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

EXECUTIVE REPORT

We're Clinical Social Workers and Proud of It!

by Allen A. DuMont, CSW, BCD, Society President

As I begin my second term as your President, I look forward with confidence to our future in the 21st Century. Across the nation, clinical social workers are winning increased public and professional recognition for their primary role in the mental health delivery system. Upwards of 60% of the psychotherapy across the United States is done by clinical social workers (in rural areas we often are the only therapists available) yet many are still unaware of our profession. Some of our clients, until we educate them about clinical social workers and the contributions we continue to make, may refer to us as "psychologists" or "psychiatrists," while some of our colleagues, capitulating to the pressures of public ignorance, may refer to themselves ambiguously as "psychotherapists." It is crucial to our growth and to our professional standing that we proudly announce our traditions, our heritage and our achievements in mental health and human services, that we proclaim we are CLINICAL SOCIAL WORKERS!

Analogously, many of our social work colleagues do not know of the New York State Society and the Clinical Social Work Federation, which was formed in 1971 by New York, California, Illinois, Kentucky, Louisiana and Texas to protect our right to practice and to address practice concerns that had received inadequate attention. Since that time New York and the CSWF have been the premier advocates and champions of the clinical social work

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Over four hundred turned out for the 7th Conference of the National Committee on Psychoanalysis in Clinical Social Work on January 20th at the New York Marriott, World Trade Center. One panel included Judy Ann Kaplan, Nalda Brodegaard Rothe, Edith Schwartz, Patrick Casement, Leon Wurmser, Crayton Rowe.

Thomas W. Libous, Senate Licensing Bill Sponsor, Honored

Mary Ann McLean, Society lobbyist, presents a plaque to Senator Libous.

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Executive Report

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

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profession and provide a home base for the education and nurturance of those engaged in clinical work. Yet too few know about us. In New York, we uphold the highest standards of clinical practice and reserve the highest category of membership to those who have advanced their levels of clinical skills and experience, professional study and knowledge and deepened personal self-knowledge. Through our offering of educational conferences, workshops, study, reading and mentor groups, peer consultation, supervision and salons, we encourage and support professional growth and provide opportunities for senior colleagues to nurture and mentor the succeeding generations.

We uphold the highest standards of clinical practice and reserve the highest category of membership to those who have advanced their levels of clinical skills.

In order to acquaint the public and our professional colleagues with our Society and the services we have to offer, the following initiatives are planned.

First, in conjunction with Sheila Peck, our Public Relations Chair, the Society will be establishing its own website, enabling professionals to learn about our Society, and benefits of membership, our affiliation with the CSWF/OPEIU Guild, the benefits of Guild membership, Society policy and position papers, chapter locations and offerings, practical information and resources, educational offerings, opportunities for teaching and writing and — in the future — possible employment opportunities and classified ads.

Second, our New York State Referral and Information Service, chaired by Howard Lorber, is about to be launched and will provide the public and professional community with help in locating needed clinical social work services while implicitly publicizing our Society. The RIS will appear on our Website and will be publicized through distribution of literature to professional and community referral sources.

Third, I will be writing to NYS R-social workers to acquaint them with the work and activities of the Society as well as to provide useful information for the practitioner. They will be invited to call officers and members of the State Board, including Chapter Presidents and Committee Chairs for further information. As a result, some may decide to join us to participate in our programs.

Fourth, our mentorship program, chaired by Barbara Bryan, is being renewed in the schools of social work to inform new social workers about our Society and to welcome them to the field. Our mentoring program promotes and aids the development of the new professional and can be of great help in launching a career. The free workshop, offered in September 1999 at Fordham by Sheila Peck on Private Practice Development, was a great success and exemplifies the support the Society gives to the clinical profession.

Fifth, we will place ads in publications reaching the social work community to let our colleagues know of our availability and interest in providing a home base for like-minded practitioners. Prominent in these ads will be our affiliation with the Guild which offers us a strategic opportunity to advocate for our clients and our profession in the face of managed care abuses.

Sixth, as we develop our relationship with the CSWF/OPEIU Guild, it will be essential to begin educating the more than 700 constituent unions of the NYS AFL-CIO, which has close to 3 million members, about clinical social work, who we are, what we do and how we can be helpful to them and their families through their EAP's and self-insured benefit plans. Don Goldberg, Guild Committee Chair, will be assisting in this effort.

Lastly, our work to educate and work with the NYS Legislature, under the leadership of Marsha Wineburgh, about the value and importance to the consumer of social work licensure will continue to dominate the legislative agenda.

Let our voices be raised in unison as we proclaim our pride in the profession of clinical social work. ■

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The Clinician

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Vendorship & Managed Care

COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

In my last article for *The Clinician,* entitled, "A Reversal of Trends," I pointed out that our Committee members have been receiving fewer complaints about managed care and many more inquiries about how to work outside of managed care and how to resign from panels. We continue to receive inquiries regarding resigning, as many members are finding out that this is not as easy as it appears. For even when they send in return-receipt resignation letters, patients who come to them are still being told that their therapist is on the panel, and, as a result, are being denied out-of-panel reimbursements (which are often more money and less hassle than in-panel reimbursements). Often, by the time the mix-up is settled, the patient has reduced the frequency of sessions or terminated altogether, due to financial constraints. One wonders if this is the new managed care maneuver to keep costs down?

For example (and this is not uncommon), one member who submitted an out-of-network bill to Vytra/Value Options (from which she had resigned a long while back) was told, as was her patient, that according to their records she was in-network and that since she didn't pre-authorize the treatment, she would not be paid (nor the patient reimbursed).

Several companies are still notorious for late payments and seem not to mind paying the 12% late fee penalty when called to task by the Dept. of Insurance. It appears that such seemingly cavalier behavior has begun to wear heavily on clinicians in New York and the move away from managed care is a definite trend.

In many other states managed care continues strong. Yet, with increased benefits which allow people to go outside of their networks (PPOs and POSs), even these states are noticing more members cutting the percentage that they allow for managed care patients in their practices. It is a fact that many more enrollees are seeking to sign up for more choice, even if it costs them more out of pocket (as documented from the CSWF National Hotline and the *New York Times*). The word is out to the consumer that managed care is not all that it should be.

When I first became the Vendorship Committee Chair in 1989 (pre-managed care epidemic), the problem posed by members was "how do I market my practice and get new patients." It seems that many are now being faced again with the same problem, as managed care makes less referrals, as clinicians pull out of these networks, and as more people purchase plans with choice options outside of panels. The getting-new-patients question is probably best answered by our Public Relations Chair, Sheila Peck, who specializes in helping clinicians market their practices. However, suffice it to say that the challenge for all clinicians is to do the leg work in contacting local referral sources, writing articles for the local papers to become known in the community, and joining local organizations so others become familiar with who they are and what they do. In other words, the burden is back upon the clinician.

When I first became the Vendorship Committee Chair in 1989 (pre-managed care epidemic), the problem posed by members was "how do I market my practice and get new patients." It seems that many are now being faced again with the same problem.

There are those in the Society who still are holding onto the hope that managed care will take care of them, in spite of the numerous suits, going as high as the Supreme Court level, filed against HMOs for malpractice, and in spite of the fact that Wall Street has stopped backing managed care companies. However, it is my belief that what we can look forward to in the future is a retreat from the HMO position of doling out services. I see a move back to allowing the patients to have more rule over choosing their providers and allowing providers more decision-making power with regard to treatment decisions (choice and liability are the two main agenda items in the state and national legislatures). However, I do see that some managed care companies will flourish by going in this direction while continuing to hold a utilization review role for certain treatments—those which tend to be costly and driven by the marketplace and not necessarily medical need (e.g., in-patient substance abuse treatment, long- term psychiatric in-patient stays, etc.). I do believe that clinicians must be accountable for their treatment decisions and can no longer base them upon how much coverage the patient may have.

Opening New Markets: Self-Insured/Self Funded Companies

By way of an amendment to their contract, the Carlson Company (which includes TGI Fridays, Radisson Hotels and Carlson Travel) now includes independent clinical social workers as reimbursable providers. This provision opened up independent reimbursement for clinical

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Referral and Information Service

by Howard Z. Lorber, CSW, State Chair, Referral and Information Service

By now you have received two letters and an application form for the Referral and Information Service (RIS). More than 300 members have applied for inclusion and we are still accepting applications.

What is the RIS? Broadly defined, the RIS has been developed to fulfill the Society's public service mission. Specifically, the RIS aims to: 1) disseminate information to the general public about the clinical services offered by Society members and complimentary or supplementary agencies; 2) promote a deeper knowledge and understanding of the value of clinical social work to other professionals; 3) offer a free brief assessment to callers and give appropriate direction; 4) help other professionals and the general public to locate and make informed choices regarding qualified therapists.

A Cooperative Effort

Crucial to the operation of this program, and a key to keeping our costs down, is the fact that this is a cooperative. Each of us will be called upon to provide labor to ensure the proper functioning of the program. All of us will be trained and called upon to be page holders. This will be a regular rotation of 3 – 7 days, depending upon the size of the local chapter and the number of incoming calls. The largest chapter, Metropolitan, for example, will have three page holders per rotation, while smaller chapters, such as Rockland, will have one page holder per rotation. Each local chapter, under State Committee guidance and concurrence, will develop the details of transfer of pagers, training of page holders, and other committee work.

Outreach and Education

The next major step will be to educate the public, professional and community resources about the RIS. Drawing on the unique talents of our members, we each will build on our own informal referral networks to acquaint them with the convenience of our service. Through one easy call, it will be possible to access a network of colleagues who offer a range of specialized services that can complement and supplement our own. We will call upon those who excel in public speaking to publicize the RIS as they publicize their own services. Similarly, we will be calling upon those skilled at writing to prepare articles, press releases and literature that will let the public and professional community know about the RIS, what it does and how it can help. In the future, we hope to develop public service spots for local cable TV stations and radio.

We are moving ahead! We've got the pieces in place, the therapists' data is being entered in our database, and we are working to integrate the program as soon as possible. Those of you who have sent in checks and filled in applications, I thank you for your patience. Those of you who have not yet joined – there's still time!

How to join? The best way to get an application is to contact our Secretary, John Dunn, at (914) 469-5724. Or you can contact Howard Lorber via email: hzl@allbluescounseling.com.

How the Program Works

1. The potential client calls into an 800 telephone number.
2. This number is linked to a computerized host service—essentially, a kind of email box with a pager function.
3. The page then goes out to the page holder (a member of our cooperative service).
4. The page holder then calls the prospective client and conducts a brief interview to find out what is needed.
5. The page holder then uses the pager itself—a hand-held communications device—to contact our Internet web site. On the website will be our database of therapists.
6. The page holder inputs the required information and retrieves a name or names of therapists suitable for this case. (The names of the therapists will be on a rotating list from which the computer will make random selection within the required criteria. When a therapist has received a referral, his/her name will be held in reserve until referrals are made to all others on that criteria's list. This randomization will ensure against favoritism.)
7. Once the names are retrieved, the page will notify the therapist(s) of a possible referral.
8. Once the therapists have been notified, they will either call the potential client or be called by the client, depending upon client need or preference.
9. As soon as a client contact has been made, the therapist contacted will then call the page holder to inform them of this and will also send a special post card into the relevant committee to log the information and ensure proper rotation. At regular intervals, members will be asked to resubmit credentials: insurance face sheets and certificates of licensure.

Go for the Guild!

by Don Goldberg, President-Elect Nassau Chapter, Guild Committee Chair

Over the past few months I have had the privilege of speaking to many of you on a one-to-one basis regarding the Guild. The question that occurs most often seems to be, "why join?" I would like to answer that first with a few personal thoughts and then with some hard facts.

We are presently in a field that is undergoing very radical changes. Until now, we have been compelled by outside forces to go along with many of these changes. Managed care has set the pace and told us how to treat patients, when to treat patients and how often we may treat our patients. Frankly, I don't like being dictated to by people who are more interested in the bottom line than the human beings. While each of us can probably talk about winning occasionally in our attempts to help one patient, it is quite difficult for us as individuals to battle million- and/or billion-dollar companies every day. The Guild gives us considerably more clout and an opportunity to educate legislators, unions and, in some instances, managed care companies who might be more inclined to hear us when we speak. Without the Guild, I assure you managed care will not be willing or ready to sit at the table with us.

Now some facts:

1. The Guild recently was invited to the Blue Cross/Blue Shield National Labor Forum. This organization is dedicated to working with members of Organized Labor who are responsible for the healthcare purchases their unions make. Also attending was a representative of United HealthCare which, as you may know, is a national subcontractor for Blue Cross/Blue Shield. Another meeting with Magellan will be held shortly.

2. Low-cost health insurance is now available to members of the Guild. To say that the rate structure of this plan is highly competitive is an understatement. If anyone has not received a healthcare packet, please call me at (516) 221-6522. The pricing of this policy, in most instances, more than makes up for the cost of joining the Guild.

3. A Patients Bill of Rights is moving to a House/Senate conference. This bill has provisions for Point-of-Service, or out-of-network access. As I write this, it is a little bit less than a year since we affiliated with the Guild. I know that some of you have wondered just what you are getting for your dues. The answer is — a lot with more to come. Please understand that this is something new and we *have* had our share of start-up problems and missteps, However, be assured we are working as hard as we can for you as individuals and as members of a very proud profession. I will do my best to keep you informed of our progress.

GUILD NEWS UPDATE

As we prepared to go to press, we received this update:

1. The Guild health plan will be operational as of February 1, 2000.
2. Union Labor Life Insurance has asked for a list of Guild members in New York for inclusion on their panels.

We will keep on working to make your membership in the Guild offer larger and larger dividends.

Revised Medicare Clinical Social Workers

Fee Schedule

NEW CODES FOR 2000
EFFECTIVE JANUARY 1, 2000

CODE	DESCRIPTION	LOCALITIES			
		1	2	3	4
90804AJ	Individual psychotherapy, insight oriented, behavior modifying and/or behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	54.40	52.28	48.05	51.89
90806AJ	Approximately 45 to 50 minutes	83.36	80.18	73.65	79.55
90808AJ	Approximately 75 to 80 minutes	128.53	123.38	113.27	122.47
90801AJ	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other medical or diagnostic studies; in certain circumstances other informants will be seen in lieu of the patient.)	121.77	117.24	107.89	116.32
90846AJ	Family medical psychotherapy (without patient present)	83.57	80.31	73.71	79.70
90847AJ	Family medical psychotherapy (cojoint psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated)	96.55	92.99	85.51	92.25
90853AJ	Group medical psychotherapy (other than of a multiple family group) by a physician, with continuing medical diagnostic evaluation	30.14	28.85	26.32	28.64

LOCALITIES

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

NOTE

"Interactive" codes have been left out of this schedule as they do not apply to verbal psychotherapies. For further explanation of codes and fees call Mary Cooper of HCFA (Health Care Financing Administration) Coding Section at (410) 787.5302.

This paper was delivered at the 30th annual New York State Society for Clinical Social Work Conference, held on May 15, 1999, entitled, "The Power of Love and Hate: The Impact on the Self and Other."

Impenetrable Mothers:

The Psychic Dilemmas of the Daughters Who Love Them

Presented by Maureen Buckley-Fox, CSW, BCD at the 30th Annual Conference

Maureen Buckley-Fox, CSW, BCD, is in private practice on Long Island. She is affiliated with the Metropolitan Center for Object Relations Theory & Practice in New York City. She is also on the Board of Nassau Chapter of the Society.

Last Fall, when the Society invited proposals on the topic of the power of love and hate, it arrived just as I was in the early middle phase of treatment with a 30-year-old client who was grappling with intense feelings of longing for her mother's unrequited love, and hate and rage related to her experience of being sexually abused by older siblings, while her chronically mentally ill, emotionally and physically unavailable mother turned a blind eye. The "power of love and hate" was palpable and became a compelling theme as I listened to her and other clients who suffered the experience of being parented by "impenetrable mothers," mothers who were "emotionally absent/dead" due to severe emotional disturbance, profound personality deficits or addictions.

This developing theme of love and hate and impenetrable mothers dovetailed with my interest in Harry Guntrip's writings on object relations and the schizoid phenomena, and in particular, his psychoanalytic biography by Jeremy Hazell, in which Guntrip's struggle to survive his own profoundly unrelated mother is detailed. The last 18 months of experience doing Infant Observation further sharpened my awareness of the mother-child relationship and the impact of the "impenetrable" mothers with whom some of my clients struggle.

Given that "emotional growth/development is lodged in the matrix of relation and communication between mother and baby from the first," (Waddell) I started to listen for derivatives of the relational experience of these clients, who were subjected to the rejection of impenetrable, unresponsive mothers. The range in intensity of rejection varies from that of a 43-year-old single woman, the dutiful daughter of a mechanically efficient, but impersonal, schizoid mother (my client's "hate" derives from her life-long experience in an atmosphere devoid of warmth, spontaneity, curiosity or passion for life), to the overt violence experienced by the 30-year-old client who was sexually and physically abused while her mother turned a blind eye, even when directly confronted by her daughter's visible wounds and pleas for help. Though the spectrum of experience is broad, the damage to the sense of self runs deep. Such experience creates within the client a sense of an irreparably bad/damaged self, evoking rage that is inwardly directed, threatening to keep her entrapped in such a way as to prevent the full realization of her potential.

This sense of a damaged self is expressed clearly in the poetry of the 43-year-old, "Break away before you're damaged by routine and expected programs. Your life, my life, save it now...Can I perhaps just not see or accept that the way I live my life is my life. If there are no significant human relationships on a sustaining basis is that any real loss? Yet my writing will allude to a sorrow over no intimacy..." We hear poignantly the impact of the damaged mother/damaged holding environment, with an insufficiently strong sense of adult identity and interpersonal capacity for relating to her child in any way beyond that of going through the motions of living.

In identifying this client's mother as "impenetrable," I am reminded of what Winnicott noted early in his psychoanalysis of Guntrip. He identified Guntrip's core problem as not the actively bad mother of Guntrip's later childhood, but the earlier mother who "failed to relate at all." Jeffrey Seinfeld notes that "a chronic sense of a void is probably due to an object relationship with severely dampened affect, which gives the sense of a void." Each of these clients had a mother with severely dampened affect, producing the void echoed in my client's poem. One senses, indeed, what Guntrip describes, "the vital heart of the self is lost, and an inner deadness is experienced...for practical purposes (s)he is 'not all there': the living, feeling, loving heart of her is absent; not absolutely, for it is hidden deep in the unconscious..."

With regard to the 30-year-old client first referred to, the mother's chronic emotional absence has led not only to my client's profound sense of 'badness,' but her mother's absence had left her unprotected from the unbridled

rage of older siblings, whose needs also went unmet.

In both cases, these clients internalized a nonresponsive object that was incapable of sustaining libidinal object seeking. Subsequently they are dominated "by their internal persecuting bad objects, and often lack internal good objects and a sense of autonomous self. They fear separating from their inner demons because to do so may result in falling into psychic black hole." (J. Seinfeld, *Containing Rage, Terror, and Despair*) Basically, something is better than nothing. Thus, they "cling to their inner bad objects and remain within a closed psychic system even though it comes to feel like an inner hell."

For these clients to become free of their inner demons, they must first internalize the therapist as a good-enough object. Thus, in becoming an internalized good object for the client, the therapist, in Fairbairn's (1958) words, "effects a breach in the client's closed psychic system not only by interpretations but also by establishing a corrective relationship." In this process, the therapist is allowed entry into the patient's inner world by containing the patient's rage, despair, and terror. The therapist is eventually internalized as a containing object, especially needed when the patient begins to separate from her inner bad objects and is not yet able to contain by herself the feelings aroused by this separation. In this way, the internal bad object world becomes open to modification." (J. Seinfeld)

Thus, the road to modifying the internal bad object world goes through the transference, and along this road are innumerable therapeutic roadblocks, detours and challenges. The repeated experience of an emotionally impenetrable mother impedes the client's developing an autonomous self (including the development of a capacity for self-soothing and for satisfying interpersonal relationships) and an integrated sense of self (due to splitting, projection of parts of self into others for safe-keeping, repression and, in the extreme, through dissociation). Such disruptions arouse hatred in the client, which is bound to get expressed in the transference. As with my 30-year-old client, who is the eleventh of 12 children born to a mother who suffered severe, chronic depression, the mother's inability to be physically and/or emotionally available to her child/children led to my client's frequent sexual abuse by a brother ten years her senior. The chronicity of the sexual assaults and the failure of her parents to respond to her direct complaints, have left my client with a pervasive sense of aloneness, inner emptiness, and little capacity to self-soothe. In the process of remembering perhaps her most horrific attack by the oldest and most regular assailant, at age 7 (he 17), she states: "A part of me died that day. I no longer felt like a little girl after that. I was so confused, so lost...my heart was shattered..." A few sessions later, continuing to process the memory, she said: "I realized how much of the time my mother was home when these things happened to me. She was in the next room, only a wall separated her from me. She knew what was going on, she didn't do anything to stop it. I kept on waiting for her to come in and tell me I was all right, but she never came." The violation of her sense of bodily integrity, the lack of comfort with which to learn self-soothing, the enormous void was so painfully vivid in her expression of this awareness.

This sense of a damaged self is expressed clearly in the poetry of the 43-year-old, "Break away before you're damaged by routine and expected programs. Your life, my life, save it now...Can I perhaps just not see or accept that the way I live my life is my life. If there are no significant human relationships on a sustaining basis is that any real loss?"

"In this climate of profoundly disrupted relationships the child faces a formidable developmental task," says Judith Lewis Herman, M.D., in *Trauma and Recovery.* She must find a way to form primary attachments to caretakers who are either dangerous or, from her perspective, negligent. She must find a way to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe. She must develop a capacity for bodily self-regulation, in an environment in which her body is at the disposal of others' needs, as well as a capacity for self-soothing in a environment without solace. She must develop the capacity for initiative in an environment which demands that she bring her will into complete conformity with that of her abuser. And ultimately she must develop a capacity for intimacy out of an environment where all intimate relationships are corrupt, and an identity out of an environment which defines her as a whore and a slave." Herman goes on to describe the child's equally formidable existential task of preserving hope and meaning in an environment that fosters despair. To preserve her faith in her parents, she must deny her own perception that something is terribly wrong with them. When it is impossible to avoid the reality of her experience, she

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Water from the Well:
Spirituality & Social Work

Jill M. Sitkin, CSW

Jill M. Sitkin, CSW is an ordained interfaith minister. She works as a Volunteer Director for Calvary Hospital Hospice, maintains a private practice, and presents workshops on how to incorporate spirituality into social work and everyday life. Please contact her for reference materials at P.O. Box 235 Croton-on-Hudson, NY 10520; (914) 537-1181.

Pouring little bits of water on our dry land does not help, but...we will find a living well if we reach deep enough under the surface of our complaints. —Henri Nouwen[1]

• • •

A person goes to a priest and says, "Father, my soul is in pain." The priest says, "Make a novena and in 9 days you'll feel better."

A person goes to a foot doctor and says, "Doctor, my sole is in pain." The doctor says, "Put this arch in your shoe and in 3 weeks you'll feel better."

A person goes to a social worker and says, "Social worker, my soul is in pain. And the social worker says, [FILL IN THE BLANK].

What would you say? Probably something similar to what other workers have said in completing the above riddle: "Come in, and together, over time, we will find ways to help your soul to heal."

What is it like for you as a worker to be confronted so often with issues of such depth and pain, without having the luxury of a handy prescription which can be given to clients who then leaves to continue their cure on their own? Our work entails a different sort of healing process than other caring professions. It is an honor to be entrusted with clients' confidence that we can help them and a wonderfully creative challenge to determine how to best work with them in finding solutions. However, the amount of energy that we must pour into an ongoing, intimate, intense relationship with our clients can drain our spirits dry and make us thirsty for renewal. By digging deeper into the spiritual dimension of our work we can tap into a source of energy which can yield a continual flow of strength and creativity. Spirituality can also provide us with a well of replenishment from which our clients and we can draw inspiration and nourishment.

When we talk about spirituality we can get into a muddy area of amorphous terms and notions. For instance, this article deals with spirituality, which reflects a more individual expression of beliefs, rather than religion, which is generally more focused and structured. There are many different possible relationships between spirituality and religion, and aspects of each need to be addressed with clients as part of the therapeutic process. For the purpose of this article, I'd like to introduce two definitions of spirituality for your consideration. In the first definition, spirituality (literally the breath of life) is conceptualized as a complex, intrapsychic dimension of human development, in which the individual moves toward "higher" states of connectiveness, well-being, consciousness, and/or meaning. A desire to realize one's "true self" or "inner potential."[2]

The second definition states: The spiritual element of the person is the aspect of an individual's psyche, consciousness and unconsciousness, that is also called the human soul. It is in terms of the spiritual dimension that a person strives for transcendental values, meaning, experience, and development; for knowledge of an ultimate reality, for belonging and relatedness with the moral universe and community; and for union with the immanent, supernatural powers that guide people and the universe for good and evil.[3]

Spiritual beliefs can be as individual and difficult to express as thoughts and feelings. However, people generally find it a relief and a comfort to be invited to express their spirituality. Yet it is only recently as a society and as a profession that we have begun to feel comfortable initiating discussions that can reveal the intimate inner workings of our strivings to make sense of our lives and our place in the world. As social workers we are used to being aware of the interaction between emotional, mental, and physical dimensions in our work. Introducing the concept of spirituality offers us a tool for assessment and intervention which can help bring elements of feeling, thought, and action together into a stronger and more meaningful whole.

Before addressing spiritual issues in our work with clients it is important for us to explore and formulate our own spiritual beliefs. Spiritual attunement is as important as awareness of our own emotional issues

since we communicate so powerfully with clients, both directly and indirectly. First, we need to be aware of possible spiritual countertransference issues. Second, and perhaps more importantly, our own spiritual beliefs can provide a source of strength for our clients and ourselves.

There are a variety of spiritual assessment tools available, which workers can use or adapt for themselves and clients.[4] Some examples of questions that can help people to consider and express their spiritual beliefs are as follows:

- When you think about your life, what gives you hope?
- What are some of the most meaningful aspects of your life thus far?
- When faced with life's difficulties, what gives you comfort?
- How do you express or experience your spirituality in your everyday life?

After examining our spiritual beliefs about our personal lives, we can then go on to look from a transcendent stance at what we believe about our clients' lives, as well as the therapeutic process itself. For instance, if we can draw upon a strong belief that there is meaning to life, it becomes easier to have faith in our clients' ability to survive and thrive, no matter what their life circumstances:

> *"[a] spiritual perspective requires that we look at the meaning of life, that we look beyond the fears and limitations of the immediate problem with the goal of discovering something inspirational and meaningful..."*[5]

While clients' emotional states and/or behaviors may be problematic, these aspects are considered only part of their current functioning and not necessarily the total expression of the individual self. Clients can be seen as having a spiritual dimension, a soul, which is evolving towards wholeness, and a source of wisdom which is intuitive and far-ranging, defying purely linear, rational, left-hemisphered experiences. By becoming more practiced at transcending problems and challenges and placing them in a more expanded view of their lives, clients can become empowered to examine issues in a new and positive way rather than merely repressing them or denying their existence. As a client's perspective broadens, negative aspects can become less overwhelming, diminishing in proportion in relation to the larger issues and strengths afforded by a spiritual outlook.

One client, who continues to struggle with family of origin issues as well as difficult interactions with her husband, periodically credits the therapeutic process with enabling her to "ride the waves" of her life's ups and downs more easily than before beginning therapy. Although this client finds it mentally or verbally difficult to explain her new-found ability to cope more easily, when describing the change she conveys a sense of peace and strength at the soul level which is manifested through a calm physical and emotional demeanor. When I resonate with the client at such moments, it is not at a purely intellectual or emotional level, but in a spiritual space that both encompasses and transcends the mental, emotional, and physical dimensions of daily circumstances. Even without a clear understanding of the process, my client has indicated to me that she expects that once having learned how to survive that she will be able to go on and thrive. It appears that my client now has a sense that she can tap into a well of spiritual strength that can help her to function in many areas over time.

A spiritual approach can help free us from assuming the responsibility of "curing" clients and instead transform us into channels for healing energy which clients can draw upon and make use of in ways that make sense to them. Our job is to create a safe place in which clients can do their healing work as we help them examine their beliefs about the nature, meaning, and purpose of their lives. While the worker can help clients sort through outward manifestations of inner perceptions, clients themselves must assume ultimate responsibility for the uncovering and full expression of their souls' unique purpose. The worker helps clients reach down into their own wells of strength and inspiration and draw up what is needed. An instrument of focus and intent, the worker suggests possible methods and provides support as clients learn to replenish themselves. The worker empowers clients to be self-aware and self-fulfilling, able to obtain what they need from the environment around them and the resources within them. By accessing the well of spirituality, the work can flow more easily, with both worker and clients able to feel refreshed rather than drained by the process. ■

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1 Henri Nouwen. (1986). REACHING OUT. New York: Doubleday, 36.

2 D. Derezotes. (1995). Spirituality and religiousity: neglected factors in social work practice. ARETE 20 (1), 1; as quoted in Willie F. Tolliver (1997). Invoking the spirit: a model for incorporating the spiritual dimension of human functioning into social work practice. SMITH COLLEGE STUDIES IN SOCIAL WORK 67 (3), 478.

3 M. Siporin. (1985) Current social work perspectives on clinical practice. CLINICAL SOCIAL WORK JOURNAL, 13, 210-211; as quoted in Patricia Sermabeikian (1994). Our clients, ourselves: The spiritual perspective and social work practice. SOCIAL WORK, 39 (2), 180.

4 An example of a spiritual assessment tool, along with other reference materials, may be obtained from the author—see contact information at end.

5 Patricia Sermabeikian (1994). Our clients, ourselves: The spiritual perspective and social work practice. SOCIAL WORK, 39 (2), 179.

Impenetrable Mothers

CONTINUED FROM PAGE 7

constructs a meaning that justifies it, namely, that her own innate badness caused the abuse. If she brought this upon herself, then she can change it — something we are all familiar with in practice, as we work with the derivatives of these experiences.

The therapist's management of emotions aroused while dealing with the emergence of these issues is crucial to the treatment. "The client is helped not only by correct interpretations but, more importantly, during these times of great emotional turbulence, by the sense that the therapist can tolerate the client's chaos, terror and rage without desiring to prematurely fix it, make sense of it, or cure it. Such affect should not only be tolerated, but should be welcome, because its expression may have positive therapeutic value." (Seinfeld, *Containing Rage, Terror, and Despair*) Very often, creative approaches are necessary to promote release of the toxic hatred within the safe environment of a therapy which, while it has structure, rules and boundaries, also permits the expression within the sessions of the original fear, terror, yearning and dependency. Flexibility in clinical technique and stance often facilitates the client's healing process. Such creative measures as drawing, work with clay, poetry, anger work, and self hypnotic techniques, may prove helpful to the client.

Ultimately, patience with oneself, the client and the therapeutic process, and careful attention to providing holding so that the client can internalize positive, supportive experience, facilitates the restorative power of mourning the losses sustained in relation to the impenetrable mother.

In my work with the 30-year-old client, the intensity of her pain and tears (that often cannot be ameliorated by the end of a session) leaves me feeling like a failed container. Relaxation techniques, self-hypnotic techniques, EMDR, are either rejected outright or insufficiently protective against the break through of the pain. In contrast, but nonetheless painful, working with the 43-year-old's despair of being able to change attacks my own sense of therapeutic hopefulness, making me wonder if there is a "self" "buried in cold storage," (as Guntrip says) awaiting a safe space in which to reemerge. This attack stirs self-doubt in me and guilt. I feel like I've led her out from Egypt, and now she remains "stuck" in the desert, unable to attain the promised land of satisfying interpersonal relationships.

Other countertransferential binds: the 30-year-old client's identification with the "unavailable, impenetrable mother" through her silence. She withdraws into silence in sessions in times of rage, confusion and pain. At these times, she is deeply inaccessible, impenetrable, leaving me on the other side of "the wall" in confusion. This is a repetition of her experience with her mother — with my client now in the place of her mother and I in my client's original place, locked out, ignored. With such prolonged silence, I, too, sometimes fall into a counter transference enactment, myself becoming "impenetrable," as I retreat for a few moments into aloof disengagement. At other times, I struggle to resist the temptation to counter attack with premature interpretation. When I do, my client feels misunderstood and attacked. Glen Gabbard, in *Love and Hate in the Analytic Setting,* states that in working with the client's "malignant hate," the therapist must be "a durable object who holds one's ground and attempts to contain and understand that which is being projected."

A number of authors (Bion, Grotstein, Ogden) have written about the therapeutic processing of projective identification. "One of the principle functions of the therapist is to serve as a container for the self and object representations as well as the affects connected with them, that are projected into the therapist by the patient. Bion (1967) linked his model of the "container-contained" to his understanding of the developmental process in the infant, who projects the unwanted aspects of his internal world (the contained) into the breast-mother, who serves as a container. The mother holds and processes the projected elements and returns them in modified and detoxified form to the infant. In a similar manner, the therapist contains and modifies the patient's projections before the patient reintrojects them. In both the original developmental situation and the later therapeutic one, the result of containment is growth and integration of one's internal self and object representations." Elsewhere, Gabbard notes, "quite apart from any interpretative effort, then, the therapist's response to the projections provides a new object and affect for internalization by the patient. In this regard she breaks the repetitive cycle of pathological object relations that has characterized the client's life."

Ultimately, patience with oneself, the client and the therapeutic process, and careful attention to providing holding so that the client can internalize positive, supportive experience, facilitates the restorative power of mourning the losses sustained in relation to the impenetrable mother. In the secure, understanding relationship with a durable therapist, the client is hopefully able to discover her own indestructible inner life.■

Mentorship Program Update

by Barbara Bryan, CSW, BCD, Founder & Director of Mentorship, Metropolitan Chapter
Coordinator, NY State Mentorship Programs

The Society's Mentorship Program creates an opportunity for graduating social work students and new professionals to receive valuable guidance from seasoned clinicians. The mentor/mentee groups, currently going strong in three chapters, offer an opportunity for relaxed networking and clinical dialogue. Time is set aside for case presentations and clinical supervision. Mentors share resources and referral information, and a sense of pride in the field. They support mentees who are navigating agency and organizational life, thinking about continuing education, or having ethical dilemmas.

Currently, the Brooklyn and Nassau each have one mentorship group that meets once a month. The Metropolitan chapter has five groups meeting once a month. In five other chapters (Mid-Hudson, Rockland, Syracuse, Westchester, Suffolk), programs are in various stages of development. The long distances members and mentees need to travel in these chapters have been the main obstacles in keeping their programs going.

A few years ago, the Federation formed the New Professionals Committee, whose purpose includes the promotion of mentorship programs throughout the state chapters. Barbara Berger, president-elect of the NMCOP and chair of the New Professionals Committee, is providing a forum for state mentorship coordinators to consult on development of such programs. And, as state coordinator, I will be responsible for providing our accumulated experience to chapters in an effort to help them participate successfully in what can be a most stimulating and rewarding endeavor.

Vendorship & Managed Care

CONTINUED FROM PAGE 5

social work services for over 16,000 insureds nationwide. The Committee has been marketing this self-insured company for clinical social work inclusion for several years and is delighted that its efforts have now been realized. It often takes years before big organizations get around to change.

Other companies that the Committee is marketing to currently are the Bedford Central School District in Westchester, Pepsico, Sun Chemical, Quick and Riley Inc., The Mark Hotels, UFCW, local 174, Nova Health Care, and the Electricians Union. We are using our new connections in the AFL/CIO to enhance our efforts with these large corporations.

Saying Goodbye and Thank You

It seems that with the waning of the managed care revolution (or should I rather say, the hostile takeover), I, too, am going through a radical change. This will be the last article written by me as the Chair of the Vendorship/Managed Care Committee, as I am resigning my position effective Spring 2000. I have spent 11 years as the Chair and have enjoyed the experience immensely. Through your inquiries, I have learned a great deal about insurance reimbursements, self-insured companies, managed care, and how to advocate to the maximum for our patients. I have enjoyed assisting many of our members over the years and have been blessed with the good fortune to have met (if only by phone) many of you. Your feedback and dilemmas have provided me an education that very few are lucky enough to receive. I have also been blessed with the good fortune of being surrounded by very talented and dedicated Committee members, who gave of their time and efforts to assist the members, the chapters, the Society and the profession. They have worked to see to it that you received the professional acknowledgment and financial recognition that you deserve.

In closing, I ask that you join me in applauding the following individuals who have worked tirelessly on the Vendorship/Managed Care Committee over the years: Jerry Bowen (Nassau), Joan Bornstein (Syracuse), Brian Quinn (Suffolk), Barbara Rothbart (Met), Ninnette Setton (Brooklyn), Marilyn Stevens (Mid-Hudson), Judith Weiss (Staten Island), Mark Dworkin (Nassau), Lenore Green (Rockland), Laura Salwen (West NY), Pat Demyan (Syracuse), Lesley Post (Brooklyn), Dorothy Sokol (Suffolk), David Daly, Anne Gordon (Westchester) and the current and ongoing Committee of Fred Frankel (Nassau), Liz Ruggiero (Westchester), Beth Pagano (Rockland), Sharon Kern-Taub (Met), Rudy Kvenvik (Staten Island), Adrienne Lampert (Brooklyn), Shirley Sillekens (Queens), Ellie Perlman (Suffolk), Alice Garfinkel (Medicare Spec), and Gary Dunner (Syracuse).

Editor's note: John Chiaramonte now lives in New Jersey with his new wife, Wendy, and two step children. He still maintains his practice in NYC and has opened up a new office in Summit, New Jersey. He continues to advocate for clinical social workers as the Marketing Chair for the Clinical Social Work Federation and is accessible as one of the responders of the Clinical Social Work Hotline for managed care and other insurance problems. This hotline is a free benefit of your affiliation to the CSW via your State Society membership. The hotline number is (800) 270-9739.

The Practical Practitioner

by Sheila Peck, LCSW, Public Relations Chair

There are a number of free web sites on which clinicians in private practice can list themselves and their practices. Two which come to mind are the Clinician's Yellow Pages and Psychotherapy Finances website. And soon, the NYS Society for Clinical Social Work is going online, too!

Although we already have a web page (how many of you knew about it?) on the site of the Clinical Social Work Federation, (www.cswf.org) we're working on getting our own. We've already registered an address: clinicalsw.org. But don't try to visit it until we notify you. Our site is going to be technically implemented by Dean Allman, a colleague from Colorado who is webmaster of the Federation. Some of you, over the last few months, have already sent your e-mail address in order to join our planned NYSSCSW professional discussion list—and we've been saving every name we received. As soon as the site is up and running, we'll notify everyone via e-mail. Look for further information in the next issue of *The Clinician* as well.

The site will have two separate thrusts — one aimed at professionals and the other for consumers. Here is a randomly organized list of some of the ideas we have so far:

- Mission Statement
- Board list
- Job bank
- Information about our Referral & Information Service (RIS) panel (with an eventual searchable database of all our RIS participating therapists
- Articles for the consumer: depression, anxiety, school violence, drugs, societal issues, managed care, mental health, etc.
- Interactive check list of symptoms which might indicate a need for consumer mental health services
- Legislative alerts for members
- List of NYS social work schools
- Separate pages for each of our chapters that wishes to have one
- Information about what to see and do in NYS
- Data about the Federation
- E-mail discussion list for members
- E-newsletter for members to supplement *The Clinician*
- Conference and calendar announcements
- "What Is Clinical Social Work" seasonal and news related articles
- Relevant book and movie reviews
- An exchange of "links" with other sites, both commercial and professional

Remember that each page of a web site has its own address, so that we can include on the home page (the first place people see when accessing our site), clickable buttons for "Consumers" and "Professionals." We can also list different pages with search engines under a number of keywords, so that when a potential visitor is searching for the kind of information we present, we'll be easy to find. We also plan to publicize the site on-line once it's in operation. This will cost us little or nothing to do and will help attract visitors, both professional and consumer, to "drop in." And, of course, this will help our soon-to-be Referral and Information Service get known, too. Marketing via Internet is a very "Y2K" activity in which to engage; every day more and more people search the Web for resources of all kinds, including mental health services.

Currently we are also planning a lot of sensational graphics to help the site come alive. These "bells and whistles" will come later, of course, since our first priority is to get the site operational and then make incremental changes. Because a website is so easy to change, if something important comes along we can make additions in real time. In the meantime, we've been visiting other mental health-oriented sites to see how our colleagues do it. If you have any ideas not mentioned above which you would like to think about for our website, please contact Al Du Mont at 718-224-4886 or Sheila Peck at Sheila2688@aol.com.

Thomas W. Libous, Senate Licensing Bill Sponsor, Honored

by Marsha Wineburgh, MSW, BCD, Legislative Chair

Thomas W. Libous, a Republican-Conservative from the 51st Senate District in Broome and Tioga Counties and parts of Chenango County, was presented an award for his vital work as the primary sponsor in the State Senate for licensing the social work profession. Unable to attend the 30th Annual Conference of the State Society, his plaque was presented to him by our lobbyist, Mary Ann McLean, on the Society's behalf. Since early 1994, Senator Libous has worked continuously to support this landmark legislation for consumer protection.

Born and raised in Johnson City, Mr. Libous served two terms on the Binghamton City Council. Since his election to the Senate in 1989, he has served as the Chair of the Majority Program Development Committee, which is responsible for major program bills for the Senate legislative agenda. He has also been Chair of the Committee on Mental Health and Developmental Disabilities, which oversees two major state agencies, the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities.

The Senator has also served as Chair of the Select Committee on the Disabled, working to increase employment opportunities for persons with disabilities and to increase treatment programs for those with traumatic brain injuries. He has also served as the Chair of the Alcohol and Drug Abuse Committee, sponsoring landmark legislation to consolidate the Division of Alcoholism and Alcohol Abuse (DAAA) and the Division of Substance Abuse Services (DSAS) into the Office of Alcoholism and Substance Abuse Services. Senator Libous's standing committee assignments include being Chair of the Committee on Mental Health and Developmental Disabilities, and serving on the Consumer Protection, Education and Health Committees. Given these interests, we can only be grateful for his considerable support for licensing the social work profession.

Legislative Update

As members of the Senate and Assembly return to Albany to settle in for the new session, your Legislative Committee is gearing up, in coordination with the other professional groups, for what we hope is the final assault to pass our landmark legislation licensing psychotherapy in New York State. As we have discovered on our long journey to license clinical social work, our wish to have better consumer protection is important to many other groups in the health care world that also offer mental health services. Hopefully, we can use our combined strength to influence passage of this long overdue legislation.

Mid-Hudson Chapter's Roving Board Meetings

Carolyn Bersak, President

In June 1999, we met as a chapter board to discuss the dilemma of an inactive membership. Our conclusion was that the location of our board meetings, as well as educational workshops, was inaccessible to many members, who did not reside in the Poughkeepsie region of Duchess County. So we came up with an appropriate strategy: roving board meetings. We also decided to add an educational component — to ask one of our members to present a workshop after each meeting. Bingo! Success!

Our first meeting was held at the Women's Wellness Center in Kingston followed by a presentation on echopsychology. At our next meeting, in Hopewell Junction, we learned about forensic social work. Our meeting in January was in Wappingers Falls and we were treated to a talk on EMDR. The February meeting will be held in Staatsburg, and the topic is "Introduction to Mandalas."

New members have been participating, we have all learned about varied and interesting topics. Phone calls by board members inviting the members precede each event. The members seem to appreciate this personal reaching out. And we make it easy for them to attend by going to where they are. In addition, a newsflash is sent to all members informing them of the next meeting.

All the presenters as well as the board members deserve credit for helping make this idea so successful.

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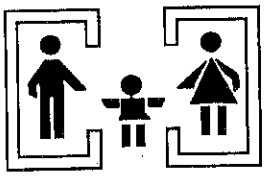

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