Education Department who have worked diligently, above and beyond the call of duty, under significant time pressures without any significant increase in resources and staff, to prepare and distribute 69,179 LMSW and LCSW new license parchments and 41,546 new registration certificates when our new licenses became effective, to process the large volume of grandparenting, new license and "R" applications that have been and continue to be submitted, and to address and attempt to resolve an overwhelming number of inquiries from members of the social work community while completing the complex initial regulatory process for implementation of the new licenses and concurrently handling the regular and customary responsibilities for the State Board for Social Work. They all have our heartfelt thanks, appreciation and admiration for an exceedingly difficult job done so well.

Contact Information

If you need to contact me on Society business please e-mail me at **nysscsw@mindspring.com and, in addition to your message, please provide your day and evening phone numbers.**

I continue to chair the Society's Committee on Ethics & Professional Standards and Committee on Forensic Clinical Social Work. If you need to get in touch with me in that regard please e-mail me at **clinicalswethics@mindspring.com and, in addition to your message, please provide your day and evening phone numbers so that I can call you back.**■

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