# The CLINICIAN

WINTER 2001 ▪ VOL. 32, NO. 1

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


# Looking for Meaning at the 4th Joint Conference

SANDRA INDIG

*The presenters and committee for the conference included (Front row, l to r): Michael DeSimone, PhD; Marsha Wineburgh, PhD; Eda Goldstein, DSW; Carol Tosone, PhD; Roberta Ann Shechter, DSW, RoseMarie Perez Foster, PhD; Charles Rizzutto, MSW; (back row, l to r) Michael M. Crocker, MA, MSW; George Patterson, PhD; Arlene D. Litwack, MSW; Debra Roth, MSW; Helen Hinckley Krackow, MSW.*

Over 250 participants were at the right place on Saturday, November 4, 2000, attending "Looking for Meaning in All the Wrong Places: Clinical Issues and Implications," the very successful Fourth Joint Conference of The New York State Society for Clinical Social Work and New York University Shirley M. Ehrenkrantz School of Social Work PhD Program.

Keynote speakers included Rosemarie Perez Foster, who presented "Searching for Soul: Looking Beyond the Symptom Frame," and Carol Tosone, who presented "The Social Work Therapist's Narrative: A Common Tale." Marsha Wineburgh was the discussant.

In the afternoon, attendees broke up into 12 workshops, including "Compulsive Sexual Activity: Diagnosis, Treatment and Countertransference Issues," "The Therapist's Dark Side in the Treatment of Sadomasochistic Pathology," "How Thin Is Too Thin: The Excessive Pursuit of Thinness," "The Action of Doing in Doing Nothing: Understanding and Treating Passivity," and "Removing Barriers to Intimacy: The Treatment of Internalized Homophobia in Gay Men." ■

EXECUTIVE REPORT

## Investing in Our Future

*By Allen A. DuMont, CSW, BCD, Society President*

Investing in our future, like investing in the stock market, is best done for the long term. As we have learned from the most recent roller-coaster rides on Wall Street, the get-rich-quick strategies that promised stellar gains may prove disheartening when market winds shift. Preferable are the strategic, incremental approaches that are applied with patience and forbearance, based on sound values.

What we decide in these initial years of the 21st Century should be guided by a similar philosophy. We, as a state organization of clinical social workers, cannot stand alone without peril to our survival.

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# Executive Report

*By Allen A. Du Mont, CSW, BCD, Society President*

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Our strength is interdependent with that of our neighbors, and a strong national organization enables us to establish a presence commensurate with the contributions we make to our Society.

That is why it is so important for us to promote the health and strength of the Clinical Social Work Federation. Standing shoulder to shoulder with other national professional associations in Washington, the CSWF can advocate for the interests of our profession and the consumer, while also assisting in the development of state societies across the nation. Those societies that are in a better position to do so, like New York's, can help the CSWF during its time of financial crisis to carry on its essential operation of lobbying on behalf of us all.

Recognizing CSWF's importance, the Board unanimously approved the contribution of $10,000 towards a Lobbying Fund which will help finance limited lobbying activities until a more permanent plan can be developed. I am happy to report that, not long after our Board acted, the Pennsylvania Society voted to contribute $2,000 to the fund. And a few weeks later, the Washington State Society added $500. I am hopeful that other states will be inspired to make contributions as well in the next few months.

### Other Investments: Guild, Referral Service, Chapters

Our investment and participation in the National Guild of Medical Professionals forges an alliance with organized labor. It will help us achieve a stronger position in the marketplace, assisting us in withstanding the pressures of managed care and in advocating for consumer protections and patient rights. We also will be negotiating with local unions for Guild members to provide mental health services for their members and to be included in their health plans at rates of compensation that recognize the value of our services.

Our investment in the Information and Referral Service will help gain more visibility for the State Society by publicizing the availability, quality, and wide range of services offered by clinical social workers, as well as providing an opportunity for practice development of RIS members. Plans are being developed to reach out to clinical social workers who work and practice throughout the state, but who have not yet heard of us. Our goal is to make this truly a state organization which advocates for the profession, establishes and promotes standards of practice, provides essential support services and member benefits, and encourages statewide participation.

Delivery of membership services on the local level is a highly important magnet for new member interest. The Board wisely voted to increase revenue sharing with the chapters to assist and support their activities. Opportunities for collegial association, sharing of information, and for networking has long made our Society a haven for clinicians looking to share interests with like-minded clinicians.

The Board's unanimous decision to raise our dues for the first time in eight years reflected an understanding of the work we must do and the investment we must make in our future.

On behalf of the Board, I wish to thank you all for your continuing support as we grow and develop into the organization we must become.


**The Clinician**

**The Clinician** is published three times each year by
The New York State Society for Clinical Social Work, Inc.
**SOCIETY PHONE:** 1-800-288-4279
**SOCIETY WEBSITE:** www.cswf.org
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New York, NY 10011 ▸ (212) 352-0126
**EDITORIAL CONSULTANTS:** Helen H. Krackow, Newsletter Chair, Carolyn Colwell, Lesley Post, and Susan Soph-Rivera
**DEADLINES:** January 10, April 5 and September 1


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Display ads must be camera ready. Classified: $1/word; min. $30 prepaid.

## IMPORTANT PHONE NUMBERS

| | |
|---|---|
| NYS Attorney General's Healthcare Hotline | 800-771-7755 |
| US Department of Labor | 212-637-0620 |
| NYS Department of Health Managed Care Complaint Hotline | 800-206-8125 |
| NYS Public Advocate's Healthcare Complaints | 212-669-7606 |
| Department of Insurance Late Payment Complaint Line | 800-358-9260 |
| The League of Woman Voters for Members of Congress | 212-677-5050 |
| Senator Charles E. Schumer | 212-486-4430 |
| Senator Hillary Clinton | 212-666-5150 |



NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

# CSW Expert Testimony Affirmed

## *Maryland Accepts Clinical Social Workers as Expert Court Witnesses*

*Ellen T. Luepker, MSW, BCD, Past Chair, Committee on Clinical Social Work & Law/Forensic Practice, CSWF*

The question presented to the Court of Appeals of Maryland last March was "whether the Circuit Court for Washington County had erred in permitting a licensed clinical social worker to testify as an expert witness and to provide diagnostic expert testimony."

Because the issue in this case had significance for clinical social workers in Maryland and nationally, the Clinical Social Work Federation (CSWF) helped develop a "friend of the court" *(amicus curiae)* brief to assist the court in understanding the parameters of clinical social work practice. In its decision filed on September 13, 2000, the Court of Appeals of Maryland agreed with all aspects of our *amicus* brief, affirming that the "trial court neither erred nor abused its discretion in receiving the diagnostic opinions."

Dr. Carleton Munson, a Maryland licensed clinical social worker and member of the Greater Washington Society for Clinical Social Work, notified CSWF last winter of the Maryland appellate case. He informed us that the Maryland Department of Human Services had hired him to evaluate a woman and a five-year-old child for an adoption and guardianship court hearing. He had considered, among multiple factors, the mother's history of a serious and persistent mental disorder, including her several suicide attempts in front of the child. He had testified in the Circuit Court for Washington County that, in his professional opinion, the mother's mental illness had impaired her capacity, at least for now, to provide adequate care for her young child. The judge had accepted his qualifications as a licensed clinical social worker to testify regarding the mother's diagnosis of an emotional and mental disorder. The court also had agreed with his professional recommendations.

The Maryland Public Defenders' Office, however, petitioned the Court of Appeals, arguing that Dr. Munson was erroneously "practicing medicine" by rendering a "medical diagnosis." The Petitioner also argued that while psychologists are named by Maryland statute as experts in court, "social workers" are not, and therefore are not qualified to provide diagnostic expert testimony in the courtroom.

In its 14-page opinion, the Court of Appeals distinguished between definitions of licensed "social worker" and "clinical social worker." The Court noted that the latter's requirements are "more stringent than those required for the non-clinical licensure, which does not include a similar grant to diagnose mental and emotional disorders." It acknowledged further that the District of Columbia and 33 other states in our country have similar statutes which "define clinical social work as including diagnoses or evaluations of mental disorders."

The Court also stated that the absence of a Maryland statute specifically citing clinical social workers as experts qualified to testify to their diagnostic opinions in court was of "no consequence." Referring to Maryland law and several court opinions that have allowed clinical social workers' expert testimony, the Court upheld the general rule that qualifications of expert witnesses are to be determined within the discretion of the court.

CSWF developed the *amicus* brief for the Court of Appeals of Maryland in collaboration with the following organizations: the Greater Washington Society for Clinical Social Work; Maryland Society for Clinical Social Work; Committee on Psychoanalysis in Clinical Social Work, Inc.; Family Therapy Practice Academy; Clinical Social Work Guild No. 49 of the Office and Professional Employees International Union; AFL-CIO; the National Association of Social Workers (NASW); Maryland Chapter of NASW; and the American Board of Examiners in Clinical Social Work.

I am delighted that CSWF played a pivotal role in assisting the Court of Appeals of Maryland to understand clinical social work practice. The Court's opinion will have positive significance for clinical social workers in Maryland and nationally. My thanks to the Committee on Law/Forensic Practice and other CSWF members for generously contributing time and information to our brief on short notice, to the attorneys at Dickstein, Shapiro and Morin for ably representing CSWF, and to our colleagues in all of the organizations noted above for their thoughtful and respectful collaboration.

### REFERENCE

Quotations above are from the written opinion of the Court of Appeals of Maryland #134, September Term, 1999. In Re: Adoption/Guardianship No. CCJ14746 in the Circuit Court for Washington County.

# Independent Practitioner's Fees

*by Iris Lipner, CSW, BCD*

*Iris Lipner, CSW, BCD is a social worker-psychoanalyst who is in private practice in Manhattan and Brooklyn, NY. Her co-authored book,* Saying Goodbye to Managed Care: Building Your Independent Psychotherapy Practice *was just published.*

Social worker-psychotherapists in a direct pay practice are often caught in a quagmire of conflicting issues surrounding fees. Our education, code of ethics, and heritage intermingle with our desire to do "meaningful" work. We are ambivalent about making money, as we fear that it conflicts with our role as helpers of all who are in need. The challenges of an independent practice reflect our inner sense of self, our transferences-countertransferences in dealing with money, our comfort and discomfort in setting fees and marketing ourselves.

Multi-leveled unconscious processes often lead us to believe that we are unable to build our practices, as we fear we will either be seen as worthless and incompetent or as greedy, grandiose, and unprofessional social workers. Central to the confusion is an altruistic ideal that we believe in—that we need to care about our patients, help humanity, and be a dedicated worker.

There is an unconscious wish to conceal the fact that we want money for our work. This happens, in part, because most of us have worked in institutions and agencies where we did not negotiate the fees. Usually we were paid a salary and did not get involved in handling payments. Our ranks are mostly made up of women, who are traditionally paid less and have more trouble dealing with fees.

In a reader survey of private practitioners by *Psychotherapy Finances* [v23, n5 May 1997], women's fees across all categories were $5 lower per hour than men's. Social workers are among the lowest paid mental health workers and are viewed as "low status" mental health workers compared to psychologists and psychiatrists. In addition, our schools of social work do not have courses on practice building, establishing fees, and entrepreneurship. Getting paid is incidental to our profession.

**A successful practice is based on excellent clinical knowledge and skills combined with business planning. It is appropriate to want to get paid and make money.**

We do not see ourselves as business people providing a professional service, but only as dedicated therapists providing psychotherapy treatment. We never learned how to be business owners.

In order to be successful as independent practitioners, we must begin to see ourselves as business people providing a service. We are social worker-psychotherapists providing various types of clinical social work, assessment/evaluation, and psychotherapeutic and psychoanalytic services. We sell a service, and that is our business. Money is an unmistakable part of our service. We need to be paid in order live our lives, meet our financial responsibilities, care for our families, and take vacations.

In sum, the fee is an essential part of a financially healthy independent psychotherapy practice. We may wish for a certain level of income and think that if we are caring and good therapists we will get it. But fees should be based on our credentials, graduate and postgraduate training, licensure, and specializations.

A successful practice is based on excellent clinical knowledge and skills combined with business planning. It is appropriate to want to be paid and make money. To have a decent income, we must have a viable and profitable enterprise.

## Setting the Fee

Payment for our services is addressed in the NYSCSW Code of Ethics:

> When setting fees, clinical social workers should give consideration to the client's ability to pay and make every effort to establish fees that are fair, reasonable, and commensurate with the value of the service performed. [Code of Ethics, p.10]

What is reasonable for a client to pay depends on many factors. Working toward an openness about money can serve as a frame for our own and the client's exploration about finances. Clients have multiple practical and emotional reactions to discussing the fee and what they can afford. Much has been written about this topic, especially about the preconscious and unconscious forces, trust, worth, motivation, and fantasies at work [Herron and Welt 1999, Whitson 1999]. Whether low or high or usual, the fee is the boundary between the therapist and the client.

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# Vendorship & Managed Care

## COMMITTEE REPORT

By Alice Garfinkel, ACSW, DCSW, Chair

The VMCC continues to support Society members in their dealings with managed care and third-party insurance payors. We assist members when there is difficulty in getting paid for authorized sessions, obtaining continued authorization for patients, getting on or off panels, and with confidentiality and Medicare questions.

### Opening New Markets: Self-Insured/Self-Funded Companies

The VMCC also markets to self-insured companies that do not recognize clinical social workers for independent reimbursement for mental health services. We are currently marketing Pepsico, Daimler-Chrysler, Sun Chemical, The Mark Hotels, Bedford School District, Quick & Riley, Nova Care, Ford Motor Credit, IIT Research Company, Unisys Corporation, DTS Travel Enterprises, UICI, and Chemed Corporation. We are also using our connections in the AFL/CIO to enhance efforts with the unions that do not recognize social workers as providers.

### Recent Medicare News

Medicare Part B has a new toll-free number: 1-877-869-6504. Medicare also has a waiver of liability designed to describe who is responsible for payment when a claim is denied because a service was considered not reasonable and necessary under Medicare guidelines.

Usually providers do not bill for services they believe are not medically necessary. However, if a provider bills for a service they believe may not be covered, he/she should obtain a waiver of liability statement from the patient. When filing a claim, the provider uses the modifier "GA" to denote that, even though the provider feels the service being billed is not covered by Medicare, the claim is being filed because of the patient's right to a determination. If a waiver is not signed by the patient in advance of filing a claim for a service that is expected not to be covered by Medicare, the patient will not be responsible for payment.

### Participation Is Still Needed!

The VMCC is instrumental in helping Society members learn how to address problems and know whom to contact for advocacy. This often makes the difference between resolution and victimization.

Peter Smith is the new representative for the Metropolitan Chapter and we are thrilled to have his help and interest. We are still looking for VMCC representatives in the following areas: Cap District, Mid-Hudson, Western NY, Staten Island, and Rockland. If anyone is interested in learning more about the Committee or has any suggestions, please contact your local chapter representative. You may also call me at 718-352-0038 or 917-424-3545.

For assistance with an insurance or managed care problem, call Vendorship/Managed Care Committee Representatives.



### VMCC REPRESENTATIVES

| | | |
|---|---|---|
| BROOKLYN | ADRIENNE LAMPERT | 718-434-0562 |
| CAP DISTRICT | ALICE GARFINKEL | 718-352-0038 |
| METROPOLITAN | PETER SMITH | 212-744-6428 |
| MID-HUDSON | ALICE GARFINKEL | 718-352-0038 |
| NASSAU | FRED FRANKEL | 516-935-4930 |
| QUEENS | SHIRLEY SILLEKENS | 718-527-7742 |
| ROCKLAND | BETH PAGANO | 914-353-2933 |
| STATEN ISLAND | ALICE GARFINKEL | 718-352-0038 |
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| SYRACUSE | GARY DUNNER | 315-488-1884 |
| WESTCHESTER | LIZ RUGGIERO | 914-618-8919 |
| WESTERN NEW YORK | ALICE GARFINKEL | 718-352-0038 |

### Medicare Clinical Social Worker 2001 Fee Schedule

EFFECTIVE JANUARY 1, 2001

| CODE | DESCRIPTION | LOCALITIES (see below) 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 90804AJ | Individual Psychotherapy (20-30 min.) | $58.78 | $56.54 | $51.67 | $55.96 |
| 90806AJ | Individual Psychotherapy (45-50 min.) | 88.56 | 85.19 | 78.00 | 84.32 |
| 90808AJ | Individual Psychotherapy (75-80 min.) | 133.51 | 128.52 | 117.53 | 127.20 |
| 90801AJ | Psychiatric Diagnostic Interview | 131.41 | 126.49 | 115.89 | 125.21 |
| 90846AJ | Family Psychotherapy (without pt) | 87.23 | 83.92 | 76.82 | 83.06 |
| 90847AJ | Family Psychotherapy (cojoint) | 103.12 | 99.32 | 90.99 | 98.30 |
| 90853AJ | Group Psychotherapy | 31.79 | 30.38 | 27.69 | 30.08 |

**LOCALITIES**

1. Manhattan
2. Brooklyn, Bronx, Westchester, Richmond, Rockland, Nassau and Suffolk Counties
3. Putman, Sullivan, Orange, Dutchess, Ulster, Columbia, Delaware and Greene Counties
4. Queens County

# The Body Speaks, the Body Weeps:

## *Eating Disorders, Self-Mutilation, and Body Modifications*

*by Sharon Klayman Farber, PhD, BCD.*

*Sharon Klayman Farber, PhD, BCD is in private practice with children, adolescents, and adults in Hastings-on-Hudson, New York. She is the founder of Westchester Eating Disorders Consultation Services. Her book, When the Body is the Target: Self-Harm, Suffering, and Traumatic Attachments, will be published by Jason Aronson Inc.*



Suddenly self-cutting, a clinical problem that evokes considerable anxiety, seems to be almost everywhere, bursting onto the cultural scene in much the same way eating disorders exploded into our awareness twenty or thirty years ago.

Self-mutilation is more of a problem than has been thought, especially with people who have eating disorders (Farber 1995, 1997; Favazza 1987). In fact, individuals with eating disordered behavior, especially bulimic behavior, are at high risk for self-mutilation (Favazza, DeRosear, and Conterio 1989; Walsh and Rosen 1988) and are more likely to do so the longer they have had the eating disorder (Farber 1995, 1997).

Self-cutting is only part of a spectrum of self-mutilating behavior, the infliction of injury to one's body resulting in tissue damage or alteration. Other forms of self-mutilation include burning, scratching, needle-sticking, hair-pulling, severe nail/cuticle biting, and chewing. We are also struck by the increasing prevalence of body modifications, passive self-mutilation in which a person engages another to pierce, brand, cut, or tattoo his or her body (Juno and Vale, 1989). And if you think about it, the results of bulimic behavior—internal injuries and lacerations, bleeding, and severe dehydration of internal organ tissues—constitute a form of self-mutilation from the inside out.

The association between eating disordered and self-mutilating behavior makes sense when we consider that those with either problem tend to have significant body image problems and struggle with issues of boundaries and body ownership such as: What is this body? How much space does it take up? What is inside it? How does it work? How does it feel? Does it belong to me? Or does it belong to my mother, father, spouse, or partner? They suffer from a sense of being alienated from their bodies (Walsh and Rosen 1988) and may harm themselves to define amorphous body boundaries (Krueger 1989) or to claim ownership of their bodies. For example, Kim, who had been sexually abused in childhood by her father, wrote in her journal:

> Tonight I've done everything to distract myself from thoughts of cutting...I feel angry and I'm not very good at that feeling. They say that behind anger is always fear. So I ask myself: "What are you afraid of?" Well, what do you think?! I'm afraid my father will jump right through my skin and scare the silence right out of me. When I put down this pen, who'll get me first? My daddy or me? I'd rather get there first. This belongs to me! cut, cut, cut. (Kim 1993, pp. 3-4)

Many people who acquire body piercings or tattoos do it to claim ownership over the body, a common concern of adolescents and of those whose bodies have been abused and intruded upon. Not surprisingly, those with eating disorders and those who mutilate themselves or become "addicted" to the pain of piercing or tattooing have suffered considerable trauma in childhood, including separations and loss, family violence, physical or sexual abuse, coercive and intrusive medical and surgical procedures, and the more ordinary everyday trauma of being ignored, emotionally neglected, and robbed of a sense of self.

Above all, they suffer from painful and traumatic attachments to the earliest and most important people in their lives, repeating the trauma in their self-harm. So the self-harm behavior of a sexual abuse survivor can, without words, communicate something of the trauma she suffered and her attachment to her abuser. It may even serve as a bodily reenactment of the trauma she has suffered, but in the reenactment she is in control and active, as opposed to the circumstances of the trauma. She may shove food into her mouth in a depersonalized frenzy as others shoved a penis, fingers, or other objects into her body, or may penetrate her flesh with a razor blade, lit cigarette, or fingernails, as her abuser penetrated her. She may vomit the food out to rid her body of those things that were inserted by force, or may watch the liquid oozing from the wound, feeling relieved that the vile stuff that had been inside her (semen, the hateful parts of herself) is being expelled, leaving her clean and pure. She also has the pleasure of discharging rage and violence onto the abuser. She is both the abuser and the one being abused, the sadist and the masochist. She is a cool observer of her own self-abuse, like the parent who was present but failed to protect her. In the self-harm regression, all these become condensed as she oscillates crazily from self to object and back again.

Self-harming patients make extraordinary demands on therapists and other health care professionals in terms of countertransference, transference, and management issues. The potentially life-threatening risks they take evoke intense counter-transference responses of anxiety, avoidance, anger, helplessness, over zealous caretaking, and efforts to control them, which often

*(This review is reprinted from The Renfrew Perspective.)*

exacerbate their self-harm symptoms. Treatment comes to feel like an adversarial procedure for patient and therapist alike, and ultimately fails.

If we can overcome our fear of knowing about the darkest, most destructive part of the self that exists in some measure in all of us, we can come to understand more about the language of self-harm. One needs to know that despite the sometimes life-threatening nature of the self-harm, it may be more about living and surviving than about dying. That is, it may be the patient's best attempt to keep from hurtling into the abyss of suicide or psychosis. The physical pain they inflict upon themselves diverts them, at least momentarily, from their intolerable emotional pain. They crave this intensely stimulating body experience the way a hungry person craves food. That is, they tend to crave and live more in the immediacy, stimulation, and excitement generated by bodily experience and less in the self-containment provided by a more structured self that can use words as symbols of inner experience.

Traumatic events may involve real or perceived threats to life or bodily integrity, inspiring terror, helplessness, and the fear of annihilation (Herman 1992). The traumatized person is made utterly powerless and loses any sense of control, meaning, and human connection. Trauma has been described as the experience of feeling ourselves to be utterly and completely alone, what we feel when we suffer grief or other object loss (Winchel 1991). "'Aloneness' is man's biologic destiny—and but for our ability to undo our aloneness, we might all rip ourselves to bits (Winchel 1991, pp. 10-11)." That is, it is the human attachment to another human being that saves us. The body speaks of that which cannot be said in words, of secrets, lies, and trust that has been broken.

**If we can overcome our fear of knowing about the darkest, most destructive part of the self that exists in some measure in all of us, we can come to understand more about the language of self-harm.**

As Judith Herman has said, "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma (Herman 1992, p.1)." But we know that repressed or dissociated experience has a power and energy of its own. Like food that is stuck in the throat, the experience must be chewed, swallowed, digested, and metabolized or the body will try to discharge it physically. The body will exercise madly, binge, purge, starve itself, cut or burn itself, or get itself tattooed or pierced repeatedly. When the voice is silenced by trauma, all that will emerge are such gestures and guttural utterances (McLane 1996). When the body attacks itself with a blade, this is a gesture that should make us wonder to whom the body is speaking and for whom the rage is meant. When the body weeps tears of blood, we need to wonder what terrible sorrows cannot be spoken. When food that had tasted good suddenly feels like poison and has to be purged from the body, we should wonder what traumatic experiences exist that cannot be contained, metabolized, and integrated. One needs to decode the bodily narrative in order to understand the mysterious paradox and power of self-harm. When the body speaks, the key questions are: To whom is the body speaking? What is the body saying?

The aim of treatment is to help the patient develop the ability to differentiate, tolerate, think about, and regulate her emotional states, her depression, anxiety, dissociation, and hyperarousal so that she does not have to rely upon her self-harm for self-regulation. The focus is on helping the patient develop the ability to move from the language of the body to expressive spoken and written language. It is meant to help the patient come to identify, tolerate, and regulate mood and affect states and expand the affect array. So instead of saying, "I am fat" or "I am ugly," she might come to be able to say, "I feel angry" or "guilty" or "sad" or "ashamed" or "frightened."

Take the case of Jane, whose body spoke of the trauma of witnessing family violence, of secret shame, of a lack of secure human attachments. Jane, age 26, was a college graduate with a good job who lived at home with her alcoholic father and frightened, submissive mother. She was depressed and quite overweight. Her father had been a problem drinker for a long time, and since early childhood Jane had been a compulsive overeater, but in her sophomore year of high school her father's drinking and then her eating had become more out of control. Jane had become more withdrawn from friends, coming home after school feeling ashamed and depressed. She completed college while living at home, then went to work. When she came home, she would try not to witness or hear her father's frightening alcoholic rages every night. Ever since sophomore year in high school the evening routine was that she would stay in her room and "go away" in her mind into a dissociated state. When her father's rampage was over and it had become quiet, Jane would sneak into the kitchen. She would load up on food, bringing it to her room to feed to herself, her behavior saying that she needed no one, that she was the comforting mother feeding the hurting child.

Jane was a somatizer, expressing emotion through her body. Her fair Irish skin would get very red and very hot, her body overheating. She was constipated and would sit on the toilet straining, until she started to feel

CONTINUED ON PAGE 12

# Society Workshop: Proposal Writing

**TRANSCRIPT OF A PRESENTATION ON SEPTEMBER 24, 2000**

By Roberta Ann Shechter, DSW

*Roberta Shechter, DSW, is a Certified Psychoanalyst in private practice in Manhattan, Associate Editor of Psychoanalytic Social Work, and a writing consultant.*

## Selecting a Topic

We have come together today to discuss how to write a workshop proposal for a clinical conference. The anticipation of writing a proposal and presenting at a conference can trigger performance anxiety in any clinician. Performance anxiety often begins during the initial stage of proposal writing, so let's begin our workshop with a story that addresses the psychological issues involved in selecting a workshop topic, our first writing task.

> John Smith, a senior clinician, a social worker with many years of experience, receives the Clinical Society call for conference papers in his office mail box and has a spontaneous series of connected thoughts:
>
> "Hey...this conference might be interesting to attend! (Pause) Hey...always the bridesmaid, never the bride. Maybe it would be fun to do a workshop at this conference. I wonder? (Pause) I certainly could use the professional exposure. My caseload is down. They say that patient referrals and supervisees can come from doing presentations. People meet you, like your ideas and see how you work. (Pause) What should my topic be? (Long pause.) No, I'm too busy to do a workshop. I have too much on my plate already. (Longer pause.) Maybe another time...there is always a conference possibility..."
>
> Three months later John Smith takes the final form of the same conference program out of his mailbox and thinks again that the conference is interesting and wonders again if he should attend. He looks through the program to select a workshop and is surprised to find the name of his supervisee, Ted, on the list of presenters. Now John's silent reflections run something like this:
>
> "If Ted can talk about that topic because of what he has learned from me, I certainly could. I should have tried to participate in this conference. (Pause.) The truth is, I did consider it, but I couldn't think of anything new to say, nothing original. Now, looking at the program I think the focus of this conference is exciting. After all, it is in my area of practice. But when I considered doing a workshop I couldn't think of a worthwhile topic, at least one that hasn't been done a hundred times before. If I had settled on a topic, just any topic, it probably would have seemed repetitive or ordinary, and I would have felt foolish conducting the workshop."



I believe that there is no "original" workshop topic. John's belief that his topic had to be original was the product of an underlying grandiosity. Vulnerability to low self-esteem and/or castration anxiety was stirred in John by the thought of publically airing his ideas. John Smith was struggling with the normal phallic-narcissistic issues that plague all of us at some point in our professional lives. John lost that struggle and did not write a workshop proposal. Everyone attending this gathering today is ready to do battle with his or her own performance anxiety and present a conference workshop. Some of you have topics ready-at-hand, others are still evolving ideas.

Selecting a topic and writing a workshop proposal is easily done when you accept the assumption that your workshop does not need to address a new idea in order to be considered worthwhile and acceptable to a conference. Clinical learning is the goal of most conferences, and colleague-led workshops are the means to that goal. Original ideas are admirable, but not necessary. Basic science has long accepted that there is no totally new idea under the sun, just variations on a theme and research expansions. Each variation and expansion has value. It pushes the knowledge base of science forward. The same is true in our clinical world. Schools of psychodynamic thought build on each other. There is a lot to learn, and most clinicians are in a state of perpetual learning. We never know enough. Attending conferences is a continuing education activity that addresses our need to know more. The best workshop clearly addresses that need. It teaches clinicians what they need to know in order to practice. So when you are planning to write a proposal, frame your topic by thinking in terms of teaching other clinicians one small part of what you know about in your area of practice. Read the conference call for papers with a limited teaching goal in mind, and your workshop topic will unfold.

When I read a call for papers and consider participating in a conference, my thoughts are guided by several questions:

1. What is the basic theme of this conference?
2. How does my work as a clinician intersect with that theme?
3. Is there anything that I feel equipped to teach another clinician that is connected to the conference theme?
4. Is there anything that I would like to talk about to a group of clinicians that they might find interesting?
5. The fit between my work and the conference topic

may not be obvious. So how can I rephrase the conference theme to fit my practice experience, and in that new language, what would I like to teach others?

6. Since I enjoy doing case-focused workshops, do I have a patient in my past caseload that fits the population addressed by the conference?

### Limiting Your Focus

Once you have your topic, remember most workshops are one hour or 90 minutes in length, so you will not have enough time to present all of your knowledge on the topic. Thus, it is probably a good idea for your workshop to be highly structured and clearly focused on one or two concepts with clinical case examples connected to those concepts. A good workshop allots time for audience participation or discussion.

Many conference committees expect workshop leaders to use written papers in their presentations. Written papers, in my opinion, help a presenter structure a workshop. I always go in with a written paper. I may not stick to the page, but it helps timing and focus. If your workshop is 90 minutes in length, you might spend the first 25 minutes delivering a 10-page paper filled with your ideas, and then move on to a free-flowing discussion. Your paper sets the tone and the intellectual parameters of the workshop. Slow and clear verbal delivery of a paper is approximately 2 minutes for every double-spaced typewritten page. So 10 pages will take 25 minutes.

I begin many of my workshop presentations by defining a concept and using one or two brief case examples to illustrate that concept. I don't try to be brilliant. I simply want to present my work in a way that stimulates the thoughts of other clinicians, so that they take in my ideas and come forth with their own in our discussion. How case material is disguised for presentation, maintaining patient confidentiality, can be discussed at a later point...Let's move on now to the mechanics of writing a proposal.

**Selecting a topic and writing a workshop proposal is easily done when you accept the assumption that your workshop does not need to address a new idea in order to be considered worthwhile and acceptable to a conference.**

### Structuring the Written Proposal

There are many ways to write a workshop proposal. I have copies of proposals that have been accepted by society conference committees in the past. First, I would like to share how I write a proposal, structure it and fill in each section. I usually divide my proposals into four sections: Introduction, Theoretical Formulation, Case Illustration, and conclude with a 5 to 10 item Bibliography. The entire proposal is no more than 3 to 5 double-spaced typewritten pages. I structure my proposal like this because I want the conference committee reader to be comfortable with it. I want the reader to view it as scholarly and well organized, with clearly expressed ideas and definite presentation parameters.

In my Introduction, I state my workshop topic and suggest in what way my workshop will make a contribution to our clinical world. This statement may be general or somewhat political in tenor, i.e., I plan to focus on a much-overlooked dynamic in the fantasy life of many patients, sibling transference. The introduction section is meant to engage the interest and curiosity of the reader.

A Theoretical Formulation is all-important. In it, I define the basic concepts that I will explore in my workshop. At the end of this section I refer to the case material that I will be presenting in the workshop. I do this in order to root the concepts that I have defined in a clinical context. My hope is that the proposal reader will become curious about my presentation and consider attending it.

A Case Illustration section can be part of your proposal, but it need not be a finished product. You might briefly describe the kind of patient that you will be discussing. Use identifying information that is colorful and somewhat dramatic or describes a situation that a reader and/or audience can easily identify with. The more polished this section, the more likely your proposal will be accepted. If you carefully make your case material illustrate the concepts in your theoretical framework section, then your proposal will have an overall consistency and seem scholarly, making it even more likely to be accepted by the conference committee.

### Preparation

This is the important task that is completed after your proposal is accepted. Now you write the 10-page presentation paper, a paper that you will trim several times in an effort to maintain your limited focus and remain within workshop time constraints. It is difficult to write a short paper. Most clinicians are highly verbal people who tend to be obsessionally all-inclusive, especially when they want to make an excellent presentation. In a workshop, less is always better. But save your castoff pages. Most workshop material can be used as the basis for a published paper.

### Audio/Visual Aids

A slide projector is most often used when a paper is delivered in a large auditorium to a sizable audience. Most workshops engage in group process and are limited to 8-15 people. Thus workshop audiovisual aids are usually chart handouts, blackboard diagrams, short films, and prepared bibliographies. I use diagrams that help my listener take in ideas and participate in discussion. I occasionally give a copy of my own published paper on a related topic or an additional bibliography as an "ending gift" to workshop attendees.■

# A Primer For Child Psychotherapists

Reviewed by Susan B. Sherman, DSW

*Susan B. Sherman DSW has an adult practice of psycho-analysis and psychotherapy and a child practice of psychotherapy in Manhattan and Long Island. She is a faculty member of the Society for Psychoanalytic Study and Research and the Jewish Board of Family and Children's Services Clinical Training Institute, and the Adelphi University School of Social Work. Sheis a member of the National Study Group of the NMCOP.*



By Diana Siskind
Published by Jason Aronson, Inc.
$40.00

Although Diana Siskind calls her indispensable new book a "primer," it contains essential information for both new and experienced child psychotherapists. At base, this book is not a "how to," rather, a "how to deeply understand and transform that understanding into practice," a much more fruitful enterprise. The book reflects the good common sense we all possess, but has eluded organization and documentation before now. It is also profound and original in confronting the thorny issues of work with children, which implies the often thornier work with parents, and here we are afforded new and thorough ways of thinking. In its question-and-answer format of a clinician posing questions to a very experienced mentor, this unique book literally raises the sometimes delicate, often times wrenching and dumbfounding questions we routinely ask ourselves in our complex and demanding work as child psychotherapists.

The book is divided into two parts; On Beginning and The Treatment Process. As these headings suggest, Siskind first examines the evaluation process, where she outlines the basic differences between treatment of children and treatment of adults, explaining how these differences affect the crucial engagement and assessment period with a new child patient and how we share our findings and recommendations with both the parents and the child. In Part II, Siskind takes us from the not so pragmatic (we quickly learn) task of selecting materials for the treatment room to how we begin, how we manage the myriad problems of management and the "typical" but nonetheless difficult nitty gritty dilemmas we face in our work with children. For example, how do we handle personal questions asked of us, what do we do with secrets, gifts, and the parent counterparts, e.g., what do we do when they demand advice, don't pay their bills, have values that clash with our own? Additionally, there are chapters on the special problems encountered when parents divorce, and how termination can be best negotiated. Throughout the book, Siskind helpfully italicizes ideas that she considers basic principles and places these again in an appendix, one of the most valuable appendices a child psychotherapist could own.

Very early in the book, Siskind states a major thesis of the book: "The child therapist has to stand equidistant to child and parent. Only when positioned that way can the therapist be alert to all the subtle shifts of affect and behavior that inform and guide our work" (p. 19). She has previously stated this position in her book, *Working with Parents: Establishing the Essential Alliance in Child Psychotherapy and Consultation* (1997). So many of her examples occur in that space where we attempt to negotiate the equal distance between us, the parents, and the child, and, as all child therapists know and Siskind vividly demonstrates, this challenging part of our work is where failures in child treatment most often occur. One cause of our difficulty in maintaining our place is the inevitable countertransference that arises, frequently with parents, when we overidentify with a child, wish to rescue him or her, and fail to see the parents as our patients, too.

In the arduous task of joining the parents as allies in helping their child, Siskind recommends being as "...mindful of our communications with the parents as we are of our communications with the child" (p. 19), and in acknowledging their attitude of hope in choosing to come to us, we reflect back a belief that things can change (p.33). One of many examples she gives that stands out is a situation in which a parent asks the therapist to babysit for a younger sibling during her patient's session while the mother does errands. The therapist feels offended and demeaned by the request. Siskind shows the therapist how to transform her strong countertransferential reaction into formulating a clearer and more comprehensive diagnostic picture of the mother. The therapist realizes, through their mutual discussion, that she has not treated the parent as a person in her own right, that she may have reacted differently had she been working with an adult who was her "actual" patient. Siskind explains that when we experience what feels like "inappropriate" or "social behavior" from parents, we know we need to look further. What follows is a logical and reasonable approach to this parent which comes out of a full exploration of the many facets of the case. Each question in the book is treated in the manner of the preceding example; that is, the question we pose may not be what we are really asking: "What do I do when...?" How we arrive at a solution to our dilemma can never be automatic, proscribed, or general, but must take into account what is going on inside the parent, the child, and the therapist.

The parts of the book that address interventions with children offer a wealth of both sound reasoning and guidelines. Siskind first thoroughly investigates a child's

*This review is reprinted from the NMCOP Newsletter.*

need for therapy, how one assesses a child's development, his or her readiness for treatment and the parents' parallel dynamic picture. She shows how play therapy can best be presented and explained to parents and children. Especially helpful is the chapter, "The Child Therapist's Office: Selection and Use of Play Materials," which offers not only quite specific and practical advice about setting up our space, but why, and most importantly how, we safeguard the special place and time we give to a child through its sameness, reliability, predictability, and safety. In her discussion of a child's first session, Siskind emphasizes evaluating the level of anxiety of the child to determine both what he or she can tell us and hear from us. Listening carefully to the first communications, protecting the child's privacy and how we establish the therapeutic alliance are beautifully elucidated.

Management problems are a given in child work. Siskind gives an example which reflects her belief that the therapist is "...the boss of the therapy situation," and "...implicit in this principle is the goal of helping the child become the boss of her affects and behavior, a person who can think and talk instead of just acting out" (p. 102). We must always be in charge of defining, protecting, and facilitating the therapeutic process (p. 118). She describes a five-year-old psychotic boy who, after a long period of therapy, has a fifteen-minute battle with her about taking home a crayon. A rule about objects not being removed from the office to preserve its reliability had been established at the beginning of the treatment. Siskind would not relent, insuring the strength of her commitment to help him. At home, no one said "no" to this boy; he had great difficulty achieving inner controls. At the end of the battle, the child finally says to his therapist, "I know you never let anything leave this office because you like me to always find everything looking the same...when I want to take something home, you always say "no," always, always, always. You're like a traffic light, green is always walk and red is always stop. I wish you were on every corner" (p. 199).

Siskind discusses some special but not unique occurrences in which her approach is, as always, deeply thoughtful and often original. Such is her example of a 16-year-old boy who, during the consultation period, revealed he had attempted suicide on two previous occasions and was probably going to attempt suicide again. His parents were unaware of these attempts. She explains her intervention, which is to tell the boy that she will have to tell his parents, and because there will be a breach of confidentiality, she knows she will unfortunately be unable to work with him, but will refer him to a very competent colleague. She explains why she did not try to get the boy's permission to tell his parents or to try to work out the breach of confidentiality within the treatment process: the heavy demands of her practice at that time would make taking on such a patient not in his best interest or her own. Her brave and honest approach and open discussion of this case is impressive.

Siskind includes an excellent bibliography for exploring the underpinnings of her ideas. This book also speaks to the necessity, not only for reading and re-reading the works contained in the bibliography, but for our own treatment, sometimes to return to treatment when our analyzing instrument hits a wall, and the need for ongoing clinical training and supervision because, without it, our most valiant attempt to master the important thinking contained in this book and to do our best work will not succeed. This is a book to keep on our bookshelves and frequently take down, read, re-read, teach with, and learn from.■



# Arts in Clinical Practice Committee Now Statewide

The Arts in Clinical Practice Committee of the Met Chapter has become a state level practice committee. Sandra Indig, CSW-R, ATR-BC, will continue as the chair on both the Met and state levels.

Workshops for this past fall included Genie Wing's "Introduction to Psychodrama Utilizing Social Atom," and Sandra Indig's "Aesthetic Communication." Both were experiential and included theory, examples from individual practice, and ample opportunity for group sharing.

We are more actively pooling information concerning conferences and seminars plus noting the introduction of new institutes to our community devoted to expressive arts therapy psychoanalytic training. As many of our members are certified in the arts as well as holding the CSW-R, we are considering outreach efforts directed toward inviting the expressive arts practitioner to learn about us and of the advantages of joining our Society.

## Spring Calendar

**January 21** Robin Young, MSW, "Revised Psychoanalytic Theories of Female Development"

**February 18** Nancy Einbinder, MSW, "Enactment in the Treatment Process"

**March 18,** Linda Marks, MSW, "Play Therapy for Adults"

**April 22** Etty Cohen, PhD, "Dialogues of the Unconscious"

**May 20** End-of-the-Year Outing

All members who have a background in the creative arts or interest in the creative process are welcome. Contact Sandra Indig at: (212) 330-6787.

CONTINUED FROM PAGE 7

dizzy, and would almost pass out and fall off the seat. "It wants to come out but it can't." She would lose a sense of time on the toilet; it felt like she was in a trance sometimes as she moved her bowels. I noticed some bruises on her arms and legs and patches of irritated skin, but she could not account for any of these, shrugging them off saying she must bruise easily because her skin is so fair. I noticed that there were times in the session when she would rub her arm or leg hard, or pinch it or pick at it. When I told her of this observation, she was shocked because she said she had no real awareness that she was doing it.

Over time, she was able to develop more ability to control the dissociation and came to observe herself picking and pinching herself in the session. She observed that sometimes, while straining on the toilet, she'd think of her mother placating her father, and she'd pick at her skin. In time she came to feel angry at her mother instead. Sometimes she'd think of her father, drunk again, and the next thing she knew, she was pinching herself so hard it was a wonder she did not scream. In time she came to experience the anger at him. We began to work on trying to identify what feelings were stirring in her right before she pinched or picked at herself. This was difficult because she did not know what feelings were, except for the feeling of being depressed. I had to educate her about a range of affects. All she knew about was feeling bad, and I acquainted her with the varieties of bad feelings one could have: shame, guilt, annoyance, fury, anxiety, terror, sadness, depression, etc. She was amazed. No one had ever done this before. In time she came to understand that no one had ever helped her to know what she felt, and she stopped blaming herself for these lacks. She was becoming more attached to me and less to self-harm. She came to experience different kinds of "bad" feelings and even occasionally different kinds of "good" feelings. As the affect array expanded, we worked on affect tolerance, both analytically and using cognitive-behavioral methods, with the aim of becoming able to tolerate affect without having to resort to dissociation, compulsive eating, and self-injury. Verbal expression of affect, especially anger, conflicted with both her religious beliefs and family "style", which had to be explored. She came up with the idea of playing music when her father was yelling and enjoyed a sense of power in shutting him out in this way. In time she joined an ACOA group which got her out of the house with some regularity and helped established other new attachments. Over time the eating calmed down; the picking and pinching diminished; she was able to move out into her own apartment and opened up her life to new friends and dating. As her life became more regular and self-regulated, so did her eating and bowel functioning. Out of a safe and secure attachment to me that helped to regulate her, Jane had become more capable of regulating herself.

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# In Memoriam: Yaffa Weitzman

*By Rosemarie Gaeta*

On April 5, 2000, Yaffa Weitzman, our fellow NMCOP Conference 2000 Planning Committee member, died after struggling with cancer. Yaffa coped during her time of illness with a dignity and strength that can only be admired. The Committee will always be indebted to her for her generous contribution at our conference as a panelist on the panel entitled, "The Impact of Catastrophic Events in the Life of the Analyst."

Yaffa was not only an active member of NMCOP and the State Society, she also was Chair of the International Relations Committee for the Council for Psychoanalytic Psychotherapy (CPP). There she worked diligently on setting up connections with psychoanalytic institutes in Europe and Mexico as potential affiliates of CPP.

Yaffa was a graduate of NPAP; she was on faculty for the NY Center for Counseling and Guidance; she was a creator of two study groups dealing with life threatening illnesses; and she wrote several papers on illness.

Yaffa gave to her colleagues with a generous and courageous spirit right up to the last few months of her life. She was and will always remain an inspiration to our profession.

CONTINUED FROM PAGE 4

In our profession there are ways of dealing with our desire to do work that involves extremely low-fee clients or that is voluntary. Many of us have attended psychoanalytic institutes and other postgraduate programs where we can be involved in providing services to clients who cannot afford a regular fee. If we wish to do pro bono work, it is available and in great demand. For example, in Maryland there are 550 clinicians in the Maryland Pro Bono Counseling Project [NASW News 2000], and there are many social agencies here who would welcome our free services for their clients.

For some of us, the livelihood we had wished for has been diminished by forces that want to reduce the cost of health care and eliminate mental health insurance payments. We are struggling under the weight of the managed care corporations' need for ever-increasing profits and for managed care executives' excessive compensation. Managed care has negatively impacted our practices and challenged the basic tenets of confidentiality and privacy.

Many predicted that managed care and corporate insurance companies would take over and that solo practices would die. But this has not happened. Managed care organizations have played on our guilt about fees and devalued us by calling us "providers." Although managed care continues to be a force in our work, for some it may continue to make up a large part of their income.

**"As a therapist, one might not get all that is fantasized, but one can legitimately ask for payment for knowledge, skills and services. The dedicated helper is not selfless, and a life of service does not have to be a life without desire for money." [Herron and Welt, p. 48].**

There is, however, a large potential for a direct pay practice. Clients are finding value in professional services offered by independent practitioners, especially when they feel demoralized by invasions of privacy by managed care organizations. Many consumers have considerable discretionary income and can pay out of pocket. More and more frequently, consumers are willing to pay for the confidentiality of self-pay versus using their limited and restrictive insurance benefit.

### Developing a Self-Pay Practice

Developing a successful independent private psychotherapy practice free of managed care takes a conscious effort. There are many opportunities to help you make the shift. Here are five ways to foster your move from a managed care to a self-pay practice. Consider some of the following:

- Develop a specialization. Get additional training and work with specialized populations in areas such as health issues, parenting dilemmas, and workplace concerns.
- Expand your practice to include treatment groups, consulting work, and supervision.
- Offer consumer-friendly services, such as workshops and coaching of clients and mental health professionals.
- Give a talk at your local Y, church, synagogue, book store, or Kiwanis Club.
- Network with colleagues, friends, and professionals in other fields.
- Stay in touch with your contacts; get to know them. The more contacts you have the more people will be in touch with you. Most referrals come from people who know us and what we do.
- Become active in organizations (e.g., NYSCSW, American Mental Health Alliance NY, or the National Coalition for Mental Health Professionals and Consumers) and get involved.

As independent practitioners, we are the owners of our businesses. Individually, we may not be in a position to solve the problems of the seriously emotionally ill or the low-fee client. Hopefully, a national mental health service, such as the one that exists in Canada, will evolve as part of the solution.

As independent social worker-psychotherapists, we can integrate an image of ourselves as paid helpers and business people that is both ethical and moral.■

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**Donald E. Kalsched, Ph.D.** *The Psychotherapy of Early Trauma: Intrapsychic and Relational Perspectives*
***Saturday, May 5, 2001*** *10 a.m. to 3 p.m. with a break from noon to 1 p.m.*

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- *50 years of excellence in training mental health professionals (CSW, PhD and MD)*
- *Clinical experience provided in many programs*
- *Join an established and extensive professional network*

**Applications are being accepted for the following programs:**

- Adult Psychoanalysis and Psychotherapy
- Introductory Program in Psychoanalytic Psychotherapy
- Child and Adolescent Therapy
- Analytic Group Therapy
- Supervision of the Analytic Process
- Family and Couples Therapy
- Pastoral Counseling

*For more information about our programs and events, please contact*
*Mary Beth Cresci, PhD., Dean of Training*
*Tel.: (212) 576-4168*

**To learn more, please join us for one of these Spring 2001 events:**

OPEN HOUSE AND LECTURE SERIES:
"AGGRESSION IN SELF PSYCHOLOGY"
Thursday, March 8 and Thursday, April 5
Open House - 6:30 p.m. Lecture - 8:30 p.m.

TRAINING DAY:
*A PREVIEW OF ANALYTIC TRAINING*
Saturday, April 21, beginning at 10:00 a.m.
(Lunch provided)

## WCSPP

WESTCHESTER CENTER FOR THE STUDY OF PSYCHOANALYSIS & PSYCHOTHERAPY

### *Professional Education Is A Lifelong Process*

- **Four-Year Psychoanalytic Training Program**
- **Two-Year Psychotherapy Program**
- **Two-Year Child and Adolescent Program**
- **One-Year Supervisory Training Program**
- **Treatment Service (Sliding Scale)**
- **Reduced Fee Supervision and Inservice Training**

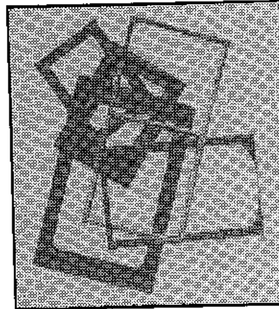
*Chartered by the Regents of the University of the State of New York in 1974, the Westchester Center provides training in psychoanalysis and psychotherapy across a range of contemporary psychoanalytic approaches.*

WCSPP, 29 Sterling Avenue, White Plains, NY 10606

**Please call for a brochure and information about our next Open House: 914-946-9462**

## MANHATTAN INSTITUTE

*FOR PSYCHOANALYSIS*



Currently in our twentieth year, The Manhattan Institute for Psychoanalysis is at the forefront of psychoanalytic training programs. Our emphasis on Interpersonal Psychoanalysis includes the study of Relational models. We integrate theoretical knowledge with clinical and personal experience.

Earn a *Certificate in Psychoanalysis* in the context of:

- A collegial atmosphere among candidates, graduates, and faculty which provides an exciting environment for growth as a clinician.
- Clinical and theoretical courses at the cutting edge of scholarship; small classes; maximum opportunity for clinical presentation.
- Distinguished supervisors and faculty representing Contemporary Interpersonal, Object Relations, and Relational orientations.
- Training and private practice referrals through our Clinic.

**Save this Date = March 30, 2001.** Sophia Richman Ph.D presents: "Wolf in the Attic: A Personal Narrative of Holocaust Trauma". Admission Directors will be available to answer your questions.

The Manhattan Institute for Psychoanalysis selects candidates from qualified psychologists, social workers, nurses and psychiatrists.

**For information contact:**
**Manhattan Institute for Psychoanalysis**
**67 Wall Street, Suite 21, New York, NY 10005**
**Tel: 212.422.1221 • Email: Minstitute@aol.com**
**see our website: manhattanpsychoanalysis.com**



*"The practice of psychotherapy should be interesting, appealing and charming"*
-MILTON H. ERICHSON, M.D.-

NYSEPH

The New York Milton H. Erickson Society for Psychotherapy and Hypnosis Training Institute
Chartered by the New York State Board of Regents

### Comprehensive Training Program in Ericksonian Hypnosis and Psychotherapy

This is a 5 part, 100 hour program, meeting 2 hours a week. Emphasis is on ongoing supervised practice, on demonstration, and on refinement of a wide range of hypnotherapeutic techniques.

The course is open to health care professionals with graduate degrees and to students in accredited graduate programs. The training is accredited 100 hours by the American Society of Clinical Hypnosis towards ASCH membership and ASCH certification and is receiving 100 CEU"s from the National Association of Social Workers.

Classes start in October and February. We welcome your inquires and applications. Please contact Rita Sherr at (212) 873- 6459, Fax: (212) 874-6148.

For referrals to an Ericksonian Hypnotherapist, call Karen Sands at (212) 362-6044.

HYPNOSIS FOR PAIN AND STRESS MANAGEMENT

20 hour specialty training in hypnosis for pain and stress management. Meets 2 hours per week. Open to all nurses and health care professionals. 20 CEU's approved. Call Dorothy Larkin, MA, RN, CS 914-576-5213.
www.nyseph.org

## ICAPP

**INTERNATIONAL CONFERENCE FOR THE Advancement of Private Practice In Clinical Social Work**

### *ICAPP's 40th Annual* Clinical Conference

**"Life Transitions"**

**Sunday, June 2 - Thursday, June 7, 2001**
**ROYAL YORK HOTEL, Toronto, Ontario, Canada**

***Early Bird Registration:***

**Before March 1, 2001 – ICAPP Member: $275 – Non-member: $350**
**After March 1, 2001 – ICAPP Member: $350 – Non-member: $450**

**For International Registrants:**
**At current exchange rate payable in US Dollars**

For ICAPP Information: Adrienne Lampert, MSW, BCD
(718) 434-0562 • Fax: (718) 859-5058
E-mail: alamp12619@aol.com

**EXCELLENCE in training...**
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- Secure your professional identity
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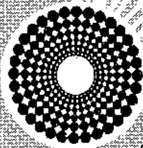
- Small classes, New York and Long Island



THE NEW YORK SCHOOL FOR PSYCHOANALYTIC PSYCHOTHERAPY AND PSYCHOANALYSIS

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**Fordham University**
**Graduate School of Social Service**
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*in*
**CHILD & ADOLESCENT THERAPY**

◊ Specialized advanced training
◊ Supervised internship-one evening
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◊ Tarrytown campus

**Celebrating 15 Years!**

**For Information call or write:**
NANCY BOYD WEBB, DSW, DIRECTOR
FORDHAM UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SERVICE
TARRYTOWN, NY 10591
(914) 332-6008

The Postgraduate Center for Mental Health

**GROUP THERAPY DEPARTMENT**

*Two Year Program in Analytic Group Psychotherapy*

now offering Daytime and Evening Classes

**This program, begun in 1957, has had a major influence in the development of group therapy in this country and abroad.Graduates and faculty include some of the most respected professionals in the field.**

One year Certificate program and a Basic Curriculum program also offered.

Postgraduate Center For Mental Health

The Psychoanalytic Institute
138 East 26th Street
New York, NY 10010-1843

For more information call the Registrar:
212 576-4168 or 212-879-2228

**NIP**

- Adult *(4 Year)*
- One-Year Evening
- Child & Adolescent *(Full Time & Part Time)*
- Supervisory Process
- Externship/Internship
- Spirituality
- Recovery

Contemporary Psychoanalysis & Psychotherapy Training

Explore your opportunities.

*Contact us to receive our Bulletin.*
**National Institute for the Psychotherapies**
330 W. 58th St., Ste. 200, New York, NY 10019
**Ph: 212-582-1566 ● Fx: 212-586-1272**
http://www.nipinst.org

*Chartered by the Board of Regents of the University of the State of NY*

*Thinking about Psychoanalysis?*

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Celebrating 50 Years of Open Intellectual Inquiry and Clinical Practice

**Think about our training program.**
- clinical preparation in traditional and contemporary theories.
- choice of your own schedule at your own pace.
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- direct referrals into your own practice from the Theodor Reik Consultation Center.
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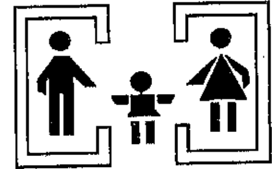
http://www.npap.org

***Preparing Psychoanalysts for the Next Millennium***
Chartered by NYS Board of Regents.
Publisher of *The Psychoanalytic Review.*

NPAP
National Psychological Association for Psychoanalysis

**Divorce Mediation Center of L.I.**

Established 1982



- Mediation Explained
- No Cost Consultation
- Brochure Available
- Legal Referrals Provided

Mineola and Commack Locations

*For Information Call:*

**Emanuel Plesent**
Ed.D., R-C.S.W., B.C.D.
Director

**(516) 747-1344**





**THE WOMEN'S THERAPY CENTRE INSTITUTE**

562 West End Ave. #1A
New York, NY 10024
212-721-7005
FAX: 212-721-5554
www.wtci-nyc.org

The WTCI offers a unique feminist perspective on contemporary relational psychoanalysis:
- Three Year Post-Graduate Psychoanalytic Psychotherapy Training Program
- One Year Post-Graduate Training Program on Eating and Body Image Problems
- Lecture Series: Presenters-
  - -Leonore Tiefer, Ph.D.
  - -Carol Gilligan, Ph.D.
- Psychodynamic anti-diet six week groups on eating and body image issues. Separate groups for clients professionals.

Call for further details.

**Training Programs Chartered By the New York State Board of Regents**

**Basic Training in Divorce Mediation**

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June 9,10,11;23,24,25; **2000**
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Nov. 10,11,12;17,18,19

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May 18,19,20; June 1,2,3
Oct 19,20,21; Nov 2,3,4

Also ongoing Practicum & Seminars

**Center for Mediation & Training, Inc.**

**Call for Details: 800 613-4867**

# NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

# 32nd Annual Conference

SATURDAY, MAY 12, 2001

## Complexity of Gender and Sexuality: Clinical Implications

KEYNOTE PRESENTATIONS:

*From Little Woman to Superwoman: Intrapsychic, Interpersonal, and Clinical Challenges*

Eda G. Goldstein, D.S.W.,
Professor and Director, Ph.D. Program in Clinical Social Work,
New York University Shirley M. Ehrenkranz School of Social Work.
Author, *Ego Psychology and Social Work Practice*

*When Men Have Trouble Loving and What to Do About It*

Terrance Real, M.S.W.,
Director, Gender Relations Program,
Meadows Institute, Wickenburg, Arizona.
Author, *I Don't Want to Talk About It: The Secret Legacy of Male Depression*

WORKSHOPS AND PANEL (a choice from eight) :

Topics include:

- *The Impact on the Family System of a Same Sex Couple*
- *Wanting it All: The Wish to Be Both Sexes*
- *Male Sexual Masochism: Analytic Perspectives*
- *Gender Development and Superego Function as it Relates to Sexual Compulsivity*
- *The Impact of Unresolved Maternal Loss on the Integration of Female Gender and Sexuality*

and others

LOOK FOR YOUR CONFERENCE BROCHURE IN THE MAIL MARCH 2001

*For conference information and/or brochure call* 212·539·8847

# POST-MASTER'S CERTIFICATE PROGRAMS

New York University
Shirley M. Ehrenkranz **SCHOOL OF SOCIAL WORK**

### Advanced Certificate in Clinical Social Work

Designed for experienced social workers. Enrich your practice skills while you gain the necessary credentials for career advancement. This 24-credit program of study can be completed on a part-time basis.

If accepted to our Ph.D. program, 15 of these credits may be applied. Make strides toward your doctorate.

**Deadline for applications:**
**July 15, 2001**

For more information about opportunities for post-master's study,

**call 1-800-771-4NYU, ext. V17.**

**E-mail: essw.admissions@nyu.edu**

### Post-Master's Certificate Program in the Treatment of Alcohol- and Drug-Abusing Clients (TADAC)

NYU's School of Social Work Post-Master's Program in the Treatment of Alcohol- and Drug-Abusing Clients can provide you with the specialized educational courses required for you to become a New York State Credentialed Alcohol and Substance Abuse Counselor (CASAC). Designed for professionals with a master's or higher degree, the six required courses—a total of 17 credits (250 hours)—integrate sophisticated, psychodynamically-oriented clinical knowledge with good, basic skills in addiction counseling. Courses are scheduled in the evening to enable working professionals to complete the program in just three semesters of part-time study. Supervised field internships are arranged on an individual basis.

NEW YORK UNIVERSITY IS AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY INSTITUTION.

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