The CLINICIAN

WINTER 2025 | VOL. 56, NO. 1

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

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www.nysscsw.org

Group Therapy for Trauma

Groups are Wonderful Containers for Helping People Recover

By Richard Beck, LCSW, BCD, CGP, AGPA-F

"People who have been traumatized do not need an intellectual interpretation, rather, they need an authentic human experience." —ANNA FREUD (1974)

Egyptian group therapists with Richard Beck at an IAGP conference in Cairo.

About ten years ago, I was invited to give a keynote and run a small group at a conference in Pretoria, South Africa. During my talk, I referenced the quote above, attributed to Anna Freud, which speaks to my thinking about working with people who have survived traumatic events.

This approach has colored all of my clinical work. I have responded to traumatic events such as the aftermath of 9/11 here in the United States, coordinated responses to disasters here and abroad, and now I lead groups for Ukrainian mental health professionals, Ukrainian high school students, and also college students from Russia, Ukraine and Belarus living in the U.S. and Canada.

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> "It is the group's cohesion that is most important for trauma survivors, not the insights from the leader."

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New York State Society for Clinical Social Work

The Professional Voice For Clinical Social Work Since 1968

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Kristin Kuenzel, *Administrator*
Debbie Lebnikoff, *Administrative Assistant*

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The Advanced Clinical Education Foundation of the NYSSCSW

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Website: ace-foundation.net

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Director of Professional Development	Kara Dean-Assael, DSW,LMSW	drkara.acefoundation@gmail.com

Message from the Outgoing President

As I prepare to end my term as president, I am delighted to turn the role over to our new president, Beth Pagano, LCSW-R, who has many years of experience in leadership positions in the Society. Beth was the Rockland Chapter president for more than ten years before moving to the State Board of Directors as a member-at-large more than 20 years ago. There she chaired the By-Laws, Nominations and Elections, and Leadership Development committees, and served as vice president. Beth will continue with the projects recently undertaken and lead the board in developing new ideas to grow and strengthen the professional community which you have known and benefited from as members.

It has been a privilege to work with the dedicated board members, chapter presidents, and committee chairs who bring fresh ideas to create educational programs, social and networking events, and provide critical information about developments in the field in New York and across the country. They will continue to lead the Society through new challenges ahead.

I wish to thank the board members for their ongoing support and hard work, as well as the tireless TMS team: Kristin Kuenzel, Debbie Lebnikoff, and Deb Guston. They navigated the tragic loss of the company founder and leader, Sheila Guston, in June 2024. Sheila was instrumental in encouraging the board to have a more expansive view of the possibilities of our organization. In addition, the work of Helen Hinckley Krackow, LCSW-R, Newsletter Chair, and Ivy Miller, Editor, on *The Clinician*, now covering a different theme in each edition, has increased the

depth of the topics and is highly regarded by our members along with having become a valuable marketing tool.

In the coming year, our newly-upgraded website will continue to provide updates on individual chapter events and important information on licensure and serve as a location for members to report abuses by insurance companies. We expect a marketing and membership campaign to launch in 2025 to advance clinical social work throughout the state, grow the membership, develop new chapters, and revive chapters that have been dormant.

I will continue my involvement with the board as Past President and at every opportunity will encourage you, our valued members, to get involved and contribute whatever amount of time you can spare. Share your talents, ideas, and knowledge to contribute to our vibrant professional community.

–Karen Kaufman, Ph.D., LCSW-R

At the 2024 Annual Membership Meeting in October.

The Clinician

THE NEWSLETTER OF THE
NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.
Tel: 1-800-288-4279

Published twice yearly:
Spring/Summer & Fall/Winter

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ACE FOUNDATION

Introducing Kara Dean-Assael

New Director of Professional Development

Kara Dean-Assael, DSW, LMSW, has been working in the social work field since 1997. As an innovator, she develops, coordinates, manages, produces, and facilitates various programs, projects, and trainings both locally and nationally. From 2006–2013, she was a collaborative member of the research team that developed, tested, and disseminated the nationally known evidence-based treatment, the "4 Rs and 2 Ss for Strengthening Families Program" and currently trains mental health practitioners on the model.

In 2012, she co-founded the 501c3, Fareground, Inc., an anti-hunger program focusing on food justice in Dutchess County, NY and surrounding areas. Dr. Dean-Assael is passionate about collaboratively creating and disseminating programs and practices to improve mental health and outcomes for youth, families, and adults and centering human rights. She served on the Commission on Human Rights in the City of Beacon, NY from 2020–2024.

Dr. Dean-Assael holds a B.A. in Psychology with minors in both sociology and women's studies from West Virginia University (1996), an MSW degree from Columbia University School of Social Work (2001), and a Doctorate in Clinical Social Welfare from New York University (2020). As a native of West Virginia, she's attached to her roots of family and resilience.

"I'm honored to be in this position to work with you all on bringing quality continuing education offerings to mental health providers," she told ACE and NYSSCSW leaders. "I believe continuing to grow through education and practice training is one of the most important aspects of our field."

Kara Dean-Assael: drkara.acefoundation@gmail.com

HEADQUARTERS UPDATE

We hope you all enjoyed your holidays. TMS has gone through some changes this year. We lost our founder, Sheila Guston, in June. I stepped into her role over the summer and became Chief Operating Officer of Total Management Solutions. Debbie and Sandy continue to work with the Clinical Society and the ACE Foundation.

The annual meeting was once again a success! It was great to see so many familiar and new faces on a beautiful day in Westchester. It was also wonderful to honor so many members who give so much of their time to the organization.

Membership renewals were sent in November through email and in December through regular mail. We are always available to help with updating your membership.

The website has been a work in progress, but it is finally here! If you haven't seen it you should definitely check it out. www.nysscsw.com

As always, if you need assistance we are here to help.

Best wishes for a happy and healthy 2025!

Kristin

Kristin Kuenzel, *Administrator*
Debbie Lebnikoff, *Administrative Assistant*
Sandy Squillante, *Bookkeeping*

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SAVE THE DATES:

Saturday, April 26 & Saturday, May 3, 2025

The New York State Society for Clinical Social Work with the ACE Foundation Present:

THE 56th ANNUAL EDUCATION CONFERENCE

Energizing the "Social" In Clinical Social Work Practice

One of social work's major contributions to both generic practice and clinical assessment and treatment is the concept of "person-in-situation."

Clinical social work has a unique position in the therapeutic landscape as it inherently considers the person's treatment to include their environment, life history, family, social class, culture, and/or religious beliefs. Clinical social work practice also holds a dynamic view of the inextricable linkages between a person, family, or community bound together with its social surroundings (Fjeldheim, Levin, & Engebretsen, 2015). Holding this knowledge helps us to understand the simultaneous static and dynamic states of the social spaces within which we function. Energizing and emphasizing this allows for a deeper and intersectional understanding of ourselves, our work, our communities, and even our systems.

This conference will focus on various aspects of how clinical social work practice integrates curiosity and empathy for the social, political, and environmental conditions we live within.

PLEASE JOIN US ON ZOOM ON TWO SATURDAYS:
Live Online CE Contact Hours Available Each Day

DAY 1 / Saturday, April 26, 2025, 9:00 am – 12:30 pm / 3 CEs (1.5 each presentation)
DAY 2 / Saturday, May 3, 2025, 9:00 am – 12:30 pm / 3 CEs (1.5 each presentation)

Details coming soon at nysscsw.org and ace-foundation.net

This clinical conference is appropriate for licensed mental health professionals and clinical interns with all levels of experience.

By Marsha Wineburgh, DSW, LCSW-R, Legislative Chair

Highlights of 2024 New York State Legislative Activity Impacting LCSWs

Thanks to the Clinical Society's lobbyists, we have had a quiet year with minimal threats to our professional licenses. The Legislature concluded its regularly scheduled 2024 session on June 8, 2024. Not unusual for New York, this session was squeezed by protracted state budget negotiations pressing several volatile issues into the end-of-session hysteria. As a result, a number of high-profile issues were left unresolved.

A summary of legislative proposals affecting LCSWs has been collected out of the approximately 800 legislative proposals that passed both houses. The Senate introduced 1,850 pieces of legislation, passing 1,679; while the Assembly introduced 1,973 and passed 960. This is a dramatic decrease in legislative proposals over prior years' high-water marks when often 8,000 to 10,000 bills might have been introduced.

"Scope of practice" or professional licensure bills continued to advance sparingly through the Higher Education committees. For instance, in the Assembly Higher Ed Committee, 378 bills were introduced this session, 176 of which involved the licensed professions. Of these, 26 were actually placed on the committee agenda, 16 of which involved a licensed profession. Of these, 7 were passed by both houses. Note that 10 pieces of legislation affecting the professions advanced to passage in both houses through committees other than Higher Education.

Chapter 636 of the Laws of 2024 AN ACT to amend the penal law, in relation to expanding the definition of mental health care provider for purposes of sex offenses: Enacts Gittel's Law, expanding the list of mental health care providers as related to sex offenses between providers and patients to include licensed mental health counselors and licensed marriage and family therapists.

A.9018 (Bronson)/S.8715 (Brouk) AN ACT to amend the social services law, in relation to authorizing licensed creative arts therapists to bill Medicaid directly for their services. VETOED (Note that LCATS do not have the diagnostic privilege.)

Chapter 546 of the Laws of 2024 AN ACT to amend the workers' compensation law, in relation to claims for mental injury premised upon extraordinary work-related stress; Expands to all workers, not just police officers, EMTs and other emergency personnel, the ability to receive PTSD coverage under workers' comp for work-related stress.

EMERGING ISSUES

Interstate Licensure Compacts: A number of bills had been introduced by minority (Republican) legislators in both houses which attempted to authorize interstate professional licensure compacts for a number of professions by simply stating that an interstate compact for audiology and speech language pathology, for occupational therapy, for physical therapy, for psychology, for emergency medical service personnel, for nursing and advanced practice registered nursing, and medicine was created. These efforts did not advance.

Minimum Wage Increase: Effective January 1, 2025, the minimum wage will increase $0.50 for a total of $15.50 per hour, $16.50 in New York City. Another $0.50 increase is scheduled to take effect January 1, 2026, with annual increases thereafter.

GOING FORWARD

Wednesday, January 8 was the first day of the 2025 legislative session in Albany. First up is the April 1st budget deadline. On Thursday, in both houses of the Legislature, several committee leadership assignments were made, and committee memberships were appointed. We are particularly interested in both the Senate and Assembly appointments in Higher Education, Mental Health, and the Health Committees. Already, several bills have been introduced which we are following:

S 988 BROUK/A701 Gonzalez-Rojas: Repeals the requirement that applicants must pass an examination in order to qualify as a licensed master social worker.

A 780 Berger: Enacts the "Supervising Upcoming Professionals for Practice in Official Roles in Therapy" Act. This bill provides that for licensure as a clinical social worker, an applicant may satisfy the experience requirements under supervision of a mental health practitioner who has been granted the privilege to diagnose and develop assessment-based treatment plans.

Roles in Therapy (SUPPORT) Act: Provides that for licensure as a clinical social worker, an applicant may satisfy the experience requirements under supervision of a mental health practitioner who has been granted the privilege to diagnose and develop assessment-based treatment plans.

S 998 BROUK/A 949 Lunsford: Permits telemedicine services for mental and behavioral health issues under the workers' compensation system; permits one in-person visit within twelve months unless such in-person visit causes undue hardship on a patient.

S 263 HARCKHAM: Relates to collaborative prescriptive authority for psychologists. Allows a licensed psychologist to apply to the Department of Education for conditional prescribing certification if the psychologist meets certain requirements; allows the Department of Education to waive certain requirements for an applying psychologist; provides that a conditional prescribing certification shall be valid for a period of two years.

S 1001 BROUK: Relates to including outpatient care provided by creative arts therapists in certain insurance policies with the privilege of diagnosis.

S 1312 GOUNARDES: Requires licensed or certified school social workers in each elementary, intermediate, middle, junior high and senior high school.

We are off to fast start with a newly formed Legislative Committee of members experienced in national and state social work politics. We continue to be committed to protect clinical social workers' rights to practice in New York State and nationally.

WELCOME NEW MEMBERS OF NYSSCSW!

Abbot, Rob, LCSW	LI
Bambara, Marnessa (Marnie), LCSW	ROC
Bazes, Deborah, LCSW-R	WES
Berne, Serena, Student	MET
Bohl-Fabian, Noel, LCSW	MET
Bruno, Christopher, LCSW	MET
Bucci Olsson, Kara, LCSW	MID
Callahan, Christopher, LCSW	LI
Cutler, Matthew, Student	MET
Esposito, Suzanne, LCSW	WES
Fanjul, Lucia, LCSW	MET
Feldman, Lee, LCSW	MET
Feuerstein, Dennis, LCSW	LI
Friedman, Arielle, LCSW	MID
Gallenstein, Anne, M.S.Ed.	LI
Garland, Muhammed, LCSW	MET
Gorman, Daniel, LCSW	MID
Hanley, Mary, LCSW	LI
Harman, Jess, LMSW	MID
Jabul Mercer, Jacquelyn, LCSW-R	MET
Jackson, Vanessa, LCSW-R	MET
Kahn, Jonathan, LP	WES
Kahn, Lisa, LCSW	LI
Kenny, Christine, LCSW	ROK
Linden, Peter, LCSW	MET
Lockhart, Samantha, LMSW	MET
Marin, Samantha, LMSW	MET
Mazzella, Dina, LCSW-R	MET
Neufeld, Adam, Student	MET
Price, David, LCSW-R	WES
Rivera, Amilinda, Student	ROK
Roeshman, Gail, LCSW	MET
Ruben, Brenda, Student	ROK
Shaw, Malka, LCSW	MET
Smith, Marj, LCSW	ROC
Studioso, Jacob, LCSW	ROC
Tomei, Nina, LCSW-R	LI
Vaughn, Kellie, Student	ROK
Weeks, Thomas, LMSW	MET
Zarate, Andrew, LCSW	MET

CHAPTER KEY: LI–Long Island; MET–Metropolitan; MID–Mid-Hudson; ROC–Rochester; ROK–Rockland County; SI–Staten Island; WES–Westchester County.

State and Chapter Leaders Honored in 2024 for Exemplary Service to NYSSCSW and Dedication to the Advancement of Clinical Social Work

STATE HONOREES

Marsha Wineburgh DSW, LCSW-R

NOTE: Marsha Wineburgh and her colleagues in the NYSSCSW embarked on advocacy and legislative campaigns in 1978. Their persistence finally paid off with passage of the licensing law in 2004 which gave legal recognition to clinical social work as an independent profession in New York State.

I am very grateful to the Clinical Society for giving me the opportunity to explore and discover my own abilities while at the same time, with a lot of help from you, strengthening the clinical social work profession in ways I could never predict.

In 1963, I had no idea social work existed. If it weren't for my college roommate's mother, who was a social worker, I never would have ended up at NYU social work school.

In the 1970s, I was recruited to the Clinical Society by Helen Goldberg to write for their newsletter and attend a meeting. That meeting is imprinted. . .What was impressive was how knowledge of the bylaws and Robert's Rules of Order allowed two women to control the outcome. They were Mary Gottesfeld, founder of the *Clinical Social Work Journal* and her colleague, Florence Lieberman, both renowned professors at Hunter's school of social work.

In the following decades, I became a teacher, supervisor, and training analyst for a psychoanalytic institute. I taught psychopathology, ethics, and casework. I did field placement for a social work school, wrote exam questions for the LCSW, and earned a DSW. I served in many different board positions, and as president of three social work organizations, and I helped launch an education foundation, known as ACE.

It was the Clinical Society that gave me entrée into the world of state and federal legislative work and advocacy. What an education it has been! And with a great deal in intelligent assistance, what a success!

Serving on the Board in many different capacities has been a source of lasting responsibilities and of everlasting friendships. I would not trade this experience for any other. Thank you for your trust and respect. ■

Shannon Boyle LCSW

Shannon Boyle is the Executive Director of New Ground, a nonprofit organization on Long Island serving homeless Veterans and families.

Shannon has been an active member of the NYSSCSW for over 20 years. First, as a member of the Nassau Chapter, she served on the chapter board in various roles including Membership Co-Chair and Program Chair. Within a few years, she became active on the State Board and has held various positions including President, Vice President, Treasurer, and Secretary.

She has also chaired several committees including Membership, and currently, the Communications and Listserv committees. Shannon is passionate about the social work profession and helping those in need in our communities. She is also committed to the advancement of clinical social work in New York State. ■

Henni Fisher LCSW-R, BCD

A member of the New York State Society since the 1980s, Henni Fisher is currently First Vice President on the State Board. She served as Co-President of the former Brooklyn Chapter (1999-2006) and also as a Member-at-Large from Brooklyn.

Now a member of the Metropolitan Chapter, Henni has served on the Legislative Committee, the Vendorship Committee (now called the Practice Management Committee), and is Co-Chair of the Issues on Aging Committee for both the Met Chapter and the State Board.

Henni is a Licensed Clinical Social Worker with an "R" and a Board-Certified Diplomate in Clinical Social Work. She is also a member of the Clinical Social Work Association. ■

CHAPTER HONOREES

Barbara Murphy LCSW, BCD
Long Island Chapter Honoree

When Barbara Murphy began a private practice dedicated to the treatment of children, adolescents, and their families in 2003, she became a member of the Nassau Chapter (now the Long Island Chapter). She currently serves as President of the Long Island Chapter and member of the State Board as Public Relations Chair. She has been actively involved in updating the Society's website and hiring a public relations firm to recruit new members.

A social worker since 1977, Barbara has extensive experience in medical and mental health settings in both direct service and administrative roles. She has trained and supervised many students and social workers and presented on topics such as working with children in a hospital setting; helping children grieve and develop self-esteem; teens and body image; and the cultural and spiritual aspects of patient care. She is a graduate of the New York School for Psychoanalytic Psychotherapy and Psychoanalysis.

A volunteer community organizer for many years, in the aftermath of 9/11 and a local church shooting, Barbara developed a support program, "Rainbows for Children." She has served on the boards of the Muscular Dystrophy Association, the Make A Wish Foundation, and the Girl Scouts of Nassau County. ■

Eleanor Perlman LCSW, ACSW, BCD
Long Island Chapter Honoree

Eleanor Perlman has been very active as a member of NYSSCSW since she joined in 1980. Initially, she chaired the Referral Service Committee at the state level, from 1981 to 1985. She then assumed a long list of positions in the Suffolk County Chapter, such as Co-Chair of the Vendorship/Managed Care Committee (1997-2004), Co-President (2000-2001), President (2001-2004), Chair of the Vendorship Committee (2006-2009), and a member of the Lobbying Committee (2006-2009).

After becoming a member of the Nassau Chapter, Eleanor continued to serve in many leadership positions, such as Treasurer (2014 to the present), Programming Committee Co-Chair (2020-2022) and Chair (2022 to the present), and Co-President (2020-2022). Eleanor was awarded Diplomate status in the Society in 2001. ■

Chris Ann Farhood LCSW
Met Chapter Honoree

I remember well how excited I was to mail the NYSSCSW membership form that I had picked up from my NYU student mailbox on the day I graduated from social work school. Over the years, the Society has supported my professional identity through educational programs, and most importantly, it has advanced our profession as a whole through lobbying that led to successful legislation.

I completed analytic training in individual psychotherapy and psychoanalysis, as well as child and adolescent therapy, and currently have a private practice in Manhattan. Since January 2011, I have held positions on the State Board as a Member-At-Large, Treasurer, and Recording Secretary. I have also chaired the Met Chapter and State Mentorship Committees and led a mentorship group.

I joined the chapter's Membership Committee to help recruit the next generation of clinical social workers. I conceived of and implemented the Diana List Cullen Memorial First Year MSW Student Writing Scholarship. I also attended many MSW Job Fairs to recruit graduating students. I will continue to advocate for the future of the Society which rests squarely on the recruitment and involvement of MSW Students and recent MSW graduates. ■

Lisa Beth Miller LCSW-R, BCD

Met Chapter Honoree

Lisa Beth Miller is the Outreach and Referral Coordinator at the Lighthouse Guild, a non-profit organization that serves people with vision loss and blindness. She provides behavioral health services at the clinic and assists people adapting to vision loss in navigating the interconnected health, mental health, and blindness systems to access resources and services.

Lisa's extensive experience also includes working on an inpatient psychiatric unit, outpatient mental health clinics, in schools, and in private practice.

As a member of the Met Chapter, Lisa served as Recording Secretary, initiating and developing the Society's online listserv of over 2,000 clinical social workers, a much-appreciated membership benefit. Her article, "Addressing Vision Loss," appeared in *The Clinician*, Summer 2023, and then was updated for publication in July 2024 in *Behavioral Health News*, as "Aging Vision: How Social Workers Can Help Address Vision Loss."

Lisa maintains a private practice on the upper west side and virtually. She is preparing to publish her first book, which sits at the intersection of fiction and memoir, a genre she calls "transformational biography." She laughs every time she reads it and is delighted when others do too. ■

Kevin Melendy LCSW

Rockland Chapter Honoree

For over a decade, Kevin Melendy has served as Rockland's Education Chair, leading the chapter in the adoption of CEUs and through the Covid pandemic.

His interest in the field evolved while doing residential work in Northern N.J. Drawn to the complexity of mental illness and social work values, he enrolled in the NYU Silver School of Social Work. He joined the Rockland Chapter as a student, immersing himself in the camaraderie and learning opportunities it offered. He credits mentors and professors like Dore Shepard and Bill Rubach with preparing him to face the challenges of clinical work.

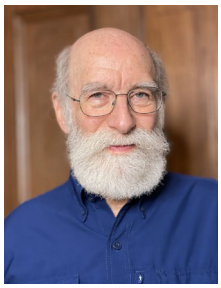
Following graduation, Kevin began a career at Steinway Child and Family Services in the South Bronx where he grew as a clinician providing the outpatient psychotherapy that he loves to this day. He transitioned to another clinic, Pascack Mental Healther Center, where he also got involved in policy and staff development.

Licensed in both New York and New Jersey, currently Kevin maintains a private practice in Englewood, NJ where he enjoys seeing people dealing with life transitions, relational challenges, anxiety, and identity issues. He has a clinical interest in working with creative inviduals and artists, adoptees, and highly sensitive persons. His contributions to the Society and social work profession are significant, and he demonstrates a kindness, curiosity, and commitment to his work every day. ■

ABOVE: Orsolya Clifford, Chapter Pres., Kevin Melendy

Dennis Guttsman LCSW

Staten Island Chapter Honoree



A two-year stint as a Peace Corps volunteer in Ceylon (now Sri Lanka) was the inspiration for Dennis Guttsman to enter the field of mental health when he came home.

He joined a team that would go on to build a new kind of state mental hospital, one with community outreach programs. The experience led him to get a social work degree from Columbia University, and to launch what would become a 55-year-long career.

Among his many accomplishments, Dennis helped set up an adolescent inpatient unit, running wards and supervising social workers and graduate students as a New York University Adjunct Associate Professor. He also served as a field supervisor for all the New York City schools of social work.

Dennis joined the Society in 1978. He has been active in the Staten Island Chapter, serving as Mentorship Chair for decades, as well as Vice President, and currently, as President. He has maintained a private practice for almost 46 years, working with a diverse population and specializing in treating the problems of people from South Asia. ■

Andrea Kocsis LCSW

Westchester Chapter Honoree

A member for decades, Andrea Kocsis served as President of the Westchester Chapter for eight years, and currently serves as Secretary.

During her presidency, the chapter sponsored nine CEU presentations each year, and four or five Zoom CEU presentations yearly during the Covid pandemic. In the last two years of the pandemic, the chapter held several Zoom membership meetings and sponsored two December holiday social events at a local restaurant.

Andrea said she is very thankful for the support of the chapter's board during the years that she held office.

A graduate of Smith College, Andrea received her Master's Degree from Columbia University School of Social Work. She had specialized training in alcoholism and substance abuse counseling and was certified in acupuncture detoxification.

Andrea has worked for the New York City Bureau of Child Welfare and was CEO of Human Development Services of Westchester, a provider of housing and rehabilitation services for persons with serious psychiatric and medical conditions. She has been an Adjunct Assistant Professor at Columbia University and New York University and is co-author of *The Halfway House: On The Road To Independence* (1998, Bruner Maisel U). She is the past chair of the Community Services Board of the Westchester County Department of Community Mental Health. ■

Nan Miller Ph.D., LCSW

Westchester Chapter Honoree

A member of the Westchester Chapter for 46 years, Nan Miller has provided service of enduring value. She has been co-chair of the Referral Service and, more recently, of the Mentorship Committee, providing support and guidance to new and experienced social workers as they progress in their careers.

Nan also chairs our Website Committee and is a member of the Board, where she reliably offers important insights and comments. Her outreach to schools and new participants has brought committed members into our group. A knowledgeable, grounded clinician, she enjoys sharing her expertise as well as continuing to learn from others.

Nan graduated with a Master's degree from Columbia University and a Ph.D. from New York University. She received training in working with children at The Center for Preventive Psychiatry; psychotherapy training at the Blancks' Institute; and substance abuse training for her work in Westchester high schools. As part of her work with the Mt. Kisco Drug Abuse Prevention Council, she applied for and coordinated a federal Drug Free Community Grant for four years.

Her work experience also includes private practice, consultant to an assisted living residence, part-time teacher at NYU, and supervisor of other clinicians.

Nan began her private practice in 1978, providing individual and group family therapy, and supervision. She has also been an individual and group therapist at assisted living residences, and she has taught post graduate classes at NYU.

Long Stories Short

Two stories illustrate Nan's commitment to her clients. The first is the case of a young girl she treated who had been sexually abused by her grandfather. She returned to therapy with Nan as an adult, and then entrusted Nan with the treatment of her own child.

The second case is a mentally-challenged woman that Nan has treated for 43 years. The woman was living in a shelter when therapy began and now is in assisted living. Nan has helped her in innumerable ways—for example, with visits to her parents, to medical appointments and surgeries—providing unconditional lifesaving support. ■

Honoree photos by Shannon Boyle and others.

Long Island Chapter

Barbara Murphy, LCSW, President

We sponsored our first social networking event in Suffolk County at Danfords in Port Jefferson on September 1, which drew a small, intimate group of 16, including the Dean of Social Work School of Adelphi University. We are currently exploring the possibility of using Adelphi's Hauppauge facility for future continuing education conferences or social networking events. On September 29, a small gathering of 12 attended the educational lecture entitled, Sibling Abuse as a Complex Trauma: Understanding the Family Structure and its Residual Dynamics, given by Amy Meyers, Ph.D., LCSW at Molloy University in Rockville Centre. On October 5, our Let's Talk Salon series resumed with the topic, Lifecycle Transitions: Facing the Journey with Courage and Grit, led by Judith Ruskay Rabinor, Ph.D., the author of several books, who led a lively discussion with the 17 participants. It was at the lovely home of our new Mentorship Chairperson, Judith Schaer, LCSW, in Greenvale.

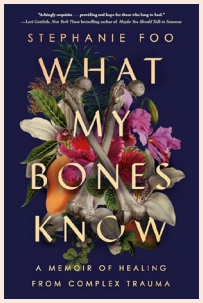
The next Salon series on the topic of The Perverse Enjoyment of Hate will be presented by Ronnie Levine, Ph.D., an author and psychoanalyst on November 24. Our Book Club meeting on November 10 was attended by 10 members with a guest appearance by the author.

The next Book Club will be held in the spring, when we are also planning a continuing education conference at Molloy University led by Jude Treder-Wolf, LCSW on the Use of Creative, Improvisation, and Action Methods-based Exercises in Individual Treatment.

At the NYSSCSW annual luncheon on October 19, Eleanor Perlman, LCSW, Treasurer and Programming Chair of the Long Island Chapter, and I were honored for our contributions to the field of clinical social work and exemplary service to the Society. I have been invited to speak on the podcast, *What Would Dr. Amy Do? Insights not Oversights*, about my professional journey and current concerns about the profession. It will likely take place in 2025; stay tuned for details.

I am blessed to have such a talented and hardworking board, but we are always seeking new members to join the board or our committees. You are always welcome to attend Board meetings to raise any issues or concerns. The dates for 2025 are February 2, April 27, July 27, and November 23.

Barbara Murphy: askier@verizon.net



The Long Island Chapter Book Club

C-PTSD and intergenerational trauma were the topics of the book club brunch hosted by the Long Island Chapter in November 2024 at the home of Susan Kahn. The book under discussion was *What My Bones Know: A Memoir of Healing from Complex Trauma* by Stephanie Foo, a history of the author's abusive childhood and her quest to find a cure for her C-PTSD. It elicited a lively discussion aided by a brief virtual appearance by the author herself, a journalist, radio producer (This American Life), and teacher at Columbia University.

Open to all members of NYSSCSW, the next meeting of the book club is scheduled for May. Details to be announced.

By Susan H. Kahn, LCSW-R, BCD

shkahn18@optonline.net

Several Adelphi University School of Social Work (ASW) leaders attended a Long Island Chapter networking event. (l. to r.) Barbara Murphy, Chapter President; Dr. Joanne Corbin, ASW Dean; Faith Kappenberg, Chapter Scholarship/Ed. Committee; Elizabeth Szpilka, ASW Director of Outreach; and (back) Jennifer Budhan, ASW Program Coordinator.

Met Chapter

Helen Hinckley Krackow, LCSW-R, President

The Met Chapter has had a successful fall working on the growth of our five area Peer Groups, three CE workshops, and five special practice groups.

Our Peer Groups function in Riverdale, Upper East Side, Upper West Side, Lower Manhattan and Brooklyn. These groups offer our members support for their practices and networking with other clinicians in their area. The mission is to rebuild our professional community post-Covid.

Our workshops have covered a range of current clinical concerns. Malka Shaw, LCSW, delivered an extensive history and review of Judaism, addressing current issues of antisemitism and its impact on mental health, as well as holding a discussion of treatment and methods of strengthening resilience. We had a brilliant presentation of challenges in the field of sexual practices given by Danielle Knafo, Ph.D.. She spoke of the growing use of life-size sex dolls, chatbot apps, catfishing, and pornography. Treatment cases were shared. Our third workshop, by Luise Weinrich, D. Min., LSCW, presented psychoanalytic approaches to reaching severely damaged patients by unearthing their unconscious shame due to rejection and abuse.

The Infertility and Family Practice Committee is having a presentation on Sunday, December 1 on pregnancy and polycystic issues. We look forward to two more in the coming months. In January, Nancy Gershman, LCSW will present on a creative technique she developed and in February, Roger Keizerstein, LCSW will conduct a workshop on neuropsychology and treatment.

We appreciate your support of these CE programs which give us great education and Society visibility.

✉ Helen Hinckley Krackow: hhkrackow@gmail.com

Also from the Met Chapter:

P. 17 Psychology of Christian Nationalism
P. 18 NYS Expands Opioid Treatment
P. 25 Antisemitism: Workshop Review
P. 31 Infertility from the Male Perspective

Mid-Hudson Chapter

Barbara Solomon, LCSW-R, President

Our Chapter is moving forward. We are happy to announce the addition of a new Board Member, Janne Dooley, LCSW. She has been working with clients in psychotherapy since 1981, on Long Island (Babylon) and more recently in the Hudson Valley (New Paltz). She has been trained in Gestalt and Family Systems Therapy and EMDR. Janne specializes in healing from childhood trauma as well as recovery from addictions and codependency. She is also a Life Coach.

Janne has trained with the International Society for the Study of Trauma and Dissociation (ISST-D) and is currently a member of the New York City Interpersonal Neurobiology Study Group (NYCIPNB). She received her Coach training from Mentor Coach. She has also trained with The Foundation for Shamanic Studies and attended extensive workshops on Celtic and Native American practices as well as Buddhist meditation and thought. We are excited to add her energy and expertise to our Board.

Our Education Committee has been working hard on planning and presenting interesting webinars. Education Committee members are Cynthia Muenz, LCSW-R, Eileen Duffy Traslavina, LCSW-R, and Rachael Cea, LCSW. On September 28, our chapter hosted The Complex Psychology of Being Adopted: What Psychotherapists Need to Know, presented by Doris Bertocci, LCSW and Linda Mayers, Ph.D. On November 9, we hosted The Use of Relationship Apps and AI with Couples Therapy, presented by Keith Jordan, LCSW.

On February 1, 2025, we will host Letting Go of the Work You Love: How Therapists Can Prepare to Retire or Close a Practice with Care and Compassion, presented by Lynn Grodzki, LCSW, MCC and Margaret Wehrenberg, Psy.D.

On October 25th, our chapter held another Hudson Valley Therapist Meet Up at The Storyteller in Hyde Park. This type of gathering is a great opportunity to network and socialize with fellow clinicians in the Mid-Hudson Valley. Our gracious host was board member Eileen Duffy Traslavina, LCSW-R.

We cordially invite you to the next Meet Up (details to come). You will enjoy socializing, free appetizers, and we will have some good swag to pass out. You can score a free NYSSCSW tote bag or pen!

Mid-Hudson continues to offer the Peer Consultation Group, an opportunity for licensed clinicians to support and learn from one another. The group focuses on

CONTINUED ON PAGE 14

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. Our facilitator is Chapter Vice President Susan Deane-Miller, LCSW-R.

In closing, I want to point out that we are always interested in hearing from Chapter members as to how we can best meet your needs. We are also always actively looking to add Chapter members to our Board and encourage you to consider attending our next Chapter Board meeting. If you have any questions or concerns, please feel free to contact me.

Barbara Solomon: BGS234@gmail.com

Rochester Chapter

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

As we approach the Rochester Chapter's first anniversary in January 2025, it's remarkable to reflect on how much we've accomplished in this inaugural year of start-up and growth.

Our chapter continues to hold monthly meetings where we actively shape the direction and purpose of our group. With nearly 20 members now, we are steadily expanding our reach and encouraging colleagues to join us on this exciting journey.

We've built a dynamic leadership team dedicated to fostering growth and creating opportunities for our members. Our focus remains on setting meaningful goals and exploring initiatives such as mentorship programs, peer support systems, workshops, and strategies to further expand our membership base.

These monthly gatherings have become invaluable for fostering connections, sharing practice models, and supporting one another. Additionally, we've discussed broader issues affecting the field, such as the SW Compact, licensing updates, and concerns surrounding licensing exams.

One of our current priorities is delving into the question: *What is Clinical Social Work?* To address this, we are planning an informational networking event aimed at clarifying and promoting the scope and significance of our profession. We are committed to engaging with local communities and collaborating with clinical social workers and allied professionals who share an interest in advancing our field.

As we approach the new year, the Rochester Chapter is striving to unify its vision and purpose. Our lively monthly discussions continue to generate enthusiasm, innovative ideas, and strategic direction for our chapter's future.

Peter Navratil: pknavratil@gmail.com

Rockland Chapter

Orsolya Clifford, LCSW, President

The Rockland Chapter has been excited to build back our in-person programming and membership and we are offering more than ever to Society members. This fall, we had two great programs facilitated by one of our members, Ian Laidlaw, LCSW-R: Private Practice: Medical Necessity Training and Documentation, and Brief Strategies for Constructing Childhood Narratives for Adults with Limited Childhood Memory.

2025 is going to be a spectacular year with a great line up of presentations offering CEUs and a new support group for Thomas Aquinas College. **Our March CEU program will be free to members in honor of social work month! Save these dates!**

ONGOING MONTHLY: Building Your Ideal Practice, facilitated by Ian Laidlaw, LCSW-R. For more info or to join please email: info@engagepsychotherapy.com

MARCH 23, 2025: Understanding and Treating the Transmission of Generational Trauma and Families Created by Adoption, presented by Dr. Aminda Heckman, Ph.D.

APRIL 20, 2025: The Therapist Body Encounter Transference as a Source of Information When Working with Clients with Trauma, presented by Dr. Amanda Arena–Miller, Ph.D.

TBD: Self Disclosure and Transference, presented by Dr. Stephen Kuchuk, Ph.D.

Orsolya Clifford: ovadasz@optonline.net

Westchester Chapter

Mindy Levine, LCSW, President

In December, the Westchester Chapter celebrated its Annual Holiday Party with an amazing mix of members, including past presidents Rosemary Sacken, LCSW, Andrea Kocsis, LCSW and Roberta Omin, LCSW. Collectively, they represented decades of involvement, which speaks to the great value our chapter has had for its members over the years, and vice versa. Also heartening to see were the newer members, who bring a wealth of experience and ideas to our meetings.

I am continually impressed by members' work in agencies, organizations, and private practice. We are talented group of clinicians who do so much to serve so many diverse groups of people.

It was another year of interesting membership meetings and CEU presentations. Our Education Committee works to bring us an interesting array of speakers. Led by Ruthie Kalai, LCSW, the members include Sandy Demopoulos, LCSW-R, Roberta Schaffer, LCSW, Laura Himmelstein, LCSW, CHTP, Andrea Kocsis, and me.

The speakers and topics in 2024 included:
Roberta Omin, The Professional Will; Amy Meyers, Ph.D., LCSW, Sibling Abuse as a Complex Trauma; Gae Savino, MPA, LCSW, CT, Loss/Grief: Impact of a clinician's personal death awareness on grief counseling; and Julia Blaugrund, LMHC and Marianne Walsh, M.S., C.T., Grief Through the Lifespan.

Previews of 2025 CEU presentations:
Roberta Omin, Part 2: When the Therapist Becomes Ill and the Professional Will, and Ian Laidlaw, LCSW-R, Brief Strategies for Constructing Childhood Narratives for Adults with Limited Childhood Memories.

Our membership meetings have been a mix of connecting, collaborating, and learning from each other's experiences. This year Roberta Schaffer presented Animal Assisted Therapy, and Patti Julianna, Ph.D., LCSW, presented Developments at SAMHSA—The Substance Abuse and Mental Health Services Administration of the US Federal Government.

New and Diverse Members
Like the Society as a whole, our chapter is concerned with increasing our membership to include as many clinicians who might benefit as possible. We have been discussing ways to provide valuable information on developing private practices. There is an abundance of vital information on insurance filing, documentation, and how to develop your practice, to name a few topics. We will reach out to chapter members to gather their input on topics of interest. We are hoping to have a series of membership meetings to address these issues. Developing a more diverse membership will also be a priority in the coming year.

I am excited about our chapter's activities in 2025. We are developing many informative, compelling CEU presentations, and working to expand and diversify our membership.

I am also hopeful that members will join our Board and fill positions that currently are open. We are seeking leaders for the Membership Committee, Mentorship, and a Vice President. Please reach out to me if you are interested.

Mindy Levine: mindyglevine@gmail.com

In Memoriam

Louise Daly Marcigliano

ON JULY 17, 2024, Louise Daly Marcigliano passed away from cancer at home surrounded by loved ones. She was born in Dublin, Ireland in 1947. The family moved to England when she was a child, and in 1965, at the age of 18, she moved to New York City. There she met and married her husband, Frank, and moved to Port Washington, where they raised their two children, and later settled in Rhinebeck.

Louise earned an MSW from Adelphi University. She worked for nonprofit organizations in New York City while maintaining a private practice until illness led her to retire in 2023.

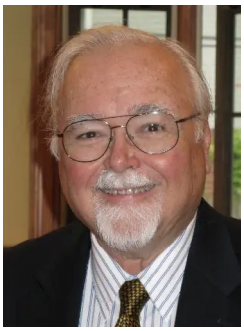
She served on the board of the Mid-Hudson Chapter for many years. As Secretary, she developed the agendas for meetings, taking notes and distributing them. She also kept the Board contact list up to date. In addition, she helped with in-person trainings held at Mental Health America.

Beyond her work on the Board, she served on the Dutchess County Board of Mental Health and Hygiene Sub-Committee.

Louise was passionate about her career and loved her work. She was always a supportive, reliable colleague who shared her wisdom, kindness, and experience generously.

She is survived by her husband, two children, four grand-children, and five brothers and sisters in England. Donations can be made in Louise's memory to Women in Need: winnyc.org or to Cancer Research: giving.mskcc.org.

—Barbara Solomon, LCSW-R



Joseph Reiher

JOSEPH REIHER, A PAST president of the Nassau Chapter, passed away on August 5, 2024, following a protracted illness. A long-standing member, he assumed leadership of the chapter in 2013, following the devastating effects of Hurricane Sandy. It was a time when the Chapter was adrift as members were forced to deal with their own losses.

Joe single-handedly pulled together a new board, and with characteristic determination, reinvigorated the chapter. The unique newsletter, *NewsNotes*, was revitalized, and a tradition of honoring members for their contributions at an annual Spring Fling was inaugurated.

Joe was also one of the founding members of the Ace Foundation. He served as President until 2019, stepping down after the death of his wife and when his own health started to fail.

A graduate of St. Michaels and NYU with a Master's degree in English literature and social work, Joe opened his practice as an LCSW in Plainview, specializing in anxiety disorders, grief and bereavement, LGBTQ+ issues, and PTSD, working with police, firefighters and other first responders. He was actively involved in the Nassau County Department of Social Services and provided services to residents of the Dawn Hill Retirement Home for Veterans. He also published a book entitled, *The Reading Tree*.

Warm and generous, devoted to his family, Joe was well liked and respected by his patients and colleagues alike. He served in the U.S. Army Reserves and was interred with full military honors at the Melville Cemetery. A contribution in Joe's honor was made by NYSSCSW to the Lustgarten Foundation for Pancreatic Cancer Research.

—Susan H Kahn, LCSW-R, BCD

The Psychology of Christian Nationalism:

Why People Are Drawn In and How to Talk Across the Divide

By Pamela Cooper-White

Reviewed by **Kathryn Sedgwick, LCSW**
Chair, Met Chapter Gender & Sexuality Committee

In *The Psychology of Christian Nationalism: Why People Are Drawn In and How to Talk Across the Divide*, author Pamela Cooper-White gives voice to an experience many of us have had in recent times. Sadly, it is an experience that inadvertently ends up illustrating a concept she had hoped to resist, the notion of there being "two Americas": "After attending a political biker rally, visiting a gun shop, and viewing televangelists on YouTube and television, I have had the disorienting experience of finding myself in a completely different world, surrounded by people living in an alternate reality."

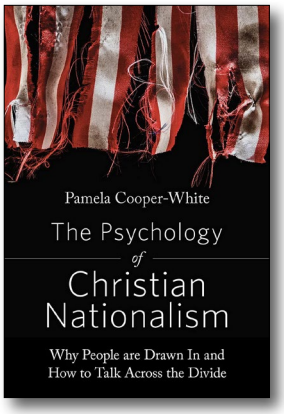
The emergence of this alternate reality can be traced back at least to the Reagan Revolution and '80s deindustrialization, if not before. While there have always been strong undercurrents of reaction and violence in American politics, our current moment seems particularly fraught. To her credit, Dr. Cooper-White, who holds degrees from Harvard and Chicago's Institute for Social Work and is a certified clinical Fellow in the American Association of Pastoral Counselors (AAPC), takes an optimistic tact. She strongly believes, much current evidence to the side, that those of us who do not share their philosophy—and especially those of us who practice the healing arts—have a moral obligation at least to try bridging the ever-widening gap between ourselves and the Christian Nationalist cohort. To this end her work is a serious, well-thought-out attempt to help therapists, and others whose moral compass is still pointing north, communicate more skillfully with our opposite numbers across the Great Divide.

Who, exactly, are these so-called Christian Nationalists? They live in states including North Dakota, Mississippi, Alabama, and West Virginia, where half or nearly half of residents support the view that Christians should dominate all areas of American society, including its laws. Most support the Seven Mountains Mandate, the idea that Christians are to take control of all sectors of society, government, even media and entertainment.

In terms of formal education, "[T]he vast majority (83%)…—the fully convinced Christian Nationalists—have not graduated from college. Annually, they earn the least among all Americans, with a majority at $50,000 per household or less and many below the poverty line. . .[S]oft [less radical] Christian nationalists have somewhat higher rates of formal education (about one-third have college degrees or beyond), but slightly over half still earn only $50,000 or less, with almost a quarter below $20,000—which in most cases also amounts to living in poverty."

More generally, according to a February 2024 NPR article based on a survey by the Public Religion Research Institute, "[A]bout three in ten Americans believe [...] ideas that claim the U.S. is a Christian nation and that the country's laws should draw from Christian values. Today, white evangelical Protestants are the most supportive of Christian nationalist views and make up a third of the Republican party [...] 66% of white evangelical Protestants support or sympathize with Christian nationalism."

The same organization found that "'a non-trivial 15%' of all Americans believe that the government, media, and finance are controlled by Satan-worshiping pedophiles and that American patriots may have to resort to violence to save the country, and 20% believe a storm is coming that will sweep away the elites in power and restore the rightful leaders."



Cooper-White meets the existential concerns of this formidable bloc using a "triage" framework, urging her readers to assess "how hardened the potential dialogue partner is in their beliefs," "who is the right messenger," and also to look at "the context—is this the right time, the right place, the right social context in which to have such a discussion?" Also helpful is her analogy of a traffic light to read the potential of specific conversations: red (stop when there is a risk of harm or of violating our sense of personal integrity; yellow (tread carefully where there is a sense of some openness); and green (move forward).

The author's more general recommendations communicate numerous practices and principles she has gleaned throughout her career, many of which will be familiar to clinicians. These include listening with intention (and listen more than you speak); choosing your battles; modeling civility, allowing anger; mirroring; bracketing; making "I" statements; and being willing to admit your own failings. She utilizes concepts derived from her study of object relations, talks about trauma and splitting, and draws several striking parallels between techniques employed by cult leaders and those used by fundamentalist pastors.

In short, there is a great deal of information packed into these 136 pages (plus notes and bibliography). As dust continues to settle from the 2024 election, it behooves us to learn much more about what can no longer simply be sloughed off as *their* American reality when it is, in fact, rapidly becoming *the* reality of 21st Century life in these (barely) United States. *The Psychology of Christian Nationalism* makes a compelling starting point.

NYS Expands Access to Opioid Treatment Programs

Positive Changes in Residential Rehab

By Jeffrey Zeth, LCSW, Co-Chair

New York State has responded to the growing opioid crisis with a number of new initiatives aimed at expanding access to quality treatment programs. One type of program, residential rehabilitation, has experienced a deep transformation in recent years. The changes apply to all residential addiction treatment programs with an operating certificate in New York State and impacts privately insured clients as well as Medicaid and Medicare recipients.

When someone is in withdrawal from alcohol or other drugs, there is an immediate need to stabilize that person and minimize the risks of physical withdrawal. This is often done in a hospital or freestanding substance abuse treatment program, under medical supervision or management. Once the risk of withdrawal is over, however, the patient will almost immediately need to implement lifestyle changes. Over the years, treatment providers have found that the best way to promote those lifestyle changes is to keep the patient in a protected environment—thus the need for ongoing inpatient care after the acute withdrawal episode is over.

At this point, the request might be for "inpatient addiction treatment," "inpatient rehab," or "residential rehab." In the popular imagination, and for those not directly involved treatment of addicted populations, these terms may bring up many kinds of images. However, regulatory and other changes within the past several years mean that the reality of residential rehab is often quite different than commonly understood. This is important when speaking with psychotherapy clients who may ask for help in finding a residential treatment program for themselves or a loved one. The idea of "going away somewhere" is still attractive to many addicted people who know intuitively that they cannot maintain the changes they need to make while living at home.

Continuum of Care

In New York State, residential rehabilitation is a highly regulated industry. The term "residential rehab" has at least three different meanings in the context of addiction treatment:

Residential Stabilization:
This is the highest level of care within the residential rehab continuum. Here, patients are observed for any signs of mild to moderate withdrawal. There is a higher staff-to-client ratio than in the two lower levels of care, and withdrawal medications are available. Clients are expected to remain on the property at all times, although exceptions can be made in cases of family emergencies or other unexpected problems.

Residential Rehabilitation:
At this level of care, clients are exposed to 12-step programs and taught the basics of addiction recovery, including necessary lifestyle changes and how to practice them. Treatment is structured, primarily using psychoeducational and process-oriented therapy groups and institutional 12-step meetings. Clients may leave the property with an escort.

Residential Reintegration:
Here, clients are part of both the rehabilitation community and the community they left when they entered treatment. They are free to leave the grounds without an escort, to attend 12-step programs, to work, or to visit friends and family. The expectation is that they are rebuilding their lives during the day, while continuing to come home to a supportive recovery environment in the evening.

Positive Impacts
The new regulations have brought changes that have had a positive impact on the addiction treatment field. These include:

Standardized Admission Criteria:
A standardized online tool, the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is used to assist in determining the most appropriate level of care. Clinicians answer questions relating to the patient's withdrawal potential, community supports, and level of motivation, and a series of algorithms provides a recommendation. However, a clinician always has the option to override this recommendation if an override reason is provided. The LOCADTR takes about 15 minutes to complete, and when used correctly saves much fruitless argument with insurance companies over whether a patient's condition "meets criteria" for admission or continued stay.

Photo: iStock.com/fizkes

Psychiatric Care:
All residential treatment programs under the new regulations are required to provide services of a licensed psychiatrist, or to contract with another organization to do so.

Medication-Assisted Treatment:
Programs with an 820 operating certificate are required to dispense methadone, suboxone, or other addiction medications, at all three levels of care. A residential program under these new regulations cannot refuse admission because a client is "on methadone."

Medical Conditions:
Programs with an 820 operating certificate are required to accommodate medical conditions. If a client is on oxygen, uses a CPAP machine, or has other specialized needs, a program must make reasonable accommodations for this. Requests for admission may need approval from the rehab's medical director.

FOR MORE INFORMATION:
https://oasas.ny.gov/system/files/documents/2020/02/clinical-pathway-residential-redesign.pdf

Jeffrey Zeth, LCSW received his MSW in 1992 and spent most of the past 20 years in utilization management and case management. He returned to postgraduate training in 2019 and since February 2024 has been in private practice, providing process-oriented, experiential therapy, also known as gestalt therapy. His article on gender issues in addiction treatment was published in 1997 in *Gender and Addictions*, edited by Liz Zelvin and Lala Strausser.

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becoming-yourself.com

Unique Aspects of Group Therapy for Trauma

CONTINUED FROM PAGE 1

Richard Beck, LCSW, BCD, CGP, AGPA-F is a clinician in private practice specializing in issues related to group therapy, psychological trauma, sexual abuse and incest. He was president of the International Association of Group Psychotherapy and Group Process; and a former president of the Eastern Group Psychotherapy Society. He lectures nationally and internationally on issues of trauma and therapist self-care. He is a Senior Lecturer at Columbia University, he teaches direct practice with individuals, families and groups; comparative group approaches, and treatment of childhood sexual abuse. He is also Process Group Leader for Psychiatry Residents, at New York-Presbyterian Hospital, and Lecturer at Columbia University School of Social Work, teaching evidence-based treatment of childhood sexual abuse.

rbeckny1@aol.com

Groups are wonderful containers for helping people recover from traumatic events. In 2004, the American Group Psychotherapy Association published *Trauma Protocols For the Treatment of Psychological Trauma*. I was invited to write one on "The Unique Aspects of Group Therapy With Trauma." Allow me to share some key points from that module:

- Group treatment brings with it the possibility of the restoration of meaning in social participation.
- Connection with community has often been swept away as a traumatized person swings between feeling empty and being flooded with overwhelming affects (Herman, 1992).
- It is the group's cohesion that is most therapeutic for trauma survivors, not the insights from the leader (Bessel van der Kolk, 1987).
- The primary focus of trauma work is to create a safe space for the group (Ganzarian & Buchele, 1988). This is true regardless of the nature of the trauma, for example, natural disaster, industrial accident, or an intentional act of interpersonal terrorism.
- Thinking about endings, about termination, is very important. Feelings about endings influence the work of groups, in particular, trauma groups (Strean, 1993). Endings can happen at all stages of group development: premature, planned, entire group endings (time-limited groups), or when the leader leaves and the group gets a new leader.
- Termination of beliefs (Klein & Shermer, 2000): Termination is a powerful product and process in any group and its importance is often neglected and undervalued. After experiencing violations of trust and safety, an ending of certain beliefs and truths about the world occurs.

Clinical Considerations in Leading Trauma Groups

Trauma can be defined as, "the experience of an inescapable, stressful event that overwhelms one's existing coping mechanism (Van der Kolk, 1987). It is "an event defined by its overwhelming intensity, by the victim's helplessness to respond adequately, and by its disturbing and long-lasting effects on the person's mental organization." (Laplance & Pontalis, Ganzarian & Buchele, 1988).
In leading trauma groups, it is important to consider:

- Emotional contagion around the responses to a shared trauma stimulus.
- Trauma-related symptoms such as "flashbacks."
- Addressing how not to re-traumatize people with a prior trauma history.
- Handling inappropriate self-disclosure.
- Distinguishing between adaptive and maladaptive coping mechanisms.
- Identification and management of extreme dissociative reactions (Buchele, 1993).
- Recognition and management of panic reactions.

Special Issues

- Focusing on the group as a whole (Ganzarian & Buchele, 1988) will increase group cohesiveness, the primary factor of importance (Van der Kolk, 1987) in the treatment of trauma.
- Awareness of countertransference, vicarious traumatization, and defenses such as denial, splitting, dissociation, projection and projective identification.
- Opportunities for acquiring new information, coping skills, and self-expectations through peer feedback, which is easier for group members to hear at times than feedback from the leader.
- Traumatic countertransferences include "walking on eggshells" with group members, avoidance of certain material, sleepiness, shame, guilt, hypervigilance, and rescue fantasies.
- Disclosures by group members: When someone tells the group something dramatic, such as how they experienced a trauma, or a long-kept secret:
  - Process this horizontally, both with the person and the group, not vertically, with the person and the group leader. (Yalom, 1995)
  - Don't ask for more details. Focus on the meaning for the group of hearing the information, as well as what it means for the person to be telling this material. This is critical in preventing premature self-disclosure and flooding and can help prevent re-traumatization.

I am currently leading three groups for war traumatized people in Eastern Europe. The work presents special challenges because the trauma occurred after one group of people harmed another group, and the fact that the war is still ongoing. We are working in peritraumatic times.

As one of my mentors reminded me, "It takes people to make people sick and it takes people to help people heal." We can use our social works skills to provide a safe holding environment where the group members can reduce their sense of isolation and loneliness. The support that group members provide each other is meaningful and essential. Unlike in other therapy groups, deepening the human connection among group members in a trauma group is essential.

> "We can provide a safe holding environment where group members can reduce their sense of isolation and loneliness. The support they provide each other is essential."

The repaired ceramic bowl that illustrates the articles about trauma is an example of kintsugi, a Japanese style of pottery.

"Kintsugi may be the most perfect embodiment of all our trauma-shattered lives... Instead of throwing away the broken beloved pottery, we'll fix it in a way that doesn't pretend it hasn't been broken but honors the breaking—and more so, the surviving—by highlighting those repaired seams with gold lacquer. Now the object is functional once again and dignified, not discarded. It's stronger and even more valuable because of its reinforced, golden scars." —*Jay Wolf, 2020*

Loneliness after Trauma

How can clinical social workers help people reduce their sense of loneliness after a traumatic event?

I was an invited by the President of the International Association for Group Psychotherapy and Group Process (IAGP) to attend an analytic group therapy conference in Sarajevo, the capitol of Bosnia and Herzegovina. They asked me to give a keynote address and run a small group. At that time, I was the Chair of the Task Force for Trauma and Disaster for IAGP and was coordinating responses to international disasters. I chose to speak about the topic of *Loneliness After Trauma*.

Before going, I reached out to several international trauma experts to ask them what they would focus on if they had a few minutes to speak at that conference. Here are some of the suggestions that were offered to me:

Rome: A Croatian psychiatrist, observing my description of a group at a supervisory session said, "Richard, they remind me of the Elvis Presley song, *Only the Lonely*." (Correction: It was a Roy Orbison song.)

Ukraine: "There is sadness, hurt, depression, anger, fear, but most of all loneliness."

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Photo this page and cover graphic: iStock.com/Marco Montalti

Spain: "I would emphasize the presence of silence in the communications in families and societies with those conflicts. I would describe how silence is an efficient mechanism of transmission of trauma, and also indiscriminate transmission to children, to offspring, by traumatized people without taking in account their capacity of assimilating."

United States: "I would convey that I cannot truly know what they have suffered because I was not there, but I am present now to listen, learn, understand and help in whatever way I can."

Spain: "I would [ask to] see/listen and share with those who have suffered, to recognize their pain, their despair and their stories in order to remember and to learn what could be done in the future to restore what has been destroyed if ever possible."

United States: "With dedication and persistence, our Japanese colleagues relentlessly continue their outreach work to help the victims and families that were/are affected by the tsunami and nuclear fallout. The support they have asked of us is to *walk with them*."

United Kingdom: "When you feel overwhelmed with helplessness, when you haven't a clue what words, method or strategy could possibly address the amount of unspeakable pain in front of you, get up off your chair, stand in front of the speaker and open your arms. Hold the person. Say nothing."

Israel: "When pain is overwhelming, holding, using words, is a comforting solution."

Austria: "I might say that it is very deeply shattering when we experience just how terribly human beings can behave toward each other—killing, raping and maiming for life—without any apparent reasons or qualms of conscience...that this not only traumatizes individuals, but can also disrupt the whole fabric of society... So, it is not only necessary to be there for the suffering victims... but also to work toward repairing a sense of justice and of the requirements of human dignity in the whole society at large, something that can often take many years, even generations, but that is a fight that we must not give up on."

Spain: "Those of us raised and educated as Catholics are instructed to grow with a sense of guilt due to what was explained as the *original sin*.. (I)never understood why, or what it was about. As I grew older, understood that guilt makes us accept punishment without even asking why, since punishment is the only way to erase guilt, and the uncomfortable feelings related to it."

United Kingdom: "Where there is life, there is hope, and where there is hope, there is life. By hope, I mean the ability and willingness to exercise the transcendent imagination. However, I think that it is important to understand the symbolism of the conception of Jesus by God's word through Mary's ear. Relational listening and hearing, and conveying that the traumatized have been heard, are vital for our work. It is hard not to sound trivial and pretentious in the context of so much despair while in the comfort of one's home within fairly stable democratic societies."

Trauma disconnects attachments to others as well as attachments to oneself. There was nothing more important for the group members who had lived through The Siege in Sarajevo than to create a felt sense of safety and trust.

Leading the group from behind, by following the group members, rather than making interventions that led them, allowed the members, most of whom were psychiatrists and psychologists, to take ownership of their experiences in the groups and then begin to cultivate a felt sense of mastery, or "micro-mastery," during the group.

Unlike therapy groups where the group members are screened before being invited to participate, the composition of trauma groups is based on the event itself. We, the clinical social workers leading the groups, are outsiders. This is also the case at conferences and in workshops.

As one mentor described it, we need to be "clinically nimble."

When I was elected President of the International Association for Group Psychotherapy and Group Process in 2018, I was the first social worker to ever elected to that position. I initiated weekly meetings of our executive committee to help guide and lead the organization. The vice president was a psychiatrist from Greece; the treasurer, was a psychologist from Austria; and the secretary, a psychologist from Spain. The senior member was an analyst from the Netherlands who trained at the same analytic group therapy program that I did (Postgraduate Center for Mental Health), and the young professional member was a psychiatrist from Egypt.

During one of our first executive meetings, I told the members that as an organization we needed to be "nimble." It became apparent that nobody understood that word as they searched their computers or phones to find the definition in their languages. It was a real learning experience for me with respect to language and culture, and something that I hope everyone takes into consideration when doing our work.

When my social work students graduate, I wish them the "gift of ignorance, not the gift of stupidity" when working with clients, especially traumatized clients. This "gift" helps clinicians learn more about the subjective experiences of events that their clients endured. We speak of the concept of "cultural humility." My cultural curiosity, my "ignorance," has allowed the members of the group to explain the meaning of their lived experiences to me and the other group members.

Here is a poem written by a group member in Sarajevo. A woman who had enough trust at the conference to share it with us, and then to give me permission to share it with colleagues around the world.

Silence
Silence speaks louder than words
Silence screams louder than noise
Opens windows and doors
Breaks
Jazz.
Blues.
The bass.
The base of the world.
Silence is poetry
And it says:
"I don't know what to say,
All is said,
But we can pray."
—Jasmina Mulaosmanović

I find the poem beautiful and meaningful on so many levels. In our clinical work, whether with individuals, couples or groups, we know that silence is never internally silent, is it?

Trust in the Process

I learned from the late Michael Lindenman, Ph.D. about the nature and focus of interventions that we use in groups. When we listen carefully and work in groups, there are only three types of interventions that we make: We can intervene at the level of the individual, at the level of a dyad in the group, or with the group as a whole.

Unlike groups comprised of members screened in advance, in trauma groups the leader works with whomever shows up to the group.

In the South African group, participants who were from around the world connected and the group became a safe container for expression of vulnerable feelings. We began with members introducing themselves, stating what country they were from, and what kind of therapy they did. Then I introduced Anna Freud's concept about authentic human experiences and the group process began.

An interaction between a very dark-skinned Black South African woman and a gay German man now living in South Africa captured the essence of the safety that everyone experienced. She shared what it was like to grow up as a Black woman during apartheid and he shared his experiences as a gay Jewish man in Germany.

The group members listened quietly to the interaction and applauded them at the end for their bravery, authenticity, and humanity. After the session ended, they both came up, wrapped their arms around me and hugged me tightly, and thanked me for providing them the opportunity to share and interact with each other during the group. It was a human experience that I will always remember and treasure.

One thing that I have learned is to trust the group process, to be patient and to let it unfold, as it did in this group—with this amazing interaction at its conclusion.

* * *

When the war in Ukraine broke out, I was invited to lead "support groups" for Ukrainian mental health professionals. One group has been alive for almost three years now and is the basis of my latest book chapter. My translator is a psychiatrist from Ukraine; our working alliance is excellent in that she has translated many keynotes I have given for Ukrainian mental health organizations.

Allow me to share segments of the chapter here:

"Hope is a very good thing, especially in a time of war, when the power goes out and the air raid sirens go off.

During my IAGP presidency, war broke out in Ukraine. Organizations have powerful counter transferential pulls "to do something, to rescue," and I was aware of how important it was to provide online support groups for Ukrainian professionals. I volunteered to lead one, and Dr. Olha Serha, a Ukrainian psychiatrist now living in Poland, would be my translator for the groups that were organized by Natalia Kryvokobylska, a Ukrainian psychologist, now living in Türkiye. The work would be based on the consultation model that the AGPA used after 9/11. I suggested we offer monthly consultation groups for every group leader conducting a group for Ukrainian professionals.

Those monthly groups are still alive today helping to support leaders who volunteer their time and expertise to help Ukrainian

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colleagues; groups led during peri-traumatic times, often with group members losing power. You could hear air raid sirens during group sessions.

I was exquisitely aware that both Olha and Natalia were Ukrainian. Their roles and boundaries were blurred and needed to be respected accordingly.

Each group member gave voice to their needed experience and shared what would be most beneficial and helpful to them every group.

In a time of war, when group members have little control over many dimensions of their lives, allowing group members to control of the focus of each session was front and center in my thinking.

Our group has recently added new members. There have been times that I couldn't attend a session, and the group would meet without me, led by Olha and Natalia.

Some sessions were deeply personal, as members shared meaningful moments in their lives, as well as supervisory sessions, when members brought in clinical material from their caseload and members shared their clinical insights."

A Tour of New York

Some meetings touched my heart deeply. I was online with the group in my office in New York City when I decided to take them on a tour of my neighborhood with my mobile phone. Some members were in Ukraine, others were scattered around the world. They "toured" Central Park, the Dakota (the building where John Lennon lived) and Lincoln Center. Passing the Metropolitan Opera, I spotted a musical group playing across the street. When I told the musicians that mental health professionals from Ukraine were on the call they interrupted their set and gave a little concert for our group. Amazing! A spontaneous act that made a heartfelt connection through music. Later, Olha gave the group a virtual tour of her town in Poland."

At the United States Institute of Peace, December, 2024, (l. to r.) Dr. Catherine Dale, Senior Advisor and Director, Center for Russia and Europe, USIP; Elisabeth June, Senior Program Assistant, Russia and Europe, USIP; and Richard Beck.

* * *

About two years ago, Dr. Melissa Begg, the Dean of Columbia's Social Work School, introduced me to a Ukrainian graduate student who founded Brave Generation, an organization that recruits groups to support Ukrainian high school students. I encouraged them to use the support that the American Group Psychotherapy Association could offer. Dr. Suzanne Phillips, the co-chair of the AGPA community outreach committee and I currently lead these groups every Tuesday morning.

Brave Generation also asked me to lead a group of college students from Russia, Belarus and Ukraine who left their countries because of the war. This project is sponsored by the United States Institute of Peace. I have been leading these groups online every Saturday morning and we will meet them in person in December in Washington, D.C.

In the first group meeting, I shared a story about a two-day conference given by an institute that I had attended. One attendee was a man of color; I'll call him "Mike." At some point the White woman seated to my right began to speak about "how important Black men were" to her and went on to describe her relationships with them. Then another White woman added how important Black men were to her and described her experiences.

Eventually, Mike spoke. He said that this had been his biggest nightmare—the worst experience he could have had—because people were talking *about him* but not speaking *to him*. Mike did not return to the group.

I shared this story and invited the students to get to know each other better as human beings, and not simply as Russian, Ukrainian or Belarusian.

I always write a quotation, attributed to Aristotle, during the first class I teach: "An education that educates the head but not the heart is not an education at all."

My hope for everyone reading this article is that my words have informed both your head and your heart, and that you are encouraged to learn more.

*A psychoanalytic view of developmental psychopathology. *Journal of the Philadelphia Association of Psychoanalysis*. 1:7-17. [P. 1 Anna Freud quotation]

Jewish Trauma, Resilience and Identity: Navigating a Post 10/7 World

Presented by **Malka Shaw, LCSW** / ***Reviewed by*** **Susan Birenbaum, LCSW**

Who is a Jew? What does it mean to be Jewish? In her Met Chapter presentation on October 27, 2024, Malka (Marni) Shaw, LCSW defined the Jewish community as diverse, consisting of various groups, each with its own cultural, religious and philosophical characteristics. "The history of Jewish persecution and slavery is a long and complex one, spanning centuries and various regions around the world. The history is marked by periods of oppression and discrimination as well as resilience and contributions," she said.

Ms. Shaw is the founder of Kesher Shalom Projects, an initiative addressing the trauma experienced by the Jewish community, post-October 7, 2023 (keshershalom.com). Initially aimed to equip therapists worldwide to support Jewish clients, its focus has since expanded to providing professional development and leadership in trauma and antisemitism.

Antisemitism is a form of racism and hatred directed at Jewish people—hostility or discrimination against Jewish people or institutions—based on Jewish ethnicity, nationhood or contributions. Ms. Shaw's new concept is Antisemitism of Identity Destabilization, described as the psychological impact and effects caused by deliberate defamation of Jewish individuals and communities that undermine their credibility and disrupt their sense of self. It causes internal conflict, distrust and betrayal, increased risk of PTSD, and damaged reputations, ultimately leading to hostile environments.

Trauma is any situation that leaves an individual feeling overwhelmed, unable to establish control, unsafe and isolated. It can create confusion about one's identity and roles, leading to a search for meaning. Intergenerational trauma occurs when an individual's trauma effects subsequent generations without direct exposure to the traumatic event.

Ms. Shaw introduced aspects of her GUARD system—a comprehensive framework for trauma treatment. Our role as clinicians includes:

- Checking on clients' basic needs: Are there any safety concerns? Are they responsible for caring for young children? ls antisemitism causing a disturbance in their general routine?

- Addressing clients with a sense of empathy and providing a safe place to address personal feelings, effects and reactions to their experience of antisemitism.

Antisemitism can erode a person's sense of safety and belonging. Therapy fosters resilience by helping individuals develop adaptive coping mechanisms and strengthen their support networks. Resilience is the ability to navigate adversity, trauma, tragedy, threats or challenges effectively. It includes the capacity to adjust and change and requires perseverance, emotional regulation, and the ability to cope with stress.

Antisemitism is part of the Jewish experience in the world, she said. There is no question that it has shaped Jewish identity as individuals and as a people. However, when working with clients, remind them to have pride in their faith, tradition and culture. Yes, persecution has been a part of Jewish legacy, but Jews have not only survived but thrived. Theirs is a long story of triumph and overcoming hardship.

By processing their experiences in therapy, individuals can identify patterns of discrimination and develop strategies to protect themselves from future victimization. Therapists can also provide education on recognizing warning signs of antisemitism and accessing support resources within the community.

The Trauma of Pregnancy and Infant Loss

Whatever the gestational age, whatever the reason, perinatal loss is devastating.

By Nancy Berlow, LCSW-R

Nancy Berlow, LCSW is a graduate of Columbia School of Social Work. She worked with elderly patients before becoming dedicated to working in the field of perinatal bereavement, now for over 30 years. She served as an in-patient social worker and coordinator of a perinatal bereavement program at a large hospital before starting a private practice in 2002 that is solely based in this arena. Nancy is also the clinical supervisor of the Pregnancy Loss Support Program sponsored by the National Council of Jewish Women: pregnancyloss.org.

For more information about perinatal loss: longislandpregnancyandinfantloss.com.

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Pregnancy and infant loss is a significant trauma—and a significantly underrecognized loss.

Perinatal loss can occur at any stage of pregnancy, up to and including stillbirth and newborn infant death. In this article, I will define the details of pregnancy and infant loss, how grief is experienced following a perinatal loss, and 1) how we as practitioners can be attuned to our clients' experiences, and 2) what we can do to provide support.

In the field of perinatal loss, we recognize that a loss at any gestational age can be traumatizing. In addition, bereaved parents endure *disenfranchised grief*—a grief that is not acknowledged by society. Even widely recognized forms of grief can become disenfranchised when well-meaning friends and family attempt to set a time limit on a bereaved person's right to grieve.

For prospective parents, the feelings of loss can begin with infertility. Although not a loss by definition, it is important to recognize that every month, when a desired pregnancy is not achieved, women and couples feel a sense of loss all the same. This also holds true for unsuccessful fertility treatments.

First trimester gestational losses, those that occur in the first 12 weeks (3 months) of pregnancy, are primarily referred to as miscarriages. One in four pregnancies end in the first trimester, the most common time for pregnancies to fail (the American College of Obstetricians and Gynecologists.)

Losses can be attributed to myriad issues including chromosomal abnormalities, failure of the embryo to attach properly, hormonal imbalance, thyroid issues, infections, and more. For many people, *miscarriage* connotes a "simple loss" that does not deserve much attention. Commonly, patients are told by their doctors or family members to "get over it," and "just get pregnant again."

Some medical providers may also refer to second trimester losses (12 to 24 weeks) as miscarriages. Most evidence suggests that second trimester losses through week 18 occur for similar reasons as those during the first 12 weeks. However, by week 18 and later, conditions such as an incompetent cervix or premature rupture of membranes (PROM) can also cause a pregnancy loss.

Babies that die *in utero* or at delivery who are at 24 weeks gestation and later are considered *born still* (*stillbirths*). In the U.S., one in 175 births results in a stillbirth (March of Dimes).

There are many reasons for stillbirths; and at times there is no clear reason. Some conditions that contribute to stillbirth include PROM (premature rupture of membranes), *placenta previa or **placental abruption, and umbilical cord "accidents," including a knot in the cord or the cord wrapping around the baby's neck, resulting in strangulation. Other factors such as the mother's high blood pressure, also known as preeclampsia or a more severe condition called ***HELLP syndrome, can

lead to the death of the baby or very serious health issues for the mother, including death. [Definitions on next page]

Babies born at 24 weeks gestation and later have a fairly good chance of survival with extended stays in the neonatal intensive care unit. However, babies born prematurely may not always survive the delivery or the first few weeks of life. Newborn infant deaths also fall in the category of perinatal loss.

Phases of Grief Reactions to Perinatal Loss

I am not a practitioner who subscribes to strict stages of grief. We all benefited from Elizabeth Kubler Ross educating professionals and the public about grief stages. However, we now understand that Kubler-Ross's work was directed to those people who are dying and not designed specifically for the bereaved. Grieving is normal and necessary, and it is widely known that healing is not a straight-line process.

The stages perinatal bereavement specialists use to describe the experiences are: initial response, acute stage, grief work, integration, and shadow grief. This is a framework for understanding the process of grief. Each person's grieving is unique; not everyone experiences all stages that are described, and stages often overlap or occur in a different order than presented here. Some grief reactions are experienced inwardly; others are expressed outwardly.

*__Placenta previa:__ a condition wherein the placenta blocks all or part of the cervix in the last months of pregnancy; always high risk and can be fatal to the baby.

**__Placental abruption:__ the placenta may completely or partially detach from the uterus. This can decrease the amount of oxygen and nutrients the fetus gets and can be fatal to the baby—my.clevelandclinic.org/health/diseases/24211-placenta-previa.

***__HELLP:__ (Hemolysis, Elevated Liver enzymes and Low Platelets) syndrome is a life-threatening pregnancy complication usually considered to be a variant of preeclampsia. Both conditions usually occur during the later stages of pregnancy, or soon after childbirth. The Preeclampsia Foundation (preeclampsia.org/hellp-syndrome)

Initial response: Immediately following a loss, the woman/couple are often in denial; a sense of disbelief may be a defense against the overwhelming experience of the loss. This phase can include shock, numbness, and a sense of unreality. Daily functioning is usually impaired, and the loss may seem like a bad dream. This initial period can begin when getting the news that the baby has died up to 2 to 4 weeks post-delivery and sometimes longer.

Acute stage: Following the initial reaction is the acute stage, which can include disorganization, confusion, crying, and difficulty making decisions. There can be intense psychic pain, poor appetite, too little or too much sleep, exhaustion, anxiety, nightmares, depression, vulnerability, social withdrawal, poor self-care, and poor judgment. Feelings can be out of control and one can feel "crazy" at times. Daily functioning may be impaired. Some women have unusual sensations, such as imagining they hear a baby's cry, feeling aching arms or kicking in the womb. This is all part of a normal and expected grief response.

Grief work: Aptly named, this is the toil of sorrow. Pain during the acute stage lessens, is less continuous, and is often related to specific recollections. Most initial symptoms of the acute phase diminish in intensity and frequency. One accepts the finality of the loss but still may remain preoccupied with it.

Volatile emotions are common in this phase. The only place where feelings may be expressed is at home with close family since they are "not permitted" elsewhere such as in the workplace. Anger may be placed on others—particularly the medical team. Feelings of guilt are common, as well as self-blame, blaming God, the partner, or the medical team. Feelings of failure are also common.

As the grieving process continues, women or couples may have a sense of searching or yearning. Some may have a strong wish to replace the baby or the pregnancy. The feelings of loss and loneliness may be intense and mingled with frustration, envy, emptiness, depression, anxiety, or sadness. Difficulty being with other pregnant women and babies is common. Family members and friends may feel that the bereaved parents should be over their grief at this stage, and this can exacerbate the alienation already felt.

Incongruent grief: Some may experience stress in their primary relationships, as the mother and her partner may react and grieve at different paces with different feelings and intensity. We use the term *incongruent grief*

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to describe this experience. With pregnancy loss, the mother's grief is often more intense than the partner's and may last longer. There are several reasons for this, including the fact that the mother carried the baby and felt the baby's presence sooner and formed an attachment earlier. Mothers also experience profound and abrupt hormonal changes following a pregnancy loss, which can have a tremendous impact on their moods.

Partners grieve too, but many grieve differently. They feel sadness at the loss of the baby, but they often feel relief that the woman is all right. The woman may misinterpret this relief as the partner not having cared about

the baby or the loss. Partners may also want to be strong, to protect themselves or the woman from overwhelming feelings or to provide a protective shoulder to lean on during this difficult time.

The partner may also be burdened with many practical details, such as telling others about the loss or making hospital or burial arrangements, which may lead them to postpone the outward expression of their feelings. Partners may bury themselves in work while the woman is at home recovering physically, surrounded by memories of the loss.

With awareness, couples can help each other with their grief and can help overcome misunderstandings that arise from incongruent grief reactions. Even during more so-called "normal" losses, everyone grieves differently. It is important to validate incongruent grief as normal; helping each person in the relationship hear where the other is at. The aim is to help the couple communicate effectively.

Integration, incorporation: Integration and incorporation occur when the loss is accepted as a reality and assimilated. (In the classic literature of grief, this stage is referred to as relief, re-establishment or resolution.) This may be a transitional phase, when the bereaved parents retain their memories but are more distant from the loss. As grief is resolving and being integrated into their lives, bereaved parents can feel a sense of release, renewed energy, enjoyment without guilt, and investment in new activities and relationships. Recollections of the loss may briefly rekindle grief and tears. Integration may be facilitated by the birth of a subsequent child. But it is important to allow that the loss was legitimate and the baby who died (at any gestational age) was desired and not forgotten.

Shadow grief: This is residual grief that is not debilitating or constant. On the surface, grief is resolved, and a more regular routine has resumed. A brief rekindling of grief, and sometimes tears, may occur on conception days, death days, due dates, or on other occasions when the loss is recalled, maybe during a subsequent pregnancy. Shadow grief, which resonates with the original feelings of sorrow, may occur even long after a loss. This is very common and experienced following many different types of loss (not just perinatal).

Intensity of grief: Factors which contribute to the intensity of grief reactions and the duration of bereavement for parents who have experienced a pregnancy loss include a) perceived preventability of death; b) sudden or expected nature of loss; c) degree of bonding with the baby; and d) presence or absence of social validation of grief.

Approaches to Working with Bereaved Parents

Parents never forget their pregnancy loss. It is our job to help them mourn effectively, to help them look forward to the future, and find meaning in their lives. All mourners can be enriched and strengthened by surviving a difficult time. Here are some of the ways bereaved parents can begin a healthy and productive grief process

Talk about the loss: As therapists, the best strategy is to provide a safe, comfortable space for the bereaved to talk about the loss. For the bereaved parent to verbally recall the loss to a sympathetic ear is enormously beneficial. Different approaches can include: 1) hearing the details

Photo: iStock.com/milan2099

exactly the way the bereaved wants to express them; 2) asking to hear the story of the loss in relation to how the medical team handled it; 3) asking to hear the story in relation to how family and friends are responding. Reviewing the story in different contexts, with different tangents may take weeks or months and should be supported.

Releasing a range of feelings: The bereaved will want to release a wide range of feelings; providing permission to cry is critical. Feelings of anger (at times very intense) are natural and should be permitted without judgment. Validating feelings allows them to feel understood and normal.

No timeline: There is no timeline for grief. Individuals need to feel that their grief feelings are accepted. We want to acknowledge each person's unique experience and individual pace.

External validation: At the time of and just after a loss, having the opportunity to see or hold the baby can be greatly beneficial. Planning a ritual, religious service, or burial; and cherishing pictures or other mementos, are some ways parents may choose to mourn.

Options/decisions: People are often overwhelmed following a perinatal loss. We want to provide opportunities for parents to review options and make their own decisions, particularly in relation to how to remember their baby. Patients can be offered these options following a loss at *any gestational age*. This can feel nuanced, and we need to check our own biases while giving permission to our patients to consider all options and their own needs.

Modalities of Treatment

Individual supportive therapy: One to one therapy can be very productive for many patients. There is no specific timeline for the work. Other issues in the bereaved parents' lives may impact and extend the therapy.

Attachment theory plays a part but should not be the focus when we are counseling our patients who are suffering from perinatal loss. They do not have the capacity, and often lack the insight, to spend time on deep introspection about their past—especially in the immediate aftermath of a perinatal loss. As the work continues and the acute pain is lessened, the patient may (or may not) be interested and able to go deeper. The initial work is providing support and a safe place to process the trauma of the loss.

Support groups: Finding an appropriate group with other bereaved parents who have experienced a perinatal loss can help parents tackle the post-loss experience. As practitioners, we know the benefit support groups offer allowing patients to hear others who are going through the same thing. The connection reduces anxiety, validates their experiences, and allows for human bonding around a similar experience. Support groups can be time-limited (6 to 8 weeks) closed groups, which promote ongoing connection and real bonding. Open ended, monthly support groups are also available; these can fill a need and be meaningful as well.

Peer counseling: Peer-to-peer telephone counseling is offered by some programs. Trained peer counselors, who themselves have benefited in the past from such support, are available to connect on a short-term (3 sessions) basis. This valuable support provides a sense of connection and hope to the bereaved. The counselors "have been there" and have "survived"—a very important message to the newly bereaved.

EMDR: Some women experience extreme trauma reactions and may find EMDR or Brain Spotting to be a helpful adjunct to supportive therapy.

Subsequent positive outcomes: Though not a therapeutic modality *per se*, bereaved parents who go on to have a healthy baby report feeling relief and an ongoing sense of healing once they have a healthy outcome. However, there are no guarantees in pregnancy, and this is not a curative step. It is vital to acknowledge that after a healthy outcome we want to help parents find a way to integrate the loss into their lives and into their growing family. People will choose different ways to do this; it is usually an evolving process that does not need a definitive plan.

Helping others heal: This is an ongoing way for patients to continue to do their own healing from trauma. Parents may become peer counselors; by helping others they bring compassion and hope. Some people dedicate their work to the memory of their baby. This experience helps lend meaning to their loss and their ongoing lives.

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Outlier Situations to Be Aware of in this Work

Terminations for genetic anomalies (TFMR): We consider these losses to be just as emotionally laden with grief. There is an additional layer, referred to as *the burden of choice*, for those patients who make this difficult decision. No matter what our belief system is, we need to support both the emotional experience of making the difficult decision and losing the wanted pregnancy.

Pregnancy after loss can be a difficult: This can be a tenuous time for women. It is good for women to get support during this time.

Parents of the bereaved parents: Grandparents of the baby/pregnancy that was lost often have strong reactions and no place to process them. These are important areas to be attuned to in our regular work.

Women who had perinatal losses in the past: Perinatal loss has been more widely recognized in the last 20 to 30 years. Mothers of bereaved women may have had their own pregnancy loss in their childbearing years. Women who are now in their 50s to 80s who had losses likely did not talk about or "properly" grieve the experience. Their own child's current loss may trigger them emotionally. Some may wish to disclose what they went through. It is never too late to remember, grieve and memorialize a lost pregnancy, and there are meaningful ways to do that—including planting a tree, writing a letter to the baby, or donating to a charity—all in the baby's memory. There are annual babies' memorial programs that take place in the month of October which are open for anyone to attend.

Siblings are an underrecognized group: Siblings deserve to be recognized at the time of a loss. Living siblings, depending on their age, will certainly grasp that something is amiss in the household. There is good material available for how to handle perinatal loss for living siblings.

Parenting after loss: This is also important in this field. Parents seek guidance and support about how to include their subsequent children in talking about a previous loss(es).

Surrogate pregnancy loss: There are now cases where gestational carriers have had losses, and the intended parents suffer emotional trauma when the pregnancy is not realized. Ongoing support is critical to these intended parents.

Recovery from the trauma of a pregnancy loss is directly connected to the grieving process. Studies substantiate that there is a lower incidence of postpartum depression following a subsequent positive outcome when women have had permission and support to grieve their loss. Evidence also supports that women who grieve the loss will likely bond more strongly to their subsequent newborn. Further, grieving with support allows for healthier connections to living children and relationships within the immediate family and surrounding family and friends. It is not a simple process; but finding strategies to safely and honestly manage the trauma of a perinatal loss can have a far-reaching impact.

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Infertility from the Male Perspective

By Adam S. Banks, MA, LCSW, CASAC, Chair

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Infertility can be isolating and negatively impact one's sense of identity and purpose in life. However, there are three additional issues that relate specifically to men's experiences: 1) men can feel removed from the treatment/process, 2) the cultural assumption that men do not express their feelings, and 3) the lack of existing support/services for men.

For some men, the overall treatment process for infertility can feel isolating as the onus of much of the treatment and the procedures, (i.e. blood monitoring, hormone shots, egg retrievals and embryo transfers), are on the woman/birthing partner. As such, it can feel that the only time a man is approached by the medical staff is to be taken to the sample room. And as there are fewer men in the waiting room, men can feel as though they are in the spotlight, which can be embarrassing. Some of my male clients have discussed how difficult it has been to connect with other men in the waiting room. For example, one client relayed speaking to another man in the waiting room, and all the other guy wanted to talk about was how uncomfortable he was with the reading materials in the sample room. Another client relayed having tried to make contact with another man, but the other guy seemed to be doing work for his office and did not look up once while he was there.

It is important to appreciate how strongly fatherhood can be integrated into the male identity as the ability to father a child is synonymous with who they are as a person. When this becomes difficult, men may question their role, and purpose in life. As

> "It is important to appreciate how strongly fatherhood can be integrated into the male identity as the ability to father a child is synonymous with who they are as a person."

Petok (2015) observes, this includes men's sense of their virility. If there is a problem with my sperm, then I am not virile. And if I am not virile, then who am I as a man? Furthermore, men are supposed to be "fixers," problem-solvers, and it can be frustrating or scary when they realize that this is not a problem they can solve. When men find out that conception is not as easy as they might believe, they begin to mourn the loss of their vision of what it means to be a father. Men picture themselves passing along what they shared with their own fathers, such as going a ball game or to church/synagogue/mosque. Thus, infertility challenges men to re-write their narrative of how they envision becoming a father and what fatherhood would look like for them.

Additionally, when men are faced with an infertility diagnosis, they may ask themselves a series of questions: How can I accept that there may be an issue with my sperm? Can I accept the need to use a sperm donor? Can I accept that there are other ways of becoming a father? If I can't have my own biological children, will I be okay with adoption or foster care? Or what if/when the pain gets to be too much and my partner and I feel we have hit the end of our road? If and when do we consider stopping and accept not having children?

A man may also feel that he is failing his wife by not being able to give her a child. Accordingly, men may ask themselves another series of questions. How do I fulfill my role as a husband if I am not also a father? Am I letting my family (parents, siblings, grandparents) down? My community? I can foresee the more religious clients ask what does it mean if I cannot fulfill the commandment to be fruitful and multiply? How do I reconcile being given that commandment, but feeling that the ability to do so is being taken away?

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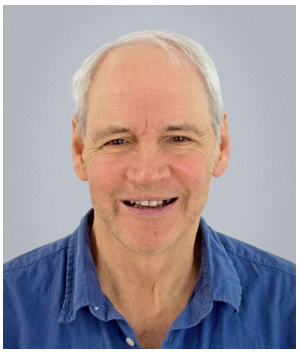
The Boy Who Needed to Act Like a Dog

By Roger Keizerstein, LCSW



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"Woof! Woof!" The compact size boy leaped forward, his small hands jutting out like paws, striking down at the carpeted floor. "Woof! Woof!"

I had been working at the Head Start Center for two years as a disability consultant. Although I was a pediatric clinical social worker by profession, the school's director had taught me how to administer a preschool screening test to evaluate whether or not a child had a learning, emotional or physical disability. If a child did turn out to have a special need, I arranged for and oversaw services provided by various helping professionals: visiting special education teachers; speech pathologists; occupational and physical therapists. If the child was suffering from an emotional disturbance, I was the one who provided the play therapy.

Upon returning from a two-week Christmas break, a teacher from the program pulled me aside in the hallway outside her classroom. "Can you help us with a child? He's barking like a dog, jumping around the room, and scaring other children. We don't know what to do."

Shortly thereafter, I met *The Boy Who Needed to Act Like A Dog*. Domingo was barely four years old. One night, it was reported, he woke up in a daze, walked into the living room, and opened up the cage where the family's dog presumably spent the night. The dog was apparently agitated enough to take a bite out of Domingo's face. When Domingo returned to school after the Christmas break, he had a thick bandage across his left cheek.

Domingo told his teacher that the dog bit him. The school reported the incident to Child Protective Services and a case worker immediately visited the school, photographed Domingo's face, then visited his home.

I sat in the back of the classroom and casually observed Domingo. During circle time he participated in songs intermittently but needed to be prompted and guided when the children transitioned from one play activity to another. At lunch he ate slowly, almost absent-mindedly, as if he were preoccupied, in a trance.

I asked the school's director to see his file. Domingo's profile rendered a picture of a child who up until recently had been developing nicely, meeting all developmental milestones. He liked playing with blocks and Legos and was able to draw with "unusual accuracy" for a four-year-old boy.

I contacted the CPS caseworker, and he arranged for me to visit Domingo's house. The CPS worker told me: "Apparently the dog's a beloved family pet and has never exhibited any aggression toward adults or children or other dogs. Their neighbors confirmed this. This family isn't going to give up this dog without a fight. We decided that if we got a court order to remove the dog, even temporarily, the family might take flight before we get to the dog. That might put the boy further at risk. People are really crazy about their dogs. They sometimes treat them better than their kids."

The irony of what the case worker last said wasn't lost upon me. Domingo lived with his family on the far eastern end of the county. His wood-framed house stood on what seemed like stilts, hoisting its

skeletal structure about six feet above ground. The house abutted a river which tended to flood the area during storms and mighty nor'easters.

I climbed the wooden stairs and knocked on the door. Domingo's father greeted me cordially. "Come in," he said. The floorboards of the house were worn but looked as though they had recently been scrubbed and swept clean. There was an old-fashioned wood burning stove to the rear of the living room and the dog, a Rottweiler, appeared to be asleep in its cage, face down on a white woolen pad.

Domingo's father led me through the living room and into a linoleum tiled kitchen.

"Coffee?" he asked.

"Yes, thank you." Domingo's family had been living in the area since the 1950s and owned their home free and clear, he proudly stated. His father, grandfather and uncles were all fishermen; his mother was a school lunch lady.

I asked Domingo's father about his son's present functioning.

"He eats well, goes to the bathroom on his own and sleeps through the night."

"No nightmares?" I asked. Domingo's father shook his head. "None."

"Very good." I smiled. "What about friends? Does he play with other children?"

"Domingo gets along with everyone. He has lots of cousins. We're all very close." Domingo's father pointed toward pictures on the wall.

"Terrific." We talked about Domingo's behavior in the classroom and about the school's concerns. Interestingly, he didn't bark or jump around like a dog in his home.

"I know that they're looking out for his welfare," Domingo's father said.

"And I am too."

Before leaving, I reassured Domingo's father that I had not come to his home to try and have his dog taken away, but to introduce myself and get his permission to evaluate and possibly work with his son if needed.

"When my wife gets home, I'll show her the permission slips. We'll get back to you by the end of the week."

"Thanks for the coffee." I shook his extended hand.

As a young therapist, I learned the hard way about being too assertive with parents who may or may not have intentionally done harm to their children. I would let my emotions get in the way. In Domingo's case, I had to bond with his parents by focusing on Domingo's emotional needs, not the dog or their possible role in the biting incident.

The CPS worker knew this as well. If the family were notified that the dog was to be removed by court decree, even temporarily, they might take off. Domingo would be without any support and would forever be blamed for telling his teachers that the family dog had bitten him.

If the dog were removed and the family stayed in the area, they would surely blame the school for the removal of a beloved family pet. They might disenroll Domingo from the school and possibly subject him to family shaming, compounding his traumatic injury. Furthermore, if the dog were as well behaved as reported by the family, Domingo and their neighbors, an injustice would have been committed by hastily removing the dog.

If Domingo were to suddenly lose his school, his loving teachers, his classmates and his therapist, his life would be altered forever. The stakes were very high. I had to proceed carefully, with the warmth of an objective but caring scientist.

The very next day, Domingo's father dropped off the signed permission slips at the school. I took my position in the rear of the classroom and quietly observed

"If Domingo were to suddenly lose his school, his loving teachers, his classmates and his therapist, his life would be altered forever. The stakes were very high. I had to proceed carefully, with the warmth of an objective but caring scientist."

Domingo, taking notes from time to time. I noticed that when he played by himself with blocks or a garage set, he appeared focused and in the moment. But when other children crossed his path, his body tensed up defensively.

Then, suddenly, "Woof! Woof!" Domingo leaped forward, more like a frog than a dog. "Woof! Woof!" The children around him froze and one began to cry. The assistant teacher gently led the frightened children away. "It's okay," the teacher whispered. "Domingo's just play-acting."

The head teacher positioned herself on the floor a few feet away from Domingo. "Are you okay?" she inquired sympathetically. Domingo seemed to stare right through her. "Domingo. Are you all right, honey?"

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Domingo nodded. The teacher stayed near him for a while, then asked. "Would you like to color?" Domingo nodded. The teacher moved closer to him, took his hand, stood up and walked him over to a table near her desk at the front of the room.

The teacher motioned to another child. "Sammy, come and color with me and Domingo." This teacher instinctively knew that what Domingo needed most was a connection to a caring adult, not admonishment, or isolation from other children.

I was deeply moved by the gentle and caring ways in which the teachers responded to Domingo, while at the same time attending to the children who found themselves within the frightening sphere of his distress. When a child, or for that matter an adult, repeats something

> "Treating trauma … is difficult in any case, but with children it takes a therapist into unknown territory; you're mostly feeling your way through."

over and over again—in Domingo's case, barking and acting like a dog—the repetition usually represents an attempt to resolve a psychic conflict or discharge pent up traumatic energy. Was Domingo attempting to do both?

That afternoon I met with the school's director, Domingo's teacher, the classroom assistants, and the school's consulting psychologist to develop a plan to manage Domingo in the classroom and also to create conditions for him to resolve any internal conflicts that resulted from his distressing encounter with the dog. Domingo apparently needed to unburden himself of the psychic energy that was still bound up inside him, and as a team, we would try to help discharge it.

"I think what you and the assistant teachers are doing is incredible," I told them. "When Domingo has his outbursts, stay calm, stay sympathetic. If the other children are upset, continue to reassure them; comfort the ones who are upset. Try to keep Domingo in the classroom, casually moving him through the day with assistance."

"Do you think that you can work with him individually? He could use some therapy," the director said.

"I agree, and I have an idea. I think I know how to help him, I said. "I'm going to try to use his drawing ability to defuse some of that bound up energy. But let me start with him in the classroom."

Hypothesis: A Half-Truth

My working hypothesis regarding Domingo's internal conflict was that there might be a discrepancy between what actually happened in his encounter with the dog and what he was told by his parents, and what his parents subsequently told the school and Child Protective Services.

The dog was most likely non-aggressive, as described by Domingo's father and confirmed by his neighbors. Therefore, how the dog came to bite Domingo didn't make complete sense to me. As the story went, Domingo woke up in a daze in the middle of the night, walked into the living room and opened the cage door. If that were the case, the dog would have had ample time to awaken, reorient himself, and recognize Domingo as non-threatening. He wouldn't have been startled into attack mode.

I believed that the story that Domingo's parents were telling was a half-truth, made up to protect the dog. A more likely scenario was that the dog was already out of the cage when Domingo entered the living room. Neither the dog nor the boy was fully awake, and when they converged, *made contact*, the dog spontaneously lashed out.

Even though Domingo didn't have a fully conscious recollection of what occurred—most people don't fully recall life-threatening confrontations—he probably had an implicit, *unconscious*, memory of what happened. His barking and leaping like a dog was an expression of it, a symptom of post-traumatic stress. Thus, Domingo's herculean challenge was to somehow unburden himself of this conflict without betraying his parents and the beloved dog.

Treating trauma and the symptoms of post-traumatic stress is difficult in any case, but with children it takes a therapist into unknown territory; you're mostly *feeling* your way through. With adults, treatment would begin with cognitive work—psychoeducation—followed by instruction on how to reduce the intensity of their symptoms, before deeper, more intense therapeutic interventions can be considered. However, young children are not amenable to this treatment because they are developmentally unable to conceptualize.

Photo: iStock.com/KariHoglund

Building Legos and Trust

I drafted an outline of how I would approach my treatment of Domingo in the classroom and gave a copy to each staff member so that they would know what I was doing at all times, know when to assist me, and when to keep their distance.

In the classroom the next day, I motioned to "Miss Mary," one of the assistant teachers, to sit with me near Domingo on the floor and initiate play between us. Although he was already familiar with my presence, I didn't want to risk frightening him or making him uncomfortable by sitting next to him before being "formally introduced."

"Let's build a house," Miss Mary said to Domingo, pointing to a clear bin of large Lego pieces. "Mr. Roger is going to help us." Miss Mary's choice of Legos was right on the mark. Domingo had already demonstrated a mastery of Lego building, and this increased the chances of our initial encounter being a success.

The three of us took turns stacking the Lego pieces and a towering structure of red and yellow bricks began to rise. "Muy bien," I said, uttering two of the dozen or so words I knew in Spanish. "You're a very good builder, Domingo." Domingo smiled, causing the raw reddish scar that lined the left side of his face to stretch and glow.

"What color is this Lego piece?" I asked.

"Red," he answered.

"Excellent. How about this one?"

"Yellow."

"Boy, do you know your colors! Doesn't he, Miss Mary?"

That was her cue to take her leave. "Domingo. I'm going to help Miss Nancy with the lunches. Have fun building with Mr. Roger," she said.

We played with the Lego bricks for a few more minutes, running a car up and over the side and roof of the house, laughing at our silliness all the while. "That was a lot of fun," I said to Domingo. "But it smells like lunch time. I'll see you tomorrow."

The next day Miss Mary called Domingo over to the classroom drawing table and I joined them. After some free-form parallel drawing, I took out a few thick pieces of white paper printed with bold black letters and shapes. I placed one on the table. "Can you copy the letter A?" I asked Domingo.

He nodded, confidently. With a firm, steady hand, he copied the letter A almost precisely as it had been printed.

"Excellent," I said. I placed another sheet of paper on the table. "Can you copy the circle?"

Smiling, without saying a word, Domingo copied the circle as precisely as he had the letter A.

With a confident hand, he continued to demonstrate an uncanny ability to replicate the letters and shapes that I set before him. I had only known one other child who was able to do this at such a young age and she grew up to be a prominent illustrator for Walt Disney Productions without the benefit of formal training.

The next time I saw Domingo, I asked him to join me at the Play-Doh and hard clay table and help me mold animals and people. "I'll need to use the Play-Doh tools," I said. "I'm probably not nearly as good at this as you are."

I began to soften a mound of hard clay and asked, "Can you make a boy out of this?"

Domingo flattened a portion of the clay to create what seemed like the base of a body, then added a head, arms and legs. He took a pencil and carefully sculpted a recognizable face, then fingers and toes. I was stunned. "Wow, Domingo. You really know how to make clay people!"

I continued to see Domingo in the classroom over the next few weeks, cultivating a relationship with him through play. Although his outbursts were fewer, less intense and shorter in duration, I attributed this only partly to his therapy, more to the passage of time. The healing of the gash on his face and the forming of a protective scar were quite helpful to him. Equally important was the fact that the tension at home had recently been defused when Child Protective Services found that his parents had not been neglectful of his welfare. Their beloved dog was safe; he would not be removed.

Since Domingo's symptoms appeared to be diminishing and the risk of retraumatizing him reduced, I decided to introduce pictures of people and animals, images that might trigger some of the traumatic energy still bound up inside of him. We took turns drawing the pictures with pencils, crayons and magic markers, but I purposely didn't present him with a picture of a dog.

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Domingo's reproductions of these more challenging images took more time and weren't nearly as precise as his replications of shapes and letters. However, his deliberateness, his apparent strategizing as he approached the rendering of images, were impressive indications of the artist's brain at work.

At about week five, after at least 10 sessions, I told the school staff that they had created a very safe environment for Domingo and helped me carve out a therapeutic space for us to work in, so I wouldn't have to take him out of the classroom. "I think he's doing much better. What is your impression?"

The head teacher agreed. "He barks much less and seems much calmer, more like the child that came to us before the biting incident. The children are no longer afraid of him."

"It really helps when he's no longer leaping around the room," I pointed out.

"It sure does," she said with a laugh.

I explained to the group that with their help and guidance I was able to establish a trusting and playful relationship with Domingo. I would soon be trying more direct interventions in an attempt to reduce and eventually drain the last of the traumatic energy still bound up inside of him. "I will be very careful, though. One small step at a time."

Titration: Carefully Timed Steps

The term used to describe this stage in Domingo's therapy is titration. The term is borrowed from the field of chemistry; it is a way of measuring changes in a given solution by adding small amounts of other substances and monitoring and recording the changes every step of the way.

The treatment of trauma with a client is similar to the process a chemist employs in the lab. Initially, it has four carefully timed steps:

- Psychoeducation
- Analysis of the distorted thinking arising from the traumatic event
- Identification of triggers
- Reduction of symptoms associated with PTS through biofeedback techniques.

When these four objectives are accomplished, deeper work can commence, without too high a risk of retraumatizing the client through over exposure to the traumatic memory.

My sessions with Domingo utilizing art laid the groundwork for me to initiate the titration process by encouraging him to draw pictures of the biting incident with his dog or anything related to his implicit or even his explicit memory of the experience. I could only employ this therapeutic modality with a child as young as Domingo because of his extraordinarily precocious artistic ability. But first I would have to test the emotional waters for levels of turbulence.

> "The introduction of pets that reside in homes—dogs in general and then Domingo's dog Sammy in particular—allowed for safe triggering, the loosening up of some of the traumatic energy inside him."

I started the next session with Domingo by presenting him with pictures of family pets: cats, birds, dogs and rabbits.

"I have two birds and a cat," I said. "Do you have any of these pets in your home?"

Domingo pointed to a dog.

"You have a dog? What's his name?"

"Sammy."

"Sammy?" Domingo nodded.

"What does Sammy do all day?"

"He sleeps." Domingo started to giggle.

"Does he ever get up to eat?"

Domingo nodded repeatedly, laughing all the while.

"Is Sammy like Daisy The Lazy Dog?" I showed Domingo the cover of a book that the teacher had read to the class a few days before.

"Yes!" Domingo was now delirious with laughter. "But he's a boy!"

"Right. Sammy's a boy dog—who sleeps and eats all day. What was I thinking?" I tapped my head lightly and shook it from side to side, feigning disbelief over what I had said.

Domingo's laughter gradually died down, but before I asked him to help me put the pictures and the book away, I extended my hand to him and said, "You sure know your dogs."

Domingo shook my hand and suddenly, almost shyly, turned away.

The introduction of pets that reside in homes—dogs in general and then Domingo's dog Sammy in particular–allowed for safe triggering, the loosening up of some of the traumatic energy inside him. This came about principally because he was able to engage the subject matter creatively and playfully without being overwhelmed by the underlying implicit, *unconscious*, memory of being bitten. This was also made possible by working with a therapist whose only vested interest was in the boy's welfare, not the protection of the family dog.

Subsequently, instead of erupting, barking, and leaping around like a dog, *impulsively expressing the traumatic energy bound up inside him*, Domingo was able to accomplish a controlled and proportional release of this energy through play and through his art, diminishing its potency and hold over him.

By the following week, Domingo's barking in the classroom was barely a whisper—his body movements more of a crawl than a leap. There was nothing menacing or frightening about his utterances or movements and the other children just went along with these episodes until they passed. Subsequently, I reduced our weekly sessions from two times to once a week.

Before our next session, I called Domingo's father and asked if he could send him to school with a picture of his family with the dog. When I received it from Domingo's teacher, I glued it to the middle of a thick sheet of white paper.

"Thanks for bringing in the picture," I said to Domingo. "Who is this?"

"Mommy."

"Who is this?"

"Poppy."

"Who is this?

"Me." Domingo laughed.

"That's you?"

"Yes."

"You've grown so big." I gradually widened my hands.

Domingo continued to smile.

"And who's this? Daisy the Lazy Dog?"

"No! That's Sammy!"

"That's right," I said. "That's your dog Sammy."

I took out a piece of paper and started to draw Domingo's family from the photo. "I'm having a hard time with this. Can you help me with this drawing of your family?"

Domingo nodded. I gave him a few wider sheets of paper, so he had enough room to draw all the figures side by side if he so desired. He drew his mother, father, himself, and Sammy the Dog in that order. His mother was roundish, his father tall and thin, he was small and round, and the dog long and bulky. All the figures received dotted eyes, noses and lips like his clay moldings.

"Excellent." I said. Domingo smiled. I set his drawing of his family members and the photo of his family side by side.

"In the picture of your mommy is she happy or sad?" I asked.

"Happy."

"How about Poppy? Happy or sad?"

"Happy."

"How about Domingo? Happy or sad?"

"Happy."

"Don't forget Sammy the Dog? Happy or sad?"

"Happy." Domingo replied. His replies were calm and quiet.

"So," I said as a way of summing up our session. "Your mom and dad and you and Sammy the dog are happy."

Sammy nodded affirmatively, without saying a word.

A few days later, with the assistance of Miss Mary, Domingo presented the photo and his drawing of his family to his classmates during show and tell. He told them about the time they all went fishing together on his father's boat and Sammy the Dog slept the whole way through.

Since Domingo was doing so well, I decided not to address—or have him address—the memory of the biting incident. Instead, the Head Start center consulted with an art teacher and set up an enrichment program for him in the classroom. I continued to see Domingo every other week until the spring semester came to an end and the school turned into a three-days per week summer camp in which the children were taken on day trips to places like Sesame Street Park, petting zoos and indoor aquariums.

In the fall, upon returning from summer break, I was told by the director that Domingo had transitioned successfully to a preschool/kindergarten program in his school district and that they promised to cultivate his artistic ability. With his parent's permission, I sent copies of Domingo's artwork to his new teachers. A few months later, I contacted Domingo's father and his new preschool teacher, and they both assured me that he was doing well.

Trauma and Eating Disorders: A Turmoil of Emptiness and Fullness

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. Visit EmotionalEating.org for book introductions and more information.

When shame erodes the past and fear erodes the future, there's no living in the present.

—Malachy McCourt

Trauma such as abuse, violence, and abandonment can shatter the heart and soul of a person so deeply that it often becomes a primary trigger for self-harm behaviors. Victims of trauma may be plagued with guilt, shame, fear, anxiety, rage, and self-punishment. Eating disorders are an example of self-harm behavior where people seek the soothing comfort, protection, and anesthesia that food offers. Food, after all, is the most available, legal, socially sanctioned, cheapest mood-altering drug on the market.

Bulimia, anorexia, and binge eating are mood-altering behaviors that can help detour, divert, and distract a person from inner pain. Food can also provide pleasure when pleasure is in short supply.

Judy was born into a family of ten children with two more following her birth. Judy was starving in the chaos of family life, never getting enough nurturing or enough food. She learned to make do with scant little. When she was eight, her older brother began crawling into her bed and molesting her. This was frightening and yet . . . the closeness to her brother, another hungry person, was also comforting and consoling. And confusing. Her parents never noticed.

After five hospitalizations for anorexia and bulimia, Judy reluctantly arrived at my office at age 20. She asked if during our session, she could sit on the fire escape outside my window, the furthest point in my office from where I was sitting.

With that one request, Judy told me a great deal about her trauma and her eating disorder. She was conveying:

> Stay away from me! People can't be trusted. I want to keep you at arm's length. I try to keep food at arm's length. I cannot take in nurturing, caring, or food because it turns to hurt and pain. My brother loved me and hurt me. My mother didn't have time to love me and hurt me. I'm afraid my bottomless hunger will swallow you up. Maybe you're hungry too, like my brother, and will want to swallow me up. Are you brave enough to go out on a limb (the fire escape) to rescue me?

What's the connection between trauma and eating disorders?

Trauma is like a tsunami that overwhelms and hijacks our inner sense of self. Are we hungry (for food or for emotional connection)? Are we full (of food or feelings, of shame, of despair)? The traumatized person with an eating disorder is like Goldilocks: the first bowl of porridge is too hot, the second bowl is too cold. The porridge of life—food or human connection—never truly nourishes or hits the spot. Hot? Cold? Full? Empty?

Trauma can be held in the body for years, but the unspoken pain continues to exert its power. Unable to dislodge the "knot" in one's body by crying and grieving, many traumatized eating disorder patients turn to the pain-relief "medication" of bingeing, purging, or starving.

For many people with trauma and eating disorders, trusting food is safer than trusting people. Food never abuses you,

never abandons you, never hurts you, never rejects you, never dies. It is the only relationship where you get to say when, where, and how much.

But, clearly, no amount of manipulating one's food or weight resolves the injured heart and spirit of the traumatized person.

The Eating Disorder Mirrors the Therapy Relationship

Eating is a relationship that can be either nurturing, neglectful, or abusive and reflects the kind of early attachment we had with our parents, be it secure, ambivalent, or traumatic. Encoded in the symbolism of the eating disorder lies the story of the trauma. Through the lens of attachment theory, we see how different eating styles will become illuminated in the relationship with the therapist and will develop in the treatment.

Brianna called me for an initial consultation and added laughingly, "You are my eighth therapist in five years." Evidently she was bulimic—bingeing on therapists and then purging them. She had unwittingly disclosed

"Encoded in the symbolism of the eating disorder lies the story of the trauma. Through the lens of attachment theory, we see how different eating styles will become illuminated in the relationship with the therapist and will develop in the treatment."

her diagnosis before we even met! In session, I learned her father left the family abruptly when she was five, returned when she was seven, and left again shortly thereafter never to be seen again. Here today, gone tomorrow, in and out—just like she treats her food, her multiple boyfriends, just like she treats her therapists. A repetition compulsion in every aspect of her life.

The bulimic wavers back and forth between secret gorging rampages and violent purges of the food she has consumed. She purges to "repent" her neediness in the hopes of proclaiming: *I really can manage with very little. I'm able to give it back. I didn't mean to take it anyway.* This oscillation between gorging and purging parallels her ambivalence about whether it is even safe to take in food—or a relationship—and keep it. Like Brianna, she'll take in a portion of the therapist and then be compelled to get rid of it.

The anorexic abhors her emotional neediness and will starve herself as a way of proclaiming: *Look how strong I am. I have no needs. I don't need food. I don't need anyone. I am in control!* Not needing is her badge of honor, and she will reject and defend herself from the therapist's help. Like Judy, she wants to sit far away on the fire escape.

For the overeater, the world never seems to offer enough sustenance. She does not trust in the abundance of food, just as she does not trust in the abundance of love and human kindness. When I suggested to Nancy, a young woman adopted when she was three, that she come twice a week, she left the session and binged for the whole next week, "You would never be able to give me as much as I need," Nancy reported in the next meeting.

The connection with the therapist becomes a mirror to better understand the inner world of the traumatized emotional eater, providing a rich avenue of exploration. When we focus on the patient's relationship with us, the eating disorder behavior emerges in the treatment—a rich porridge of transference and countertransference reactions.

Treatment

Many treatments exist for trauma and for eating disorders from psychodynamic therapies to behavioral/cognitive strategies to EMDR to exposure and somatic therapies as well as psychiatric medications and psychedelic assisted therapy.

The language of pain comes in many dialects. Emotional eating problems and the fear of being fat is one such dialect in which we recruit our bodies to express what we cannot utter in words. Our eating problems become a vehicle to communicate matters of the heart that have no other channel. The language of food and fat is a symbolic one, a way to express our inner emotional battles over feelings of emptiness and fullness, vulnerability and protection, urge and restraint, desire and despair, guilt and shame.

Although everyone's eating disorder and trauma history are as unique as a fingerprint, the therapist introduces the idea that all eating disorders are a language that needs to be translated into feelings and words: *If your vomit could talk, what would it say? And to whom?... If your gorging on food in the middle of the night could speak out loud, what would it say?* The idea that eating disorders are a symbolic communication needing to be decoded and deciphered helps the patient take a step back from emotional eating and begin to reflect and make meaning of her behaviors. The therapist helps the patient create the link between their eating behaviors and their need to expel, starve, binge, and dissociate from trauma.

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Blood, Sweat, Tears, and Vomit (hers)

Over 20 years have passed since Judy first arrived at my office. She is now married with a family and is basically free of bulimia. Judy registered with an organ transplant association and over the years, she has donated a kidney and a piece of her liver (I consider getting rid your body parts to be bulimic equivalents even though it may be viewed as altruistic).

The treatment of choice for her was "blood, sweat, and tears," arguably not an approved scientific psychological methodology, but it worked. In this slow, painstaking treatment, the consistent presence of the curious therapist helped begin to unfreeze her aloof stance.

For quite a while, Judy said very little. She was giving me meagre thoughts, feelings, and words—thin broth, emotional "bare bones." Having worked with anorexics before, I was wary of speaking too much, which can often cause them to feel as if they are being force fed with words.

I learned that Judy prided herself on how little she required growing up; her goal was to spare her mother any extra work. Early on, she received praise for her "maturity," even though that maturity was rooted in silencing and repressing her emotional hunger and not in true emotional development. Judy's refusal to eat, her striving to have no needs (and no fat), became her badge of worth. She was consumed by an ongoing attempt to starve out her inner badness—her secret voracious needs and the horrifying feelings of shame and guilt at her brother's molestation.

Working with Judy often made me feel discouraged and unhelpful. I came to recognize my sense of inadequacy with Judy was also a reflection of how she felt in her own life—ineffective, inadequate, and unimportant. By her refusal to take me in, she was inducing me to experience her inner world. I decided to tolerate my "inadequacy" and just observe her efforts to devalue me. I studied how and when she undermined me as a way to understand her internal workings.

In one session, we were speaking about old age. "When you're an old lady, I'll take you in to live with me and take good care of you," Judy said. I was astonished by her "offer," since she had never shown me any warmth or demonstrated that I was important to her in any way. I understood her offer to "take me in" as meaning that emotionally she was beginning to take me in.

And I recognized in this role-reversal script she recreated that she was the mother and nurturer, while I was the helpless little old lady needing her care. This was a mirror image of how she experienced her own childhood with her mother—a role reversal where she cared for her mother and not the other way around.

I asked how she would take care of me. And I teased her about whether she would feed me as little food as she fed herself. We began laughing and kidding each other. Some ice was broken, and we began having a new way of relating—through laughter. This freed us up.

At times, when Judy particularly irritated me, I began to dramatically raise my eyes to heaven and proclaim, "You are so impossible!" I now felt comfortable venting my aggravation directly to her in words in the hope she would join me and use *words* to express herself and her hostilities. But her chronic self-expression through starving and vomiting continued on and on.

"In this slow, painstaking treatment, the consistent presence of the curious therapist helped begin to unfreeze her aloof stance."

Then, because of some new-found openness, Judy began relating experiences from a childhood filled with deprivation and sadness. Anorexic Judy was now beginning to "flesh out" her story. Her mother never sang her a lullaby nor read her a bedtime story. Her reaction—*I can do without*—made her feel less vulnerable and less disappointed. She now began feeling anger and betrayal as well as sadness and compassion for herself and her brother, that his molesting her had sprung from their deep emotional needs and hunger.

When Judy was nine, she deeply yearned for a Cabbage Patch baby doll. It was so unusual for her to want anything for herself. Her aunt agreed to buy it. Finally, she would have a doll of her own. But it was not freely given; her aunt asked Judy to pay her back. In effect, Judy had to buy the doll for herself. And so, once again, she had to be a grownup.

She told me this story with no emotion, but tears jumped to my eyes. I felt the sorrow for her that she could not feel for herself. It was too dangerous for Judy to own that sorrow and deprivation. Her self-starvation numbed and blocked out dangerous feelings, memories, hurts, needs, desires, yearnings, anger.

I fantasized buying her a Cabbage Patch doll. I took note that in my fantasy, I was no longer the helpless old lady nor was she the mother caring for me. I was feeling

like the mother who wishes to buy a doll for her little girl. She was letting me take care of her in my fantasy life. The tide was shifting.

She wrote me a letter. "I would love to share some meaningful feelings, thoughts with you. There is a particular pain in being unable to put them into words. Just try to understand me in a way deeper than words, beyond words. So, I'll communicate in silence. Other than the two most important words, 'Thank you.' "

Our unconscious, nonverbal communication continued in surprising ways. She was seeing me twice a week and, in a burst of tenderness toward her, I thought silently in our session, "I wish Judy could come to therapy three times a week."

Simultaneously, she said out loud, "I hate therapy!" At the very moment I was wanting another "portion," she was spitting it out, starving herself!

Me: "And here I was thinking I wanted to see you three times a week."

Judy: "Well, that's basically the same thing as me hating therapy."

We laughed heartily at the absurdity of our different positions. Me, the therapist, who enjoys eating, did not have any problem wanting another serving. Judy, the anorexic client, frightened of hunger—physical or emotional—was all prepared to starve me out. Yet, we recognized that we were feeling mutually tender toward each other in our own ways.

After much mutual spilling of blood, sweat, tears, (and her vomit), Judy has allowed herself to develop and internalize a caring, secure attachment to me. She has been free from starving and vomiting for a number of years. She revealed to me this summer that she was enjoying her solitude and her own company—the first time in her life that she did not need to be running away from herself and undigested trauma. *Girl Interrupted* has become *Woman Flourishing*.

Conclusion

Therapy is a collaborative effort to reweave the torn emotional fabric of the trauma so the person can live more fully and peacefully in their skin without intrusive echoes of the past. Eating disorders and trauma have frozen our patients' feelings. Their relationship with us can help them thaw. And as our patients come to express their hurt in words, digest and metabolize their pain, then the porridge of life can become "just right" enough.

EPILOGUE

Feeding a baby goes beyond food nourishment and is an introduction to our parents' acceptance of our lusty hunger, delight in our food exploration which communicates the message that the baby is loved and approved of. This baby (all things being equal) will grow up at home with her needs.

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Other babies will have the feeding experience tainted with teasing, bullying, and the parents' needs for power and control. They receive "emotional malnutrition" with the message that the world can be insensitive, depriving, and hurtful.

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Some parents weave deception and trickery into the feeding sessions with their children. What message about the world will a child get from this experience?

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In the ideal, non-eating disordered world, parents also have the opportunity to inculcate the love of food as one of life's most basic sources of pleasure. ●

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In addition, infertility can threaten one's sense of generativity through becoming a parent, of being able to bring forth the next generation (Erikson, 1980, pp. 103). As such, this poses yet another series of questions: How can I be generative without having children? Aren't we taught that there is more to life than just work or hobbies? Aren't we taught that one of the most important things in life is to have a family? What happens when that becomes too hard or not possible for us?

So, we may ask, what are the barriers for men getting therapy? Most importantly, the services that are available are far and few between and/or underutilized (Petok, 2015). I wonder if the lack of development of services or lack of referrals to existing ones is based upon the presumption that men won't use them.

A note on the social construction of men not sharing their feelings. There is a stereotype that men are resistant to therapy. Part of this may be from the common belief that men see themselves as having to be the rock for their spouse, to hold her up, or avoid expressing their feelings out of concern that it would make their spouse feel worse. However, I have difficulty with this, maybe I am an outlier as a male therapist, but I honestly believe that men can and will express themselves in situations in which they feel safe to do so—there are two circumstances in my work in an Agency in which I have seen that this can happen when we can create emotionally safe spaces for men. I have found that focusing on improving group members' ability to connect with, process, and express their feelings in my Young Men's Group and an Adult Support Group has been integral to their healing and recovery. In addition, I have witnessed how normalizing participation in therapy is crucial for destigmatizing the need and reaching out for support of our mental health. For example, I once saw two guy friends greet each other in the waiting room happily. I saw no hint of embarrassment for either of them to say they were there to see their own therapist, but rather they were proud to have been there and seen each other. I would not have been surprised if they went out for a beer afterwards.

I'd like to conclude by offering some suggestions of how to help men cope with the emotional stress of infertility. First, we as a culture need to recognize that taking care of our mental health is just as important as taking care of our physical health, (i.e. brushing our teeth and eating, sleeping well) and our spiritual well-being. For example, meditation and relaxation techniques, including diaphragmatic breathing exercises, as well as yoga or tai chi can be very helpful in reducing stress and improving overall well-being. Both journaling (Pennebaker, 2018) and focusing on gratitude, which Sansone & Sansone (2010) defined as "...the appreciation of what is valuable and meaningful to oneself and represents a general state of thankfulness and/or appreciation," have been shown to improve our mental health and well-being.

As infertility can be very isolating, I believe wholeheartedly that improving social support, including the use of family and friends, as well as individual and group therapy, is integral in the healing process. Individual therapy can provide a safe space in which men can process their feelings about their experiences in infertility and journey to parenthood. Group therapy provides support from other men who face infertility and can be normalizing and reparative. Additionally, Men's Helpline, menshelpline.org, offers a peer-to-peer support program to help men connect with other men who have experienced infertility. Participating in these kinds of support services can normalize the experience of going through infertility and provide a safe space for men to connect with, process, and express their feelings.

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For further information about men and infertility, please visit Men's Helpline (menshelpline.org), or other challenges to family building, RESOLVE (resolve.org), or the American Society for Reproductive Medicine (asrm.org), as well as the ASRM's Mental Health Professional Group (connect.asrm.org/mhpg/home).

In addition, Adam can be reached by telephone at 929-483-5337 or by email at adambankslcsw@gmail.com.

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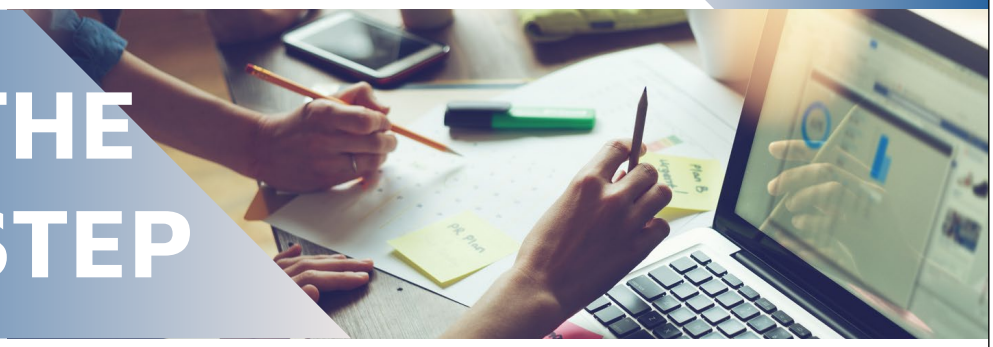

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