The CLINICIAN

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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

IN THIS ISSUE

www.nysscsw.org

The Neurobiology of Aging:

Clinical Wisdom, Psychodynamic Depth, and the Adaptive Mind

By Inna Rozentsvit, M.D., Ph.D.

There is an undeniable vulnerability that comes with aging—the aching joints, the fraying memory, the growing awareness of mortality. But there is also another, less discussed truth: aging brains can remain astonishingly adaptive. Consider Eric R. Kandel, the Nobel Prize-winning neuroscientist, who continues publishing and lecturing well into his 90s. Or Martin Bergmann, the psychoanalyst and Holocaust survivor, who was still leading analytic seminars past his 100th birthday. William Edward Burghardt Du Bois, American sociologist and Pan-Africanist civil rights activist, who was active until his death at 95. Winston Churchill, British prime minister, who died at 90, and who did not retire from politics until the age of 89.

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"The concept of neuroplasticity, once thought limited to childhood, is now recognized as a lifelong capacity for the brain to change."

On Aging

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

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MESSAGE FROM THE PRESIDENT

Professional Unity Will Facilitate Change on the Micro and Macro Level

Beth Pagano, LCSW-R

It is an amazing historical time in which we live. The rapid pace of change on every level of experience is incomprehensible. Unanticipated reactions to this rapid change have become problematic. People are suffering. Human freedoms have been taken away and more are at risk of being taken away. The earliest recorded history reports that human oppression and inequity were part of the human experience and sadly this inequity and oppression continues. I can say with utmost certainty that these facts have something to do with, maybe everything to do with, why we practice clinical social work.

Degrees of freedom differ greatly within different groups of people, in different countries and even in many families. We hear about this in our psychotherapy sessions all the time. We have our own personal experience. What do we do? We listen, we educate ourselves, we strengthen our professional community, and we hold on to our social work values that say none of us are free unless all of us are free.

Choosing to be a clinical social worker means we have chosen to address interpersonal and societal conflicts that present as maladaptations. Choosing to be a member of our professional organization means that we are dedicated to this career and interested in learning and growing within the field of clinical social work to better ameliorate these interpersonal and societal maladaptations.

In this issue of *The Clinician*, we explore the psychology of aging, the aging patient and aging therapist. We look at end of life experiences and the expressed desire for life to have had meaning. We are all in the process of becoming. This issue of the newsletter simultaneously introduces you to professionals at the very beginning of their social work journey. The New York State Society for Clinical Social Work has a long-standing history of awarding scholarships to students working towards attaining their Master of Social Work degree. This year the faculty from the MSW programs chose scholarship recipients who are advanced academic scholars, demonstrating clinical competence and effectiveness, and exceptional clinical judgment commensurate with their experience.

> “We listen, we educate ourselves, we strengthen our professional community, and we hold on to our social work values that say none of us are free unless all of us are free.”

How beautiful it is that this edition of *The Clinician* simultaneously highlights the novice and the expert, placing emphasis on the circulative nature of our evolution! The expert and the novice have enormous value and a dedicated unique purpose. In integrating the wisdom of the expert, we hold on to what has already been established, using this knowledge and experience as a foundation. In integrating the wisdom of the novice, we expand our empathic understanding of the ever-changing and current constructs of the human experience, using this knowledge to propel us forward. The circular unity combining the knowledge of the expert and novice, and everyone in between, keeps clinical social work viable.

When we examine the social problem of inequity and lack of freedom, we know clearly that generational trauma exists. Generational enactments are obvious. The discord between nations, individuals, families,

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COMMITTEE REPORT | MENTORSHIP

We are pleased to report that efforts to revitalize the Mentorship Committee, a valuable benefit of membership, have been going well.

We have enlisted eight new mentors, all highly experienced practitioners in the Society, and others have expressed an interest in group or individual mentoring. To date, eight new mentees have been referred to mentors and the program is being promoted on chapter listservs, *Friday E-News*, and the website.

Mentees are at different levels of practice: MSW students, LMs, and LCs who are interested in a change of direction in their careers. They receive guidance regarding career paths, scope of practice for LMs, best practices for securing clinical hours for the LC exam, legislative matters in our field, and advanced training. Mentees at all levels of practice receive support and guidance from each other in their shared experiences and from the mentors.

We can offer mentoring Monday to Friday at different times of day and evening. The groups meet on Zoom. Please feel free to get in touch for more information.

Please contact one of the Co-Chairs:

Karen Kaufman Ph.D., LCSW
karenkaufman17@gmail.com

Lena Zairis, LCSW
lnz204@nyu.edu

SAVE THE DATE

Saturday, October 18, 2025

11:00 AM – 3:00 PM

THE NYSSCSW ANNUAL MEMBERSHIP MEETING

Luncheon & Meeting
Red Hat on the River
Irvington on Hudson, NY

Details available soon

ACE Foundation

ACE, the Advanced Clinical Education Foundation, is a not-for-profit 501c.3 corporation whose mission is to provide education for the mental health field. It was founded through the generosity of NYSSCSW in 2015 following the establishment of a continuing education requirement for the social work profession.

ACE has consistently aimed to offer quality clinical presentations to licensed clinicians. In New York State alone, our programs are offered to 72,000 licensed social workers, 16,000 psychologists, 13,000 mental health counselors, 2,000 MFTs, and 800 psychoanalysts.

We invite you to get to know us. Here's what we have accomplished to date:

As an approved NYS provider, we have given over 300 continuing education presentations to more than 1,100 mental health professionals. As of 2024, this adds up to more than 2,500 approved education contact hours.

We have 1,300 Learning Center users and *E-news* subscribers as of 2024, and more than 7,000 website visits. We get more visitors every month, the greatest number from New York, Boston and Georgia. Internationally, we have had visits from the Philippines, China, and Qatar.

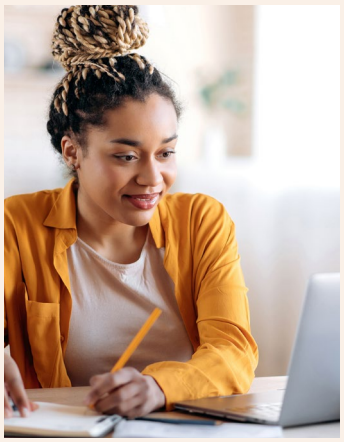
Our future plans include a clinical library and certification courses. As we grow, we will stay committed to relevant clinical education and, in particular, to preserving psychodynamic approaches.

Please visit ace-foundation.net and join us.

Marsha Wineburgh, DSW, LCSW-R, *President*

THE ACE FOUNDATION AND THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK

Explore Our Continuing Education Programs for Fall 2025



We understand that renewal is about more than your license, it's about staying relevant in a field that continues to grow and change. *We offer you the opportunity to:*

- Explore exciting trends in mental health.
- Connect with dynamic presenters
- Enjoy the company of peers.
- Master new clinical skills.

Our high-caliber presentations feature accomplished educators who are authors, teachers, and working mental health professionals. We also strive to improve our offerings by actively engaging attendees and presenters about the issues they face in their offices with patients and outside the room as they navigate their clinical careers.

Stay Creative. Stay Curious. Stay Current.

For Details and Registration Visit these Websites: ace-foundation.net and nysscsw.org

ACE FOUNDATION

Friday, September 12, 2025
Evidence-Based Strategies for Treating Anger and ADHD
LIVE ONLINE VIA ZOOM | 2.0 CE CREDIT HOURS

Saturday, September 13, 2025
Maintaining Professional Boundaries in Psychotherapy
LIVE ONLINE VIA ZOOM | 3.0 CE CREDIT HOURS | NYS REQUIRED COURSE

Friday, September 26, 2025
Mandated Identification and Reporting of Child Abuse and Maltreatment/Neglect
LIVE ONLINE VIA ZOOM | 2.0 CE CREDIT HOURS | NYS REQUIRED COURSE

NYSSCSW PROGRAMS

Sunday, September 28, 2025
The Neuroscience of Eating Disorders and Implications for Treatment
LIVE ONLINE VIA ZOOM | 3.0 CE CREDIT HOURS

Sunday, October 19, 2025
Negative Thoughts on Trial: A Clinical Social Worker's Approach
LIVE ONLINE VIA ZOOM | 1.5 CE CREDIT HOURS

The 2025 Annual Student Scholarship Winners

Congratulations to the student scholars chosen by their schools to receive the 2025 NYSSCSW Annual Student Scholarships. The awards recognize academic excellence, extraordinary performance in their internships, and exceptional contributions in the classroom.

The MSW scholarship recipients were honored on June 7 at a luncheon at the Half Moon restaurant in Dobbs Ferry. The BSW students will be honored with a Zoom celebration on July 27.

The faculties of social work schools across the state have been generous in answering the call of our chapters to nominate worthy MSW students for awards.

The Long Island Chapter has long celebrated scholars with bachelor's degrees in social work. BSWs receive grants and one-year Society memberships. The LI Chapter can assist others in starting their programs.
See Page 9 for information.

MSW Scholarship Winners

Frank Abbott – *SUNY Binghamton MSW Program*

Frank has a background in public safety and experience in mental health as a Certified Peer Advocate for first responders. His journey has been shaped by a strong commitment to trauma-informed care and supporting those who serve. He completed a placement at a children's residential home, providing therapeutic support to young people. He is passionate about advancing mental health care for first responders and veterans and aims to build a career centered around their healing and resilience.

Lauren Barragan – *Silberman School of Social Work at Hunter College*

Lauren earned an undergraduate degree in psychology at Wesleyan University. She has interned with the Department of Education, engaging teens in social-emotional learning and use genograms to facilitate building connections to their families of origin. She cultivated her clinical skills in a Bronx community center where she worked with adolescent and adult survivors of family violence and crime. Before meeting with clients, she engaged in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) training.

Lauren's research and clinical curiosity is in historical intergenerational trauma and storytelling. This speaks to both her African American and Afro-Latinx ancestry. She hopes to tap into her generational awareness, trauma-informed skills, and passion for storytelling to continue to work clinically with individuals, families, and small groups of diverse backgrounds.

Greg Brin – *Nazareth University MSW Program*

Greg is a Nazareth University MSW graduate specializing in evidence-based practice in mental health.

Brielle Brook – *Fordham University at Molloy University MSW Program*

Brielle was a Palliative Care Fellow while pursuing her MSW at Fordham. She completed her specialist year internship at Cohen Children's Medical Center in the Stem Cell Transplantation & Cellular Therapy unit, providing clinical and practical support to pediatric hematology/oncology patients and their families.

Brielle holds a B.A. in History from Vassar College. She worked with the pediatric oncology population for five years as a year-round staff member at Sunrise Day Camp-Long Island before pursuing her MSW. She looks forward to continuing to serve this population as a clinical social worker.

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Delia Rayne Duran – *Long Island University/ Post MSW Program*

Delia holds a Bachelor of Science in Gerontology Studies from SUNY Oneonta. She has provided social work services to vulnerable populations across Long Island, with a focus on older adults and veterans.

Delia began her career with an internship at the Family and Children's Association LinkAge Program, working in care coordination, community outreach, and short-term case management. She interned at the Community Living Center and Intimate Partner Violence Assistance Program at the Northport Veterans Affairs Medical Center.

As President of the LIU Social Work Student Association, Delia has demonstrated strong leadership, integrity, and organizational proficiency.

She aims to pursue a career as a social work professional, committed to advocating for and supporting individuals in need, while adhering to the core values of the profession.

Candice Leon – *Adelphi University School of Social Work, Hudson Valley*

Candice's academic achievements include maintaining a 3.975 GPA, through both Adelphi's Masters of Social Work and Arizona State University's Bachelors of Psychology programs. During her academic pursuits, "I have been the mother of two amazing young children, and the wife to my wonderfully supportive husband. As a private yoga and meditation coach, I've developed strong leadership skills and a passion for finding the 'eye of the storm' and cultivating peace and unconditional compassion amid the chaos that is life." She is dedicated to learning and making a positive impact in the future.

THE 2025 MSW SCHOLARS:
Frank Abbott, SUNY Binghamton MSW Program
Lauren Barragan, Hunter College Silberman School of Social Work
Greg Brin, Nazareth University MSW Program
Brielle Brook, Fordham University at Molloy University
Delia Duran, Long Island University/Post MSW Program
Christie Hanson, Fordham University, Lincoln Center
Candice Leon, Adelphi University Hudson Valley MSW Program
Daniella Martinez, Adelphi University Garden City MSW Program
Elizabeth Policano, NYU Silver School of Social Work, Westchester
Ainsley Rinkerman, NYU Silver School of Social Work, Rockland
Carlina Soraia Segredo Baptista, Adelphi University NYC MSW Program
Rachel Zuckerman, NYU Silver School of Social Work Washington Square

THE 2025 BSW SCHOLARS (LONG ISLAND CHAPTER):
Sarah Beck, BSW, Adelphi University School of Social Work
Alma Calderon, BSW, Molloy University
Kelly Maloney, BSW, Long Island University/Post
Isabelle Yoon, BSW, Long Island University/Post
Lemuel Zamor, BSW, Adelphi University School of Social Work

Not all photos and bios were available at press time.

Daniela Martinez – *Adelphi University MSW Program, Garden City*

Daniela is a first-generation MSW graduate with a strong commitment to advancing equity, empowerment, and community healing. As a Senior Case Manager at one of New York City's largest mental health centers, she led a department focused on serving marginalized populations with compassion and culturally responsive care. Daniela is inspired to advocate for underserved communities and work to remove the barriers they face. She is now working toward clinical licensure "in order to continue to help people directly and support long-term change in the system."

Elizabeth Policano – *NYU Silver School of Social Work, Westchester*

Elizabeth is passionate about working with individuals and communities from diverse populations while advocating for systemic change.

She interned at Hudson River Care and Counseling, providing individual and family counseling to a diverse group of clients with a focus in trauma-informed care. As an Adaptive Leadership Fellow, Elizabeth addressed adaptive challenges identified through practicum and client interactions. As an animal lover, she is captivated by the human-animal bond and advocates for animal welfare and the social worker's role in veterinary medicine.

Elizabeth is this year's recipient of the NASW MSW Student of the Year award. She pledges her commitment to the field of social work as a lifelong journey that is ever-changing and growing.

CONTINUED ON PAGE 8

Ainsley Rinkerman – *NYU Silver School of Social Work, Rockland*

Ainsley has brought a grounded, trauma-informed approach in her work in outpatient addiction treatment and DUI education with court-mandated clients. She is known for strong ethical judgment, the ability to build trust with clients navigating complex systems, and a commitment to client autonomy. She is especially interested in how clinical care and education can work together to support self-determination and long-term change.

Carlina Soraia Segredo Baptista – *Adelphi Univ. New York City MSW Program*

Carlina has over five years of experience as a care manager, supporting individuals with serious mental illness, chronic medical conditions, and intellectual/developmental disabilities. Her Cape Verdean background and personal journey have shaped her passion for helping others — especially women in recovery. She is currently building skills in motivational interviewing, CBT, and group facilitation, with plans to complete her CASAC.

Rachel Zuckerman – *NYU Silver School of Social Work, Washington Square*

Rachel has completed clinical internships at elementary school P.S. 38 and a not-for-profit outpatient mental health clinic, Fifth Avenue Therapy. She is hoping to continue working clinically with children and adults after graduation.

Prior to pursuing an MSW, Rachel served as the director of executive strategy research at Advisory Board, a healthcare research firm. She holds a B.A. in English from Princeton University.

BSW Scholarship Winners

Sarah Beck – *Adelphi University*

After graduation, Sarah plans to earn an MSW and to continue her current work with children. She has been a camp counselor for several years and also works from time to time at an early childhood center.

Alma Calderón – *Molloy University*

Alma chose the field of social work out of an innate desire to help others. She currently works as a senior counselor at a nonprofit facilitating group sessions for children. "Receiving this award is deeply meaningful to me," she wrote, "as it validates the work I have put into my education and my commitment to making a difference."

Kelly A. Maloney – *Long Island University*

After working in the restaurant industry, Kelly decided to go back to school to become a social worker. Certain life experiences "opened my mind and made me realize that this is what I was meant to do with my life." She has valued the learning experience and her internships. "My passion for this field and what it contributes to the lives of others fills me with pride and excitement for the future."

Lemuel Zamor – *Adelphi University*

"Witnessing my mother's own battles with mental health has inspired me to pursue a career as a clinician," Lemuel wrote. Before attending Adelphi, he worked with the AHRC, supporting the intellectual and developmental disability population with developing ADLs, understanding the complexity of relationships, and supporting them through community.

As an incoming transfer student, Lemuel worked as a Bridges to Adelphi social coach. In this position, he helped the neurodiverse population develop and improve social skills and navigate school with a better understanding of social norms. He also interned at Adventures in Learning in Manhasset as a homework helper supporting Black and Latino children. In addition, he interned at the Adelphi Mindfulness Center, creating a program to help college students incorporate rest and mindfulness practice. In his "free time," Lemuel likes to play games, do calisthenics, and he is "really into Japanese music."

BSW Scholarships:

Supporting Our Newest Learners

Since 2019, the Nassau Chapter (now the Long Island Chapter) has offered scholarships to BSW students. It is a chapter initiative that compliments the statewide MSW student scholarship program.

The BSW program supports our newest learners, strengthens our connection to the schools of social work and recognizes excellence in social work education and practice at the foundational level. This year, the Chapter gave grants of either $250 or $500 to five BSW scholars from three different university programs. The winners receive the same one-year student membership as MSW winners.

The program was created as a lasting memorial to a beloved Society leader, Sheila Peck, LCSW-R, who died in 2018. It was initiated in 2019 in partnership with Molloy College, now Molloy University; LIU Post soon joined the effort and then Adelphi University.

Expanding Statewide – Any chapter that is interested in offering BSW scholarships can feel free to contact Catherine Faith Kappenberg. A Zoom Q & A meeting may be scheduled in the fall for those who are interested.

—***Catherine Faith Kappenberg, Ph.D., LCSW***
Dbt.capes.cfk@gmail.com

Student scholars socialize at the annual awards ceremony.

PRESIDENT'S MESSAGE Continued from page 3

systems, and groups expresses humanity's crucial situation regarding definition and sustainability. The current strife and oppression expressing itself on the macro level, or collective expression, appears to be inherited and archetypal. Societies are expressing internal personal conflict and internal inherited collective conflict.

Great transformation is possible! Psyches need healing. Both the oppressors and the oppressed are suffering. We need to remember this. As each individual becomes more conscious and moves away from enacting maladaptive repetitive behaviors, the collective benefits. Clinical intervention is imperative. As each of us progresses, we all progress.

Mental health professionals are called to action. There is always upheaval before transformation occurs. Let us have hope in this process as we experience the turmoil and the growth unfolding. As you work diligently with your patients, your Clinical Society is there for you during these existentially challenging times.

There is strength in numbers. Our work is always challenging, so we need to connect now more than ever. Community will get us through this. Life-long learning will enhance our ability to provide what is needed.

How do we do this? We do this by making sure clinical social workers have a strong foundation in understanding psychodynamic theory and practice. We do this by building on the strong fabric of our being provided for us by our clinical social work ancestors, while weaving into this tapestry the unique, timely brilliance of the novice clinician.

Postgraduate continued education not only strengthens clinical skills, it also affords clinicians the opportunity to be connected in community. Unity in our profession comes from engagement. We are there for you.

Please explore the Clinical Society's rich array of activities and ways to engage with your professional community. They include educational programs offered by the Chapters and the ACE Foundation, mentorship, peer consultation, student programs, volunteer and leadership opportunities, book clubs, listserv connections, the Community Bulletin Board, and networking and social gatherings.

We would love to hear from you. We would love to include your ideas about new or existing activities.

Clinical Social Workers are ambassadors of peace. It is comforting to walk alongside you. Stay strong. Stay safe. If you need something, just ask.

–Beth Pagano, LCSW-R

Long Island Chapter

Barbara Murphy, LCSW, President

Our Let's Talk salon series was well attended in November 2024 with 26 participants, 19 members 7 non-members. The topic was The Perverse Enjoyment of Hate presented by Ronnie Levine, Ph.D., an author and psychoanalyst. The next salon, Cultivating Hope and Connection in Uncertain Times, was presented in June by Howard A Friedman, Ph.D. and Neil Friedman, M.Ed. Our Mentorship Chair, Judith Schaer, LCSW, hosted the series at her lovely home in Greenville; 24 people attended, 16 members and 8 nonmembers.

Facebook Group Comes to Networking Event In March 2025, our social networking event at Mims restaurant in Roslyn was attended by 19 social workers. Seven of the nine nonmembers who came belong to the Facebook group, Long Island Social Work (INFORMAL), comprised of about 6,000 members. Efforts are being made to reach out to other Facebook groups of social workers on Long Island.

Workshop In March, 21 members participated in an interactive workshop led by Jude Treder-Wolf, LCSW on The Use of Creative Improvisation and Action Methods-based Exercises in Individual Treatment at Molloy University in Rockville Centre.

Our Book Club Brunch on May 4 was attended by 8 members *(see photo, right)* at the lovely home of our board member Susan Kahn, LCSW in Great Neck. The next Book Club will be held in the Fall.

BSW Students as well as MSWs Are Granted Scholarships Through an initiative that began in 2019, the Long Island Chapter has granted BSW student scholarships annually as a complement to the Society's MSW scholarship program. We encourage other chapters to contact us to discuss how they might set up their own BSW scholarship programs.

This year's BSW recipients are Sarah Beck, Alma Calderon, Kelly Maloney, Isabelle Yoon, and Lemuel Zamor. The MSW student winners are Daniela Martinez, Delia Rayne Duran, and Brielle Brook. [See Supporting Our Newest Learners and Student Scholarships in this issue for more details.]

Podcasts on Clinical Practice Long Island Chapter President Barbara Murphy released her first podcast on May 6 on Transitioning to Private Practice, as Episode 111 of the podcast series, What Would Dr. Meyers Do?, at https://linktr.ee/drmeyerspod The series is hosted by Amy Meyers, Ph.D., LCSW, a Professor of Social Work at Molloy University. Barbara's next podcast on her work with a teenage boy with suicidality will be released soon. [See Podcast article in this issue, page 15.]

Education On September 28, our next continuing education presentation on Eating Disorders will be given by Dr. Jeffrey DeSarbo on Zoom.

Committees and the Board The Committee on Aging meets every other Sunday on Zoom. We welcome new members to join this and other committees as well as the Board, which will meet again on July 27 and November 23. Please check our chapter's section on the NYSSCSW website for updates and details.

Barbara Murphy: askier@verizon.net

Long Island Chapter Book Club: (L. to R.) Sheila Rindler, Alicia Brackman Munves, Barbara Murphy, Prudence Emery, Sammy Touma, Eleanor Perlman, Helen Beegel, and Susan Kahn.

Met Chapter

Helen Hinckley Krackow, LCSW-R, President

First In-Person Party The Met Chapter held a joyous in-person party on March 23. 2025, the first face-to-face chapter-wide event we have held since the pandemic. This undertaking enabled us to offer the heart-warming connection that the Society was able to provide in pre-Covid times. The event included vegan kosher appetizers, wine, and soft drinks. The Chapter invited "Uptown Sound," the acapella group that sang for us some 20 years ago at the Society's licensing party at the Harmony Club. We were serenaded with 30s and 40s jazz and ragtime, and Beatles songs. A satirical original poem by Kathryn Sedgwick, LCSW was also presented. Networking and some new educational programming developed out of this meeting. It really strengthened the Chapter to celebrate in person.

CE Programs We are planning four CE programs for next season, all presented by our members. The first will be in September: "Understanding and Treating Intergenerational in Families Creates by Adoption" by Aminda Heckman, Ph.D. The second will be in October by Joseph Goldfield, LCSW-R: "Negative Thoughts on Trial: A Clinical Social Worker's Approach." Joe is presenting an original technique he developed to challenge our clients' negative beliefs and cognition by putting them on "trial." He will use techniques from narrative and visual therapies.

In January 2016, we will present Carol Kramer, LCSW on the use of ketamine in couples work. Finally, in February, Judy Kurzer, LCSW will present "Hypnotic Strategies for Enhancing Inner Strength and Resilience."

Peer and Practice Groups The Chapter continues to sponsor five peer run case discussion groups for peer supervision on a monthly basis. The groups include Riverdale, Upper East Side, Upper West Side, Lower Manhattan, and Brooklyn. Our practice groups, such as Infertility and Family Building, Gender and Sexuality, and Aging Issues, continue to meet.

As we come to a quieter practice time, we want to wish you a restful summer. We are looking forward to an active fall season starting in September.

Helen Hinckley Krackow: hhkrackow@gmail.com

Mid-Hudson Chapter

Barbara Solomon, LCSW-R, President

ISO Board Members The Mid-Hudson Chapter has been undergoing many changes. We are hoping to encourage all Chapter members to consider joining our Board. The current officers are ending their terms on June 30. If the Board is to continue to exist and flourish as it has for many years, we urgently need more members to step up to leadership positions. We have provided members with quality training, as well as educational and networking opportunities, and we hope to continue to do so.

Webinar On February 1, we hosted a webinar, Letting Go of the Work You Love: How Therapists Can Prepare to Retire or Close a Practice with Care and Compassion. The presenters were Lynn Grodzki, LCSW, MCC and Margaret Wehrenberg, Psy.D.

Peer Consultation Mid-Hudson continues to offer the Peer Consultation Group which provides an opportunity for licensed clinicians to support and learn from one another. The group focuses on improving clinical and administrative skills. It meets via Zoom on the second Friday of each month. The group is free for NYSSCSW members; all others pay a small fee.

In closing, I want to point out that we are always interested in hearing from Chapter members about how we can best meet your needs. Again, for us to continue and thrive we are asking chapter members to step up and get involved. Please contact me. I would be happy to speak to you about the various open positions we have.

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Rochester Chapter

Peter K. Navratil, LCSW-R, ACSW, President

The Rochester Chapter continues to grow. As we enter our second year, we continue to have monthly get-togethers.

I-Smash Rochester Networking Event In April, the Chapter hosted a networking event at I-Smash Rochester. We had a smashing time, collaborating and networking while taking turns smashing and breaking items as a somatic release of energy—sometimes aggressively—mostly while laughing and connecting. It sparked conversations regarding aggression, somatic energies, and other interesting connections to clinical work. Mostly, it was far more fun than therapeutic, at least, it sure felt that way.

Collaboration, Connection Our focus has been on collaboration, the sharing of clinical interests, expertise, and ideas. Recurring themes include the practical, ethical, legal, and financial sustainability of clinical work and the impact of the current social/political environment.

We are still in the planning stages for an educational event in the fall drawing on the interests of some of our members. More to come on that. We are also in the discussion stages of planning our next networking event.

We continue to encourage our colleagues to join us as we create this opportunity to gather as a local professional group of concerned and committed clinical social workers. We are interested in connecting locally and to other social workers and social work chapters around the state.

Student Scholarship The Chapter was successful in engaging with Nazareth University to recruit a scholarship winner in their MSW program, Greg Brin. We had support from faculty members Michael Rood, LCSW and Meena Lall, LCSW. Due to staffing and other changes, we were unsuccessful at getting the other local universities in this year's scholarship program, but outreach and engagement strategies are already in place for 2026.

Special Thanks Our Chapter continues to deepen its vision as we look to the future. I would like to thank Chapter members Charlie Cote, LCSW; Meena Lall, LCSW; Jacob Studioso, LCSW; Jacob Studioso, LCSW; Jeffrey Young, LCSW; and Dan Rosen, LCSW for their active participation and commitment to the Chapter. I would also like to thank Marcella Colilli, a second-year student in the Master of Social Work program at Nazareth, for attending some meetings and sharing her perspectives with the members.

We will continue to work on developing meaningful ways for the Chapter to reach out and expand our membership and create more networking and educational opportunities over the next few months. As I end this report, I would like to take this opportunity to thank the leadership of the New York State Society for Clinical Social Work for their on-going support and encouragement as we continue to develop and grow the Rochester Chapter of the NYS Society for Clinical Social Work.

✉ Peter Navratil: pknavratil@gmail.com

Rockland Chapter

Orsolya Clifford, LCSW, President

The Rockland Chapter had a great start to 2025. In January, we launched a Private Practice Support Group led by our member Ian Laidlaw, LCSW-R. It takes place monthly on Fridays at 9:00 am via Zoom. If interested in joining, please contact us.

Continuing Ed We have also hosted two fantastic in-person presentations this spring. In March, we held a 3-hour CEU program, "Understanding and Treating Intergenerational in Families Creates by Adoption," by Aminda Heckman, Ph.D. In April, we hosted Amanda Arena-Miller, Ph.D. for an engaging 3-hour CEU presentation, "Feeling What Is: The Transmission of Somatic Awareness Between Client and Therapist." We are looking forward to bringing our members a full line up in the fall.

Student Scholar Now, at the end of the 2025 academic year, we honor our MSW scholarship winner, Ainsley Rinkerman, who attended the NYU Silver School of Social Work, Rockland. Congratulations Ainsley! We wish you all the best!

✉ Orsolya Clifford: ovadasz@optonline.net

Sandra Indig (1938–2025)

By Inna Rozentsvit, M.D., Ph.D.

Sandra Indig, LCSW-R, LP, ATCB

Sandra Indig was a rare soul whose presence graced multiple worlds—psychotherapy, art, poetry, movement, education—and whose contributions to each were profound. She passed away on March 7, 2025, leaving behind a legacy of compassion, creativity, and visionary integration that continues to inspire those who knew and worked with her.

Sandra was a longtime and deeply valued member of the New York State Society for Clinical Social Work (NYSSCSW). She chaired the Creativity and Neuro-Psycho-Education Committee for many years, a role in which I was honored to serve alongside her. Our work together reflected our complementary passions—Sandra curating New York City art museum visits and psychoaesthetic dialogues, while I led neuro-psychoeducational explorations. Her ability to bridge the emotional, sensory, and cognitive dimensions of human experience made every gathering meaningful.

Trained at Syracuse University (BFA), NYU's School of Social Work (MSW), and the Washington Square Institute, Sandra also completed an art therapy internship at Rikers Island—an early indicator of her commitment to working with vulnerable populations. Throughout her career, she treated adults and children with histories of trauma, abuse, addiction, and neglect. Her psychoanalytic approach was innovative and embodied, integrating verbal, visual, and kinesthetic forms of expression. She also worked deeply with artists and performers, understanding that creativity was not a luxury but a lifeline.

> "Her psychoanalytic approach was innovative and embodied, integrating verbal, visual, and kinesthetic forms of expression."

Sandra was a practicing artist whose paintings and poetry blurred the boundaries between psyche and canvas. Her work was exhibited in New York City galleries and online platforms, such as the Charles Street Collection, and was featured at the Object Relations Institute's 2019 annual conference. As publisher of her book *Talking Colors: Seeing Words / Hearing Images*, I witnessed firsthand the poetic resonance of Sandra's inner world—a tapestry of myth, emotion, symbol, and lived experience. Her art was not meant to illustrate psychoanalytic ideas, but to evoke them, acting as "keys" to unconscious doors.

Her creative affiliations were numerous—including the New York Artists Circle, the Jewish Art Salon, and residencies at MacDowell Colony, VCCA, and Vermont Studio Center. She was a two-time Gradiva® Award nominee

in Art, and her chapter "Reclamation and Restoration: Heroes in the Seaweed" was published in *Art, Creativity, and Psychoanalysis* (Routledge). She also performed with *Dances for a Variable Population*, embodying movement as another form of psychological truth.

Sandra was, above all, a generous spirit—curious, brave, and ever attuned to beauty in its many forms. Her clinical wisdom was shaped by depth and humility, her artistic voice by mystery and daring. Her faith, love for Israel, and devotion to her synagogue community were quiet anchors in a life devoted to healing and expression.

We at NYSSCSW, and all who were privileged to know her, mourn her passing and honor her many contributions. May her memory be for a blessing—and may her art, her words, and her spirit continue to move through the lives she touched.

Experiential Therapies for Treating Trauma

Edited by Evan Seinreich, Shulamith Lala Ashenberg Straussner, and Jordan Dann

ROUTLEDGE, 2025

Reviewed by Jeffrey Zeth, LCSW

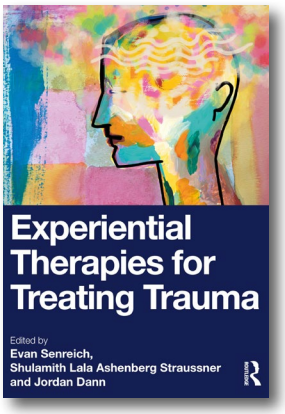
The last several decades have seen an increase in the need for specialized modalities for the treatment of trauma. Ever since the inclusion of Post-Traumatic Stress Disorder (PTSD) to the DSM-III in 1980, psychotherapy has been looking for more and better ways to help combat veterans, victims of terrorism, Holocaust survivors, and others who have survived trauma. More recently, researchers have included in this category those who have suffered complex trauma—prolonged or repeated exposure to traumatic events or situations, rather than a single event.

These populations have needs that often go beyond what standard forms of therapy can provide. Modalities that depend primarily on verbal communication for their effectiveness can be particularly challenging for some trauma survivors. Talk takes place at the level of the mind, and recent research into the neurobiology of trauma has shown that trauma memories are stored not only in the mind, but also in the body. Authors such as Bessel van der Kolk have documented such phenomena as alexithymia—the difficulty identifying and expressing basic emotions—as special challenges faced by traumatized people. Also, according to van der Kolk, traumatic events can interrupt or disable certain cognitive processes that are essential for integrating many kinds of past experiences, with the result that talking "about" past events often serves only to re-traumatize the patient.

Early evidence suggests that a focus on present experience between patient and therapist in the here-and-now can help. Research is still scanty and incomplete, but early signs are that therapies that use sensation, embodied experience, the creative arts, and present-centered awareness can be effective in the treatment of trauma.

A new book, *Experiential Therapies for Treating Trauma*, edited by NYU Professor Emerita Lala Ashenberg Straussner and by gestalt therapists Evan Seinrich and Jordan Dann, makes a convincing case for this. The book's 24 chapters provide an overview of 15 different experiential modalities, including somatic, mindfulness-based therapies, sensorimotor therapies, expressive therapies such as creative arts therapy, and Gestalt therapy. The book is a useful guide for anyone working with trauma and looking for new ways to approach trauma patients. It can also be used by clinicians who already have training in some of these modalities who are looking for new directions for additional training, so they can work with trauma survivors.

Each chapter follows a similar format: there is an introduction to the technique followed by a brief history and summary of how the founders of the technique discovered or invented it. The authors then describe the fundamental clinical concepts of the technique and describe the therapy process in detail—what a session, or series of sessions, often looks and feels like. This is followed by a section detailing the specific application of the technique to trauma work, and by one or more case examples. When the modality has a firm basis in evidence, a brief literature review of the available research is also presented. The authors then review the strengths and limitations of the technique and provide resources for further study. All the authors are experts in the modalities about which they write, and many have also been teaching and supervising in their respective modalities for several years at least.



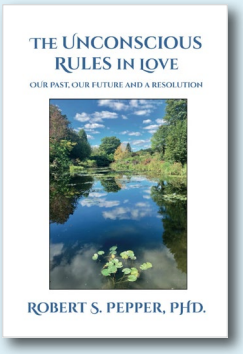
Not every modality will appeal to every reader, but the book has something for everyone. Psychoanalysts will appreciate the chapter on Intensive Short-Term Dynamic Psychotherapy (ISTDP), while therapists oriented towards holism and present-centered experience will find value in the chapters on Gestalt therapy and somatic experiencing. Creative arts therapists will find something useful in the chapters on psychodrama and expressive arts therapy, while those in the evidence-based world will appreciate the chapter on EMDR. For those whose primary focus is mindfulness, the chapter on Hakomi provides an interesting direction for the treatment of trauma.

The authors acknowledge that not every experiential modality is represented. Mindfulness techniques that are focused on teaching meditation and mindfulness practices were left out, as was any heavily didactic therapy oriented towards teaching clients a skill-set, such as Assertiveness and Commitment Therapy (ACT) and Dialectical Behavioral Therapy (DBT). Also, modalities that are highly specialized or with small followings in the United States, such as Pesso-Boyden Psychomotor work (an outgrowth of psychodrama) and eco-psychotherapy (a modality that encourages healing through deeper connection with nature) are not represented, though most would consider them experiential therapies.

This book will be a useful aid for trauma therapists interested in expanding their repertoire and looking for opportunities for additional training. Although the evidence basis for many of these modalities is still scarce, the qualitative research as well as the anecdotal evidence is compelling and points to future directions for research and practice.

The Unconscious Rules in Love

By Robert S. Pepper, Ph.D.



This book explores how our past determines our future when it comes to the partners we pick and the relationships we have. Our "unconsciously on purpose" choices play a part in the scenarios we repeat, the identifications we project, and the communication we have. And while we can't change the past, we can react differently in the present in a way that will affect, improve and often resolve our relationships in the future.

Sea turtles don't need group therapy, as they are a species that don't know their parents. But the rest of us can benefit from group therapy, often more than from individual therapy. A group can provide progressive emotional communication that is one of the keys to finding and keeping a happy and healthy love relationship.

Dr. Robert S. Pepper specializes in analytically oriented group and couple therapy. He has been running groups for 45 years and has a special gift in helping members resolve conflicts with relationships, both personal and professional. He has published more than 35 professional articles, speaks often at conferences, teaches at the college level, and is the author of *Some People Don't Want What They Say They Want: 100 Unconventional Interventions in Group Therapy* and *Emotional Incest in Group Psychotherapy: A Conspiracy of Silence*. Dr. Pepper resides in the New York City area.

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PODCAST

What Would Dr. Meyers Do?

www.linktr.ee/drmeyerspod

Have you checked out Dr. Meyers' clinical podcast? From student to seasoned practitioner and everyone in between, *What Would Dr. Meyers Do?* is the podcast you didn't know you needed—until now.

Amy Meyers, Ph.D., LCSW hosts the bi-weekly podcast. Her goal is tri-fold: 1) to have therapists see themselves in others' work, voices, and experiences; 2) to develop insight into countertransference and build clinical knowledge; and 3) to spread awareness about sibling abuse and its manifestations from a theoretical perspective and survivors' lens.

But this podcast is not only for therapists. Your clients will benefit too. The podcast is all about learning: about the dynamics and emotional journey of a clinical case; building self-awareness and reflective practices; and you. The podcast addresses challenges of doing the work with wisdom, compassion and wit. Dr. Meyers is able to get to the heart of her guests' perspectives with ease and insight. Whether navigating relationships, career, emotions, or just trying to get unstuck, Dr. Meyers explores the vulnerabilities we don't often share, including her own. Topics include EMDR, trauma-informed practice, diversity, high conflict parenting, immigration, OCD, shame, trans justice and much more.

Several episodes have featured NYSSCSW members as guests. Want to be a guest? Dr. Meyers is currently open to suggested topics, and specifically: Dialectical Behavior Therapy (DBT) applications; Dealing with the resistant client (mandated and/or voluntary); Confronting clients; A case of transference; termination; Therapeutic approaches for children with disabilities; Ketamine-assisted therapy; Self-disclosure: When? How? How much?; and Integration of AI in mental health practice.

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The Neurobiology of Aging:

Clinical Wisdom, Psychodynamic Depth, and the Adaptive Mind

CONTINUED FROM PAGE 1

Dr. Inna Rozentsvit, M.D., Ph.D., MSciEd, MBA, is a neurologist and neurorehabilitation specialist trained in psychoanalysis, as well as an educator and neuropsychoanalytic researcher. She serves as the scientific faculty member and programs director at the Object Relations Institute for Psychotherapy and Psychoanalysis (ORI). She is also the founder and the executive director of the Neurorecovery Solutions, Inc., a non-profit organization supporting neurologically impaired individuals and their families.

Dr. Rozentsvit is the founder and serves as an editor-in-chief of the ORI Academic Press, MindMend Publishing Co., and *MindConsiliums*, a peer-reviewed interdisciplinary journal. She is also the founder of the MindMend Media, Inc., an associate editor of Clio's Psyche, and a co-director of the Psychohistory Forum.

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We must also highlight women whose longevity combines mental sharpness with public impact. Melchora Aquino de Ramos, known as 'Tandang Sora,' who played a key role in the Philippine Revolution at an older age. She died at 107 years of age. Ruth Bader Ginsburg, who served on the U.S. Supreme Court into her late 80s, worked through cancer treatments while writing landmark decisions. Edith Eger, the Holocaust survivor and psychologist, published bestselling books in her 90s, still teaching and mentoring others. These individuals didn't simply "age well"—they aged *actively*, exemplifying a form of neural and emotional agility rooted in purpose, discipline, and social contribution.

The Aging Brain: Vulnerable Yet Plastic

The aging process entails biological changes—shrinking hippocampal volume, slower synaptic transmission, and loss of white matter integrity (Raz et al., 2005). Memory and executive function often decline, particularly under chronic stress or social disconnection (Lupien et al., 2009). However, aging is not synonymous with irreversible cognitive deterioration. The concept of neuroplasticity, once thought limited to childhood, is now recognized as a lifelong capacity for the brain to change (Park & Reuter-Lorenz, 2009).

Indeed, fMRI studies show that older adults engage both hemispheres to compensate for age-related losses—a model known as HAROLD (Hemispheric Asymmetry Reduction in Older Adults) (Cabeza et al., 2002). Aging brains adapt by recruiting more diffuse neural networks to solve problems, process emotions, and maintain function—in other words, they are using the wisdom function.

Abstract

Aging is often associated with decline, yet contemporary neuroscience, psychodynamic theory, and clinical experience paint a more nuanced picture—one of adaptability, resilience, and meaning-making. This article explores how aging brains remain dynamic through neuroplasticity, how psychodynamic processes evolve across the lifespan, and how clinicians can apply integrative therapeutic strategies to support emotional depth and cognitive agility. Drawing from empirical research and lived examples, it offers a multidimensional framework for helping older adults flourish, despite biological vulnerability, mortality, and sociopolitical fragmentation.

KEYWORDS: *aging, clinical work, longevity, neurobiology, neuroplasticity, Oliver Sacks, psychodynamic*

Memory: Decline or Reorganization?

Memory changes with age, but it doesn't simply "decline." Rather, different systems, like episodic, semantic, procedural—age differently. Semantic memory (general knowledge and vocabulary) often improves with age, while episodic memory (events, time-bound details) becomes less reliable (Nyberg et al., 2012). Emotional memory remains robust, particularly for meaningful experiences.

The hippocampus and prefrontal cortex are most affected by aging, yet their deterioration can be slowed or partially reversed with cognitive engagement, aerobic

activity, and social interaction (Erickson et al., 2011). Memory training programs have shown durable improvements in older adults, especially when they include novel and meaningful content (Rebok et al., 2014).

Lifelong Learning and Self-Directed Neuroplasticity

Learning is one of the most effective ways to preserve brain health. When older adults engage in cognitively demanding tasks—such as learning a language, studying music, or exploring new technology—they stimulate synaptogenesis (building new connections between neurons) and even neurogenesis (building new neurons) in the hippocampus (Draganski et al., 2006). The *Synapse Project* showed that older adults who learned complex new skills (e.g., photography or quilting) demonstrated significant improvements in memory and executive function (Park et al., 2014).

Beyond formal learning, **self-directed neuroplasticity** allows people to consciously reshape their brain activity through practices like mindfulness, goal setting, journaling, and reflective dialogue (Schwartz & Begley, 2002). These techniques stimulate the prefrontal cortex and reinforce neural pathways that regulate mood, decision-making, and memory (Hölzel et al., 2011; McGaugh, 2015).

Mortality and the Therapist's Role

Aging invariably brings proximity to loss. For patients and clinicians alike, this can stir existential fear. Therapists may avoid discussing death for fear of their own emotional vulnerability. Yet, openly confronting mortality can lead to deeper integration and vitality (Yalom, 2008). Questions like "What legacy matters now?" or "What remains unfinished?" shift the narrative from decline to meaning-making.

Reflecting on legacy and mortality evokes the memory of neurologist Oliver Sacks, who, when asked during a 1989 *MacNeil/Lehrer NewsHour* interview how he wished to be remembered 100 years from now, replied:

"I would like it to be thought that I had listened carefully to what patients and others have told me, that I've tried to imagine what it was like for them, and that I tried to convey this. And to use a biblical term, the feeling, 'he bore witness.'"

In his later years, Dr. Sacks reflected deeply on aging, mortality, and the meaning of life, concerns he explored in his final works, *Gratitude* and his final published essay, "Sabbath." His writings emphasized the importance of aligning medical care with individual values and preserving dignity in the face of decline. Rather than distancing science from the human experience, Sacks demonstrated how the two can be integrated. His legacy continues to influence the fields of medicine, psychotherapy, and public discourse on aging by modeling a compassionate, reflective, and person-centered approach to care.

Many women outlive their male partners and face aging in female-dominated social groups. These communities often offer rich opportunities for emotional support, shared experiences, and mutual caregiving—whether through gardening clubs, museum outings, family gatherings, or lunch dates with friends. Women, on average, maintain more robust social networks into old age and often report greater satisfaction in relational life compared to men.

From a neurobiological perspective, research on brain connectomes suggests that female brains tend to integrate emotional, cognitive, and social information more fluidly, supporting adaptive responses across varied life contexts (Ingalhalikar et al., 2014). In contrast, male brain networks tend to be more modular and task-focused, which may partly explain the steeper decline some men face post-retirement or in the absence of clearly defined roles. Therapists can help older clients (especially men) anticipate and adapt to these transitions and support older women in leveraging the strengths of their social ecosystems while also encouraging autonomy, growth, and continued purpose.

Many older adults also transition to assisted living or long-term care communities. The impact of this transition often depends on the individual's prior mindset and life experience. Those who enter these environments with a sense of agency and openness often continue to thrive, forming new friendships, participating in structured activities, and maintaining cognitive vitality. Others, however, may experience a passive shift into the role of "patient," becoming more dependent and disengaged.

One compelling lens into the emotional and existential dimensions of assisted living comes from Howard F. Stein, a psychoanalytically informed medical anthropologist and poet. Now residing in an assisted living facility, Stein has composed a series of poignant poems that bear witness to the textures of daily life—from institutional meals to glimpses of autumn leaves through lobby windows. His collection, *The Quiet Resistance*, chronicles not despair, but defiant presence. In "Patch of Autumn Red," Stein writes of taking pleasure in a mere sliver of fall foliage, "an accidental act of defiance." His work stands as a quiet counter-narrative to cultural scripts that equate assisted living with resignation. Through poetry, Stein affirms that dignity, creativity, and reflection can persist, even within institutional walls. The full poem, "Patch of Autumn Red," appears in the appendix [page 21] as a literary witness to these themes.

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Therapists can support clients in navigating this transition by reinforcing identity, encouraging meaningful participation, and helping them preserve a sense of dignity, choice, and purpose in their daily lives.

Social Fragmentation, Loneliness, Echo Chambers, and the Illusion of Support

In today's polarized world, the need for belonging can drive older adults into ideologically charged "support" spaces that reinforce despair or fear. Chronic exposure to such narratives may increase rumination and stress. Neuroimaging studies show that group conformity activates brain reward circuits, even when contradicting personal beliefs (Campbell-Meiklejohn et al., 2010).

At the same time, many older adults suffer from profound loneliness and social isolation—factors that have been linked to increased risk for depression, cognitive decline, and even premature death (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020). Loneliness has been shown to activate stress-related neural circuits and increase inflammatory markers, creating a neurobiological cascade that can worsen both emotional and physical health.

Therapists should validate clients' feelings while encouraging engagement beyond echo chambers. This includes structured social environments that promote reciprocal connection, creative collaboration, and shared meaning-making—spaces that offer genuine support without reinforcing polarization or hopelessness.

The COVID-19 pandemic made the devastating consequences of social isolation painfully visible in older adults. Restrictions in long-term care facilities meant that many residents died without the presence of loved ones. The absence of physical touch and human contact during the final days of life not only compounded emotional suffering but likely had physiological impacts as well, given the well-documented relationship between stress, immune function, and inflammation. These tragedies underscore the critical role of social connection in both quality of life and neurobiological resilience.

Emotional Manipulation and Financial Scams: Recognizing the Hidden Triggers

As older adults face social isolation and cognitive decline, they become prime targets for scams, ranging from fake IRS calls and romance fraud to online phishing and "grandparent" emergencies. These schemes exploit not only diminished executive functioning but also the emotional hunger for connection, reassurance, or control.

A common tactic in the "grandparent scam" involves invoking urgent emotional scenarios, such as a grandchild in danger or jail, and deliberately bypassing parents to confer a false sense of special responsibility and agency on the grandparent. Similarly, romance scams often exploit older adults' hope for love and companionship, offering narratives of new beginnings and shared futures. Investment scams, meanwhile, often appeal to an older adult's wish for independence and security, especially for those living on fixed incomes or retirement savings. These scams may promise lucrative returns or exclusive opportunities, preying on fears of outliving one's resources or becoming a burden.

Neuropsychological studies have shown that aging brains often exhibit reduced activation in areas responsible for risk evaluation, particularly the prefrontal cortex, increasing susceptibility to deception (Spreng et al., 2016). Moreover, scammers deliberately use emotional manipulation to bypass logical thinking and trigger stress responses and urgency.

Clinicians can play a preventive role by helping clients build digital literacy, recognize red flags, and reduce isolation. AARP and the FBI both maintain resources to help educate and protect older adults. Therapists should routinely assess for signs of exploitation—financial, emotional, or otherwise—as part of holistic care.

Rethinking the Pill Paradigm: Aging Beyond the Biomedical Model

Mainstream aging often emphasizes symptom management through pharmaceuticals and surgeries. While some medical interventions are necessary and life-extending, there is a growing tendency to seek quick fixes, especially for pain, fatigue, or existential discomfort, through invasive procedures or multiple medications. Older adults may undergo surgeries that offer little long-term benefit or even result in complications such as delirium, cognitive

> “Neurons that fire together, wire together… Engaging in pleasurable activities can reinforce emotional well-being. [They] stimulate the brain’s reward system, supporting motivation and vitality. This is a buffer against becoming the stereotypical “grumpy old man or woman” and instead fosters emotional flexibility and joy in aging.”

decline, or loss of independence. Chronic polypharmacy, too, increases the risk of adverse drug interactions and impaired mental functioning (Maher et al., 2014).

This biomedical approach frequently overlooks the inner life of patients. Physical symptoms may mask psychological or existential distress that remains unaddressed. Depression, for instance, heightens risk for both dementia and cardiovascular disease (Ownby et al., 2006). Meanwhile, a growing body of research in placebo studies reveals how the brain’s belief systems can initiate real physiological improvements. The placebo effect, long dismissed as incidental, is now seen as evidence of the mind’s power to influence outcomes, particularly in pain management and chronic conditions (Benedetti, 2008).

Notably, placebo-controlled trials in surgical contexts have demonstrated that many common procedures provide little benefit beyond what could be achieved through expectation and belief. The ASPIRE guidelines (Beard et al., 2020) emphasize that placebo effects in surgery can be substantial and ethically justify the inclusion of placebo arms in trials where surgical efficacy is uncertain.

A compelling case is that of Dr. John Sarno, who treated at RUSK/NYU thousands of patients with chronic back pain through a psychosomatic lens. His theory of Tension Myoneural Syndrome (TMS) posited that emotional repression contributed to physical pain. By helping patients confront unconscious emotional conflicts rather than undergoing surgeries, Sarno reported significant improvements. Although not widely accepted in mainstream medicine, his work underscores the power of narrative, emotional processing, and belief in healing.

Clinicians can offer a deeper, integrative approach that considers how illness reshapes identity and meaning. Encouraging patients to explore their suffering in relational, symbolic, and neurobiological terms allows for more comprehensive healing and often avoids unnecessary medicalization of the aging process—restoring the human story behind the symptom.

What the Longest-Lived People Share

Studies of centenarians reveal common traits: strong social ties, physical activity, plant-rich diets, spiritual or religious engagement, and a sense of purpose (Buettner, 2012). Physiological resilience, the body’s ability to recover from stress, is a more accurate predictor of longevity than age itself (Pyrkov et al., 2021).

From a neurobiological perspective, the neurobiological phenomenon “use it or lose it” reflects the reality that cognitive and emotional engagement help preserve neural function. When individuals cease learning, pursuing hobbies, or engaging in meaningful conversations, brain circuits may weaken or atrophy, accelerating decline. Conversely, when people maintain active mental lives, they reinforce synaptic strength and adaptability.

Longitudinal twin studies have further shown that even among individuals with genetic predispositions for Alzheimer’s disease, those who pursued higher levels of education, such as an additional four years of college, developed symptoms of dementia nearly a decade later than their genetically identical counterparts who did not engage in similar learning activities (Gatz et al., 2006). This underscores how environmental enrichment and continued intellectual engagement can buffer against genetic risk.

Another key mechanism, “neurons that fire together, wire together,” demonstrates how engaging in pleasurable activities can reinforce emotional well-being. Enjoyable practices stimulate the brain’s reward system, supporting motivation and vitality. This is a buffer against becoming the stereotypical “grumpy old man or woman” and instead fosters emotional flexibility and joy in aging.

Women tend to live longer, often due to hormonal, behavioral, and relational factors. However, men may experience steeper declines if they are unprepared for retirement or dependency. Therapeutic work should address these gendered patterns and support both men and women in building new adaptive frameworks.

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CLINICAL GUIDELINES: SUPPORTING AGILITY AND DEPTH

1. Honor Mortality

Invite reflection on legacy, grief, and unfinished tasks. Encourage conversations about meaning, not only at the end of life but throughout the aging process, to help patients face existential fears with agency rather than avoidance.

2. Foster Purpose and Engagement

Encourage volunteering, mentoring, and new learning. Purposeful activity supports identity continuity and stimulates neural engagement, counteracting both apathy and social withdrawal.

3. Teach Neuroplasticity Practices

Recommend journaling, mindfulness, and cognitive training. These activities reinforce adaptive neural pathways and can improve emotional regulation, memory, and executive functioning over time.

4. Challenge Echo Chambers

Validate group support while promoting individual perspective. Support clients in finding spaces for connection that also allow for cognitive flexibility and constructive discourse, rather than reinforcing grievance or despair.

5. Support Physical Vitality

Encourage movement, nutrition, and sleep as foundations for cognitive and emotional resilience. Regular physical activity—whether walking, dancing, gardening, or gentle yoga—supports hippocampal function, enhances neurogenesis, and reduces inflammation. Nutritional interventions, such as Mediterranean or plant-forward diets, have been linked to improved cognitive outcomes and reduced risk of neurodegenerative disease. Sleep hygiene is equally essential: even mild sleep deprivation can impair memory consolidation and executive functioning. Therapists can reinforce these self-care practices not just as medical advice, but as acts of agency that strengthen mind-body integration and support autonomy in the aging process.

6. Embrace Integrative Care

Advocate for a holistic view that bridges physical, emotional, and cognitive health. Collaborate with other providers when possible and explore how psychosomatic factors may underlie or exacerbate physical symptoms.

CONCLUSION: A REFLECTIVE AGING

Aging well means more than avoiding illness; it means cultivating meaning, curiosity, and connection in the face of loss.

The aging brain, though vulnerable, retains a remarkable capacity for change. Our clinical work can help patients harness this capacity—not just to survive, but to flourish. As therapists, we do not merely accompany decline; we help author new chapters of transformation.

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A Poetic Witness to Aging

The following poem by Howard F. Stein, medical anthropologist and poet, offers a personal and lyrical reflection on institutional aging. Composed during his residence in an assisted living facility, it embodies the quiet resistance, emotional subtlety, and retained personhood that this article seeks to explore. Included here with permission, the poem serves as a literary lens into the inner world of late-life transitions.

Patch of Autumn Red

By Howard F. Stein

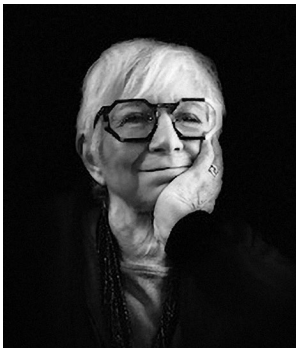
As I sat in the back
Of the spacious lobby
Of my old folks' home,
I saw through the front window
A patch of red leaves
On an otherwise green tree.
A surge of thrill drew me
To walk outdoors towards
This curious, welcome sight.
Except for this
Mysterious red splotch,
The three landscaped,
Manicured trees along
The entrance of the
Old folks' home,
Behaved as if summer
Still reigned here, though
The time in Oklahoma
Was late November.
The building complex sat
Far from tree-lined neighborhoods,
City parks, and still-wild swaths
Of trees, bushes, and grasses
That trumpeted the oranges,
Yellows, browns, and
Occasional reds of autumn.
Except for cool, brisk air
And early sunset,
I would not have known
The season had changed.

Only car outings
To doctors' offices
And a few visits
To my son's home
Provided me a link
To the crazy quilt city
And the earthy world
Of Oklahoma red dirt
I had known before
A rupture in my life
Brought me here.
For my family,
My kinship with the world
Carried far less freight
Than my supposed
Safety and health.
My protests futile,
I dwell where old people
In the way are placed –
So our kinfolk can now
Thrive by our absence.
Am I content with
This mere tincture of fall
In a red patch of leaves
Outside the lobby window?
No . . . but I take pleasure
In this accidental act
Of defiance of those
Who would deny me
The slightest glimpse
Of autumn at all.

On Treating an Aging Patient

When Loss is the Leitmotif

By Lois Nachamie, MFA, LCSW-R



Lois Nachamie, MFA, LCSW-R, is a retired board-certified diplomate and certified end-of-life counselor who practiced for some 30 years in Manhattan. On a humble-brag note, she was fortunate to have treated teachers, couples, and many whose face recognition and wealth presented them with a special set of difficulties. The author of seven books, four of which are on parenting, she was a senior staff member of the 92nd Street Y Parenting Center, the director of Parenting from the Heart, and the So Glad We Waited Network at Claremont Preschool. She is adjusting, in a manner of speaking, to retirement in Wilmington, Delaware.

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The author requests the reader's indulgence for the personal rather than academic tone of this article.

Dealing with loss is the major presenting problem of patients over 70 who are seeking therapy. They may be facing the loss of:

- Physical efficacy
- Mental acumen
- Position or stature in the world
- Purpose
- Friends, family, spouses.

External conditions that affect many patients, with perhaps more intense ramifications for seniors, include:

- Unsettling political instability
- Financial insecurity
- A broken healthcare system.

Physical efficacy

Diminishing physical prowess contributes mightily to mood for older patients. This writer's experience is a case in point. When my cohort turned 70, my friends—from kindergarten, through graduate school, to the present day—started emailing one another about the sudden, alarming changes to their bodies. Whether they are dedicated marathon runners, or committed couch potatoes, they all felt dismayed. It was as if the warranty on the machine that houses the soul had run out.

Canes, walkers, and sometimes wheelchairs have entered their lives. Getting in and out of chairs, buses, cars, and taxis is regularly grueling and frustrating. Fighting with packaging is a daily struggle. Getting up from the toilet presents a hurdle at home, or in other people's homes, and squatting in public restrooms is attended by fears of falling.

Some seniors have trouble getting in and out of bed. Enter those hospital beds that can be raised and lowered but seem to transform a once-beautiful bedrooms into an infirmary.

Cutting toenails, putting on and tying shoes, pulling on pants—all involve struggles. Constantly grappling with the most mundane tasks is depressing, enraging, or both depending on the temperament of the individual.

A surprising positive change for seniors who have been severely myopic their entire lives is that their vision may improve. The downside is the expense of new lenses.

Hair may disappear from where it's supposed to be, only to show up in unwanted places. This may contribute to a negative sense of self for both men and women.

Mental acuity

The loss of mental acuity is disturbing and depressing or enraging, or both. Notwithstanding the plethora of T-shirts with funny sayings *(Can't remember s...; Where's my phone?)*, the incessant reality of life for seniors is that it's difficult.

In one's twenties, *What am I doing here?* is an existential question. In the later years, it is a question often muttered to oneself, meaning, *What am I doing in this room? Why did I come here?*

At social gatherings, seniors may stand around smiling inanely when they can't follow the conversation because of mild hearing loss. Seriously impaired hearing can contribute to mental fog and dementia.

The inability to remember the name of someone one has known for decades can be mortifying. Nora Ephron captured that experience in her book, *I Remember Nothing*.

Position or stature in the world, and purpose

If patients are still working, they undoubtedly face ageism on the job. Younger colleagues think they don't understand the world, and they might be right. Work ethics and behaviors have changed since they entered the workforce. Common workplace jargon is just this side of gibberish to those in their seventies and up.

Speaking of up, the "uptalk" of younger employees can be baffling to older people, just as their speech patterns can seem oddly antiquated to the young.

Retired patients may face an entirely different array of issues and losses. Their position in the world is no longer defined by work, and they may experience a diminished lack of purpose. With retirement comes the lack of a daily schedule, the lack of colleagues, even the lack of a reason to groom or dress well.

Friends, family, spouses

The loss of friends and family takes a great toll on our older patients. They receive the grim news often, whether by phone, emails, listservs of high school and college friends, and social media such as Facebook.

Our patients are facing their own deaths as well, or the death of a spouse or partner due to illness.

A broken healthcare system

While waiting in line to enter a medical facility, a woman "of a certain age" quipped, "I've made so many new friends lately! And all of them are doctors!"

Seniors must deal with our broken healthcare system when they are most in need of medical care and most vulnerable. They spend inordinate amounts of time getting to and from appointments and waiting to be called. They are presented with countless administrative tasks, such as online check-ins that give error messages, reject passwords, or insist that birth dates are wrong. For the "technologically challenged," the many online forms to fill out becomes mind-numbing and frustrating, further contributing to a diminished sense of self.

Unexpected medical bills that insurance companies decline to pay affect the young and old alike, but they are very onerous for senior patients. Some face financial insecurity, which exacerbates the distress caused by the "deny, defend, and depose" stance of many insurance companies. They do not have extra money to throw at a problem, such as taking a cab instead of a bus, or waiting interminably for Access-a-Ride; or buying a new, more comfortable chair to ease chronic pain. In the current political climate, threats to Social Security, Medicare, and Medicaid are particularly stressing for seniors in financial straits.

Treatment

As therapists, we are successful when we help patients identify the historical and present-day sources of distress, including behaviors that have had negative effects on their lives. We help them incorporate new, healthy strategies so that they can go on to cut a positive swath through the world in the years ahead.

But being elderly, or a senior—whatever term we use—means having fewer years ahead. And at this stage, loss is the leitmotif. Therefore, therapists need specialized tools in their toolboxes for seniors. They include:

- The therapeutic alliance
- Medication assessment
- Lifestyle choices
- Coping strategies
- Resolving any lingering negative relationships with family and friends
- Encouraging social engagement, including old and new friends, and family
- Life review, including successes and regrets
- Facing death, including making sure all end-of-life arrangements are complete
- Incorporating humor

The therapeutic alliance is essential. More than anything, the patient simply needs to be heard. Age is not "only how you feel" (an annoying falsehood perpetrated by those who have not yet grown old). Age is a mathematical reality, measured not in our minds but on the calendar. Aging is accompanied by scientifically documented diminishing abilities.

Medication assessment. Therapists should resist the understandable impulse to medicate unless the patient has a history of biological depression and has found antidepressants helpful. For patients who are depressed without a biological cause, antidepressants have the potential to exacerbate mental fog and engender lethargy, both of which contribute even more to the presenting distress.

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Lifestyle choices. It is well-documented that healthy eating, including limiting refined foods and sugar, and curtailing or stopping alcohol and marijuana consumption, will promote sharper minds. Furthermore, exercise and healthy sleep habits promote a more salubrious experience.

When treating younger patients, healthy lifestyle choices are often a part of the person's willingness to address issues and improve their lives.

However, there is cognitive dissonance for many seniors when presented with obviously sound advice. Seniors dealing with chronic pain, anxiety, loneliness, and despair often turn to alcohol and pot for symptom relief. Many seniors with sleep problems use gummies because prescribed sleep medications are either addictive or contribute to "senior fog." In addition, many seniors feel that: *At this point in life, I'll eat anything I damn well please!*

> "If your patient is amenable to healthy changes, excellent. If not, the therapeutic alliance should be preserved. Undue pressure when they are unable to change their habits can make seniors feel worse about themselves."

If your patient is amenable to healthy changes, excellent. If not, the therapeutic alliance should be preserved. Undue pressure when they are unable to change their habits can make seniors feel worse about themselves.

Although exercise is clearly called for to improve the life experience, it presents the extra challenges for seniors of overcoming pain, mobility issues, and lethargy. A referral from a general practitioner for physical therapy, which Medicare should cover, will help. Having an appointment with a competent PT enables the patient to overcome lethargy, as well as providing a social experience.

Coping strategies

Breathing exercises have proven to be efficacious in allaying anxiety, particularly first thing in the morning. Navy Seal box breathing and Huberman Lab breath-work (cyclic sighing) are both useful. Meditation is extremely useful in counteracting anxiety and despair. A plethora of links can be found online, including YouTube's guided imagery.

Life review, including successes and regrets

We know that the concept of life review is therapeutic. Sharing successes and regrets can be a comfort for a senior whose friends, family, spouse or partner are familiar with the events and might not want to hear the same stories again.

Resolving any lingering negative relationships with family and friends

Help your patients identify any lingering negative relationships that affect their lives. Encourage them to go into detail (who wronged whom?). Once it is off their chests, you can begin to help them repair.

The old curmudgeon, grouchy and impatient with people, is a well-known figure in popular culture. Feeling ill, misunderstood, or forgotten may be at the root of this personality change.

In the popular media, seniors are encouraged to keep up with their friends. Sadly, for many this becomes difficult. Seniors can often misinterpret the comments or actions of a friend. Without a reality check, the misunderstanding can grow into an irreconcilable rift. Once again, we are looking at a painful loss.

Patients can be helped to repair their family relationships. If they have children who are parents, help them refrain from criticizing their children's parenting styles. Insightful patients may be able to reflect on their own parenting missteps, which would go a long way toward healing any rifts with their adult children. Encourage them to spend time with grandchildren as much as possible. If there is a geographical distance, help them deal with that loss.

Volunteering

For some seniors, volunteering is very therapeutic. For others, time commitments and travel make volunteering a burden rather than an enrichment.

Taking classes

If your patient is interested, taking classes can enrich their lives. Osher Lifelong Learning Institutes (OLLI) are in all 50 states and free of charge. Seniors are also eligible for free classes in most state colleges and universities. OLLI is often a more comfortable fit, as it is comprised of seniors. Besides learning new things, OLLI provides a place to make new friends.

Facing death

Seniors face a more imminent death—whether consciously or not—than younger patients. Some will enter therapy longing to discuss the inevitable. Others are in denial.

As professionals, we cannot espouse religious values per se. We do have an obligation to aid our patients in embracing their own beliefs. A practical way to open the dialogue, and a very essential issue to address, is end-of-life planning.

Help your patient make sure that all legal documents are complete, including powers of attorney, health care proxies, and other advanced directives.

Ultimately, your patient is seeking comfort—not solutions—to an insolvable, inevitable event in the life cycle.

On a final note, do not underestimate the power of laughter and fun. Having pets, or petting animals, and laughing with children, even with strangers—all make the day feel better, which is what your patient is seeking.

As an example, I offer a personal vignette that took place when I was writing this piece.

I was taking the M5 bus from 57th Street heading north, a beautiful ride from midtown along Riverside Drive. The bus stopped at 66th and Broadway, the Lincoln Center stop, and a glamorous woman boarded. Tall, elegant, and stunningly dressed, the stately bearing of this African American lady suggested she had been on the stage or screen in her younger years.

She stepped up, tapped the farebox, and announced, "Grandma's here! I'm 94!" Then she took a seat across from me and we began chatting, the usual getting old is not for sissies conversation.

And then she began, and I readily joined in, a rousing, full-throated rendition of, "When You're Smiling, The Whole World Smiles with You."

I'd like to report that the other passengers broke into applause. They did not. But they were all grinning broadly. A toddler in a stroller was very interested.

I share this story for several reasons. One, it was just so much fun. But more to the point, it encompasses the positive aspects of aging. Finally, you are not concerned anymore about what others think. You can seize pleasure when it comes your way, enjoying as many moments as you have left. You can engage with others, savoring life. Ultimately, this is the best antidote to depression and despair.

There are many strategies to help your senior patients experience the final stages of life fully and with joy, notwithstanding the incessant reminders of the evanescence of life.

A THERAPIST'S GIFTS

I listen
enter her world
hear stories
fears hopes
the honor of being
trusted
lessons learned

Her question
What will happen
when
I'm older
alone
no partner
no money
her today
dreads
her tomorrows

A year later
the obituary
a heart attack
her worries
thieves that robbed her
days

At twelve
I lived in small now
moments
older was sixteen
Old
was far
far
away

Now
I greet gifts
lessons
learned

BE HERE NOW

—Cynthia Muenz, LCSW
March 27, 2025

Aging Along with Adam

By Barbara Willinger, LCSW, BCD

Barbara Willinger, LCSW, BCD, is an institute trained practicing psychoanalytic psychotherapist in Manhattan with more than 35 years of experience. Her individual virtual practice includes patients ranging in age from their twenties to their eighties who present with interpersonal difficulties, anxiety, depression, as well as aging issues.

Barbara was the lead author of a book dealing with social work experiences during the AIDS crisis. Additional publications focused on "Psychopharmacology and Clinical Social Work;" "Psychosocial Interventions with HIV Clients with Co-Occurring Mental and Substance Use Disorders;" and "Modified Group Psychotherapy with Renal Dialysis Patients." An active member of the NYSSCSW Manhattan (Met) Chapter, in the past she served as Chair of the Referral Committee.

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Little did I know when Adam walked through my door that, 34 years later, our therapeutic relationship would still be strong. We have aged together—both of us are now senior citizens. While maintaining my analytic frame, we now have a real relationship.

But Adam's trajectory has taken a downward turn from a functioning adult to a dependent, compromised adult/child. As a therapist, I have assumed varying roles over the years: psychoanalytic psychotherapist, advocate, teacher, and facilitator with agencies. The course of therapy with Adam has been both similar to and unexpectedly very different from my work with other patients.

Adam was 37 years old when he was referred by his primary physician who could no longer provide the emotional support and connection he required. Adam described his presenting problem as "anxiety and depression," but it soon became evident that he also suffered from OCD and a pervasive developmental disability or autism spectrum disorder, as we know it today.

Adam was an only child, gainfully employed and still residing with his parents. His mother was the dominant parent who remained a toxic force throughout his life and kept him dependent: dinners were eaten out together; she signed all his checks; they traveled together, always sharing a room; and she purchased his clothing. While I was unable to form a satisfactory diagnosis of her, her painful verbalizations to Adam indicated a lack of appropriate boundaries and disinhibition.

His father owned a neighborhood store and amassed a substantial income, allowing him to provide financial support for Adam. However, his father was extremely passive, schizoid and unable to protect Adam from his mother's frequent verbal abuse, leading to Adam's humiliation and shame.

Despite the negative introject of his mother, Adam had a small group of acquaintances, who were similar to him and with whom he would infrequently socialize. At the time he began treatment, his life revolved around his employment as a mail clerk for a city agency, his meals with mother, and retreating to his bed, where he repeatedly watched John Travolta videos or early 1950s shows.

In the early stages of treatment, I suggested that Adam prepare and sign his payments to me. His ability to do this convinced me that his usual response of "I don't know" was perhaps a compromise in order to remain attached to his mother and a defense against his suppressed rage but, at the same time, a response to a wish for separation.

During his forties and fifties, treatment focused on understanding his obsessive thoughts which portrayed him as subject to his mother's unrealistic and competitive expectations as well as her profound toxic disappointment. To her he was a failure: "For this I almost died giving birth?" Therapy provided space for his

feelings to be acknowledged and validated, juxtaposed to challenging his delusions and obsessions. My referral to and collaboration with a psychiatrist, who prescribed several different psychotropic medications over the years, helped soften the negative impact of the delusions which resulted in broadening Adam's life.

He began taking weekly group dance lessons, which not only complemented his fantasy identification with Travolta but provided an opportunity for appropriate touch, sorely lacking from his parents. He also developed an anniversary ritual of subscribing to philharmonic concerts to self-soothe the anxiety and negative introject of his delusions of failure which intensified during a specific four-month period.

As Adam entered his sixties, his mother decompensated, perhaps triggered by the death of her husband a year earlier. Her increasing verbal abuse along with physical violence toward Adam resulted in police intervention and her subsequent admission to an in-patient psychiatric unit. Her transfer to an Alzheimer nursing unit culminated in her death about a year later.

During this period, Adam continued to reside alone and for the first time made his own decisions. While his needs were technically being managed by others, including meals and laundry, he initiated these and other activities, even learning to minimally understand his checkbook and spending habits.

Despite this, his cognitive and linguistic limitations remained an ongoing focus in treatment. It was difficult for him to understand why his intense, constant staring at women induced uneasiness and fear in them. It led to him being barred from some restaurants and stores and, finally, to harassment charges filed against him at work. Ultimately, I interceded with his employer and convinced them to allow Adam to retire rather than be fired.

It was during this time that I became increasingly aware that, given the absence of family, I was the only person with a close relationship to Adam. Acquaintances and his financial guardian were his only other contacts. While he was still functioning and caring for himself adequately, we began discussions about moving to an independent living facility which would provide socialization opportunities. He agreed to the idea and the transition went smoothly.

For a few years, Adam remained stable with the addition of a senior group exercise program, his dancing, and concerts. I still viewed myself as his therapist, continuing twice weekly sessions, and processing interpersonal interactions, including the confusion he felt when others distanced themselves from him. I was hoping that our relationship would remain as it was indefinitely.

But life threw us a curveball when Adam's residence announced it would be closing soon. But when? And where was he to go? We immediately began a search for another independent living facility. A date was established for his transfer, which helped Adam remain calm in light of the unknown date of closure.

Life, however, threw its biggest challenge at us—Covid—and brought with it a turning point in Adam's life. The loss of structure in his life during the lockdown, including contact with me other than by phone, resulted over time in ER visits for suicidal ideation. However, Adam was never admitted to the hospital. Without an active plan, he was not considered to be at immediate risk of suicide.

"…I became increasingly aware that, given the absence of family, I was the only person with a close relationship to Adam. Acquaintances and his financial guardian were his only other contacts."

As the ER visits increased I began to wonder if, unconsciously, Adam wanted to be admitted. He had always described his hospital admission as a teenager in positive terms; he had received good food and kind attention. What for many could have been experienced as negative or fearful, Adam saw as only positive given the toxic relationship with his mother.

At the same time, the intersection of isolation, anxiety, and uncertainty seemed to trigger the beginning of a regression to an early child state. Despite my frequent attempts to help the residence staff understand Adam's need for contact, they eventually insisted that I hire a twelve-hour aide for him. Unfortunately, by the time the Covid lockdown was rescinded, and the new residence was able to admit Adam, he was no longer able to meet their admission criteria. My only option was a nursing home.

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I found myself angry and sad that neither he nor I had any control over this outcome. The Covid pandemic and his early traumas had robbed him of his fragile but manageable functioning in the world. A nursing home offered safety and structure. However, the reality of a nursing home, as many know, is that it can be a warehouse for the dependent person.

Adam regressed further in the months that followed his admission to nursing home, despite my intense and frequent advocacy and collaboration with staff. His ambulation mimicked a toddler learning to walk, toileting accidents began, obstinacy and anger became evident, and his uncontrollable touching and angrily holding onto me and others increased. At the same time, when not agitated, his memory remained intact and limited conversations ensued. They often vacillated between my verbalizing his sadness or anger along with providing hope that, with stability, he might be able to live in an independent living facility.

Between my weekly visits with Adam, several brief psychiatric admissions, and adjustments to his medications, over time some stability returned. I then arranged an interview at an independent living facility and escorted Adam to it.

That day, he enacted the struggle between his wish to please me versus his need to remain in a regressive state. He left the nursing home walking like a toddler, but upon arrival he began walking upright, and appropriately answered the intake questions. It was an Adam I had not seen for some time and for whom I felt hopeful.

However, upon returning to the nursing home he immediately resumed his previous behaviors. In less than two days, his agitation was overwhelming, and he was admitted to an in-patient psychiatry unit. I saw, then, that pre-Covid Adam was lost, his ego too fragile to withstand any transitions, and that the nursing home would be his final home.

What unfolded, and continues to surprise and delight me, is Adam's vacillation and struggle between self-assertion and dependency. His familiar responses of "I don't know" or "I can't" often belie his ability to do more than he admits he can. For example, with encouragement he manages to put on his shoes as well as walk unassisted. His verbalizations of "I don't know" are sometimes mitigated by my giving him permission to make a mistake, and then we are able to have conversations.

As for me, I continue to provide constancy through my therapeutic responses, advocacy, and weekly visits when I bring the cookies he requests. For the most part, I have symbolically become the "good breast," positively feeding and holding his sadness and anger respectfully and non-critically. I continue to voice an empathic understanding of his current behaviors as they relate to his early childhood.

> "I remain saddened by this man/child whose life enjoyment seems to be waning . . . But until life throws us another curve and I can no longer visit Adam weekly, I am committed to being his therapist, one who accepts and can hold his struggle."

I recognize the coincidence that Adam is living in a nursing home, as his mother did at the end of her life. Does this have some unconscious meaning for him? On the other hand, recently and for the first time since beginning treatment, Adam voiced his acknowledgment of his mother's toxicity. And, while never being able to say "no" to her directly, he can do so with me. Perhaps in his senior years, our therapeutic work is helping him make some repairs to the traumas of his childhood.

As I write this, I continue to vacillate and struggle with this outcome and remain saddened by this man/child whose life enjoyment seems to be waning. Increasingly, in my presence his activities revolve around food and bed. He eats cookies in bed while lying in a fetal position, rarely wanting TV, radio, or his John Travolta books. He is the perpetual toddler struggling with his internalized introjects.

But until life throws us another curve and I can no longer visit Adam weekly, I am committed to being his therapist, one who accepts and can hold his struggle.

Clinical Work with Older Adults

By Karen Kaufman, Ph.D., LCSW

Karen Kaufman, Ph.D., LCSW has been in private practice since 1986 when she completed psychoanalytic training. She taught at Fordham University GSSS/Westchester Division in the advanced year for 16 years. She is the immediate past president of the NYSSCSW, past president of the Met Chapter, and held various board positions in the Westchester Chapter prior to moving to Met. She remains actively involved with the Society, now co-chairing the Mentorship Committee with Lena Zairis, LCSW and is on the board of the ACE Foundation.

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As a young therapist building a private practice in the late 1980s, I joined the Medicare provider panel, having enjoyed working with some older adults in my postgraduate training. In addition, I considered this to be a public service given the high incidence of depression and isolation in the older population.

In retrospect, I recognized my narrow and somewhat ageist outlook, since I expected that much of the work with this population would be supportive rather than introspective and psychodynamic. I also questioned how it would enhance the deepening of my clinical practice. However, the patients I worked with were not at all like the disabled and homebound elderly people I made home visits to in my first social work school internship. They were working successfully in the creative arts, teaching, traveling, enjoying the cultural life of New York City, and actively engaged in maintaining their physical health. For many, it was the combination of stable health, finances, and the extent of their support systems that determined how their lives were led.

As my work with older adults unfolded, along with some incidence of depression and isolation, I encountered profound early experiences of loss, realistic fears regarding the aging process, hypochondria with ramifications in medical care obsessively sought or avoided, untreated personality disorders, substance abuse, extreme religious beliefs that prevented self-reflection, later-life crises with great impulsivity, and sexual addiction.

Transference with older adults is an interesting experience, especially when there is a greater age gap with a younger therapist, with significant changes as the gap narrows. They may think of the young therapist as a grown child or grandchild, and then as a peer, but the parental and caretaking role is also assigned to the therapist, even if it is denied or minimized. This topic deserves more attention but is beyond the scope of this article.

Many patients I worked with started therapy in their sixties and seventies, some approaching therapy for the first time with deeply disturbing, unresolved matters. Some still had the chance of resolution with those involved but, in other cases, the significant people in their lives were long out of contact or deceased. These situations included an unwanted teenage pregnancy because of the parents' opposition to abortion; unresolved marital, family, and career issues; and long-standing eating disorders. Among the personality disorders of some patients were varying degrees of narcissism regarding how their lives "should have" unfolded; others presented with borderline qualities: extreme rigidity and extremes in thinking that precluded demonstrable growth or progress.

My "public service" evolved in a very rich and meaningful way for the patients and for me. The work did not differ greatly from clinical practice with younger adults, although the pressure of limited time as they neared the end of their lives was often felt. In the clinical examples that follow, names and identifying information have been changed for privacy.

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Davida

Davida, a 72-year-old divorced, White woman, was referred by another patient, a colleague of hers in a creative arts field. She asked her first question the moment she sat down in my office: "Is it too late?" After informing her of the benefits of therapy that she would retain in the years to come, we embarked on a nine-year relationship. Davida's given name was actually a male name with a creative spelling. It was obvious that her parents never considered the possibility that the baby they expected could be a girl.

Her father was employed by the State Department; her mother was a lawyer who worked on international cases. They lived in several European countries during Davida's adolescence. An only child, she was a bright youngster who became multi-lingual.

When they resided in Ireland for several years, her mother often pointed out the former convent laundries that served as homes for unwed pregnant girls sent from their homes in disgrace. [It later came to light that the nuns were not only abusing the girls but also selling and in some cases killing and burying the newborns on convent premises.]

This was her mother's method of teaching her daughter about sexuality and the prevention of unwanted pregnancy. However, nothing was done to protect Davida when she reported to her parents that, during their many house parties, some of the inebriated men were making advances and, on one occasion, had sexually abused her.

Davida started to be sexually active in her teens and became pregnant with her high school boyfriend. Her parents had the means and connections to help her terminate the pregnancy, but she was forced to leave school and carry the baby to term. Fortunately, she was not sent to one of the convent laundries. However, she never saw her newborn boy who was quickly whisked off for adoption, as she was told. For her parents, this method of handling the pregnancy was meant to teach her a lesson. The grief she felt had to be contained, and she rarely discussed the subject with anyone before our relationship.

Davida returned to the states for college, attending an Ivy League school, followed by graduate studies at a European college that is well known and respected for creative arts. She studied with colleagues who became world-renowned, but alcoholism interfered with her own professional progress.

In her late twenties, Davida married a British man, and they had two children. The marriage was troubled, and she later returned to the states with her children, residing in California before moving to New York to pursue her creative work and achieving some professional success.

At the time we met, Davida had been sober and active in AA for more than 20 years, but much damage had been done to her relationships with her children, one of whom was a substance abuser and estranged for several years. While this subject was extremely delicate, she came to understand that she had been unable to bond with him in infancy, having never resolved the feelings about the son she lost. She was able to explore in depth the temporary relief she found in alcohol despite her knowledge of the physical, emotional, and professional damage taking place.

After several years, she embarked on a journey to locate the son taken from her at birth who, at that time, would have been in his late fifties. She searched the internet, adoption databases, historical information about the Irish convents, and ancestry sites, maintaining the hope of meeting him. At long last, threads of information led to the adoptive family, but she discovered that her son had died not too long before she located them.. This caused an overwhelming level of grief related to the original trauma and her dashed hopes of meeting him. She desperately had wished for the opportunity to explain her teenage circumstances and lack of options, hoping for his understanding and forgiveness.

"At one point, we discussed writing to those she felt had harmed her, since she never before had permission to express her feelings. Her parents were long deceased, but her ex-husband was alive and remarried with a second family. The writing exercise proved to be a valuable outlet for her feelings, whether or not the letters or emails would ever be sent."

The work of healing was followed by a period when the long-simmering rage toward her parents overflowed. She described them as not knowing or seeing her. She was an appendage in their lives; they made no adjustments to accommodate a child. She was a lonely child who felt like an ornament, forced to be on the sidelines of their high society activities. It was during her parents' many parties that she started to sample alcohol.

At one point, we discussed writing to those she felt had harmed her, since she never before had permission to express her feelings. Her parents were long deceased, but

her ex-husband was alive and remarried with a second family. The writing exercise proved to be a valuable outlet for her feelings, whether or not the letters or emails would ever be sent. She wrote a deeply emotional letter to her parents which she read aloud to me in tears, causing me to choke up with emotion in the session.

At long last, in her late seventies Davida was expressing feelings that her parents never allowed and, later in life, were inhibited by her own adopted behavior of containment. While most of the letters were unsent, the exercise was liberating for her. She did send a letter to her ex-husband that helped open the door to more contact between him and their children.

In the following years, our work focused on repairing her relationship with her estranged son, along with allowing more meaningful experiences to enter her life. She enjoyed success in securing creative work, developed more of a social life as a result of feeling more trust in others, and she even attempted some online dating, with amusing results. I had become the idealized mother with whom she could express her feelings without fear of punishment or abandonment and with whom she felt safe and protected.

At approximately the eight and a half-year mark in our relationship, we started to discuss termination, which occurred some months later. She felt very grateful for all that she had accomplished in our work and more ease in her approach to various matters.

Approximately three years later, I received the news from her formerly estranged son, with whom she had succeeded at some reconciliation, that she had become ill and had died. I was deeply saddened by the news, but I knew that our work together brought her relief, understanding, and cohesion in the eighth decade of her life.

Martin

Martin, a 71-year-old White man who had retired from public service, was referred to me by the colleague who is treating his wife. Martin had impulsively left his reportedly happy marriage of more than 30 years after an encounter with a former high school girlfriend. They had not seen each other in more than 50 years, but he felt he had been in love with her since their youthful romance. However, he quickly realized his error in judgment after spending some time with her and hastily planning a move to the southern town where they grew up.

Martin was raised with three siblings in a household that, from his description, met his physical and educational needs but was devoid of feelings and connection. He typically refers to his parents as William and Louise, underscoring the distance he feels from them. His father had a civil service job and rose in his professional ranks; his mother was a homemaker who expected her children to do their school work and chores but provided little support or expression of feelings. However, her life lessons were valued as "practical."

Martin proudly described his rebellious nature as a teenager and young adult, particularly during the Vietnam war. He reported smoking marijuana and growing his hair long, attending protests, and volunteering for political activities that took him to Washington, DC. In retrospect, he saw the contradictions in his nature, describing his more "buttoned up" life after this period. He said his parents were surprisingly supportive of his activities; while they were conservative in their lifestyle, they were a proud Democratic family.

Martin attended an in-state university and graduate school and reports that he did not pursue money; rather, he wanted to contribute in some way to the betterment of the country. His interest in life in a larger city brought him to New York, where he worked in city government at the same professional level for most of his career. By his own description, he was not ambitious and did not consider his career to be a great success. He married in his late thirties and the couple did not have children. His wife has a successful professional career in the non-profit sector. She has postponed thoughts of retirement since Martin's recent crisis.

> "Life was going well until Martin received a message from Mary, his high school girlfriend… He described "sparks flying" when he saw her."

As a couple, they enjoy travel, sports, and cultural activities in the city. Life was going well until Martin received a message on social media from Mary, his high school girlfriend for several years. She had learned of his plan to visit his hometown through a former mutual friend. He described "sparks flying" when he saw Mary—he felt young and alive again. It was as if a volcano of suppressed emotion had erupted and overflowed.

Work with Martin is still in an early phase, and he is open to exploring his behavior, motives, and feelings. He approaches therapy with both intellectual and amused curiosity since his impulsivity was a shock to him and those who know him. He does not use his intellect defensively and, while he has some difficulty identifying his feelings, he does not avoid or shut down these discussions

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despite this being a new experience for him. He demonstrates appropriate affect and expresses some relief at the prospect of feeling more integrated and whole as a person.

Martin fully understood the risk he took in re-engaging with Mary, coming close to losing the life he had built with his wife. They are currently working on reconciliation, for which he is grateful. A prominent topic in our work has been mortality, which he feels was a great contributor to his impulsivity, since he was experiencing feelings last felt as a late teenager and young adult. He does not yet connect anything grossly lacking in his marriage that could have caused him to be more susceptible to Mary's attention.

In these and other examples, working with an older group of patients went well beyond my earlier limited expectations. The patients brought a lifetime of experiences and entered therapy at a time when they still maintained the hope of resolving long-standing conflicts, finding relief from years of pain, and achieving greater insight and understanding of the roles they played in their young lives, and how early experiences shaped them.

Although I ended my public service as a Medicare provider, I have still enjoyed referrals of older adults. I feel grateful for what they continue to teach me about resilience, hope, and the capacity for change at any life stage. I am often reminded of the MSW students I taught for many years, some of whom made declarations in class such as, "I couldn't work with that group," or that "type" of disorder or traumatic experience. At any stage of practice, we may be pleasantly surprised by our own and our patients' capacity for greater depth, self-awareness, and relief from the burdens carried for nearly a lifetime. I hope that I succeeded in teaching some students that lesson.

FIN FACTS

Orca Grandmothers Crucial to Grandkids' Survival

Studies of the Southern Resident orcas of the Pacific Northwest show that these female orcas, like humans, live beyond their reproductive years. A new study shows that not only do orca grandmothers exist, but they are crucial to their grandbabies' survival!

Orcas, also called killer whales, live in close-knit family units. Born into their mother's pod, they stay with her and her extended family for life. Studies revealed that the older females were living beyond their reproductive years, like human grandmothers. This is extremely rare in the animal kingdom; only three other species—all toothed whales—are known to experience menopause.

It is believed that orca grandmothers, unencumbered by their own children, can give their daughters' offspring the best chance at survival. This is known as the "grandmother effect."

One orca, known as Granny, was thought to be over 100 years old, but likely stopped having calves around the age of 40. Presumably, this gave her time to share inherited cultural and ecological knowledge with her pod—and likely the wider community—such as where and when to find Chinook salmon, in both times of plenty and time of scarcity.

Testing the "grandmother effect" was challenging, but researchers had decades of data on these orcas, collected since 1976. What they found is remarkable: The death of a Southern Resident orca grandmother significantly reduces the survival chances of her grandbabies; in fact, following her death, they are 4.5 times more likely to die.

This reflects the highly significant role these post-reproductive females play in calf raising, impacting survival both at the pod, and population level.

SOURCE: https://www.wildorca.org/the-grandmother-effect/

Aging? I Refuse!

By Mary Anne Cohen, LCSW

Mary Anne Cohen is director of The New York Center for Eating Disorders and author of three books on the treatment of eating disorders, which are available for CE credits. Visit her at www.EmotionalEating.Org to read the book introductions.

Ponce de Leon would have a good laugh if he could see us now. Ponce was looking for the Fountain of Youth but could never have imagined the measures we take to stop the hands of time: the tight face lifts, the puffer fish lips, the Brazilian Butt Lifts, breast implants, tummy tucks, and liposuction.

The menu of additional contemporary surgeries we can choose to "halt" the aging process is endless: trout and salmon sperm injections into the face in place of traditional fillers, "vampire facials"—a procedure that injects your own blood to rejuvenate your skin, and RibXcar, a procedure to reposition the 10th, 11th, and 12th ribs inward to create a more sculpted, pinched waistline.

"Regenerative aesthetics" also include labiaplasty—vaginal rejuvenation to achieve a "designer vagina"—which has shown a steady progression in popularity with about 12,000 surgeries performed annually in the U.S. And for the men, we have penis enhancement surgeries. Improving the aesthetics of aging genitals has become big business! 1

We read that Christie Brinkley, 71, is "ridiculously gorgeous" in her fiery bikini photos. Martha Stewart, 83, "defies age" in a sultry Instagram "thirst trap" while she's "getting younger" every day, and Vanna White, 68, who sets strict schedules to stay glamorous, has been seen lifting weights in her dress and high heels before taping her television episodes.

A popular reality television show, *Botched*, has sprung up in which two plastic surgeons operate to fix the mistakes made by other doctors. Next up, *Botched Bariatrics*. And in the fictional series *Nip/Tuck*, the plastic surgeons ask each new patient, "Tell me what you don't like about yourself." The assumption is that if you are a woman and if you are over a certain age, there is definitely something you don't like about yourself.[2]

While cosmetic surgery can help some people feel better about themselves, for others, it can also be an attempt to find an external solution to *internal* anxiety and unhappiness. Some people who are obsessed with serial cosmetic surgery never alleviate, in a lasting way, their inner yearning to feel better about themselves. Resolving chronic body discomfort is an *inside* job about untangling emotions, not banishing wrinkles.

Cultural Considerations

If you could turn back the hands of time – would you?
If you could erase the years of worry from your face–would you?
If you could feel pretty again–would you?
(INTERNET AD FOR COSMETIC DERMATOLOGY)

These surgeries and celebrity stories illuminate our fear of aging with a hyper-focus on appearance. The anti-aging industry often markets aging as a problem to be fixed. This reinforces the idea that older women are less desirable, while older men are often referred to as distinguished, debonaire, or silver foxes. And with Ozempic bursting on the scene, everyone can just take their weekly injection to lose weight and regain their high-school-reunion ready figure from decades ago.

Ageism is a form of discrimination or prejudice against seniors in the workplace, healthcare, and social environments. Older adults frequently encounter stereotypes that undermine their abilities and worth, leading to diminished self-esteem, isolation, and depression.

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A recent article in the *New York Times*, "Honey, Sweetie, Dearie: The Perils of Elderspeak," addresses the patronizing of older people, and the development of a new training program that teaches aides in hospitals and nursing homes to address older people as adults (sad that we need that!).[3]

Debunking the notion that we should strive to "age gracefully," Julianne Moore, 64, criticizes the term and questions the implication of elevating youthfulness to such an ideal. There's so much judgment inherent in the term "aging gracefully," she points out, "which is just code for 'still looks young.'" And Helen Mirren reminds us: "Aging is a requirement of life: You either grow old or die young."

Psychological Considerations

Ageism doesn't just affect how others treat older women—it shapes how women see themselves as well. Women can internalize ageism and believe the negative stereotypes about themselves. This internalization can lead to self-doubt, shame, and increased body dissatisfaction.

"Invisible Women Syndrome" leads women to feel dismissed or devalued as they age, contributing to diminished self-worth.[4]

A study in *Aging & Mental Health* examined the relationship between body satisfaction and self-esteem among older women. The findings highlight the complex interplay between societal standards and self-perception.[5]

Psychotherapy in Later Life

Once upon a time in school, the 3 R's referred to Reading, Writing, and 'Rithmatic. Now, for older people, the 3 R's often refer to Rue, Regret, and Recrimination.

Helping patients process emotions around declining health and mobility, anxiety, loss, retirement, illness, death, grief, and "what could have been" is the role of therapy in later life. Building self-compassion and helping patients accept aging as a natural process, and that we're all eventually in the same boat, can help reduce distress.

As Judith Viorst, analyst and author, describes in Necessary Losses, the stages of life can be summarized as "loving, losing, leaving, and letting go." Now, at age 94, her new book says it all: *Making the Best of What's Left: When We're Too Old to Get the Chairs Reupholstered*. Her title made me sad as I thought of my friend Cynthia, who lamented the year before she died, "But when I'm gone, who's going to polish the silver?"

> Your time on earth is limited,
> Don't try and age with grace.
> Age with mischief, audacity, and
> A damn good story to tell.
>
> AUTHOR UNKNOWN

Profile sketches of older patients I have worked with:

- Amelia was delighted to retire and then horrified that her husband decided to retire with her. She was looking forward to time alone, which was in short supply since she was a young mother. She needed help in therapy to feel her resentment and guilt and strategize how to talk with Jack about needing this precious alone ti me.

- Linda was forced to sell her house of 35 years as her husband could no longer manage the stairs. She moved them into an assisted living facility, although she remains vibrant and takes tap dancing classes every week. She needed help in her therapy to grieve the loss of her home and especially of the energetic husband she used to have.

- Esther was married to a renowned scholar who left behind his library of 14,000 books when he died. Although Esther felt overwhelmed about what to do with his 14,000 "beloved children," she only wanted to deal in therapy with the 10 pounds she had gained since he died.

The therapist—especially if older—identifies, recoils, empathizes, or compares her losses with those of her patients. She tries to show up with empathy, encouraging patients to explore new sources of meaning and redefine their identity beyond their youthful hopes, dreams, and more svelte bodies.[6, 7]

Pickleball, anyone?

REFERENCES:

1. A selection of links:

https://www.forbes.com/sites/jessicaourisman/2024/12/16/plastic-surgeons-predict-the-top-aesthetic-procedures-for-2025/

https://nypost.com/2025/05/06/lifestyle/new-yorkers-are-getting-second-and-third-facelifts-in-quest-for-youth/

https://nypost.com/2025/02/05/lifestyle/youth-chasers-injecting-trout-salmon-sperm-in-faces-over-filler/

https://nypost.com/2025/02/04/lifestyle/what-is-labia-puffing-the-latest-nsfw-cosmetic-filler-trend/

https://nypost.com/2025/03/31/lifestyle/women-are-spending-20k-to-shrink-their-waists-in-viral-craze-experts-call-ribxcar/

https://nypost.com/2025/02/18/lifestyle/men-injecting-jawlines-with-bone-like-filler-to-rule-the-boardroom-not-the-old-guy-in-the-office/

2. https://airmail.news/look/issues/2023-10-6/defaced-refaced

3. https://www.nytimes.com/2025/05/03/health/elderly-treatment-aides.html

The Times printed my response: "When we would take my elderly mother to the doctor's office, invariably someone there would say she's so 'cute.' That cute 95-year-old was reading the *NY Times* Science section and the book review section every week until she died. Calling her 'cute' just insulted her intellectual prowess."

4. https://nypost.com/2025/01/30/lifestyle/women-feel-invisible-at-a-shockingly-low-age-study-reveals-why-they-blame-fashion/

5. https://www.tandfonline.com/doi/full/10.1080/13607863.2018.1544222

6. https://www.agewithoutlimits.org/resources/conversations

7. Arthur C. Brooks' book *From Strength to Strength: Finding Success, Happiness, and Deep Purpose in the Second Half of Life* explores how to shift from a success-driven life to one focused on meaning, fulfillment, and wisdom as we age. The central message of the book is that personal satisfaction and happiness in later life require embracing change, letting go of past definitions of success, and cultivating deeper, more spiritually and emotionally rewarding values.

The Long and Short of Memory

By Alfred Dorn

Turned ninety, Hal would have stumbled past the date
that marks his birth if not for that one card
from a still-breathing friend. Memories stay
fresh only when they're old.

Again he's eight,
beating his pals at marbles in the yard,
a small god flicking planets that click in play.
He's twelve, back in the Gypsy's carnival tent,
head swimming in beads, dark hair, and jasmine scent.

He's blurry about things that occurred last year—
thumb torched by greasy kitchen stove, the cut
from a trembly shave, running from chin to ear.
He's puzzled. Were those agonies dreamed or not?
He'd thank lost wits for making them disappear
but doesn't. He forgets that he forgot.

[Note: Roger Keizerstein, LCSW contributed this poem by his beloved professor, Alfred Dorn, a noted poet and critic.]

Professional Care Management Perspective on Aging & Disability

By Rosemarie Ruggero, LCSW, CCM

Rosemarie Ruggero, LCSW, CMC has worked in the aging field for nearly five decades. A graduate of Rutgers School of Social Work, she began her career interning at South Beach Psychiatric Center. Ms. Ruggero later served as Director of Social Work at Eger Nursing Home, where she led interdisciplinary care teams and championed staff dementia training, family engagement and community involvement. She then founded Elder Care Advocacy, a private care management practice that has been serving the New York Metropolitan area for over 30 years.

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"Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light."
—DYLAN THOMAS

Aging is a profound and universal journey—at times daunting, unpredictable, and deeply human. Some approach it head-on, while others struggle to cope. For those experiencing the complexities of aging or caregiving for an elder with chronic illness, the challenges—medical, functional, social, and emotional—can feel overwhelming. Seeking guidance from informed professionals, community resources, or trusted friends and family can ease the burden and foster resilience.

As of 2023, approximately 60 million Americans are over age 65. Of these, 16 million are "solo agers"—elders aging without close family or traditional support systems, adding another layer of vulnerability. Our rapidly aging population reflects the triumphs of medical advancement; however, the U.S. still lags behind other developed nations in several critical health metrics.

For instance, 38% of Americans live with cardiovascular disease. The U.S. overdose death rate is three times higher than in comparable countries, car accident fatalities are six times higher, and firearm deaths are a staggering 133 times higher. While smoking rates have dropped—from 42% of adults in 1965 to just 12% today—rates of obesity and diabetes, especially among adolescents, remain alarmingly high, threatening long-term public health outcomes.

One in ten Americans has a chronic illness; four in ten live with two or more. In addition to managing complex health needs, older adults confront retirement transitions, housing modifications or relocations, and social losses due to death, divorce, or distance. Common conditions such as arthritis, dementia, macular degeneration, and bladder or bowel dysfunction can diminish independence, leading to depression, anxiety, and isolation. These conditions are often incurable and progress unpredictably.

The Distinction: Aging Life Care Managers vs. Traditional Social Work

Aging life care managers (also known as geriatric care managers) differ markedly from psychotherapists and other social workers. Our work begins in the elder's home—a natural and familiar setting where they feel at ease. This home-based approach allows us to assess safety risks and understand how the environment supports or hinders their health and independence.

Through extended visits, we build rapport while evaluating physical, emotional, cognitive, and nutritional needs. We listen to life stories, learn about values, and craft individualized plans with empathy and expertise. Our client is the elder—even when a family member initiates the referral. We advocate based on what is best for the older adult's health, safety, and dignity.

In contrast, psychotherapists typically meet clients in office settings and focus primarily on mental and emotional health. While they provide valuable insight and support, many older adults—especially those unfamiliar with technology—struggle with remote care models. Care managers, by comparison, are hands-on, holistic, and functionally focused.

Who Are Aging Life Care Professionals?

Aging life care professionals are licensed experts in nursing, social work, psychology, or related fields. With specialized training and years of experience, we address complex, chronic health conditions like dementia and Parkinson's disease while supporting families and navigating healthcare systems. We handle:

- Home safety and accessibility evaluations
- Care coordination and crisis intervention
- Advocacy across medical, legal, and financial domains
- Referrals to elder law attorneys, home services, or hospice care
- Emotional support and education for clients and caregivers
- Guidance through public benefits and entitlement programs

Our work supports not just physical health, but the emotional and logistical dimensions of aging.

The Unique Needs of Solo Agers

Solo agers—those without close family—face additional challenges. Many live alone due to divorce, widowhood, childlessness, or geographical and emotional separation from relatives. As of 2023, 28% of Americans over 65 live alone—compared to only 10% in 1950.

Outcomes for solo agers vary widely depending on health, wealth, insurance access, living environment, social networks, and proximity to aging resources. Without a support system, even basic needs—like transportation home after surgery or post-operative care—can go unmet.

That's why early planning is essential. Partnering with an aging life care professional ensures that a trusted advocate will be there when needs arise—providing oversight, coordination, and continuity of care.

Essential Planning for All Older Adults (Especially Solo Agers)

Every older adult—especially those aging solo—should take proactive steps to secure their health, finances, and autonomy. Key recommendations include:

A) Financial Planning:

Add a trusted individual to checking or savings accounts to ensure bills are paid in case of illness or hospitalization.

B) Power of Attorney (POA):

Appoint a POA through an elder law attorney to manage financial affairs if you become incapacitated. Even spouses may be limited in access without this legal document.

C) Health Care Proxy & Advance Directives:

Designate someone to make medical decisions aligned with your wishes. Keep copies of your proxy and living will visible (e.g., on the refrigerator for EMS), and ensure your proxy keeps one with them.

D) Estate and Asset Planning:

Owning property or having significant savings warrants a meeting with an elder law attorney. An irrevocable trust offers asset protection, enables Medicaid eligibility, avoids probate, and can reduce capital gains taxes.

E) Home Safety & Aging in Place:

Simple changes—grab bars, stair lifts, lighting upgrades, and smart monitoring devices—can greatly improve safety. Technology has advanced far beyond the traditional emergency alert pendant.

F) Decluttering and Downsizing:

Clutter poses serious risks, from tripping hazards to pest issues. It also contributes to stress, embarrassment, and isolation. Professional organizers can help sort, sell, donate, or dispose of excess belongings.

A recent *New York Times* article captured the disconnect between aging parents with sentimental belongings and minimalist adult children who don't want them. Addressing these differences early can ease transitions and avoid burdening loved ones later.

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In Conclusion

Aging is inevitable but rapid decline and chaos are not. With guidance from aging life care professionals and a clear, proactive plan, older adults—especially solo agers—can maintain control, dignity, and peace of mind. Professional care management is more than logistics—it's a partnership rooted in trust, compassion, and expert navigation of the aging journey.

Summary

Erik Erikson may have captured the essence of healthy aging best:

"Elders should be able to know and trust, and know when to mistrust... The effort to form new relationships is adaptive and rewarding. Trust in interdependence. Give and accept help when it is needed. When frailty takes over, dependence is appropriate, and one has no choice but to trust the compassion of others."

These insights speak directly to the heart of aging—and lead us naturally into reiterating some core recommendations:

- **Plan ahead.**
- **Cultivate a strong network** of friends, neighbors, and professionals.
- **Reconnect with family**, if possible and desired.
- **Engage in financial planning**.
- **Complete a Health Care Proxy and Living Will**.
- **Share your wishes** before illness or crisis occurs.

As my journalist friend Gary Moore says in his column, *The Old Guy*, "Aging isn't for sissies."

It's complicated, often painful—physically and emotionally—and can be difficult to navigate. Yet aging also offers profound opportunities: the chance to watch your children and grandchildren grow, enjoy the company of friends, retire, travel, pursue a new passion, or start a second career.

To my colleagues, especially younger social workers: I encourage you to consider working in the aging field. Older adults have rich, compelling life stories, and working with them is not only personally meaningful but also professionally and financially rewarding—particularly in private practice.

That said, like psychotherapy, working in aging care requires dedication, experience, and specialized certification. It demands that you be part clinician, part strategist, part analyst, and above all, a knowledgeable advocate with deep familiarity with community resources. When done well, professional care management can significantly improve the health, safety, and dignity of those we serve as they age.

BIBLIOGRAPHY:

Vital Involvement in Old Age, Erik Erikson; W.W. Norton & Co., NY London, copyright 1986

"Aging in America," *Staten Island Advance*; September 23, 2024

"Aging isn't for Sissies," *Staten Island Advance*, The Old Guy, 1/7/2025

"Age Well Study", Mather Institute Five Year Study, Jennifer Smith, Ph.D., 2/4/2025

"Understanding Solo Aging," *Aging in Place*; Jennifer Crowley, RN, CLCP, CMC, NYALCA, 3/21/2025

"Aging Parents With Lots of Stuff and Children Who Don't Want It", Tom Verde, *The New York Times*, 8/18/2017

RESOURCES:

Aging Life Care Association, www.aginglifecare.org. Provides a list of Aging Life Care Managers by zip code and a variety of resources to facilitate discussions & decisions

Cognitive Impairment Care Planning Toolkit, www.alz.org/careplanning/downlooads/care-planning-toolkit.pdf

Flying Solo: Experiences of Older Adults Who Are Aging Alone, can be downloaded from at www.mather-institute.com

My Directives, www.mydirectives.com to create a healthcare plan accessible to your loved ones, and your medical providers

List of Elder Law Attorneys, www.naela.org

National Institute on Aging, www.nia.nih.gov/advance-care-planning offers a checklist for getting your affairs in order

RECOMMENDED READING:

On Pluto: Inside the Mind of Alzheimer's by Greg O'Brien; Codfish Press, Brewster, MA 2018. I have recommended this acclaimed book since I heard Mr. O'Brien speak at an ALCA Conference in 2019. His presentation was not only captivating but illuminating. One rarely hears a person describe their symptoms of dementia so eloquently, insightfully, humorously and honestly as he battled "the demon of dementia." As his wife and two sons spoke of the impact of Mr. O'Brien's bad days on his loving family, there wasn't a dry eye in the audience.

Engaging Aging:

Clinical Considerations of Late Life Paradoxes

By Debra Kram-Fernandez, Ph. D., LCSW and Lela Zaphiropoulos, LCSW

Debra Kram-Fernandez, PhD, LCSW, MS-DMT, 200-RYT obtained her Ph.D., in Social Welfare from the City University of New York Graduate Center/Hunter College School of Social Work after obtaining her LCSW-R. She also holds an MSW and MS in Dance-Movement Therapy from Hunter College. Dr. Kram-Fernandez is a graduate of WTCI's postgraduate training program. Her areas of expertise include understanding serious mental illness, group work facilitation, understanding forgiveness, childhood trauma, and creative arts and healing. She is currently an Associate Professor at the State University of New York (SUNY) Empire and has a small private practice.

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Lela Zaphiropoulos, LCSW, psychotherapist and supervisor in private practice for over 40 years, is a WTCI Board and faculty member as well as co-director emeritus of WTCI postgraduate training program. She leads didactic, experiential workshops on issues of aging. Prior to private practice she worked at Bellevue Psychiatric Hospital and St. Luke's-Roosevelt Hospital. She completed postgraduate training at The Institute for the Study of Psychotherapy. She is co-author of *Eating Problems: A Feminist, Psychoanalytic Model* (1995), and of *Kids, Carrots, and Candy: A Practical, Positive Approach to Raising Children Free of Food and Weight Problems* (revised 2012).

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This article is Part I of a four-part series based on our work over the past three years facilitating Engaging Aging workshops for clinicians. Subsequent articles are entitled: *Attuned Aging and the Medicalization of Getting Old, Transference and Countertransference in Working with Older Adults,* and *Aging and Identity: Continuity, Change, and Cultural Construction.*

We begin this series with a focus on older adults as a new demographic and share current statistics. We then explore cultural parameters, societal mandates, and the tensions or dialectics one then must negotiate as one enters later life.

Introduction: The Air We Breathe

Aging is both a biological occurrence and a social construct. Our experiences of our bodies are shaped by the external world, currently a youth-centric culture that venerates energy, fitness, and risk-taking. We are impacted by the power of the "dominant gaze" which is generally considered White, male, heteronormative, ableist, educated, etc., and which creates both hierarchies as well as binaries that often promote stigmatization and marginalization of older people and older bodies. One's experience of aging will be defined by measures of physical health, personal resources, as well as expectations based on cultural norms, and historical events. There are socially prescribed ideas of aging appearance, behavior, and consequences that need to be questioned and challenged intra-psychically, interpersonally, and even politically.

It has been said that the older generation has the greatest heterogeneity of any age group. In other words, this generation presents the greatest diversity in terms of health status, economics, and mental and cognitive functioning than at any other period of life. Based on this variability the needs at this stage require an array of reactions and possible solutions on medical, personal, interpersonal, social, and moral levels.

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Further, every aspect of social location and intersectionality impacts one's experience of the physical and mental aging journey. Intersectionality involves the interactions of the diverse identities that one holds as well as the established political structures that delimit these identities (Crenshaw, 1989). Access as well as obstacles can increase exponentially depending on one's power or non-power attributes determined by social structures.

The U.S. population is older today than it has ever been. About 10,000 Americans turn 65 every day. The fastest growing age group is the over-85s and they are increasingly diverse. The U.S. is projected to become a "majority minority" country by 2043 ("minority" referring to people other than non-Hispanic White) (census.gov, 2012). In addition to ethnic diversity, physical diversity, cognitive diversity, and more, the next generations will be the most openly queer. In the coming decades, an estimated 10 million older adults will identify as LGBTQIA (Wardecker, 2020). These statistics necessitate ongoing learning and proliferation of knowledge and skills that promote cultural competence in our work.

We invite you to consider some further statistics and identity information about today's older adult population. In terms of race, Black American clients aged 65 and older today would have lived the first decade of their life during the egregious Jim Crow era. Although the Jim Crow era was over in 1965, less obvious but persistent and equally damaging systems of racism continue to this day that negatively impact the aging process (LaFave, 2022). Consider that the death rate from Covid for older Black people was more than twice the rate for older White people. (ncba-aging.org, 2023).

In terms of gender, women make more frequent visits to healthcare providers, which may mean diagnosing illnesses and getting treatment earlier. Further, women are statistically less inclined to engage in risky behaviors such as smoking, drug use, and types of employment that can expose people to carcinogens and other physical risks (Harris et al. 2006) leading to differences in mortality rates.

Class is another attribute that correlates with experiences of aging. As with school districts for children, one might be able to determine health outcomes for older adults based on their zip code. When one considers where hospitals are more likely to be impacted by federal and local budget cuts, or where resources and cutting-edge equipment are more likely to be concentrated, it is not a mystery as to how one's socio-economic class can impact one's health and longevity.

Statistics on disability are also interesting. The most common types of disability in the U.S. involve difficulties with walking, independent living, or cognition (pewresearch.org, 2023). Quite compelling is the finding that older people who never identified as disabled frequently categorize their physical difficulties late in life world as medical issues rather than as disabilities. It is almost as if collectively and unconsciously we strive to mitigate the double impact of stigmas around aging and disability.

There is an important relationship between aging and body size. Being slightly overweight is not only associated with little risk in older people but in fact, is considered a protective factor (news-medical.net, 2023). Yet, a significant number of older women experience body image dissatisfaction and feel compelled to diet. Our cultural mandate to be thin and the stigma against larger bodies is so deeply internalized that many will maintain a diet mentality despite medical contraindications.

Our multiple and complex identities are imbued with cultural expectations. When ageism intersects with other biases, disadvantages increase. Add to these the narratives surrounding aging which frequently promote rigid and unhelpful assumptions and expectations, and it is no wonder so many people distance themselves from engaging with aging and mortality. This cultural lore needs to change.

In this article, we explore some central dialectics of aging which include but are not limited to ***dependence vs. independence***, ***being vs. doing***, and ***knowing vs. not knowing***. As therapists, we are always helping clients learn to hold the tensions (or dialectics) between things like good and bad, right and wrong, logic and emotion, internal experience and external pressures. However, there are some tensions that are unique to or become more prevalent as we age.

Tensions between History and Science

We hold the tension between historical views and assumptions about aging and what current science and knowledge offer. For instance, Freud asserted that a person cannot be analyzed after the age of 50, thinking that older people are too fixed in their ways and that older brains could not develop new insights (Freud, 1905). This myth still holds influence even against the backdrop of massive scientific evidence to the contrary. We now know that brain plasticity allows for ongoing growth and learning throughout life. We saw this during the Covid pandemic when, in 2020 and beyond, many older adults became quite tech savvy and able to engage in online platforms to meet many physical, emotional, social, and intellectual needs. Freud maintained his view that people over 50 lack flexibility and the ability to grow while, ironically, he did some of his major work after the age of 50.

> "As therapists, we are always helping clients learn to hold the tensions (or dialectics) between things like good and bad, right and wrong, logic and emotion, internal experience and external pressures. However, there are some tensions that are unique to or become more prevalent as we age."

We would be remiss in not mentioning another historical development impacting the aged. In 1935, when Social Security was instituted—a stunning historical event—the world changed for older people. Prior to this, most people needed to keep working into old age or, if they could not, would likely find themselves living in dire poverty. Today, we hold the tension between protecting Social Security, which is a step towards prioritizing dignity and compassion for older adults, against difficult choices involving balancing the federal budget.

Tensions within Our Cultural Norms

Many of the tensions we hold as we age are both impacted by and vary by culture. In this article, we focus on only three of the many tensions that may vary by one's cultural influences. For instance, we hold the tension between ***dependence vs. independence***. In a culture that overvalues autonomy and able-bodied-ness, how can older people feel comfortable should they need a cane, a walker, or even another person to be mobile and negotiate their physical environment? The fear of being a burden to others can promote isolation and loneliness.

This tension may be especially acute in marginalized communities, where dependence can further exacerbate existing feelings of rejection and social invisibility. That said, people who are invested in the dominant value of independence may be more at risk when experiencing age-related losses of their physical attributes. In fact, those who have developed coping strategies for living in marginalized communities may have greater resilience during their later years

Therapists can help people reframe dependency needs more realistically in that the ability to adapt to change and utilize help is a strength, not a deficit. Dependence and interdependence may be strengths, not only on an individual level, but also in a society that is increasingly technology dependent and in need of human connection. It is important to be aware that early childhood experiences of dependence/independence and how they were met (adequately or not) may well influence and perhaps further complicate this current dialectic struggle.

We also hold the tension between ***being vs. doing***. From an Eastern philosophical perspective, being is about acceptance and surrender to what is, letting go of attachment to things being a certain way. and accepting both joy and suffering. *Doing*, a more Western paradigm, is usually associated with drive and focus on productivity and achievement, even the achievement of not getting old. When we cling to youth in the face of physical, social and emotional changes instead of coping with the reality of impermanence, stress ensues. In Eastern countries, a stance of presence and reflection (a focus on *how* rather than *what*) is considered a healthy approach to living and aging. Inhabitants of Western countries usually prioritize taking charge of their own destiny: "Do Not Go Gentle

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into That Good Night!" (Dylan Thomas, 1957). It is our belief that neither coping style is inherently better or worse; rather, healthy aging means one has access to what will be most helpful in each moment.

As mentioned, Eastern philosophical ideology suggests that in life there is joy and suffering. When elaborated, it is also understood that there are ***two kinds of suffering, inevitable and optional***. Inevitably we get older, and there will be changes in our physical appearance and our stamina. This is often experienced as loss and can be processed and worked through as such. Optional suffering refers to the narratives in our minds, usually promoted by the voice of the culture that frames such changes as negative, and that frequently become persevering internal dialogues. In other words, one may need a walker to maneuver within the environment safely. That represents change and loss and can be worked through.

However, internal monologues such as, *This is pathetic; I am a burden to others with this clunky gadget; or I am no longer self-sufficient*, promote optional suffering that is harder to work through, as it is based more on prejudice than the reality of aging.

Also culturally driven is the tension we hold between ***not knowing vs. our desire to know***. So much of the therapeutic endeavor is learning to sit with *not knowing* However, regarding aging, there is so much *not knowing*: We do not know how we are going to age;. We do not know what our level of infirmity and resilience will be. Many of us don't know if we will be able to access what we need. We do not know how we will respond as the end draws near. We do not know how we will die. All of this uncertainty can be in direct conflict with our desire to know, our desire to be (or believe we are) in control.

In Western cultures, people tend to have a strong sense of personal ***locus of control***, learning from a young age that, with hard work and perseverance, "there's nothing we can't do." Other cultures score lower on locus of control, instead believing that we may have some control over our destinies but, overall, our fates are determined long before we are born. This dialectic can have a tremendous impact on how we cope with aging and mortality.

Likewise, where we fall on the continuum of ***locus of responsibility*** (Sue & Sue, 2003) can also impact how we see and treat ourselves as older people. If we have a strong sense that anything that happens to us is our responsibility, there is room for self-blame and recrimination about inevitable later life health and fitness challenges. If we believe that there are some things we are responsible for, but much is beyond our control, we may approach loss of physical abilities with more curiosity, problem solving, and self-compassion.

Personal Resources and Society's Stance on Who and What Gets Valued

A third category of tensions has to do with resources to meet basic and self-realization needs. This section is about considering ***what older people need vs. what is available***. Basic human rights as one grows older comprise the right to be a whole, included, and connected member of society; the right to maintain a sense of self-esteem, self-respect, and self-worth; the right to be regarded with respect and interest by one's communities; the right to be seen and heard in all of one's complexity.

However, what is available to promote these rights? And who is more likely to have access to what is needed? Our social welfare system does not provide access to some very basic physical/bodily necessities. Hearings aids, glasses, and dental health have a great impact on our intrapsychic and interpersonal ability to stay connected with others as well as to feel capable, confident, and whole. These entitlements are egregiously underfunded. The high costs of these aids may create a harmful interaction between older adults who are reticent to admit the need for assistive devices and society, which allows these supports to be cost- prohibitive for most. Lack of hearing aids and dental health poses a tremendous risk that older people will become isolated and depressed. In fact, there is research linking hearing loss with dementia. (publichealth.jhu.edu, 2021). Socio-economically advantaged individuals have much more access to these innovative technologies.

One way that many older adults can stay in their homes and communities and maintain social and emotional support and vibrance is through the love, support and unpaid labor of family or friends who take on caregiving roles. Caregiving, particularly caregiving with the elderly, can expose a tension between the ***emotional rewards of being of service vs. the personal costs of this service***. On one side of this dynamic, caregiving can be deeply fulfilling, with caregivers feeling a sense of usefulness, of being needed and valued, as well as experiencing an interpersonal connection. For some adult children who become caregivers, it is a chance to heal old wounds and say what needs to be said in the last stage of the life journey of an aging parent.

However, caregiving may hold some less-than-positive experiences as well. Caregivers may feel depleted and overwhelmed by the physical, emotional, and logistical demands, and the hard work of their role. Caregiving labor, as a parallel with women's work in general, is often not often seen or valued, which can lead to feelings of being disregarded or taken for granted. The tension between tending to others and meeting one's own needs can create internal disruption with guilt about focusing on the self rather than the other. One further point, our work as therapists is caregiving. If we are in another life situation involving caregiving it can feel exponentially more taxing.

Implications for Clinicians:
We are aging as our clients are aging

We must navigate our own changing professional identity in later career stages. This is a time we often encounter a particular dialectic: ***the need to simultaneously accept and surrender to aging with its life role changes vs. our need to navigate identity changes and our own continuing desire for meaning and a sense of purpose***.

On the one hand, we may confront deeply personal challenges such as loss, illness, and possible loss of capability. Decisions about whether to disclose personal health matters to clients or colleagues, how to plan for continuity of care, and when to develop a professional will are issues to address. Some clinicians may decide to retire from agency work or to close private practice. Such decisions require emotional resilience, self-knowledge and self-compassion. At such a time peer and supervisory support can be of great value.

"Working with elders may raise many questions: *Am I valued for who I am rather than what I can do? Is there something wrong with me, my body, and how I am aging?* Perhaps if we shift the question from *What is wrong with me?* and start asking simply *What is wrong?* we enlarge the conversation to explore the expectations society imposes on us as we age."

On the other hand, while direct service may become onerous or less feasible, we may still wish to contribute meaningfully to the field. Continuing to work as teachers, mentors, or supervisors is a way to share acquired wisdom and maintain professional involvement. However, choosing not to engage in such roles can be equally valid and empowering. Maintaining or relinquishing professional affiliations, such as licensure, organizational membership, or scholarly involvement, is both a choice and a deeply personal decision.

In conclusion, working with elders may raise many questions: *Am I valued for who I am rather than what I can do? Is there something wrong with me, my body, and how I am aging?* Perhaps if we shift the question from *What is wrong with me?* and start asking simply *What is wrong?* we enlarge the conversation to explore the expectations society imposes on us as we age.

For instance, we may ask the question, *Does what is reflected to older people by media and social media offer a stereotypical image rather than a range of options?* Likewise, if society's expectations are unrealistic, and, thus, the goal is impossible, then one's experience of aging and self can only be that of failure.

As therapists, we need to manage numerous tensions that encompass ambiguity, and complexity. We need to be cultural theorists and critics, identifying the limitations and potential oppression of cultural mandates and the dominant gaze, and not perceive aging and the aging body as merely a paradigm of personal failings but rather another developmental endeavor.

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HEADQUARTERS UPDATE

Since my last report, we have been busy working on education programs with the ACE Foundation and the Society's chapters. We have also been updating the website, helping with the student scholarship awards, as well as keeping up with the day-to-day activities of the Society.

SAVE THE DATE: Annual Meeting on Saturday, October 18, 2025
We are really looking forward to the upcoming events this fall. The Annual Membership meeting is always a great time, so please be sure to mark your calendars for Saturday, October 18, 2025. There are also many educational programs being added to the calendar and can be found in the Friday E-News and on the ACE Foundation website.

As always, if you need help with registration for a program, updating your profile on the website, or have any other questions—please do not hesitate to call or email the office. We hope you have a wonderful summer and look forward to seeing or hearing from you soon.

Best wishes for a happy and healthy 2025!

Kristin

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LATE LIFE PARADOXES Continued

WORKS CITED

U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now - Population - Newsroom - U.S. Census Bureau

Crenshaw, Kimberle, (2023). 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics', in Anne Phillips (ed.), *Feminism And Politics: Oxford Readings In Feminism* (Oxford, 1998; online edn, Oxford Academic, 31 Oct. 2023), https://doi.org/10.1093/oso/9780198782063.003.0016, accessed 29 May 2025.

Freud, S. (1905) On psychotherapy. Reprinted (1953–1974) in *The Standard Edition of The Complete Psychological Works of Sigmund Freud* (trans. and ed. Strachey, J.), vol. 7, pp. 257–268. London: Hogarth Press. Google Scholar

Harris CR, Jenkins M. (2006). Gender Differences in Risk Assessment: Why do Women Take Fewer Risks than Men? *Judgment and Decision Making*. 1(1):48-63. doi:10.1017/S1930297500000346

https://ncba-aging.org/wp-content/uploads/2023/01/FINAL-NCBA_Black_Aging_America_Digital_web47.pdf

https://www.census.gov › publications › demo). Females tend to live longer; even making it to 100 more often. (Do Women or Men Age Faster and Better? - *Verywell Health*.

https://www.news-medical.net/news/20230717/In-older-adults-a-little-excess-weight-isne28099t-such-a-bad-thing.aspx

https://www.pewresearch.org/short-reads/2023/07/24/8-facts-about-americans-with-disabilities/

https://publichealth.jhu.edu/2021/hearing-loss-and-the-dementia-connection

LaFave SE, Suen JJ, Seau Q, Bergman A, Fisher MC, Thorpe RJ Jr, Szanton SL. (2022). Racism and Older Black Americans' Health: a Systematic Review. *J Urban Health*. 99(1):28-54. doi: 10.1007/s11524-021-00591-6. Epub 2022 Jan 7. PMID: 34997433; PMCID: PMC8866626.

Sue, D.W. and Sue, D. (2003) *Counseling the culturally diverse Theory and practice.* 4th Edition, John Wiley & Sons, New York. - References - Scientific Research Publishing Sue, D.W. and Sue, D. (2003) *Counseling the culturally diverse: Theory and practice.* 4th Edition, John Wiley & Sons, New York.

Thomas, Dylan. (1957). Dylan Thomas, "Do Not Go Gentle into That Good Night" from *The Poems of Dylan Thomas*. Copyright 1939, 1946 by New Directions Publishing Corporation. Reprinted with the permission of New Directions Publishing Corporation. https://www.poetryfoundation.org/poems/46569/do-not-go-gentle-into-that-good-night.

Wardecker BM, Matsick JL. (2020). *Families of Choice and Community Connectedness: A Brief Guide to the Social Strengths of LGBTQ Older Adults*. J Gerontol Nurs. 1;46(2):5-8. doi: 10.3928/00989134-20200113-01.

Incubating the Future: Self-Directed Neuroplasticity and the Adaptive Mind

Presented at the 2025 International Neuropsychoanalytic Association Congress

By Inna Rozentsvit, M.D., Ph.D., MSciEd, MBA

The human brain's capacity for change has always been central to therapeutic work, but recent convergences in neuroscience, trauma research, and contemplative practice are reshaping how we understand—and facilitate—that change. At this year's International Neuropsychoanalytic Association Congress, our symposium brought together three distinct but complementary perspectives on what we termed *self-directed neuroplasticity:* the brain's remarkable ability to rewire itself through conscious, relational engagement.

What emerged from our exploration challenges a longstanding clinical assumption: neuroplasticity is not just something that happens to our clients, it is something they can actively direct, with the right understanding, support, and practices.

I opened the panel by presenting an integrative clinical framework I call the Functional PsychoNeuroBiology™, grounded in neuroscience and psychoanalysis. As a neurologist, neurorehabilitation specialist, and psychoanalytically trained clinician, I emphasized that the same neurobiological mechanisms that shape early development, such as Hebbian wiring (neurons firing together—wiring together), connectome formation, brain laterality (right-left hemisphere coordination), and autonomic regulation—remain active across the lifespan. These mechanisms, initially formed through relational experiences that start in one's mother's womb, can be reorganized through new relational experiences.

Drawing on Eric Kandel's principles of mental functioning and Paul MacLean's Triune Brain model, we can see how early caregiving environments impact the developing connectome in ways that ripple throughout the lifespan. When early experiences are attuned and responsive, they support the integration of primitive survival circuits with higher-order systems responsible for reflection, empathy, and complex reasoning. When they're disrupted, they can create patterns of reactivity that bypass our more evolved capacities. By engaging therapy, mindfulness, and self-regulation practices, clients can actively reshape maladaptive circuits. The early mind that once recorded the past can become a blueprint for a different future.

Dr. Victoria Grinman, a psychotherapist and trauma researcher specializing in Post-Traumatic Growth (PTG), introduced PTG as a hopeful clinical lens. Unlike resilience, PTG involves the emergence of a new identity forged through adversity. It reflects a neurobiological shift from automatic, intrusive rumination to deliberate, meaning-making reflection. Dr. Grinman outlined five domains of PTG: personal strength, new possibilities, relating to others, appreciation of life, and spiritual change—as markers of neuroplastic reorganization. Her approach encourages clinicians to support these transformations organically, trusting in the brain's adaptive potential rather than forcing change.

Dr. Jeffrey Rubin, a psychoanalyst, author, and integrator of Eastern contemplative and Western psychodynamic traditions, offered a deeply experiential perspective. Drawing from Buddhist meditation and Chinese qigong, he guided attendees through a four-step process: identifying stuck patterns, meeting them with loving awareness, decoding their emotional logic, and practicing new ways of being. Dr. Rubin demonstrated how attention itself is neuroplastic: when we bring awareness to unconscious patterns, we activate brain regions that promote emotional regulation and integration. These practices aren't just complementary—they are direct interventions in neural reorganization.

Together, these three approaches—neurobiological, PTG-lens, and contemplative—form a transdisciplinary vision of therapy as collaborative brain change. The brain that adapted to early environments can adapt again, in response to new experiences of safety, reflection, and relational attunement.

This understanding offers both practical tools and renewed hope: we are not fixing broken brains—we are partnering with adaptive ones.

WELCOME NEW MEMBERS OF NYSSCSW!

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REFERENCES:

Beard, D. J., Campbell, M. K., Blazeby, J. M., Carr, A. J., Weijer, C., Cuschieri, A., ... & Buchbinder, R. (2020). Considerations and methods for placebo controls in surgical trials (ASPIRE guidelines). *The Lancet*, 395(10226), 828–838.

Benedetti, F. (2008). *Placebo Effects: Understanding the mechanisms in health and disease*. Oxford University Press.

Buettner, D. (2012). *The Blue Zones: 9 lessons for living longer from the people who've lived the longest*. National Geographic Books.

Cabeza, R., Anderson, N. D., Locantore, J. K., & McIntosh, A. R. (2002). Aging gracefully: compensatory brain activity in high-performing older adults. *NeuroImage*, 17(3), 1394–1402.

Campbell-Meiklejohn, D. K., Bach, D. R., Roepstorff, A., Dolan, R. J., & Frith, C. D. (2010). How the opinion of others affects our valuation of objects. *Current Biology*, 20(13), 1165–1170.

Draganski, B., Gaser, C., Busch, V., Schuierer, G., Bogdahn, U., & May, A. (2006). Neuroplasticity: Changes in grey matter induced by training. *Nature*, 427(6972), 311–312.

Erickson, K. I., Voss, M. W., Prakash, R. S., Basak, C., Szabo, A., Chaddock, L., ... & Kramer, A. F. (2011). Exercise training increases size of hippocampus and improves memory. *Proceedings of the National Academy of Sciences*, 108(7), 3017–3022.

Gatz, M., Reynolds, C. A., Fratiglioni, L., Johansson, B., Mortimer, J. A., Berg, S., ... & Pedersen, N. L. (2006). Role of genes and environments for explaining Alzheimer disease. *Archives of General Psychiatry*, 63(2), 168–174.

Hölzel, B. K., Lazar, S. W., Gard, T., Schuman-Olivier, Z., Vago, D. R., & Ott, U. (2011). How does mindfulness meditation work? Proposing mechanisms of action from a conceptual and neural perspective. *Perspectives on Psychological Science*, 6(6), 537–559.

Ingalhalikar, M., Smith, A., Parker, D., Satterthwaite, T. D., Elliott, M. A., Ruparel, K., ... & Verma, R. (2014). Sex differences in the structural connectome of the human brain. *Proceedings of the National Academy of Sciences*, 111(2), 823–828.

Lupien, S. J., McEwen, B. S., Gunnar, M. R., & Heim, C. (2009). Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nature Reviews Neuroscience*, 10(6), 434–445.

Maher, R. L., Hanlon, J., & Hajjar, E. R. (2014). Clinical consequences of polypharmacy in elderly. *Expert Opinion on Drug Safety*, 13(1), 57–65.

McGaugh, J. L. (2015). Consolidating memories. *Annual Review of Psychology*, 66, 1–24.

National Academies of Sciences, Engineering, and Medicine. (2020). *Social isolation and loneliness in older adults: Opportunities for the health care system*. The National Academies Press. https://doi.org/10.17226/25663

Nyberg, L., Lövdén, M., Riklund, K., Lindenberger, U., & Bäckman, L. (2012). Memory aging and brain maintenance. *Trends in Cognitive Sciences*, 16(5), 292–305.

Ownby, R. L., Crocco, E., Acevedo, A., John, V., & Loewenstein, D. (2006). Depression and risk for Alzheimer disease: systematic review, meta-analysis, and metaregression analysis. *Archives of General Psychiatry*, 63(5), 530–538.

Park, D. C., & Reuter-Lorenz, P. (2009). The adaptive brain: aging and neurocognitive scaffolding. *Annual Review of Psychology*, 60, 173–196.

Park, D. C., Lodi-Smith, J., Drew, L., Haber, S., Hebrank, A., Bischof, G. N., & Aamodt, W. (2014). The impact of sustained engagement on cognitive function in older adults: The Synapse Project. *Psychological Science*, 25(1), 103–112.

Pyrkov, T. V., Slipensky, K., Barg, M. F., Kondrashin, A. A., Zhurov, B., Zenin, A., ... & Fedichev, P. O. (2021). Longitudinal analysis of blood markers reveals progressive loss of resilience and predicts human lifespan limit. *Nature Communications*, 12(1), 2765.

Raz, N., Rodrigue, K. M., Head, D., Kennedy, K. M., & Acker, J. D. (2005). Differential aging of the medial temporal lobe: a study of a five-year change. *Neurology*, 65(3), 397–404.

Rebok, G. W., Carlson, M. C., & Langbaum, J. B. (2014). Training and maintaining memory abilities in healthy older adults: Traditional and novel approaches. *Journals of Gerontology: Series B*, 69(1), 35–43.

Rozentsvit, I. (2015). A heartfelt farewell to my hero, Oliver Sacks, a man who cannot be mistaken for anything else but a human phenomenon. https://innarozentsvit.com/a-heartfelt-farewell-to-my-hero-oliver-sacks/

Sarno, J. E. (1998). *The mindbody prescription: Healing the body, healing the pain*. Warner Books.

Schwartz, J. M., & Begley, S. (2002). *The mind and the brain: Neuroplasticity and the power of mental force*. ReganBooks.

Spreng, R. N., Karlawash, J., & Marson, D. (2016). Cognitive, social, and neural determinants of diminished decision-making and financial exploitation risk in aging and dementia: A review and new model. *Journal of Elder Abuse & Neglect, 28*(4–5), 320–344.

Stein, H.F. (2025). The quiet resistance: Poems of exile and defiance. *MindConsiliums*, 25(4), 1-12. https://doi.org/10.70763/m8c7bbbba95c1025975e548cee86dfadc

Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death*. Jossey-Bass.

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We encourage you to submit an original article or review to *The Clinician*. In general, the article should—

- Be of interest to a broad range of clinicians.
- Focus on clinical issues and treatment.
- Be clearly written and jargon-free.
- Use case examples where possible.
- Not exceed 1,000 words. Shorter is better.
- Include your brief professional bio.

Please send a description of your proposed article in advance. We look forward to hearing from you.

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The Clinician

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

Advertising Information

THE NEWSLETTER is published twice a year: Spring/Summer and Fall/Winter

Please contact the Editor for deadlines. See contact information below.

DISPLAY ADVERTISING SIZES AND RATES

AD SIZE	DIMENSIONS	Cost per Insertion	
		1 TIME	2 TIMES*
1 page	7-1/2" w x 10" h	$450	$400
2/3 page	4-15/16" w x 10" h	$325	$295
½ page vertical	3-5/8" w x 10" h	$250	$225
½ page horizontal	7-1/2" w x 4-7/8" h	$250	$225
1/3 page (1 column)	2-3/8" w x 10" h	$175	$160
1/3 page (square)	4-15/16" w x 4-7/8" h	$175	$160
¼ page	3-5/8" w x 4-7/8" h	$140	$125
1/6 page (1/2 column)	2-3/8" w x 4-7/8" h	$ 95	$ 85

*** To qualify for the two-time rate, ads must run in 2 consecutive issues.**

ADVERTISING MATERIAL:

Display ads must have a border; must be submitted fully composed in digital format (PDF preferred) by email.

Color ads are now accepted at the same rates as above.

Submit all advertising materials by email to:

IVY MILLER, Editor
ivy.lee.miller@gmail.com
TEL: 917-620-3460

Maida Herman Solomon (1891–1988):

A forerunner in the field of clinical social work

Maida Herman Solomon at Smith College.

Maida Solomon was an educator, researcher, practitioner and advocate. Her contributions to the development and practice of clinical social work spanned over 60 years. [They] include authoring and implementing graduate programming…; penning some of the most seminal works and advancing theory; introducing academic and scientific approaches…; and helping to change the way that society thought about mental health and sexual health.

SOURCE: https://www.emerald.com/insight/content/doi/10.1108/jmh-06-2024-0083/full/html

NATIONAL INSTITUTE FOR THE PSYCHOTHERAPIES

Discover Training Opportunities at NIP

Established in 1972, the National Institute for the Psychotherapies provides extensive education in contemporary psychoanalysis and psychodynamic therapy, with a focus on trauma-based treatment revolving around the patient's individual path to healing. Our offerings facilitate collaboration within an intimate setting which foregrounds care and inclusivity among trainees, clinicians, and patients.

Explore Our Programs

- Adult 4YR Program in Psychoanalysis
- License Qualifying Program in Psychoanalysis
- Psychodynamic Approaches in Clinical Practice: A One Year Evening Program
- Online Evening Program
- Integrative Trauma Program
- Child & Adolescent Trauma Program
- EMDR Clinical Affiliate Program
- Psychotherapy Integration Program
- National Training Program
- Supervisory Training Program
- Continuing Education (CE) Program

•nipinst.org/events-about

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Phone: (212) 582-1566
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New York, NY 10010

New York State Society for
Clinical Social Work, Inc.
55 Harristown Road, Suite 106
Glen Rock, NJ 07452

Connect → Participate → Grow

Join the New York State Society for Clinical Social Work Today!

We are a community of highly trained clinicians committed to maintaining standards of professional education and practice in clinical social work psychotherapy. We provide mental health services in a variety of settings including private practice. Join us and network with LCSWs, LMSWs, MSW students, institute candidates, and other mental health professionals.

→ **Advance Your Professional Education** • *Continuing Education Programs, Conferences, Peer Consultation*

→ **Advocate for Clinical Social Work** • *Lobbying, Coalitions, Legislation, Practice Management*

→ **Build Professional Networks** • *Mentoring, Study Groups, Teaching, Job Listings, Referral Opportunities*

→ **Collegiality & Connections** • *State & Chapter Events, Committees, Listservs, Website, Facebook, Newsletters*

For more information please contact our office at info.nysscsw@gmail.com

www.NYSSCSW.org | 800-288-4279 | info.nysscsw@gmail.com | www.facebook.com/nysscsw/info