

# The CLINICIAN

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

## Protecting the Public's Mental Health Services: *Who is watching the store?*

By Marsha Wineburgh, DSW, LCSW, Legislative Committee Chair

The NYSSCSW Legislative Committee continues to monitor the State Education Department's (SED) progress in addressing the problems which have arisen as the result of implementing the 2002–2004 psychotherapy licensing laws. SED is currently considering the experience requirements for individual licensure as well as the registration of authorized settings for providing clinical services as provided in A.8897-A/S.5921.

### Experience Requirements for the LCSW

One of the current requirements for the LCSW is completion of three years of full-time supervised clinical experience in the provision of psychotherapy services. Where does this requirement come from? In 1977, 33 years ago, the Legislature enacted Chapter 893 of the Laws of 1977 adding sections 162 and 253(8) to the Insurance Law creating what is known as the "P." This law established the basic postgraduate

standard for the supervised clinical experience that a "certified social worker" (currently an "LCSW") was required to meet in order to attain the minimum level of competence to provide diagnosis, psychotherapy and assessment-based treatment planning, independent of supervision. The current LCSW statute also requires three years of supervised clinical experience in diagnosis, psychotherapy and assessment-based treatment planning. In an effort to simplify the regulation of social work psychotherapy, an amendment was passed to integrate the LCSW statute and the "P" insurance law. By implication, the LCSW license now includes an insurance reimbursement component.

For three decades, New York's "P" standard has required three years of supervised clinical experience providing mental health services for autonomous practice. It works. Why change it? SED, influenced by NASW and many social agencies, is considering reducing

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### PRESIDENT'S MESSAGE

## The Society's Identity and Functioning



Jonathan Morgenstern,  
MSW, LCSW

Who we are and how we function as a Society are two issues that are being addressed this year. Thank you to everyone who responded to the invitation to a discourse about our identity in the last

newsletter – your thoughts have contributed more clarity about our identity as clinical social workers – after all, who we are influences all that we do. At the heart of what the Society has to offer both current and future members is a community of like-minded individuals – psychotherapists who see the world through relationships, a common prism with its own culture and language.

As I began my second term as president, I have made membership retention and development a priority – and quickly realized that branding and marketing the Society must flow from a clear identity. The State Membership Committee, at its recent full day retreat, has been charged with identity

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You're Invited to the 41st Annual Conference  
**LIVES DISRUPTED: Contemporary Approaches to the Treatment of Trauma**  
May 8, 2010. See Page 7 for details.

## State Board Members 2010

### STATE EXECUTIVE COMMITTEE

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## President's Message

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clarification and developing new outreach approaches to agencies and schools. This committee is also in need of a chairperson – please contact me if interested.

How we function as a Society is also being addressed. The Society's administrative and clerical needs have changed over the years. Many needs have been out-sourced at considerable expense or have been handled by Society volunteers who should be available for mission-related work. Mitzi Mirkin has been a consultant to the Society, performing as the Society Executive Secretary for 32 years, and is retiring as of February 28th. She will be celebrated at our Annual Membership Meeting planned for October 3rd. She has agreed to remain a consultant on call for three months after February in case we need her to answer questions, serve as a resource, and lend us her expertise.

Society leaders have found that there is a growing need for additional administrative, fiscal and clerical supports. The Society has researched and determined that it would be best to hire an association management company (AMC), based on cost effectiveness, a need for the provision of a greater range of services, and to relieve the administrative burden on Society leaders. AMC services are supplied for a set fee that is considerably less than the Society is currently paying for fewer services; and many currently out-sourced services that the Society is paying for are included in the basic supports provided for the set fee. The AMC supplies a level of technology that the Society could not otherwise afford. It provides clerical and administrative support as well as professional expertise when needed, such as a bookkeeper, at no extra cost. This allows the board and other leaders to focus on policy, strategic thinking and decision-making, rather than on administrative and clerical tasks. Their paid staff will support our efforts and not duplicate them.

Several association management companies' proposals were considered and Total Management Solutions was selected based on offered services and competence reflected in accreditation, experience and references. They were also perceived as a good fit for our Society. As of March 1st, our 800 number will ring in their offices, where they will answer the phone with "New York State Society for Clinical Social Work." You will have the opportunity to meet Sheila Guston, Total Management Solutions President, at the Society's Annual Meeting in October. She is already working to set up the site.

I know the Society is in good hands and that we will continue to meet members' needs. The Society's infrastructure has been strengthened with renewed purpose and supports that will enable us to continue fulfilling our mission. ☑

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NEWSLETTER COMMITTEE CHAIR: Helen Hinckley Krackow

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# Leadership Committee

By Beth Pagano, LCSW-R, Chair

Congratulations to our newly elected members of the State Board and State Executive Committee. Helen Hinckley Krackow will serve a second term as Treasurer and Marsha Wineburgh will serve a second term as First Vice President. Roberta Faulk from Mid-Hudson, Lorraine Fitzgerald from Nassau and Sheldon Blitstein from Westchester will serve as Members-at-Large. Welcome newcomers, and many thanks to the entire board for their dedication to our society and the profession of clinical social work. As an organization comprised of volunteers, dedication and service is imperative if we are to thrive and meet the challenges in the field of mental health.

Our president Jonathan Morgenstern has led us through a time of transition and much has been accomplished. Communication at the State Board level and between the state and chapter boards has become more transparent and thus more effective; the administrative infrastructure of the State Board has been strengthened and essential duties have been decentralized; Society policies and procedures have been compiled into formal manuals to support current and future leaders; administrative supports to the Society have been assessed and an association management company has been retained to better meet current and future administrative support needs of the Society.

The Chapter Presidents Committee is grappling with the most effective ways to connect the statewide membership while supporting the individual identity of each chapter. Helen Hinckley Krackow, as Chapter Development Chair, has focused her efforts on the Brooklyn and Metropolitan chapters. Robert Berger and the Website/ Listserv Committee have developed a strong listserv program which strengthens and promotes networking. *The Clinician*, edited by Ivy Miller, with Helen Hinckley Krackow as the chair of the Newsletter Committee, will be available on our website and continued in hardcopy, highlighting the accomplishments of the organization while keeping the membership current on important practice issues.

Judy Crosley, chair of the Strategic Planning Committee, has led the group in the creation and completion of policy and procedure manuals. Hillel Bodek, as Ethics Committee Chair, responds to inquiries from members and non-members regarding ethics in practice issues, protecting clinical standards and consumers of mental health services. The Independent Practice Committee, chaired by Sheila Peck, has developed a comprehensive program relevant to new and seasoned clinicians.

The Mentorship Committee, with Helen Hinckley Krackow at the helm, is active in most chapters. The mentorship groups, open to non-members for a fee, serve as a public relations tool as we help new clinicians working in both private and public institutions establish and advance their clinical practice. Fred Mazor, Disaster Preparedness Committee Chair, keeps us connected with the Red Cross and updates on crisis procedures. Gloria Robbins has prepared the Membership Committee to create a societal atmosphere that will ensure membership retention and development.

Our Vendorship and Managed Care Committee, headed by Helen Hoffman, works tirelessly to keep its finger on the pulse of activity in the behavioral health financing companies. The Legislative Committee, with Marsha Wineburgh as chair, recently ran another campaign to ensure that standards of practice will not be lowered. Through the listserv, the membership received information that connected them to our lawmakers, ensuring that the Clinical Social Work License would not be diminished.

Each year the Education Committee, chaired by Susan Klett, presents a relevant, stimulating program drawing on the varied expertise of our members and other leading mental health professionals. The Arts and Creativity in Clinical Practice Committee, headed by Sandra Indig, always has an eclectic, evocative calendar of events.

The level of dedication in our volunteer organization results in the delivery of superior quality programs and services to clinical social workers and the clinical social work profession in New York State. Thank you to all committee chairs and members as well as all state and chapter board members.

Looking ahead, we are faced with the continued task of maintaining standards in education and practice in the field of clinical social work. The By-laws Committee will be reviewing the current by-laws, as amendment is necessary to reflect changes brought about by our licensing law. Practice committees – Family, Psychoanalytic and Group – will be reestablished and an Agency Practice Committee will be formed.

Leadership must continue to reflect the high standards maintained by the Society since its inception. Our next election involves nominating a president elect who serves for one year with the current president before assuming the position of president. The offices of secretary, second vice president and two members-at-large are up for election this year as well.

Service is imperative for our organization to maintain its history of excellence. We will be reaching out to current leaders and members as we begin the nominations process. Future leaders are encouraged to explore your potential in this wonderful organization. ■

# Membership Committee

By Gloria Robbins, LCSW, BCD, Chair and Jonathan Morgenstern, MSW, LCSW, Society President

The State Membership Committee is currently chaired by Gloria Robbins and includes Richard Joelson (Met Chapter), Larry Lieberman (Staten Island Chapter), Haya Caspi (Westchester Chapter) and Shirley Ross. The committee's work has led up to a full day retreat that took place in January, facilitated by Marian Sroge, consultant to the Society, and also attended by Jonathan Morgenstern, Helen Hinckley-Krackow, Shannon Boyle, Beth Pagano, Rita Smith, Henni Fisher and newly elected board member-at-large, Sheldon Blitstein (Westchester). The purpose of the retreat was to consolidate previous work and plan next steps regarding membership retention and development.

Growing the Society requires additional clarity about its current identity, goals, and activities and, hence, the value of membership, that is, what the Society has to offer. One first step is the determination whether we are a society of private practitioners or of clinical social work psychotherapists in all practice settings (e.g., agencies, hospitals). What do you think? Please e-mail Jonathan at [mjonathanm@aol.com](mailto:mjonathanm@aol.com) with your input.

The Membership Committee functions were determined to include:

- Welcoming and orienting new members to the Society and their designated chapter, and helping them find their place within the organization
- Setting up periodic orientation receptions to provide a setting for new members to meet existing members as well as members of the board
- Consulting on methods to keep the membership apprised of the work being done by committees and encouraging active participation
- Developing and implementing specific outreach initiatives to members who have not renewed their Society membership
- Communicating the needs and interests of members to both chapter and state boards
- Planning, coordinating, and implementing various activities to provide opportunities for networking among chapter members.

The following strategies were proposed and are being considered:

- Developing outreach strategies to schools of social work, agencies and private practitioners
- Member-Get-A-Member campaigns
- Recognition and acknowledgment of recruiting and new members in *The Clinician* and on the website
- Personally contacting and welcoming recently joined

- members by telephone and at specially planned gatherings
- Having state and chapter board members and Membership Committee members call new members
- Inviting new members to chapter board meetings to familiarize them with the Society's functional infrastructure
- Outreach to colleagues about the Society and what it offers, and inviting them to educational presentations.

Benefits of membership were considered to include:

- Keeping apprised of licensing law implementation and related regulations
- Access to seasoned practitioners for peer consultation
- Mentorship groups; practice-oriented educational and training presentations
- Access to a community of like-minded professionals
- Active listservs, which provide access to a wealth of useful resources
- Contributing toward and supporting the Society's efforts to maintain professional integrity and standards of practice while working to address workforce challenges.

Relatedly, the committee brought up the issue of Society-facilitated supervision services to agencies; this issue had been brought up before and merits reconsideration.

Outreach to schools of social work would emphasize access to seasoned practitioners and mentorship, including valuable professional support. Outreach to private practitioners would emphasize an alternative to feeling professionally isolated, networking opportunities, ready access to practice-related resources and information (e.g., managed care-related information), referrals, and opportunities to develop special interest areas.

Additional tools under consideration:

- Further developing the award of CEU credits at all Society-sponsored professional/educational activities
- Advertising and inviting potential members to Society-sponsored events as guests
- Public recognition of members who get members, e.g., a statement of appreciation in *The Clinician* or some other form of acknowledgment.

This is an exciting time for membership work and the committee is seeking your help. Please consider offering your support in any way. Additionally, Gloria has announced her intention to step down as committee chair and a replacement is being sought. If interested, please contact Jonathan Morgenstern at [mjonathanm@aol.com](mailto:mjonathanm@aol.com). ■

# Private Practice Matters

By Richard B. Joelson, DSW

This is the first of what will be a regular column in future editions of *The Clinician*. Issues of interest and concern to those in private practice or contemplating a practice will be discussed with emphasis on money matters and marketing. Readers are invited to submit their questions to Richard at [RBJoelson@aol.com](mailto:RBJoelson@aol.com). All questions will be responded to regardless of whether or not they appear in *The Clinician*.

*Here are some tips and guidelines for handling money matters in the current economic climate:*

**1** If, upon a client's request based on changed economic circumstances, you agree to reduce the fee, do so for a time limited basis, e.g., three months or 10 sessions, so that you build in a defined time for when the issue will be revisited and reconsidered by both of you. Many therapists reduce fees for good reason and then find it difficult to restore the original fee (let alone ever raise it) when the client's financial circumstance changes. Currently, I have three clients for whom I reduced the fee with a scheduled discussion of the matter within a mutually agreed time frame. All were quite appreciative and understanding of the idea that we have to be fair to both of us and not just one of us.

**2** If a client requests a fee reduction, this is something that should be explored, rather than immediately granted. There is probably much "grist for the mill" here that should be considered prior to a decision (e.g., is the therapy fee the only item that is being reduced in their budget or is it the only one that occurred or the easiest one to try and get reduced?). Remember that fee matters are treatment issues, not just money issues.

**3** In the current, or any, economy it is important to convey and clarify your fee policies (and if you don't have fee policies, I urge you to develop them...now!) so that clients understand what is expected of them and how the two of you will be handling financial matters throughout the treatment. I do not believe it to be reasonable or fair to create and/or invoke a policy on the spot for such occasions as late cancellations, missed

appointments, etc., if client was not informed of your policy earlier. If, in the beginning, I neglect to inform a client about my fee policies and procedures and they miss a session, for example, I do not charge for that event, but will in the future once they have been informed. Some therapists use a written policy statement which is handed to clients in the first or second session in order to insure clarity.

**4** Many premature or abrupt treatment terminations can be traced to unacknowledged and, therefore, therapist-and-client-avoided fee-related conversations in the course of the treatment. Watch for signs of fee-related issues that occur, however subtly. Examples include chronic late payment, promises to send the forgotten fee that are never received, repeated checkbook forgetting, forgetting the balance due and whether or not they paid for that month, etc. Work at getting comfortable discussing money matters if you are not already. Too many of us have been in the position of chasing after unpaid balances (often quite large) after a problematic or even conventional termination. ❏

**NEXT ISSUE:** Tips on cultivating new referral sources.

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**Richard B. Joelson, DSW**, has been a clinical social work psychotherapist, educator, and administrator since 1970. He received his master's degree from Columbia University School of Social Work and his Doctor of Social Welfare degree from Hunter College School of Social Work. He has been the executive director of a mental health clinic and the Director of Admissions and Student Affairs at New York University School of Social Work. He was an assistant professor of social work at New York University and taught in both the doctoral program and the post-master's program in social work administration at Hunter College School of Social Work.

From 1991 to 2002, he taught a course at Hunter College School of Social Work on developing and succeeding in private practice, and currently conducts workshops for his chapter on the topic. He is the new chair of the Membership Committee for the Met Chapter. E-mail him at [RBJoelson@aol.com](mailto:RBJoelson@aol.com) or visit his website, [www.richardbjoelsondsw.com](http://www.richardbjoelsondsw.com).

# Vendorship and Managed Care Committee

By Helen T. Hoffman, LCSW, Chair

The Vendorship and Managed Care Committee meets by teleconference six to eight times a year, and occasionally in person, focusing on insurance issues. Members communicate frequently by e-mail and post bulletins on the listserv. The purpose of the Committee is to gather and disseminate information about insurance issues, to assist individual members with specific problems, and to explore ways of influencing external forces. Some of their most recent issues or initiatives include:

- Anticipating the Oxford/UBH transition
- Warning members about Medicare audits and the need for careful documentation
- Discussing ethical issues raised by Medicaid managed care
- Educating members about the Federal Parity Act
- Following the national healthcare debate
- Exploring how the Society may advocate for the financial health of clinical social workers (Advocacy Study Group)
- Participation in a New York Business Group on Health pilot project promoting integrative care (see box)

*You are invited to contact members of the Vendorship and Managed Care Committee to share your experiences or obtain information on specific problems:*

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\*Medicare Liason; \*\* National Health Insurance Observer

## Integrative Care: Partnering with Primary Care Physicians

Two years ago, Frank Munoz, a speaker at our annual meeting, told us that clinical social workers need to discover new roles in order to prosper. Since then, we have been thinking about how we might reinvent ourselves. One idea that has been taking shape as a proposal for a pilot project is that of partnering with primary care physicians. A grant proposal is being drafted by New York Business Group on Health, a community coalition of which the Society is a member. This group is comprised of behavioral health and pharmaceutical executives, private consultants, and representatives from the NYC Department of Health, NAMI, and various professional organizations.

The mission of the pilot is to get primary care physicians in the commercial sector to screen, treat and follow depressed patients. More than half of patients being medicated for depression are being treated by PCPs, but the quality of care is uneven and follow-up uncertain. Access to enough psychiatrists who are on managed care panels is a serious problem. PCPs may or may not make referrals for psychotherapy.

This proposal, following an “integrative care” or “collaborative care” model, calls for the collaboration of a PCP, a psychiatric consultant provided by the insurance company, and an independent clinical social worker. Two possible types of locations are the community health group, in which the LCSW would have an office on the premises (co-location), and the solo practice, in which the LCSW would be available several days a week either in the PCP’s office or nearby, and available by telephone. The LCSW would perform assessments, follow up patients who have difficulty with medication, perform brief interventions, make referrals to psychiatrists, refer for longer term psychotherapy, and consult throughout with the PCP. Each step in the intervention would be documented for program evaluation purposes.

How to properly compensate the LCSW for these tasks is one of the main areas that remain to be resolved. Behavioral healthcare managers are being asked to propose alternatives to the existing fee-for-service model. Otherwise independent LCSWs can have reason to fear that they will be overworked and underpaid if they are recruited to participate.

LCSWs who perform as “depression care managers” in the public sector and are salaried tell us that this work takes a high degree of skill and experience and an acceptance of a more active, short-term role with the client, but that the work can be extremely meaningful. The work requires a change of mindset from traditional ideas of treatment. To help in that transition, this pilot program could include training of LCSWs for the specific role of “Depression Care Manager” or “Integrative Care Specialist.” In so doing, it could create a new clinical social work identity for LCSWs who wish to play a role in a new, less fragmented, and more collaborative healthcare system.

# New York State Society for Clinical Social Work 41st Annual Conference



## LIVES DISRUPTED: Contemporary Approaches to the Treatment of Trauma

**Saturday, May 8, 2010**

**8:00 AM – 4:00 PM**

The Nightingale-Bamford School Auditorium  
20 East 92nd Street, New York, NY 10128

### KEYNOTE PRESENTATIONS

#### *Treating Family Relational Trauma*

Catherine Lewis, LCSW, MS

#### *Extending Kohut's Concept of Selfobject*

Crayton E. Rowe, Jr., MSW, BCD-P

### EIGHT AFTERNOON WORKSHOPS

CEU credits are available

**For information, please call (212) 755-4765**

Members, Non-Members, MSW Students are welcome!

Conference Chair: Susan A. Klett, LCSW-R

## Legislative Committee

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and/or diluting the clinical experience requirements as a solution to a multifaceted problem which has made it difficult for many LMSWs to obtain the requisite three years of supervised clinical experience for the LCSW. The Clinical Society recognizes this problem with obtaining the experience needed for minimum competence in psychotherapy.

**But we oppose a solution which reduces the proven minimum experience requirements.** Such an action is detrimental to public protection and to minimum standards of competence in clinical work. It also insults our membership, many of whom have spent years in advanced psychotherapy education programs and gathered extensive supervised clinical experience beyond their initial MSW/Ph.D. and "P" experience to provide the highest quality psychotherapy services.

### Why We Need to Preserve the Current Supervised Clinical Experience Standard

1. Combining didactic education with supervised clinical experience is traditionally how health care professionals learn their trade.
2. The "P" Law established the psychotherapy insurance privilege for social work, a privilege the four new mental health disciplines (licensed marriage/family therapists, licensed mental health counselors, licensed psychoanalysts and licensed creative arts therapists) do not have.
3. Since the 1978 "P" law was passed, the knowledge base for treating mental and emotional disorders has exponentially expanded to include information from neuroscience, brain development, new findings on the etiology and evidenced-based treatment of mental

illnesses, and research studies of the efficacy of treatment modalities and their appropriate use. This increase in the knowledge base of mental health care would seem to require an increase in supervised clinical experience, not a decrease.

4. "Counseling" is not the same as "treating" mental illness.

5. When compared to the four new disciplines of mental health practitioners, the LCSW has the broadest scope of practice, and is akin to psychology's scope of practice. The LCSW scope of practice includes all the functions of the LMSW scope of practice and adds the functions of diagnosis, treatment planning, psychotherapy and the administration and interpretation of tests and measures of psychosocial functioning.

Only licensed psychologists and LCSWs are permitted to diagnose mental illnesses and to provide services autonomously, i.e. free of physician consultation, referral or supervision.

### Opposition to the Current LCSW Statute

NASW-NYC and many social agencies are currently pressuring SED to change the experience requirements for the LCSW law. Their argument appears in the most recent issue of the *Currents New York City Chapter of NASW* (Vol. 54/No.3, January 2010). In an authorless opinion article entitled "Issue Paper on Social Work Licensing in New York State," it argues that the LCSW license for diagnosis, treatment and treatment planning is too narrow and action is needed to "broaden the experience requirement for obtaining the LCSW." It mentions the

CONTINUED ON PAGE 11

# Borderline or Bipolar

# Part II



[NOTE: Part I of this article appeared in the Spring 2009 issue.]

By Brian Quinn, LCSW, Ph.D.

## Recognizing Bipolar Spectrum Illness in Depressed and Personality Disordered Patients

Have you worked with patients who have tried several different antidepressants, improved for a time on one or more of them, and then slipped back into depression? Have some of your patients become mired in lethargic, irritable, unrelenting depressions despite combinations of antidepressants and other drugs such as Abilify? The most common reason is that these patients do not just have depression or a personality disorder. They have undiagnosed bipolar illness (Sharma et al., 2005). Antidepressants can cause a number of problems in bipolar patients that may make effective psychotherapy difficult if not impossible.

Primary care physicians and psychotherapists misdiagnose 3 out of 4 bipolar patients, typically as having unipolar depression. Patients spend roughly 9 years working with these professionals before a correct diagnosis is made. Alarming, psychiatrists do not fare much better, making the wrong diagnosis in about half of bipolar patients and allowing 6 ½ years to pass before getting the diagnosis right (see charts below).

In the Spring 2009 issue of the newsletter, I discussed how familiarity with the seven cardinal symptoms of mania and hypomania\* and asking patients and their families about episodes of increased activity and productivity (the hallmarks of a hypomanic episode), can help clinicians identify depressed or character disordered patients who are bipolar.

Clinicians can further improve their chances of identifying bipolar illness by learning to recognize “features of bipolarity” in depressed and character disordered patients who do

not have a history of mania or hypomania (Ghaemi, 2008). Features of bipolarity include symptoms, course of illness patterns, family histories, and responses to antidepressant medication that occur in patients with clearly identified bipolar disorder but that are not typically found in those with classic unipolar depression.

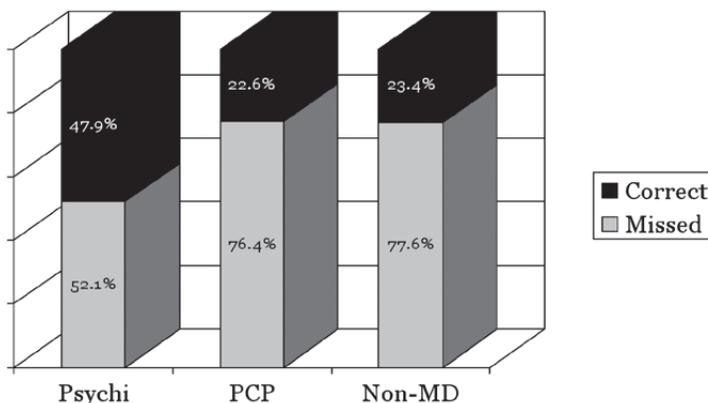
Following are the features of bipolarity clinicians should look for in depressed and character-disordered patients (especially those patients with DSM Cluster B disorders such as borderline and narcissistic personality). Patients with varying combinations of these features should be suspected of having a “bipolar spectrum illness” (Akiskal, 1996; Ghaemi, 2008) even if they have not had a clear-cut history of mania or hypomania.

## Symptoms and Signs Suggesting Bipolar Spectrum Illness

There are three symptom clusters that should alert the social worker to the possibility a patient may have bipolar spectrum illness: depressive mixed states, atypical symptoms of depression, and psychotic depression.

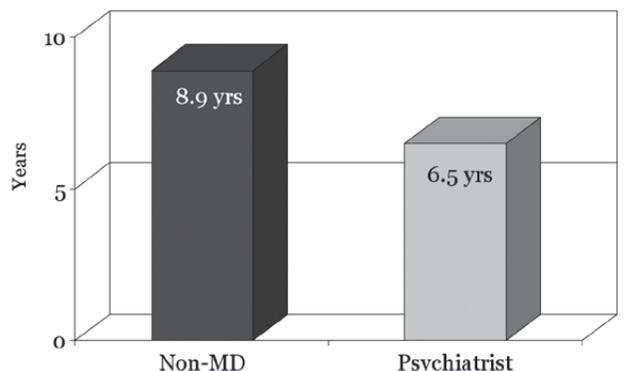
Patients are said to be in depressive mixed states when they have many symptoms of depression but also some hypomanic ones, as well. Hypomanic symptoms may include distractibility, racing or crowded thoughts (flight of ideas), and loud, rapid, and sometimes difficult to interrupt speech. These individuals may be animated, engaging, and amusing

Correct Diagnosis of Bipolar Disorder by Profession



Hirschfeld, R., et al. (2003)

Delay in Diagnosis by Profession



Ghaemi, S., et al. (2000).

despite meeting criteria for depression, but often their mood is irritable or dysphoric. Because these patients are talkative, therapists may have little opportunity to speak without feeling as if they are interrupting. Patients in depressive mixed states may have an increased sex drive (patients with unipolar depression complain of decreased sex drive).

Unipolar patients often have “typical symptoms” of depression: Middle of the night or early morning awakening and loss of appetite. The clinician’s index of suspicion for a bipolar spectrum illness should rise if, by contrast, the patient has so-called “atypical symptoms:” oversleeping, overeating or leaden paralysis (a feeling of overwhelming heaviness and fatigue in the arms and legs). Atypical features are more common in bipolar patients than unipolar ones (Angst et al., 2006).

An adolescent or young adult with psychotic depression (depression accompanied by delusions or hallucinations) is likely to later develop mania. Psychotic depression is sometimes not as easy to spot as the clinician might expect: Psychotically depressed patients tend not to reveal their delusions and hallucinations. Psychotic depression should therefore be suspected in an adolescent or young adult who is very guarded, excessively guilt-ridden, confused or has extreme psychomotor retardation (Goes et al., 2007).

### Course and Temperament Characteristics of Patients with Bipolar Spectrum Illness

Individuals with unipolar disorder typically have their first episode of depression in their late twenties. Bipolar depression begins, by contrast, in the mid to late teens. The younger the age of onset of depression, the more likely the patient will eventually develop a manic or hypomanic episode (Goodwin & Jamison, 2007).

Bipolar depressions typically have a more rapid onset than unipolar depressions (days to weeks as opposed to months), may last less than 3 months (unipolar depressions typically last 6 to 12 months), and are highly recurrent.

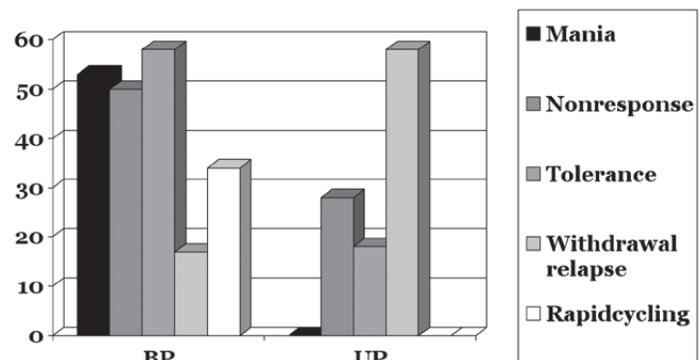
Individuals who, before their depressive episode, consistently got along on 6 hours of sleep a night or less, and were cheerful, talkative, over-confident risk-takers may have what is referred to as a hyperthymic temperament (Akiskal, 1996). These individuals often end up in business, sales, politics, or entertainment. Depressed patients with premorbid hyperthymic and cyclothymic (chronically moody, irritable, and unstable) temperaments should be suspected of having a bipolar spectrum illness.

Post-partum onsets of depression (especially psychotic forms) and seasonal cycling of depression should raise clinicians’ suspicion of bipolar illness, as well.

### Family Histories of Patients with Bipolar Spectrum Illness

According to DSM-IV a depressed patient without a history of mania or hypomania whose father or mother has bipolar illness is considered to have a unipolar disorder. Yet, antidepressants don’t work as well in depressed patients with an immediate

## Antidepressant Outcomes in BP and UP Depression



N = 40 BP

N = 38 UP

Ko, J. et al. APA 2002

family history of bipolar disorder and can prompt the earlier expression of hypomanic or manic episodes in these individuals (Calabrese, J. et al., 2006; O’Donovan et al., 2008).

But, the *absence* of a clear family history of bipolar disorder does not rule out the possibility of a bipolar spectrum illness. The most common disorder found in the family histories of patients with bipolar disorder is, in fact, depression, not bipolar disorder. Multiple relatives over several generations with depression or other evidence of mood dysregulation such as explosive temper are a marker for bipolar illness. Other family history features of bipolarity include a family history of completed suicide and alcoholism (Guillaume et al., 2009; Winokur et al., 1996).

Clinicians should consider the possibility of bipolar disorder in depressed patients who have ambitious, successful, or creative relatives. Some of the genetics at the root of bipolar disorder may also confer on some family members the drive and energy needed for high achievement (Simeonova et al., 2005).

### Responses to Antidepressants That Suggest Bipolar Spectrum Illness

In perhaps 20 percent of patients with bipolar depression, SSRI antidepressants precipitate a manic episode within 8 weeks of the start of treatment (Goodwin and Jamison, 2007). The use of mood stabilizing medication with an antidepressant lowers but does not eliminate the risk of mania.

A more common outcome of antidepressant treatment in bipolar patients is referred to as cycle acceleration: An initial positive response to an antidepressant is followed by repeated relapses into depression despite dosage increases (Goodwin & Jamison, 2007). Sometimes patients have had this experience with two, three, or more antidepressants. Women are likely more vulnerable to this adverse outcome.

Antidepressants can thus *hasten* the onset of another depressive episode in bipolar patients and actually *increase*

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## Rockland Chapter

*Dore Sheppard, President*

- On February 21st, the chapter hosted two returning speakers, Ruth Bowles, CPP, BS, and Starlee Qualter, LCSW, CEAP, who discussed treating alcoholism.
- On March 28th at 12:00 pm, the chapter will hold a Pot Luck Lunch for the Rockland CSW community to network and express gratitude for what our social workers do for the community.
- On April 24th from 12:00 pm to 1:45 pm, Helen Adrienne, LCSW, BCD, will speak on "The Challenge of Infertility for the Patient: Options for the Therapist."

Anyone who is not on the mailing list for the sites, dates and times can call me at 845-358-6433.

*Thank you!*

## Queens Chapter

*Fred Sacklow, President*

The Queens Chapter has had four board and educational meetings to date.

- On October 18th, Karen Arthur, LCSW, spoke to us about energy psychology in clinical practice.
- Sheila Peck, LCSW, shared her knowledge and experience on developing a private practice on November 22nd.
- On December 13th, Andrea Auther, Ph.D., and Gary Brucato, Ph.D., from the North Shore/LIJ System, spoke about their work on early detection and intervention for the prevention of psychosis. More info can be found at [www.raprogram.org](http://www.raprogram.org).
- Our own Hanna Turken, LCSW, spoke on January 24th on marriage, love, sex and the Internet. She shared some very interesting cases on the subject.
- On February 28th, Ed Petrosky, Psy.D., who always gives a comprehensive and well-researched presentation, spoke on the subject of adult ADD. You can find more information at [www.toolsforstudents.info](http://www.toolsforstudents.info).

We have many more presentations to come. Watch for our listings on the website.

The Queens Chapter has also been busy communicating via our listserv. I did a YouTube video which can be seen at <http://www.youtube.com/watch?v=Mr-N7tRs6Mg>. You will find many interesting things there related to social work. Feel free to contact me at [freds99@aol.com](mailto:freds99@aol.com).

## Westchester Chapter

*Martin J. Lowery, President*

We began the year with the sad news of the death of Chapter Vice-President Cori Maass. A letter of condolence was sent to her family and a gift to the American Liver Foundation was given in her name. Her father sent a hand-written note of thanks on behalf of his family. We all mourn together and remember Cori with fondness.

With gratitude for their willingness to serve, we welcome a new Vice-President, Karen Kaufman, and a new Treasurer, Ruth Rosenblum.

February's General Membership Meeting consisted of the Chapter's Annual Film Screening and Discussion. We viewed the 1993 movie, *What's Eating Gilbert Grape*, with a discussion facilitated by Jackie Mann that focused on the clinical reality of obsessional behavior and human strength in the face of familial, social and political struggles.

The monthly meetings on the Chapter on the first Saturday of each month from September to June continue to strengthen our supportive bonds and advance our skills, from the special interest group meetings that start the day to the educational presentations that end it.

We also have periodic Leadership Luncheons, during which those responsible for various aspects of the Chapter's work can bring one another up to date and ask for needed help. Following the March meeting, we hope to speak, among other things, to the issues raised at the January Membership Committee Retreat. 🍷

# ARTS AND CREATIVITY IN CLINICAL PRACTICE COMMITTEE

by Sandra Indig LCSW, ATR-BC, Chair

We opened our Sunday series of presentations/workshops on October 4th with Gloria Robbins, LCSW, BCD, presenting “Ego in Motion: Examining Patterns of Ego Structure in Child’s Play.” Through video and discussion, we examined four patterns of ego structure. Drawing from material presented and clinical practice experience offered by participants, we discussed the presenting problems, interventions, observable growth and indications of change in the vignettes of children presented in treatment sessions. Gloria is a member-at-large of the State Board as well as membership chairperson and past president of the Mid-Hudson Chapter.

On November 8th, Gary Prottas, LMSW, LP, presented “Containment of Trauma and Shame with Survivors of Sexual Abuse.” This workshop focused on issues, myths, patient symptoms, tools for the therapist, and case presentations. Personal experience from members enriched the discussion. Active group participation was encouraged and there was a lively exchange of ideas.

Gary also specializes in issues concerning free association and creativity. He utilizes meditation practices gleaned from a Tibetan Buddhist perspective, and has taught and led meditation groups.

On January 31st, Hilary Ryglewicz, LCSW presented “Color Me Green: Using Graphic Metaphors in Couple and Group Work” for the Arts and Creativity in Clinical Practice Committee of Met Chapter.

She presented a group of “graphic metaphors” (drawings) used in Dialectical Behavior Therapy (DBT)-related work with couples and groups in mental health center programs and in private practice. The graphics are used as a framework for exploring problems in affect management and communication. They function as “shorthand” for emotional and relationship issues in a variety of situations and with diverse populations.

The meeting included discussion of the spectrum of therapeutic approaches and the use of cognitive techniques within a psychodynamic framework for specific situations and patient populations. Group members discussed their own use of arts and cognitive approaches in therapy.

Hilary is a supervisor and faculty member at the Training Institute for Mental Health in New York City. She has also trained nationwide on treatment for “dual (mental/emotional and substance use) disorders.”

## Other Events

- February 26, The Morgan Library exhibit: “A Woman’s Wit: Jane Austen’s Life and Legacy”
- March 28, Roberta Ann Shechter, DSW, LCSW, “Source Material of the Writer: Reflections on Jane Austen”
- May 16, Bryan Hazelton, LCSW, CASAC, BCD, “Embracing Empathy Through the Use of Imagination in Treatment.”

## Legislative Committee

CONTINUED FROM PAGE 7

possibility that “a shortage of clinical social workers is developing.” The article also advocates expanding Medicare – which covers mental health services – to additionally include geriatric social services.

The issue paper would be more informative if it included specific recommendations for new minimum standards for psychotherapy experience in the LCSW license and considered their implications for consumer protection, first and foremost. We look forward to more information in these areas.

### The Law Regulates Practice to Protect the Public

In summary, the purpose of the 2004 LCSW law is to regulate the practice of psychotherapy in order to protect the public when they seek mental health services. It is not and never was, intended to define clinical social work, a broad spectrum of practice areas in the social work profession.

The LCSW is a license which deems the holder capable of

diagnosing, developing treatment plans and providing psychotherapeutic treatment for mental illness. This is an advanced practice specialty which requires knowledge and experience beyond the LMSW. The LCSW license allows its holder to provide mental health services in any setting, whether it is an agency, private practice, or an HMO. It is the individual practitioner whose expertise is licensed and this expertise does not depend on the setting where one provides psychotherapy.

Efforts to treat the LCSW license as a problematic, narrow definition of clinical social work practice areas misses the critical point of the legislation, protection of the public by assuring that providers of mental health services are properly qualified. Perhaps the LCSW should be re-titled “Licensed Clinical Social Work Psychotherapist” – because the standards for training for this area of practice are essential to quality diagnostic, treatment planning and psychotherapy services for people who suffer from mental illness. And that was the purpose of the legislation, after all. ■

## Borderline or Bipolar, Part II

CONTINUED FROM PAGE 9

the number of depressive episodes the patient experiences in the long run. The frequency of adverse outcomes of antidepressant treatment in bipolar and unipolar depression is shown in the following chart.

While no one feature of bipolarity is diagnostic, the presence of several of them together (particularly a family history of bipolar illness or antidepressant-induced mania) increases the probability that the patient has a bipolar spectrum illness. Effective psychotherapy with these patients generally becomes possible only after accurate diagnosis leads to withdrawal of destabilizing antidepressant medications. ■

\*The seven cardinal symptoms of mania and hypomania can be recalled using the mnemonic **DIGFAST** (William Falk, MD Massachusetts General Hospital; Ghaemi, 2008): **D**istractibility; **I**nsomnia; **G**randiosity; **F**light of ideas; **A**ctivity: goal-directed hyperactivity; **S**peech: Pressured, loud, rapid; **T**houghtless behavior: foolish business ventures, overspending, sudden travel, sexual indiscretions

References available upon request to [bquinnphd@verizon.net](mailto:bquinnphd@verizon.net)



**BRIAN QUINN, LCSW, PH.D.** author of *Wiley Concise Guides to Mental Health: Bipolar Disorder and The Depression Sourcebook*, 2nd ed., is private practice in Huntington. He specializes in working with people with mood disorders

and substance abuse. He earned his master's degree in social work at the University of Chicago and his Ph.D. in clinical social work at New York University. He has a post-graduate certificate in psychoanalytic psychotherapy from Beth Israel Medical Center in New York City. He has given seminars on the diagnosis and treatment of bipolar disorder at several graduate schools of social work, the New York and Delaware State Society for Clinical Social Work, and to thousands of clinicians nationwide in seminars sponsored by professional education seminar companies.

### IN MEMORIAM



**O**n January 1, 2010, the New York State Society for Clinical Social Work unexpectedly lost Sharon Lasky to cancer. Sharon served on the State Board for over four years as voting representative of the Brooklyn Chapter. She also served as treasurer of the Brooklyn Chapter and was tireless in her work to build the chapter.

Sharon's dedication to life and community service was reflected not only in her contributions to the Society, but in her leadership of the Hadassah Bay Ridge Chapter as well. A deeply moving memorial event was held in Brooklyn by Hadassah on February 21. Society members, work colleagues and Hadassah friends spent a touching afternoon remembering all her contributions to all of our lives and celebrating her life.

Sharon worked at Kings County Hospital for over 40 years as a Level 5 Supervisor of the Maternal Child and Pediatrics Service. She handled many high profile trauma cases and proved relentless in getting patients' needs met and following up with families. The memorial service held at the hospital was so crowded that it spilled into the corridor. There are plans to name a portion of the hospital in her honor.

Sharon was also in charge of social work training and the education of social work interns. She worked as a field supervisor for four schools of social work. She was always an enthusiastic, life-affirming person who worked hard and played hard. Her passing is a tremendous loss to everyone who knew her.

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