NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC

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Social Conscience and Clinical Social Work

By Marsha Wineburgh, CSW, BCD
Legislative Chair

The unfortunate custom of disparaging the clinical social worker as a self-concerned professional who has betrayed traditional values and forgotten the history of social work's commitment to the poor and disenfranchised is very much alive. We still find ourselves defending private practice as a legitimate setting for social work, reminding our colleagues that we can share the same ethics and values without practicing directly with the poor. This distortion continues despite the major contributions that clinical social work has made to the national health picture during the past two decades. Our segment of the profession has initiated a broad range of legislative efforts to increase public access to mental health services, advocate for parity between mental and physical illness and establish standards for consumer protection through the passage of state licensing laws.

Historically, it has been clinical social work societies that have initiated efforts to expand access to mental health services.

Historically, it has been the clinical social work societies that have been the initiators of these efforts to bring mental health services to a broader spectrum of the population. The advocacy strategies of the National Federation of Societies have led to the inclusion of mental health services and the use of clinical social work providers first in CHAMPUS, later in FEHBP and most recently, Medicare. In New York, the NYS SCSWP is supporting Medicaid reimbursement for psychotherapy services by clinical social workers. This would include qualified social workers in an non-OMH licensed setting, i.e., in private practice, family service agencies and non-licensed clinics. This means millions more of the poor, elderly and geographically isolated have a better chance of finding a competent professional who can diagnose and treat their problems.

Clinical social work has also been in the vanguard of organizing opposition to the discrimination against mental problems as a less important kind of illness. This problematic orientation is particularly apparent in the differences in insurance coverage for physical and mental illness. The history of the Kennedy/Waxman federal legislation for national health insurance reflects this bias. Initially, this legislation provided coverage only for physical illness. It took considerable lobbying on the part of national mental health groups to influence the inclusion of coverage for mental illness as part of basic national health policy. In New York State, the Society has participated in the ongoing debate over the adoption of mandatory mental health benefits, paralleling mandatory requirements for physical health care.

All but three states have some type of regulation for social work: New Jersey, Wisconsin and Indiana have none. Much of this state level licensing and vendorship work was initiated by the local clinical societies. In every state in which licensing was adopted, a board equivalent to our State Board for Social Work was created to protect the public from unscrupulous professionals. Currently, the NYS Society is supporting a more comprehensive consumer protection bill in the form of a licensing bill that would define the function of a clinical social worker rather than define what the title "certified social worker" means. *This would identify for consumers the kind of services they can expect from us and what we can be held*

continued on page 2

Consultation Panel Formed to Serve Members

Clinical Supervision Available by Qualified CSWs

By Carole Ring, PsyD, MSW

After months of preparation, the Education Committee of the State board is ready to invite clinical social workers to utilize the services of our Consultant's Panel. The purpose of this program is to inform colleagues of the availability of qualified consultants to provide clinical supervision and to help those people find a suitable person for such clinical consultation. The need for such a program was discovered a few years ago by a small committee in the Metropolitan chapter that was helping members prepare case studies as part of their application for "P" status. They found that many people had learning needs that went beyond the scope of writing a case study and that ongoing, quality education and supervision would be more helpful. The chapter studied this problem and recommended several steps, one of which was the formation of the Consultant's Panel.

Qualified Consultants/ Prospective Consultees

At this time approximately 160 consultants from 8 chapters have been approved for the panel. They represent a wide range of theoretical frameworks, areas of experience, specialties and interests. Many have a sliding scale fee, and all meet minimum requirements specified by the State board. These include: 1) Fellow status in the society; 2) "R" status; 3) completion of five 15-hour postmasters clinical courses; 4) 2 years of experience in clinical supervision.

Examples of people who might benefit from this program include those who must

continued on page 3

EXECUTIVE REPORT

Our Cadre of Volunteers: The Need for More Torch Bearers

I recently returned from the semi-annual board meeting of the National Federation of Societies for Clinical Social Work. The meeting took place in Raleigh, NC and I was accompanied by our executive director, John N. Odom, who had the opportunity to meet the national "players" and to savor the intricate interplay among the state societies, the Federation, ABE, NICSWA, related professional organizations and the broader political picture. Federation meetings have always been a special experience for me and I have always come home exhausted but exhilarated. The very presence of representatives from well over 30 states methodically working together to advocate on behalf of the clinical social worker is dynamic testimony to the growing swell of those within our profession who have not been satisfied with the leadership coming from other quarters. Our colleagues in North Carolina were warm hosts, providing a goodly touch of southern hospitality. Many thanks to Louise and Steve Coggins for inviting all the Federation representatives to their home — and to Bill Meyer, North Carolina SCSW president, for orchestrating the over-all welcome!

This national meeting was also personally notable in that our own Adrienne Lampert, Federation President as of July 1st, held forth at her first board meeting. Congratulations Adrienne! We are with you, alongside you and behind you. Specifics of the board meeting will be addressed in the Federation's Progress Report as well as in the next President's Letter.

Fuel for Our Fire

The fuel that fires all of the state societies and the Federation is the cadre of volunteers who become involved at the grass roots level and then filter out to other levels of the over-all structure. Since we are predominantly volunteer organizations, statewide and nationwide, nothing would get done without the enormous contributions of members' time and effort. And, while the larger state societies can afford to send their representatives to Federation meetings, the smaller societies cannot. Yet, the representatives do arrive and often pay part or most of their own expenses. The Federation will reimburse transportation to and from the board meeting site to full members, but other costs (hotel, food) are the responsibility of the state society or individual. Still, they come and they work diligently on your behalf and mine, without complaint. Such is the calibre of our colleagues across the nation.

Considering the large number of members in our own state society (second only to California), it is puzzling, at this point in time, that all too few actually step forth to seek state office or to chair a committee on the state level. I've wondered why this is so. Are many of our members perhaps so involved on the chapter level that they see no further than their respective chapters? Is the spirit of volunteerism, in general, on the decline?

If you have been active in your chapter and have derived satisfaction from your service, I would urge you to consider serving on the state board. Each year, on a staggered basis, a number of positions become available and need to be filled by our membership. The gratification inherent in serving your state society and your profession is an experience you will long remember with a sense of pride.

I sincerely look forward to seeing your name on a future nominations slate of the NYSSCSWP, the professional organization that represents *you* and *your* professional interests.

Philip Banner, CSW, BCD
President

SOCIAL CONSCIENCE *(continued)*

accountable for as professionals. Clinical social work has found its own way of continuing its commitment to social work values and contributing to the solution of community problems. We have our own unique vantage point, which is influenced by our clinicial interests and the settings in which we practice. Being different doesn't make us wrong.

Legislative Update:

The alcoholism counselors have passed legislation which would impose a penalty for anyone who used the CAC (Credentialed Alcoholism Counselor) title without appropriate credentialing. Passage of this legislation opens the gate for vendorship opportunities for CACs.

A 11758 We continue to work on this legislation which would amend the criminal procedure law to include qualified clinical social workers as psychiatric examiners.

Medicaid: The Society is advocating legislation that would allow Medicaid to cover psychotherapy delivered by qualified social workers in private practice or in agencies that are not licensed by New York State, such as family agencies. In process.

Licensing — The legislative committee has drafted a bill to license clinical social workers and has submitted it to the State Board for Social Work. Awaiting response.

Jury Duty: No legislation is being considered at this time by NY state legislators.

EDITORIAL OFFICE
a j collier/communications
239 park avenue south
new york, new york 10003
212/598-4530

Editor
Alyce J. Collier

Editorial Consultant — NYS Society
Haruko Brown, CSW

Coordinator — Book Reviews
Patricia Morgan Landy, CSW

Graphic Designer
Stanley Isaacs

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Advertising for Spring 1991 issue due March 1.

All advertising must be camera ready.

Therapists Held Liable as "Duty to Warn" Expands

By David G. Phillips, DSW

The 1974 case of *Tarasoff v Board of Regents* — in which a psychotherapist was held liable for his failure to notify the intended victim of his patient of the danger to her life — was probably the single event that most dramatically notified the professional community of the new legal and ethical climate in which they were now practicing. Many clinicians do not, however, know that there have been many subsequent developments that have affected the so-called "duty to warn". Several states, for example (of which New York is not yet one), have passed laws which attempt to define more precisely the responsibility of a therapist in a "duty to warn" case.

In addition, a number of other court cases have both upheld and modified the *Tarasoff* decision. It is important to note that there are cases, less well known, that have resulted in laws that go far beyond *Tarasoff* in the responsibility that they have imposed on psychotherapists. In a California case, for example — *Jablonski v United States,* 1988 — a Federal Court imposed a duty to warn on a therapist even though he had not been told specifically of his client's murderous intent.

The court did not assume . . . as had the court in *Tarasoff,* that the identity of the victim had been specified; but it concluded that the identity of the victim was foreseeable because of the client's history of directing his violence toward women with whom he was close . . . . *Jablonski,* therefore, goes beyond *Tarasoff* in a very important way. No longer is it sufficient to warn intended victims of explicit threats of violence confided by a severely mentally ill patient. Therapists must now warn intended victims of threats of violence that may be *implied* by their patients' "psychological profiles". The therapist is responsible for discerning both the identity of the targeted victim and the magnitude of the threat.[1]

In a Nebraska case, *Lipari v Sears, Roebuck,* 1980, a disgruntled patient made threats to harm people but did not specify who his victims might be or when the attack might take place. The patient later bought a shotgun and fired it into a nightclub killing and wounding several people. The therapist was held liable for his failure to protect the victims, even though there was no way of knowing who the specific victims would be.[2]

A new standard of care is evolving . . . that may curtail the confidential relationship.

Instances such as the foregoing suggest that a new standard of care is evolving in work with potentially dangerous patients, and that the confidential relationship that we can offer such patients is growing even more limited. The duty that is gradually being defined might better be called a "duty to protect" than a duty to warn. Psychotherapists may be held liable for a failure to protect victims even though there was no threat against a specific victim and no way of predicting with any degree of certainty the patient's potential for violence.

Do therapists now have a "duty to protect"?

This newly evolving "duty to protect" may, in some cases, require therapists to notify potential victims and/or a law enforcement agency. In other cases it may not be necessary to notify anyone and the "duty to protect" may be discharged adequately through more traditional and more clinical interventions. In such cases it may be appropriate to reassess the treatment plan in view of the patient's dangerous tendency and/or to refer the patient for consideration of medication and hospitalization.

Even though the appropriate response may vary from case to case, it is important that clinicians be aware of the need for action in such situations. New York State has not yet passed laws to guide us in such situations, and a State court decision in one area is not binding in another. As the cited cases indicate, there is a widening concept of therapeutic responsibility in work with potentially dangerous patients. In the next column we will discuss the current status of the duty to warn in work with AIDS cases.

References:

1. Meyers CJ. "The Legal Perils of Psychotherapeutic Practice: The Farther Reaches of the Duty to Warn." Everstine L, Everstine D (eds). *Psychotherapy and the Law.* New York: Grune & Stratton, 1986.
2. Mills M, et al. "Protecting Third parties: A Decade After Tarasoff." *The American Journal of Psychiatry,* Vol 144, No 1, January 1987.

CONSULTATION PANEL *(continued)*

accrue additional hours of supervision to qualify for "R" status; those needing assistance in applying for "P" or "R" status; those who require supervision on a sliding scale basis; those who would like to supplement agency supervision; and those wishing to consult specifically with a clinical social worker. Goals, frequency of meetings, fees and all other elements of the consultation relationship will be worked out on an individual basis between each consultant and consultee.

One can use the services of the consultation panel in two ways. A list of approved consultants is updated regularly and distributed to members through the President's Letters. The list is also available from Lynne Morris, 161 West 75th Street, New York, NY 10023. A clinician can contact individuals on the list to explore the possibility of ongoing consultation. Secondly, each chapter has a member with access to pertinent information about approved consultants in that chapter. This representative is able to provide names of consultants within the chapter whose credentials and qualifications meet the specific needs of those requesting a referral. The name of that chapter person will be announced in local chapter newsletters and can also be obtained from chapter presidents.

We hope that this will be a helpful program, benefiting our members, the Society and our profession.

Seven Awarded Diplomate Status

Seven Society members have been awarded Diplomate status, reflecting their contributions to the Society over the years. They include:

Consuelo V. Alsapiedi and **Joseph A. Ventimiglia,** Queens chapter; **Barbara Kuerer Gangi** and **Patricia Morgan Landy,** Met chapter; **Monty Kary,** Rockland; **Carole Ring, Psy.D.,** Brooklyn; and **Maria Warrack,** Nassau.

Profiles on new Diplomates will be published in a later issue.

Mandated Reporting of Suspected Child Abuse and Neglect

By Hillel Bodek, MSW, CSW, BCD

A Rand Corporation study released in January 1990 revealed that mental health professionals did not comply consistently with state laws that mandate reporting of suspected child abuse/neglect to states' child protective services agencies.* The study indicated that treatment-related reasons were most often responsible for mental health professionals' failure to report. The practitioners surveyed believed that reporting was likely to disrupt treatment; that they could provide better services to the abusing family than would child protective services; and that families already involved in treatment should not be reported because the child is already protected by the family's voluntary entry into treatment. Mental health clinicians who indicated that they exercised discretion in deciding when to comply with their state's mandated reporting statute tended to consider the poor quality of child protective services as a key factor in deciding whether or not to report.

New York State law requires all licensed health care professionals to report cases of suspected child abuse/neglect when there is "reasonable cause" to believe that a child under age 18 coming before them in their professional capacity is either abused or maltreated/neglected. Failure to make such a report is a criminal offense. Additionally, willing failure to report can render the professional liable for civil damages.

NYS law requires licensed health care professionals to report cases of suspected child abuse/neglect.

Licensed health care providers are also required to report such cases when the person legally responsible for the care of such child comes before them in their professional capacity and informs them (based on personal knowledge) of facts, conditions or circumstances which, if accurate, would render the child abused/maltreated. (This also includes persons who are regularly found in the child's household whose conduct causes or contributes to the abuse or neglect of the child.) A person is considered legally responsible for the care of a child if he or she is the parent, legal guardian, custodian or person designated legally responsible for the child's care.

Definition

Maltreated/neglected children are less than 18 years of age whose physical, mental or emotional condition has been impaired or is in immediate danger of being impaired as a result of the failure of the legally responsible person to provide adequate food, clothing, shelter or educational and health services. To constitute maltreatment or neglect, the impairment of the child's mental or emotional faculties must be such that the child's psychological or intellectual functioning is substantially diminished (i.e., failure to thrive, lack of control of aggressive or self-destructive impulses, ability to think or reason, acting out and misbehavior.) Such impairment must be clearly attributable to the unwillingness or inability of the legally responsible person to exercise "a minimum degree of care" toward the child.

Although the quality of child protective services is often poor and "mandated reporters," such as clinical social workers, often believe that their reports are not always taken seriously and acted upon appropriately, all CSWs in New York State are mandated reporters. To assure that reports from such reporting sources are given the special attention they deserve, New York State has established a special telephone number for use in reporting cases of suspected child abuse/maltreatment: **1-800-635-1522.** Cases reported through this number are assured of receiving the careful attention and rapid response they deserve.

*Zellman GL, Bell RM. *The Role of Professional Background, Case Characteristics, and Protective Agency Response in Mandated Child Abuse Reporting*. Santa Monica, Calif: Rand Corporation, 1990.

Divorce Induced Regression: The Adversarial Process vs. Mediation

By Howard Yahm, CSW

We have all seen mature, caring adults go through a divorce behaving in hateful, envious, greedy, frightened, dependent and/or vengeful ways. Usually generous and compromising, suddenly they "want it all" and "won't give an inch". Loving, competent and child-centered parents hurt their children. Friends, relatives and even hired professionals are drawn into the battle. The stress of the divorce process fosters regressive behavior.

Separation, Loss and "Being Fair"

The clearest example of this regression is the response to the separation itself and the attendant losses. How well individuals can manage separation and loss depends in large part on how well they have dealt with and resolved earlier experiences with these events and how severe the current situation seems. Divorce involves not only separating from one's spouse but also perhaps from children (either totally or partially), family and friends. Individuals often lose their homes, familiar life-styles and accustomed roles and feelings about themselves and others. Their lives become "unglued" and the experience elicits fear, panic and confusion. These stresses intrude on the ability to make rational adult decisions, follow through with plans, and understand and provide for children.

Another regression-inducing aspect of divorce is the need to define "equitable" (i.e., "fair") and to divide the couple's worldly goods on the basis of this definition. In our culture siblings are encouraged to be "fair" and to share. In the regressed sibling relationship issues related to envy, greed and feeling cheated — and the difficulty of sharing or being fair — predominate. Divorce — and more specifically these same issues — elicits this competitive, rivalrous behavior. When feelings of envy or greed cannot be satisfied, destructive actions may follow: "If I can't have it, no one can." When this struggle spills over into decisions related to children, it becomes the basis for the most destructive and costly aspect of the divorce.

The "Good Parent" and Renewed Abandonment

Marriage often unconsciously recreates for one or both parties the fantasy of the "good parent" in the spouse or in the marriage itself. Expectations may be material, emotional, social, romantic and/or sexual. The degree of idealized hope and wish and promise that either or both spouses invests in the fantasy can be a crucial factor; once again one feels betrayed and abandoned by the "good parent".

Marriage often unconsciously recreates for one or both parties the fantasy of the "good parent".

Yet another component that determines how negative the divorce experience will be is the kind of divorce process. The usual adversarial procedure prevalent in the legal aspect emphasizes authority dependence, power tactics and "winning" as much as possible by defeating one's "opponent". This exacerbates regressive tendencies. By defining the "best interests" of their clients only in monetary terms, matrimonial attorneys join with the least mature elements of their clients' personalities. Separation, loss and sibling rivalry issues are intensified. By promising to "take care of everything" and assuming control of negotiations, these professionals encourage a dependence that leaves the client feeling betrayed and abandoned — everything is, in fact, not taken care of.

Mediation vs. Adversarial

Couples seeking divorce through mediation are also involved in regressive experiences. Several factors in the mediation process, however, work to block, redirect and often resolve these. Mediation — into which both parties enter together — prevents many negative assumptions, fears and projections. Moreover, the couple can explore alternatives to divorce at any point in the process. Further, the accepting, nonjudgmental, empathic posture of the mediator toward both spouses encourages similar treatment of each other.

Finally, and perhaps most significantly, mediation blocks and discourages much of the regressive process itself. This is accomplished by:

- teaching and encouraging adult problem solving and decision-making behavior;

continued on page 7

Lydia Keitner, Forensic Expert, Deceased

Lydia Keitner, CSW, past president of the Western New York chapter and Fellow of the Society, died on August 20 at age 67. She had been executive director of Erie County Forensic Mental Health Services since 1970, and was assistant professor of psychiatry at the University of Buffalo. Considered one of the area's top mental health professionals in the criminal justice field *(The Buffalo News),* Lydia was the Society's forensic chair in 1988-1989.

An active and dynamic member, she was dedicated to serving the fledgling Upstate chapter in the mid-'80s so that it became a viable and productive branch of the Society in one of the less populated areas of the state. The chapter now has 36 members.

A native of Budapest, Hungary, she had been a school principal there before moving to Montreal in 1957, where she earned her masters degree in social work at McGill University and, later, an advanced degree in criminology at Boston University.

She was the author or co-author of several studies on criminal behavior and the impact of such behavior on Society.

Lydia was one of very few officers who came from outlying regions on a regular basis to attend board meetings. Her energy and unflagging efforts reflected her major participation on the state level and have left a valuable and lasting contribution to the NYS Society.

She is survived by her husband, 3 sons and 7 grandchildren.

Hello to New Members

New members reflect new ideas, new resources, renewed person-power for the Society. At the same time, the new alliances and knowledge available to members provide an impetus and a way to implement and fulfill the common goals of CSWs and their professional organization. The following have joined the Society since the summer of 1989. Those who have joined during the most recent membership drive will be acknowledged in a later issue. Welcome!

Brooklyn
Brown, Paul Laurence
Buonanno, Marie
Cassis, Gloria
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Glassman, Neil A.
Keown, Sue
Kitkin, Cecile
Kraus-Friedberg, Nurit
Lackschewitz, Elisabeth
Lament, Claudia
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Morris-Galvin, Barbara
Nalpant, Edward A.

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Kallett, Judith
Lauria, Marilyn A.
Michaels, Lana Marie
Poecking, Carol E.
Rosenfelder, Dorothy W.
Sells, Cindy

BOOKS

Dance Movement Therapy, A Healing Art

Fran J. Levy, Ed.D., MSW, ADTR
American Alliance for Health, Physical Education, Recreation and Dance, Reston, Va, 1988, 365 pages

Reviewed by
Theda Moss Salkind, CSW

Dr. Levy's book traces the emergence of dance movement therapy as an effective treatment modality — one that provides a creative nonverbal way of helping troubled people — and is of interest to clinical social workers.

It is useful to rely on the 1970 American Dance Therapy Association definition: Dance therapy is the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual. Aptitude for the dance is irrelevant. Dance movement therapy . . . differs from traditional verbal therapy in that it uses psychomotor expression as the major mode of intervention. It differs from body therapies in that those therapies do not focus on the psychological aspects of movement.

Dance movement therapy . . . uses psychomotor expression as the major mode of intervention.

Dance movement therapy has a history rooted in dance as a performance art and in theories of human personality. The modern dance movement was part of the social and intellectual reform movements that swept Europe and the United States earlier in our century. Its pioneers were part of the ferment and rebellion, interested in absorbing and applying the ideas of Freud, his followers and antagonists. While Freud was examining motivation underlying action, Carl Jung was exploring expression of the primitive Unconscious through art, and Wilhelm Reich was developing the concept of character armor as muscular evidence of emotional conflict. At about the same time, Schilder was creating the concept of body image, describing the relationship between movement and impressions of the senses. These clinicians were seeing things in a new way.

From theories of behavior came applications, in part directed to psychoanalysis and psychotherapy — essentially "talking cures". As action-oriented therapies came into being, acknowledging that thought and feeling exist on many levels and have many forms of expression, the limitations on recognizing the importance of nonverbal behavior were disappearing. Dance itself was no longer "writ on air". In addition to film, notation was devised by Laban so that movement could be replicated. Birdwhistell was establishing the science of kinesics, which revealed the connection between movement and mental processes. Information about body language became popularly accepted.

The history of dance movement therapy is rooted in dance as a performance art and in theories of human personality.

Close observation of students help dance movement therapists to recognize that changes in movement were connected to changes in the psyche and that these changes could be directed. Marion Chase (1896-1970) pioneered this theory with psychotic patients, whose words were irrational but whose movements could be understood and channeled. Blanche Evans (1909-1982) worked with the "neurotic urban adult," realizing people expressed in dance what they avoided in words. Growing evidence from experience convinced dance therapists that many other groups could be helped. The mentally retarded improved coordination and body image. They and those suffering from sensory deprivation could reduce social isolation. Disturbed children, the neurologically impaired, the aged, could all benefit in some way.

Fran Levy reviews the establishment of the dance therapists' single professional organization. The American Dance Therapy Association was founded in 1966 by 73 dance therapists. She also created Dance Therapy Heritage Press, which presents the ideological ancestry of the major dance therapists.

Dr. Levy is objective enough about her own contribution to the development of dance therapy to present her ideas clearly and fairly, but she does this in the third person. I would have preferred to have her shift to the first person in this section. Briefly, she incorporated some of Jacob Moreno's psychodrama into psychotherapy that includes most of the creative arts therapies, including dance movement. Levy uses all the techniques at her command to meet the patient where she/he is, recognizing whether he is strong kinesthetically, or visually, or in another way. She believes that such expression will provoke conflicting emotions and free the immobilized energy, which the therapist can then structure both verbally and nonverbally, depending on need. This allows the patient to get in touch with feelings and emotions that lead to specific images of specific people about whom there are conflicts. These emotional conflicts can then be explored through psychodramatic movement or enactment, utilizing role playing and role reversal. The patient is enabled to identify, clarify and resolve conflicts, bringing order out of personal chaos and accelerating insight.

This book is well worth reading and owning. It provides a wonderful introduction to an important treatment modality.

Theda Moss Salkind, CSW, is a Diplomate of the NYS Society and of the American Board of Medical Psychotherapists. Her private practice is in Staten Island.

DIVORCE *(continued)*

- allowing the spouses a controlled amount of emotional ventilation about and toward each other;
- leaving the negotiating process to the spouses themselves;
- encouraging open disclosure to each other;
- reminding them that they are not divorcing from their children;
- helping them focus on the needs of their children;
- seeking win/win solutions.

The mediation process fosters an atmosphere in which both parties can be allowed to remember that they once cared deeply for each other and that they both still care deeply for many of the same people and must now grieve their losses and get on with their lives.

Howard Yahm, CSW, is the author of "Divorce Mediation: A Psychoanalytic Perspective." In Lemmon JA (ed): *Procedures for Guiding the Divorce Mediation Process.* Mediation Quarterly No. 6. San Francisco: Jossey-Bass, 1984. He is the Co-Director of the Center for Divorce Mediation.

Short Slate

The following candidates have been nominated for the indicated office. Ballots will be sent through the mail.

President Elect:	**David G. Phillips, DSW (Met)**
Second Vice President:	**Fred Frankel, CSW (Nassau)**
Recording Secretary:	**No candidate**
Member-at-Large:	**Maura deLisser, CSW (Met)** **Uri Bergmann (Nassau)**