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

IN THIS ISSUE

3

President's Message

5

Mentorship

6

57th Education Conference
FOCUS ON ADDICTION

8

Legislation Impacting LCSWs

10

Self-Disclosure: To Say or Not

12

Protecting Our Patients

14

Chapter News & Honorees

20–34

FOCUS ON ADDICTION

36

Book Review:
Ozempic for Smarties

38

Engaging Aging:
Consumerism, Medicalization,
and Politicization

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Univduation, Addiction, and the 12 Steps: Recovery as a Path to Wholeness

By Peter K. Navratil, LCSW

“Addiction represents one of the great paradoxes of the human condition: a compulsive pursuit of connection that results in deeper separation. Beneath every addiction lies an archetypal longing—a thirst for union with what has been lost or forgotten. Carl Jung captured this truth in a 1961 letter to Bill Wilson, co-founder of Alcoholics Anonymous, observing that “the craving for alcohol is the equivalent, on a low level, of the spiritual thirst of our being for wholeness.” Addiction, from this view, is not merely a disease of choice or brain chemistry; it is a spiritual disorder rooted in alienation from the Self.”

EXCERPT FROM ARTICLE, PAGE 20



20 Univduation, Addiction, and the 12 Steps

22 Living in the Shadows: Sex and Love Addiction

25 Food Addiction and Relational Effects

28 A Functional Neurobiological Model



Mark Rothko (1903–1970)

Some of the world's greatest artists have struggled with mental illness and health issues that induce substance abuse disorder.

A leading post war artist, Mark Rothko's work highlights the layers of human consciousness and the space inside the mind. Depression led to his use of alcohol and prescription drugs and he eventually died by overdosing. Rothko's abstract expressionism defined an era of art history but also revealed the need for more comprehensive mental and behavioral health care.

SOURCE: <https://www.therecoveryvillage.com/drug-addiction/artists-and-drugs/Orange-and-Yellow,1956>



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for Clinical Social Work**

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For Clinical Social Work
Since 1968*

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MESSAGE FROM THE PRESIDENT



Beth Pagano, LCSW-R

It is my honor and pleasure to begin this message by thanking the editor of *The Clinician*, Ivy Miller and the Newsletter Committee Chair, a woman of many hats, Helen Krackow for creating this newsletter that climbs to new heights with each edition. There is so much valuable information provided for us on every page.

Many thanks also to the authors of the informative and evocative clinical articles that present theoretical perspectives and treatment options around current dynamics that we encounter in our practice and personal experiences. In this issue, Jay Korman gives us much to think about in his *Self-Disclosure* article and Marsha Wineburgh highlights the Legislative Committee's focused efforts in Albany. Look inside for the updates provided by our Chapter Presidents; they are the backbone of the NYSSCSW. Many thanks to everyone who contributed to this edition of *The Clinician*. Ivy has some wonderful ideas about using digital production in the future, expanding the newsletter, and giving us the opportunity to publish in a more efficient, inclusive, and abundant way. Once again, thank you Ivy Miller.

Uphill Battle for Federal Loans

As you know from information sent to you in *E-blasts* and the *Friday E-News*, the federal loan reconfiguration as presented in the One Big Beautiful Bill Act changed the MSW degree classification from "professional degree" to "graduate degree." Many other professional degrees, including psychology, nursing, occupational, physical and speech therapist, to name a few, were reclassified as well! Unfortunately, even with an enormous demonstration of dissent from the professions and elected officials who supported us, the new rule went into effect.

The NYSSCSW, as an affiliate member of the Clinical Social Work Association, our national voice, will support CSWA's work with other national mental health associations to secure legal or legislative remedies to reverse this incorrectly informed decision. The new rule, named "Reimagining and Improving Student Education" (RISE), was formulated on complete misinformation about how licensing occurs in each state. It is for this reason that there is hope for a reversal, but it will be an uphill battle. Success is imperative as the lack of access to loans will reduce the number of candidates applying for degrees in important clinical professions where services are sorely needed by the public at large. The volunteers of the NYSSCSW and CSWA work tirelessly to protect clinical social work.

CONTINUED ON PAGE 4



Website: ace-foundation.net

The Advanced Clinical Education Foundation of the NYSSCSW

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Defraying Costs of Exams, Field Work, and Loans

New York State has some important bills on the landscape. The Licensure Incentives and Fee Support for Testing Act, (LIFT) establishes an income-based eligibility to receive a voucher to pay the cost of the LMSW and LCSW licensing exams. The bill numbers are S9125/A10094. Another bill of importance proposing a funded field work pilot program involves paying MSW candidates who have finished 450 hours of the required 900 hours of field work a stipend of \$4,500 during their second field work placement. The bill numbers are S7894/A9379. In addition, there is a request for an increase in the budget for MSW degree loan forgiveness funding from \$1.78 million to \$12 million through the Higher Education Services Corporation for the fiscal year 2026-2027. There has not been an increase since 2016, and this initiative would increase the number of loan forgiveness recipients from 275 to 1,846. These changes are proposed in service of supporting those who wish to enter the field as well as those new in the field to be able to succeed. Let your elected officials know what you think.

Learning at Every Career Stage

Speaking of success, in order to succeed in the practice of clinical social work, post graduate training and continued education, lifelong learning is imperative. As you turn the pages of the newsletter you will be treated to a retelling of NYSSCSW's 57th Annual Education Conference, *Transforming Addictive Behaviors*. Indeed, it was transformative thanks to the ACE Foundation and Dr. Kara Dean-Asseal, ACE's Director of Professional Development.

Educational opportunities are provided to you through the Clinical Society throughout the year as well, hosted by

“There is hope for a reversal, but it will be an uphill battle. Success is imperative, as the lack of access to loans will reduce the number of candidates applying for degrees...”

our chapters. The Education Chairs of each chapter craft a wonderful, diverse, and stimulating array of course offerings. Topics are timely and draw attendees from all the mental health professions. Thank you to Education Chairs: Eleanor Perlman-Long Island; Ruthie Kaleal-Westchester; Kevin Melendy-Rockland; Helen Krackow-Met; Barbara Solomon-Mid-Hudson; and Pete Navratil-Rochester.

Go to the ACE Foundation website and check out the *Friday E-News* to see the CEU programs created by our hard-working education chairs. As a member benefit there is a fee discount. If you are interested in presenting, please reach out and let us know. You can propose your topic through the ACE website as well.

Soon we will be celebrating our scholarship recipients who demonstrated academic excellence in their MSW programs. We value and promote education during every phase of professional life.

There is much work to be done! There are volunteer opportunities available so reach out if you are interested. It is an honor to be part of this wonderful clinical community.

In gratitude,
Beth Pagano

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ALSO IN THIS ISSUE

For **Black History Month** in February, *Friday E-News* featured portraits of Black innovators whose vision and leadership shaped the foundations of clinical social work and psychotherapy. In March, our series for **Women's History Month** and **Social Work Month** featured women who have shaped social work, scholarship, and social change. Three honorees appear in this issue: Adelaide M. Cromwell, P. 11; E. Franklin Frazier, P. 13; and Dorothy Height, P. 19.

We are pleased to report that efforts to revitalize this valuable benefit of membership in the Society have been going well. So far, nine potential groups have been identified for mentors to lead in 2026. Two of our mentors, Diane Girdwoyn Caspe and Judith Schaer, are profiled below.

We are continuing to receive and review applications for both prospective mentors and mentees. Promotion will continue to take place on chapter listservs, e-news, and the NYSSCSW website. Mentoring opportunities are offered Monday through Friday at different times of the day and evening.

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

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Consultation Group Beginning:
Beginning and Intermediate level Social Workers. Every other week, either on Thurs. or Fridays, from 2:15 to 3:15 pm.

MENTOR PROFILES

Diane Girdwoyn Caspe, LCSW
914-714-0765 | 📧 dgirdwoyncaspe@gmail.com



Diane is on the Teaching and Supervising Faculty at The Westchester Center for the Study of Psychoanalysis and Psychotherapy (WCSPP) and is a past director of WCSPP. Her clinical experience is in psychotherapy with children and adolescents and their families, and in psychotherapy/psychoanalysis with adults.

She has worked at The Yale Child Study Center, Yale New Haven Hospital (adult OPD), and Jacobi Hospital/Albert Einstein College of Medicine, where she was the Chief Social Worker in the Division of Child and Adolescent Psychiatry. She has also been in private practice in Scarsdale since 1979.

Diane said recently, “My long career as a clinician in social work has been of great importance to me. I have supervised and mentored generations of mental health clinicians, and I value the opportunity to continue this mentoring with social workers who are new to our profession.”

Her education includes an M.S. in Social Work from Simmons School of SW (Boston) and a Certificate in Psychoanalysis and Psychotherapy from The Westchester Center for the Study of Psychoanalysis and Psychotherapy (WCSPP).

Judith Schaer, LCSW, CGP, FAGPA-L
516-835-2084 | 📧 juschaer@aol.com



Judith has been in full-time private practice for 40 years, treating individuals, couples and groups.

Early in her social work career, Judith worked at psychiatric and community mental health clinics. She is active on the Board of NYSSCSW as Networking/Mentorship Chair. She has hosted the NYSSCSW, Let’s Talk Salons. She has also been faculty for the Eastern Group Psychotherapy Society’s One-Year Group Training, the American Group Psychotherapy Association, and Adelphi and C.W. Post universities.

Her greatest joy, Judith said, “is activating and increasing my own and other clinicians’ potential through professional affiliations and through my role as Mentorship Chair.” She hopes to offer this opportunity and begin the Experiential Consultation Group Process via Zoom.

NYSSCSW with the ACE Foundation Presented

THE 57TH ANNUAL EDUCATION
CONFERENCE, APRIL 2026

Transforming Addictive Behaviors

CONFERENCE DESCRIPTION

Over 100 attendees gathered on Zoom for a two-day conference on addiction presented on Saturday, April 18 and Saturday, April 25.

A complicated mental, biological, and behavioral health issue, addiction involves a complex interplay of epigenetic, genetic, environmental, behavioral, and other factors, often beginning in early years when safety was compromised.

The speakers, all published authors, and leaders in their specialties, were very well received. Day 1 featured Jan Winhall, Andrew Tatarsky, and Harry Levant. “The presentations were thoughtful, timely, and deeply impactful,” one attendee said.

A half-hour breakout room for discussion between attendees was held at the end of each session. “Closing with breakout rooms for further reflection and peer connection was a wonderful way to deepen the learning and strengthen our professional community,” another person said.

Four exceptional Met Chapter members presented on Day 2: Michael Crocker, Shawn Petnik, Mary Anne Cohen, and Diane Barth. “The warm connection and collegiality between them were moving,” Helen Hinckley Krackow, President of the Met Chapter, wrote.

Find new course listings at nysscsw.org and ace-foundation-net



Jan Winhall



Andrew Tatarsky

DAY 1 / April 18, 2026, 9:30 am–1:00 pm

Reimagining Addiction Treatment

Presented by Jan Winhall, MSW, P.I.F.O.T.

Jan Winhall discussed the challenges of trauma and addiction treatment and harnessing the power of our body's natural healing process through accessing the autonomic nervous system. She took us on a journey of the felt sense model and how it can transform addiction. An author, teacher and seasoned trauma and addiction psychotherapist, Jan is an Educational Partner with the Polyvagal Institute where she offers a training program based on her books *Treating Trauma and Addiction with the Felt Sense Polyvagal Model* and *20 Embodied Practices for Healing Trauma and Addiction: Using the Felt Sense Polyvagal Model*, (Norton) 2025.

Centering Dignity: Integrative Harm Reduction Psychotherapy For Drug And Alcohol Problems

Presented by Andrew Tatarsky, Ph.D.

Traditional substance use treatment has typically required a commitment to abstinence as a condition for care with abstinence viewed as the primary measure of success. But what happens when therapy begins with respect, radical acceptance, and empathy instead of rigid conditions?

This presentation introduced Andrew Tatarsky's Integrative Harm Reduction Psychotherapy (IHRP), an approach that centers the client's dignity and can radically improve treatment. It comprises nine therapeutic tasks and practical tools for applying a client-centered approach for treating risky and addictive behavior. Dr. Tatarsky is the Founder and Executive Director of the Center for Optimal Living in New York City, a founding board member of Division on Addiction of New York State Psychological Association, and a Member of the Medical and Clinical Advisory Boards of the New York State Office of Alcoholism and Substance Abuse Services.



Harry Levant



Mary Anne Cohen



Michael Crocker



Shaun Peknic



Diane Barth

Gambling Disorder And Mental Health:

A Comprehensive Public Health Response

Presented by Harry Levant, Ph.D.

Dr. Levant is Director of Gambling Policy with the Public Health Advocacy Institute (PHAI) at Northeastern University School of Law. His research focuses on developing a public health approach to prevent gambling-related harm and gambling disorder. He is also an Internationally Certified Gambling Counselor (ICGC-I) and mental health therapist in private practice. Dr. Levant is a founding board member of FFOG—Families and Friends of Gamblers, a national advocacy organization that helps lead the effort to bring comprehensive public health regulation to the gambling industry and its sports partners.

DAY 2 / April 25, 2026, 9:30 am–1:00 pm

Is Food Addiction A Valid Concept?:

Cravings, Cookies, And Compulsions

Presented by Mary Anne Cohen, LCSW, BCD

For decades, a debate has been raging about whether food can be considered an addictive substance. If so: Who is vulnerable to food addiction? Is it psychological in nature? Is it the result of deprivation and diet culture? Is it neurobiological? Is it about sugar and white flour? This presentation explored the controversy about whether food addiction is a valid concept and what the latest research teaches us. Possible treatments with illustrative case examples were discussed.

Mary Anne Cohen is the director of The New York Center for Eating Disorders and author of four books in her “emotional eating” series. Her latest book is *Ozempic: A Psychotherapist Tells the Straight Skinny* is reviewed in this issue.

The Escape Within – Pornography, Virtual Sex, and the Schizoid Dilemma

Presented by Michael Crocker DSW, LCSW, MA, CGT & Shaun Peknic, LMSW, MA Psychology

As the state of the world becomes more precarious and threatening, people are increasingly turning to the internet, social media, and pornography to escape from their darker feelings. This is an escape within, and it is a particularly effective defense for the patient with schizoid leanings. This presentation explored factors that lead to patients developing compulsive behaviors involving pornography and effective interventions and treatment strategies for patients caught in the schizoid dilemma.

Michael Crocker is Founder and Clinical Director of The Sexuality, Attachment, and Trauma Project (SAT). He is a passionate advocate for shame reduction in the treatment of sexual compulsivity. His clinical approach is informed by his research on childhood trauma and attachment.

Shaun Peknic is a therapist and SAT Director, managing client intake, staffing, and educational programs for clinicians. For 20 years, he explored the human condition onstage as a theatre director, developing work centered on queer identity, family trauma, and the subconscious.

“I’m Not Addicted – I Just Love To Shop!”

Factors In Recognizing And Changing Compulsive Buying Behavior

Presented by Diane Barth, LCSW

Shopping addiction, or compulsive buying disorder (CBD), is a behavioral issue characterized by an uncontrollable urge to shop and buy excessively. CBD can involve a cycle of intense preoccupation and tension before shopping followed by relief and euphoria, but also anxiety, depression, guilt, shame, regret, and dread of being caught.

We discussed the use of an integrative approach to treating a shopping addiction. Examples illustrated individualized ways that structured, “evidence-based” therapies can be woven with an attachment experience and a psychodynamic understanding to lead to gradual change.

Diane Barth maintains a private practice with couples and individuals, provides volunteer psychotherapy at a community clinic for undocumented immigrants and asylum seekers, and supervises and teaches other therapists. Her most recent book is *I Know How You Feel: The Joy and Heartbreak of Friendship in Women’s Lives*.

NYSED Confirms the Exam Requirement for the LMSW

On December 2, 2025, NYSSCSW participated in a formal Round Table discussion about the merits of the exam for the LMSW license and ways to improve MSW student passage rates. I was invited to join as Legislative Chair of NYSSCSW and I, in turn, asked Dr. Claire Greens-Forde (former Executive Director of the city chapter of NASW) and Dr. Janice Edwards (President of AAPCSW, tenured Howard Social Work School full professor) to participate on NYSSCSW's behalf. Other participating stakeholders included state legislators, NASW, Association of Social Work Boards (ASWB), and SED staff. Here is our official position:

New York State Society for Clinical Social Work EXAMINATION REQUIREMENT FOR LICENSING 12/2/2025 NYSED Round Table

We fully support NYSED's position for an exam requirement for licensing each social work profession—LMSW and LCSW—and ASWB's new test modifications. NYSSCSW is concerned about the erosion of current professional standards which threaten the quality of skills and competencies in our licensed social workers. The exam requirement for the LMSW not only assures a standard of core skill acquisition for MSWs but also serves to assure competencies for the licensed clinical social work level. Elimination of the exam would have a grave impact on both licenses.

The gap between social work education and actual practice has long been a challenge to the profession. Two years of learning is not much time to digest the many roles and settings where social work is practiced, as well as the complexity of knowledge, values, purpose, and methods required to be a minimally competent social worker.

In addition, there have been extensive changes to social work education and field experience with the advent of online education, virtual supervision, and virtual field work. This makes the exam even more relevant as a quantifiable measure of beginning competency.

Here are some thoughts on how to improve passage rates on three levels: social work students, newly minted LMSWs, and more experienced practitioners.

Social work students:

- Unlike most graduate programs, there is no entrance exam required to apply to a MSW program. Acceptance into the program is completely dependent on the discretion of the individual social work school. It is possible to graduate from social work school without ever taking a test so that the licensing exam is the first exam in many years. Remedial course work must be offered by social work schools to make up for deficits in earlier education experiences. Several New York schools offer an exam preparation course, some free, some for a fee, but this is not remedial course work for skills in critical thinking, writing, etc.
- Many MSW programs are now requiring students to find their own field placements. When they sit for the LMSW exam, they only have the supervised field work experiences which are part of their MSW program. We recommend In-person, not virtual, field work as an essential training experience.

Newly minted LMSWs

S 7701. (a) *The practice of licensed master social work shall mean the professional application of social work theory, principles and the methods to prevent, assess, evaluate, formulate and implement a plan of action based on client's needs and strengths, and intervene to address mental, social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, families, groups, communities, organizations, and society.*

- If one has earned a BSW as an undergrad, one may earn an MSW in one year. Perhaps this should be reconsidered. To become a skilled and proficient LMSW takes discipline and slow maturation even after passing the exam. In New York State, the LMSW scope of practice allows them to provide all the services without supervision with the exception of psychotherapy. The depth and breadth of the above authorized practice activities must be measured to assure core competencies in each area to protect patients.

- The exam, taken after one or two years of master level education, offers a way to identify a provider with beginning competence. Clinical supervision, not administrative supervision, is essential for all LMSWs, not just for those seeking to become LCSWs.
- Newly minted LMSWs are exempt from continuing education for three years after becoming licensed. The beginning skills they have learned in social work school are what they have to work with. We support requiring post-master's continuing education beginning immediately upon becoming licensed. We strongly recommend the NYS mandated course in Child Abuse ID and the course in Boundaries to start.

Advanced Practitioners:

- Rapid change is all around us. Now and in the future, AI will impact mental health services. Patient consent, confidentiality and privacy need to be protected. We commend and support SED's interest in integrating practitioner experience into social policy formulations as this Roundtable hopes to do. We recommend that this continues on a regular basis going forward.

The Social Work Profession has always defined itself in terms of its values—diversity, equality and inclusion. SED's support for the exam finally includes practice competence as well. The licensing exam along with education and experience provides the public with reasonable assurance that they are being assisted by a knowledgeable professional. And, importantly, it is a way to effectively hold a practitioner accountable if need be.

Other issues:

We have lost and gained a new lobbyist in the past month, looking forward to even more effective representation in 2026. 🗳️

HEADQUARTERS UPDATE



Happy Spring! It was wonderful seeing so many new faces at the Annual Membership meeting in October 2025—thank you to everyone who made it such a success. We spent many weeks hard at work preparing for the 57th Annual Education Conference. With a fantastic lineup of unique programs and speakers, it was a great success.

A quick note on renewals: if you haven't had a chance to renew yet, we're happy to help! Just give our office a call. Also, be sure to keep an eye on our website and the *Friday E-news* for several new events just added to the calendar. Hope to see you soon!"

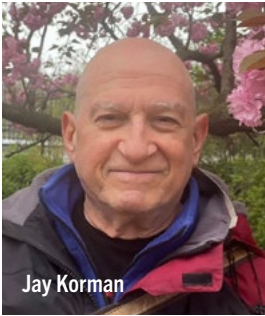
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Self-Disclosure: To Say or Not To Say. *Is There Even a Question?*



Here's a hypothetical. Your patient, who is struggling with his drinking and is seeking help, asks you if you ever had a problem with alcohol or other substances. You have been clean and sober for a number of years and know that giving up drinking, and/or other substances/

processes, is not only possible but that you can go on to live a "successful" life (depending on your definition of "success," of course.)

What do you tell your patient? Do you say that you have been clean and sober, or debt free, etc., for X years and that it can be done? Do you talk about your journey to and through sobriety? Do you deny that you had a problem? Or do you say that you won't reveal that information, whether you have or haven't had issues and how you dealt with them?

I work with substance users, as well as people who have chronic debt and overspending. I have not worked with people who have food addictions and try not to work with people who have eating disorders because I am not trained in that area, and eating disorders have a physical component that makes them potentially dangerous to the patient.

Why would you tell your patient that you had a problem but that you have it "under control?" What do you intend by this action? Is it meant to reassure your patient that it can be done just because you did it? What if that's not the effect it has? What if your patient, in response, decides that he's hopeless because you were able to do it and he, so far, has not? What if your patient decides that you are not reliable and could "relapse?" Can you assure you assure your patient that you will not "relapse" and become unavailable? What if your patient decides that you can't help him because you were "not as far gone" or "used less" than him and that he's a worse case, so you can't help him? Or conversely, what if he decides that you were using so much before you stopped that you must be impaired/damaged and can't be able to help him because of your condition?

If you were a peer counselor, there would be the presumption that your "origin story" includes some issue and

you might be expected to share some or all of your story as part of the process, but you're not a peer counselor. You are a clinical social worker providing psychotherapy, not peer counseling. You are not a peer. You are a professional, which puts you in a very different position than a peer counselor.

If this were a 12-step meeting you would be expected to share your story so that you don't forget from where you came and so others might benefit from knowing that it can be done. This is about mutual support, but you are not in your session with your patient for "mutual support." Or if you are, perhaps you might benefit from consultation/supervision and some time on the couch yourself.

You are there in your capacity as a helping, medical professional and the individual is there as your patient. Again, as stated in the previous paragraph, you are not a "peer." You are in a different position.

Lastly, who are you expecting to benefit by telling whether you have ever been in a similar situation, and what are you getting out of it? Is there a little bragging going on? Are you sure this is to help your patient or is this you showing off? How much does your patient benefit by knowing whether you have or haven't had a problem, as opposed to knowing that you are a trained helping medical professional, a clinical social worker who has experience treating use and abuse (you have had training, haven't you?) and will regard him with respect and dignity, just as you do all your patients?

Seriously, do your patients with any other condition expect, hope you have or haven't had, or want you to have the same conditions that they have? If you did, would you reveal it and why would you do that?

Personally, my choice is to decline to answer the question, with an explanation. There are many questions that


DISCLAIMER:

I am not an attorney. This article is not legal advice and should not be taken as such. It is my opinion as a person and as a professional clinical social worker. For legal advice about this or any other matter please speak to your malpractice carrier's risk-management people and/or your attorney.

we, as professionals, might choose to answer or not, or answer after hearing what it will mean to the patient to learn that information. My choice is based on what I said above about the conclusions my patient may draw from what I say, as well as the fact that what we do is therapy, not support, and there is a difference in position between my patient and myself. I do not claim to be a *tabula rasa*, as Freud directed we should be, as there's too much stuff around my office of a personal nature, as well as my choice of clothes, etc., to ever claim that. My preference is to keep that an open question, and provide treatment to my patient, the same as I do for any other condition my patient might have and that I'm competent to treat.

Regarding 12-step meetings, if you are still going to them and want to remain anonymous, you might consider making sure that you are not going to meetings that your patients might attend. Ask yourself what benefit your patient would derive from hearing your story. Would you share that information during your session with your patient? If not, then why would you allow a patient, or potential patient, to have that information about you? Same thing with your online presence. What story do you tell about your history, and is it beneficial to a potential patient? How much more do they need to know other than that you are competent to treat them?

On the other hand, if you are someone who has a history of substance/process abuse, and you are still experiencing problems, then you should be disclosing this to someone, either a colleague or a counseling program, so you can get help and remediate your impairment. You are obligated to do this by the NASW Code of Ethics. Whether you are a member of the NASW or not, it is the code by which courts and state boards make determinations about professional behavior, as well as what is listed as expected behavior on the state board's website. Similarly, if you know of a colleague who is impaired, you are required, both by the NASW Code of Ethics and the NYSSCSW Code of Ethics (Section IV, e) to speak directly to that colleague and, if that doesn't produce a change, to take it higher to make sure that your colleague is not providing treatment while impaired.

Again, except for references to the NASW and NYSSCSW Codes of Ethics, what I have written has been my opinion, which has been informed by my years of practice and my discussions with colleagues, attorneys and others. It is not legal advice and should not be taken as such. Nor is it the last word. This is presented for your consideration. If you find it useful, great. If it provokes thought, wonderful. If you disagree, you're welcome to do that, too. 

Adelaide M. Cromwell

Pioneering Sociologist and Educator



In March 2026, we celebrated both Women's History Month and Social Work Month by highlighting the powerful legacy of women who have shaped social work, scholarship, and social change.

Adelaide M. Cromwell


was a pioneering sociologist, educator, and institution builder. Her work advanced African American Studies, expanded access to higher education, and preserved Black history in Boston and beyond.

Cromwell's legacy continues to influence social work, academia, and movements for racial justice. Follow along each week as we celebrate the women whose impact continues to shape our profession.

She was the first African American instructor at Hunter College and Smith College.

She taught at Boston University and founded the university's African Studies Center in 1959 and the graduate African American Studies program in 1969.

Her impact was global. She organized the first West African social workers' conference in Ghana (1960); served on international education and cultural councils; and wrote influential books on Black history, including *The Other Brahmins*, about Boston's Black upper class.

A respected scholar and preservationist, Cromwell was widely honored for documenting and protecting African American history and for advancing Black Studies in higher education. 

Protecting Our Patients

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PLEASE NOTE: In addition to my standard disclaimer that I am not an attorney and nothing I write is to be construed as legal advice I give an extra disclaimer, namely that there are unavoidable political implications in this piece which are my own views and not those of the New York State Society for Clinical Social Work. This is written for informational purposes, not for taking a position about the topic at hand. If you have further questions about the laws and their impact, we strongly urge you to consult with your malpractice carrier’s risk-management team and/or an attorney. Also refer to the NYSSCW Code of Ethics, as well as the NASW Code of Ethics which, even if you are not a member of NASW, is the one that is considered the de facto code of ethics for social workers by courts and state boards. In addition, please refer to the New York State Office of the Professions in terms of regulations concerning the behavior of social workers in New York State, as well as the relevant social work board/ commission in any other state in which you are licensed.

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Writing Notes

Given our current and changing environment, it looks like it is time to consider how we can protect our patients, both in the notes we write and how we meet with them. Notes must be clinically relevant, of course, and the old adage “less is more” for note writing does not actually encourage clinicians to write clinically complete notes. We know that the Center for Medicare Services (CMS) has been cooperating with the Department of Government Efficiency (DOGE) in terms of allowing access to private health information. We can suppose that private carriers and ERISA plans may follow suit.

There is also the issue of being licensed in multiple states, not all of which have the same laws regarding women’s health, reproductive rights, treating transsexual minors (or adults for that matter,) and LGBTQI+ issues. What risk is there for the treating clinician and the patient? A simple complaint from one neighbor or parent can trigger an audit or license complaint.

In view of this, we would urge caution and balance in note writing. Notes must be complete enough to pass an audit, be clinically relevant and support the treatment plan, while at the same time being selective in language to protect both ourselves and patients. One example might be to say “partner” instead of clearly stating the partner’s gender (i.e., “partner” instead of “her wife.”)

We could suppose that HIPAA will protect our notes against investigation, but that is not clearly a permanent solution as there continue to be

intrusions into what has previously been private and non-disclosable information, such as information held by the IRS. Gender affirming care has been deemed to be “child abuse” in some states and so an audit workaround to identify child abuse is entirely possible.

If you create notes using AI, please know that notes created in this fashion are considered discoverable and AI can also be used to search online notes for key words that would trigger a more in-depth audit.

Meetings

That is one aspect of protecting our patients. Another is physically protecting them from the potentially illegal and unconstitutional search and seizure by immigration enforcement. This might not apply to clinicians in private practice but certainly would apply to those working in public hospitals and community mental health clinics. Including information about a patient’s immigration status, e.g., undocumented, might expose them to possible action if notes are audited. We are not saying to do this, but one consideration is whether to meet with patients virtually, especially those at risk, to avoid any confrontations with authorities.

For information about how to avoid making errors when responding to government requests for patient’s medical records please refer to the article Avoid Common Mistakes When Responding to Government Notices on the Practice Resources link of the NYSSCSW website.

For information about patient rights about search and seizure and

immigration enforcement, there are “Red Cards” which can be given to patients to hand or show to officers that explain the rights and that they are not voluntarily cooperating. These are available from many sources online. One is <https://www.ilrc.org/red-cards-tarjetas-rojas#item-4478> from the Immigrant Legal Resource Center (<https://www.ilrc.org/>). The link provided gives the ability to purchase cards as well as links for artwork to print the cards in 30 different languages, including English. The cards are formatted to print on standard business card stock for printers.

In addition, Rep. Alexandria Ocasio-Cortez (D-NY) has advised, during one of her online talks to the community, that you (and/or your patients) are not required to open the door to anyone before seeing a judicial (signed by a judge) warrant, and that you can request that it be slid under the door for your perusal before acting on it. An administrative warrant, i.e., one that is not signed by a judge but by an administrator, does not count.

These are changing times and we need to be aware of current situations to best deal with them so we can protect our patients, our practices and ourselves. Always be aware of what the laws are in the state in which your patient is located at the time of the session, not just the laws of the state from which you are practicing. We strongly suggest checking for further information as needed, either online or with an attorney familiar with the pertinent laws and regulations. 🗨️

E. Franklin Frazier

Pioneering Sociologist



“True progress comes not from gestures of goodwill but from informed struggle against injustice.”

For Black History Month, we highlighted visionary Black scholars. Among them was E. Franklin Frazier, a pioneering sociologist whose groundbreaking studies of the Black family and Black middle class pushed the discipline beyond stereotypes and sentimentality toward rigorous, evidence-based analysis. Unafraid to critique both systemic racism

and internal class dynamics, he believed that justice required honesty, structural change, and informed public discourse.

His legacy endures in sociology, African American studies, and in every scholar committed to examining inequality with clarity, courage, and conviction.

Born September 24, 1894, in Baltimore, Frazier was one of the first Black scholars to study the African American family using rigorous sociological methods. He studied at Howard University, then Clark University, and later earned his Ph.D. at University of Chicago. His Ph.D. dissertation (1932) became the influential book, *The Negro Family in the United States* (1939).

He taught at Morehouse College, Fisk University, and spent the majority of his career at Howard University, where he became one of the most influential voices in sociology.

In 1948, he became the first Black president of the American Sociological Association. Frazier’s work shaped how scholars study race, family, and inequality, and remains influential in sociology and African American studies.

He remained on the faculty of Howard University until his death in 1962, mentoring generations of scholars and solidifying his legacy in African American intellectual life. 🗨️

Long Island Chapter

Barbara A. Murphy, LCSW, BCD, President



Podcast on clinical practice: Long Island Chapter President Barbara Murphy released her second podcast on July 1, 2025, entitled Case Presentation: The Importance of Accurate Diagnoses. It describes work with a teenage boy with suicidality

and is listed it as Episode 115 on the podcast series *What Would Dr. Meyers Do?* at <https://linktr.ee/drmeyerspod>. The series is hosted by Amy Meyers, Ph.D., LCSW, a professor of social work at Molloy University.

Education: There was a large turnout of 68 attendees, both members and non-members, for a presentation on September 28, 2025, by Zoom on the Neuroscience of Eating Disorders and Implications for Treatment, given by Jeffrey DeSarbo, MD. He is a neuropsychiatrist and Medical Director of ED180 treatment programs in Garden City.

A presentation on April 12, 2026, on Zoom was on Brief Strategies for Constructing Childhood Narratives for Adults with Limited Childhood Memory, to be given by Ian Laidlaw, LCSW.

Honorees: At the NYSSCSW Annual Membership Luncheon on October 18, 2025, Barbara Murphy, president, and Linda Feyder-Sullivan, secretary, Long Island Chapter, were

recognized for their leadership and outstanding contributions to the advancement of clinical social work

Book Club Brunch: On October 26, 2025, eight members gathered at the lovely home of board member Susan Kahn in Great Neck to discuss the book, *The Nightingale*, by Kristin Hannah. The next book club meeting is planned for May 3, 2026, to discuss the book, *Something in the Water*, by Catherine Steadman.

Let's Talk Salon Series: On March 22, 2026, 18 members and 5 non-members participated in a discussion on the Lifecycle of the Therapist: A Cross-Generational Exchange, followed by a social networking brunch. This event took place in the lovely home of our board member, Judith Schaer, in Greenvale.

Committees and the Board: The Committee on the Aging meets every other Sunday on Zoom. We welcome new members to join this and other committees as well as the Long Island Chapter Board, which will meet on Zoom on June 14, September 27, and November 22 in 2026. Please check our chapter section on the NYSSCSW website for updates and details.

✉ Barbara Murphy: askier@verizon.net

Linda Feyder

Honoree – Long Island



Linda Feyder, LCSW has been on the board of the Long Island Chapter since 2019, when she became Secretary. In addition, since then she has served as co-chair of Membership and Programming. She helped to organize membership drives, outreach to new members, and has written a letter to new and returning members defining the important contributions the Society has made to the social work profession, as well as how it continues to benefit them.

Linda currently seeks dynamic speakers for the chapter's fall and spring workshops. In addition, she supports programming and clubs with the design and creation of flyers for publication on the ListServ. A graduate of New York University School of Social Work, she also earned an MA in creative writing and literature from the University of Houston. Linda, who published a book of short stories in 2021, sees fiction writing as an extension of the empathy needed in social work practice. She has been a clinical social worker since 2006 and currently maintains a private practice in Nassau County where she specializes in couples work, families coping with substance abuse, and anxiety and depression. ■



Barbara trains and supervises students and social workers. She has spoken on such topics as working with children in a hospital setting; helping children grieve and develop self-esteem; teens and body image; and cultural and spiritual aspects of patient care.

Barbara Murphy

State Honoree

Barbara Murphy, LCSW, BCD has been a practicing social worker since 1977. She has experience in medical social work and mental health settings, direct service, and administrative roles. She has trained and supervised many students and social workers and spoken publicly on a wide variety of topics, such as working with children in a hospital setting; helping children grieve and develop self-esteem; teens and body image; and cultural and spiritual aspects of patient care.

As a public hospital administrator, she co-chaired a Patient Rights and Organizational Ethics Committee, wrote protocols for intervention with victims of sexual assault and domestic violence and helped pass four JCAHO accreditation inspections. As a volunteer community organizer, in the aftermath of 9/11 and a local church shooting, Barbara set up and coordinated a support program called Rainbows for children who were undergoing difficult transitions in their families. She also voluntarily worked with local politicians and collected petition signatures which enabled the residents of her neighborhood to keep library services, and worked with her school district's character education committee to implement an effective antibullying program. She has served as a volunteer on the Boards of the Muscular Dystrophy Association, Make A Wish Foundation of Metro New York, Girl Scouts of Nassau County and currently, as NYSSCSW Long Island Chapter President.

Barbara joined NYSSCSW in 2003 while transitioning from agency to private practice. After presenting to the Nassau Chapter on relational aggression, Barbara wrote an article on this topic which was published locally and statewide. She is a graduate of the New York School for Psychoanalytic Psychotherapy and Psychoanalysis (2006) and continues to work in Mineola in private practice dedicated to the treatment of children, adolescents, and their families.

CONTINUED ON PAGE 16

Met Chapter

Helen Hinckley Krackow, LCSW-R, President



The Met Chapter had a party celebrating March as Social Work Month at Candle Restaurant on Sunday, March 22nd. Delicious vegan hors'doeuvres and drinks made for a lovely atmosphere, connection, and conversation.

Workshops The Chapter presented three important CE workshops starting with “Healing Trauma and Interrupting Men’s Violence Against Women” given by Peter Navratil, the President of the new Rochester Chapter. He has worked in the field of trauma for over thirty years. The second was titled, “Choosing Adoption and Its Impact on Self and Family,” developed by Adam Banks, Chair of our Infertility and Family Building Committee. It was presented by Sarah Gerstenzerg, LCSW, a nationally known speaker and an adoptee herself. The third was entitled, “Understanding Hoarding Disorder for Clinical Intervention and Support,” presented by Anne Pagano, LCSW.

We are planning programs on sex therapy and the use of ketamine in couples therapy for next year. We welcome requests for speakers on clinical subjects that our members are interested in. We also have three ongoing Peer Groups, and many active committees. Please contact me for more information on all activities and join us.

Climate in Therapy

Richard Beck, a prominent group therapist and longtime member of the Society, was selected by a Swedish filmmaker for a documentary, “Climate in Therapy.” It features Richard working with a group of seven renowned climate scientists who explore “their own fears, grief, guilt and climate anxiety, finding unexpected relief, solidarity and hope.” It is being shown at film festivals worldwide before being released to the public. Details are at <https://www.climateintherapy.com/>.

✉ Helen Hinckley Krackow: hkrackow@gmail.com

Genie Wing

Honoree – Metropolitan



Genie Wing, LCSW-R, BCD, has been a member of NYSSCSW since 1982. She is currently Member-at-Large of the Met Chapter, and active in the Issues on Aging Committee and the Eastside Peer Supervision group.

Genie served with great distinction on the Education Committee and the Scholarship Committee, which included reading first-year graduate students’ practice papers. Earlier, she worked with Sandra Indig on the Creative Arts Committee.

Her illustrious career began with a BFA in sculpture, then certificates in art therapy and psychodrama, an MSW from New York University, and a three-year post masters in individual clinical social work from Hunter College. Then she completed psychoanalytic training in individual and group treatment.

Like many newly graduated MSWs, she went from job to job working with hospital inpatients, substance users, in a state-run outpatient clinic, and private practice. “Then someone told me about the New York City school system! You have your summers off, major holidays off, you finish at 3:00 pm! You can do your practice and artwork, and you get a pension! It was a great gig, working with special education adolescents.”

Now retired, Genie said, “All along, the support and companionship I received in this difficult occupation was from members and friends of the NYSSCSW. Thank you all.” ■

✉ wingggus@yahoo.com

Rochester Chapter

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



The Rochester Chapter continues to grow as we enter our third year, with ongoing monthly gatherings that foster connection, collaboration, and professional support.

Networking In recognition of National Social Work Month, we hosted a networking event on Saturday, March 28, featuring a community pancake breakfast highlighting locally sourced maple syrups—fitting for March in upstate New York. This gathering offered an opportunity not only to connect, but also to pause in gratitude and honor the dedication of social workers who continue to show up each day, providing essential advocacy, counseling, and support to individuals and communities, especially during these times of uncertainty. The 2026 theme, “Social Work: Uplift. Defend. Transform,” resonates deeply with our shared mission.

Meetings Our monthly meetings have increasingly centered on collaboration and the exchange of clinical interests, expertise, and ideas. Recent discussions have focused on addressing the clinical needs of clients within the broader context of war, socio-political uncertainty, and global climate change. We have also engaged with practical concerns related to our profession, including ethical and legal considerations, financial sustainability, and the evolving future of clinical social work.

We remain committed to inviting colleagues to join us as we strengthen this local professional community—one that is both grounded in Rochester and connected to the broader network of social workers and chapters across New York State. Looking ahead, we will continue to expand our membership and develop meaningful networking and educational opportunities in the months to come.

In closing, I would like to express my sincere gratitude to the leaders of the Society for their ongoing support and encouragement as we continue to build and grow the Rochester Chapter.

✉ Peter Navratil: pknavrtil@gmail.com

Meena Lal

Honoree – Rochester



Meena Lal, LCSW has been a Rochester Chapter Member since the Chapter was formed in 2024. She is an affiliate of Tree of Hope Counseling, PLLC where she has a private practice and she also works at Nazareth University where she is an Adjunct Professor

in Social Work as well as the Youth Anxiety Center Program Manager.

Meena is a champion for the profession and has been instrumental in the success of the scholarship program for our region. She also contributes to chapter events, including peer support. In addition to her commitment and passion for her clients, she advocates for and supports her students’ development and transition into the social work profession.

Meena integrates clinical and holistic perspectives into her therapy practice that result in an intuitive, person-centered, wholehearted self-exploration. She weaves her study of evidence-based interventions, human development, emotional regulation, and the mind-body connection together. Her work supports individuals, couples, and families as they discover grounded and loving relationships, self-acceptance, an increased sense of well-being, and adjustment to life’s challenges. Areas of special focus are relationship building, including families, parent-child, couples, adolescents, and “launching” young adults, highly sensitive persons (HSP), empaths, and individuals experiencing spiritual crisis and/or cultural issues. Meena is a trauma sensitive and LGBTQ affirmative therapist who is a warm and welcome ally to all. ■

CONTINUED ON PAGE 18

Westchester Chapter

Mindy Levine, LCSW, President



Virtual Meetings The past year was the first that we began virtual in addition to in-person meetings. The virtual meetings have gone well with attendees providing positive feedback, expressing a feeling of collegial connection. The virtual meeting in

March featured three speakers discussing their connection to and experiences in Alanon and Alateen. It was both personal and extremely informative, providing clear, concise information.

Overall, I have been quite impressed by the virtual meetings, which offer clinically useful information in a warm supportive environment.

First to Offer Hybrid Meetings We are the first and only chapter to provide hybrid meetings, that is, in-person and virtual. On May 16, Steward Crane, past director of Westchester Psychoanalytic Institute, will present his published paper, “When the Big Shot Raises His Fee.” Raising fees has always been a complex, multi-layered process and we look forward to this offering.

Ambassadorships Sonia Wagner, LCSW-R, initiated the idea of ambassadorships to our chapter. Ambassadors can choose a specific project with a specific time frame. This way, a person may commit to a project which has a finite ending.

Sonia spearheaded a virtual panel discussion on Pathways in Social Work geared to new graduates and social work students. After almost a year of planning, more than 90 individuals registered for this free virtual event. About 40 attended and overall, it was very well received.

Social Media We have just launched a Social Media Committee with Diane Jaulus, LCSW-R as chair. We are actively seeking people to come and share their ideas and creativity to help create a presence for our Chapter on various platforms.

We are fortunate to have a Social Media advisor working closely with Society President Beth Pagano, LCSW-R. Our committee will channel information about our events to the social media expert and Beth, who will transfer the information to the various platforms.

Education Our Education Committee, chaired by Ruthie Kalai, LCSW, continues to get rave reviews for their CEU offerings, which take place four times a year.

Get Involved We are committed to helping social workers early in their careers as well as at later points in their work. To continue offering student events, we need more members to become involved in helping to organize and run them.

In fact, we need clinicians to get more involved in every aspect of our work, including taking leadership roles. The chapter has open positions for Vice President and Membership Chair. Please contact me if you would like more information.

Our main goals are to offer interesting, inspiring meetings and great learning opportunities, all within a warm and inviting milieu. We hope that this will help expand our membership and help us to remain the vibrant organization that we are. 🌟

✉ Mindy Levine: mindyglvine@gmail.com

Laura Himmelstein
Honoree – Westchester



Laura Himmelstein, LCSW specializes in working with children and families, often those faced with serious and complex illnesses, grief, and bereavement. Laura is the Coordinator of the Caregiver Support and Healing Touch Programs at White Plains Hospital. She also maintains a

private practice, works with community agencies, and teaches stress management, meditation, breath-body-mind classes and seminars to patients, families, and health care professionals.

The Westchester Chapter has benefited greatly from Laura’s strong belief in giving back to the profession. She is an integral member of the Education Committee, working to bring in high quality CEU programming through ACE. A new program, LUNCH and Learn, was met with great enthusiasm. Laura said she feels honored to serve on the committee with the “consummate professionals and wonderful human beings” that she admires.

An accountant in her first career, she earned her MSW and a certificate in Health Care Management specializing in Palliative and End of Life Care from Fordham University. She is also a Certified Healing Touch Practitioner, Certified Thought Field Therapy practitioner and Certified Teacher Trainer in Breath-Body-Mind Level 2 curriculum. ■

Dorothy Height
Pioneering Social Worker and Activist



“Without community service, we would not have a strong quality of life. It’s important to the person who serves as well as the recipient. It’s the way in which we ourselves grow and develop.”

In February 2026, as part of our Black History Month series, we recognized Dorothy Height, who devoted her life to advancing justice at both the individual and the systemic level. Born March 24, 1912, in Richmond, Virginia, Height was an African American civil rights and women’s rights activist.

She began her career as a case worker in the New York City Welfare Department, grounding her lifelong advocacy in direct service with individuals and families. Height exemplified social work values by advocating for structural change—challenging segregation, economic inequality, and gender bias—not just individual adjustment. Her intersectional approach to racial and gender equity anticipated modern social work emphasis on connecting client well-being with community and policy contexts.

Height received the Presidential Medal of Freedom and the Congressional Gold Medal—among the United States’ highest civilian honors. She also received the NASW Lifetime Achievement Award for her extraordinary contributions to social justice and social work advocacy.

Her life’s work embodied core clinical social work values: dignity and worth of the person, social justice, and the linkage of individual well-being with systemic change. 🗨️

Unividuation, Addiction, and the Twelve Steps: Recovery as a Path to Wholeness

Peter K. Navratil, LCSW



Peter K. Navratil, LCSW, is a clinical social worker, educator, and community practitioner with decades of experience in trauma, grief, addiction, and interpersonal violence. His work integrates depth psychology, family systems theory, and ecological perspectives to address the interconnection between personal healing and collective well-being.

Peter is the founder of emerging initiatives focused on “unividuation,” a framework that extends beyond individual development toward relational, ethical, and planetary responsibility. He has facilitated men’s groups, grief circles, and community-based healing programs, and is actively developing training and writing that prepare helping professionals to respond to the psychological and social challenges of systemic crisis.

He lives and works near Rochester where he continues to write, teach, and support individuals and communities in cultivating resilience, accountability, and compassion across generations. He is Founder Emeritus of Tree of Hope Counseling and currently serving as the President of the Rochester Chapter of NYSSCSW.

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Abstract

This paper explores the intersection of Unividuation, a Neo-Jungian concept that extends individuation toward collective and relational wholeness, and the recovery process articulated in Alcoholics Anonymous (AA). It examines addiction as a symbolic expression of psychic disconnection and the Twelve Steps as a spiritual technology of reintegration. Through a synthesis of Jungian psychology, systems thinking, and recovery spirituality, the article argues that Unividuation offers a transpersonal framework for understanding addiction not only as individual pathology but as a mirror of collective fragmentation. Ultimately, recovery and Unividuation both lead toward the restoration of relationship—with self, others, and the sacred Whole.

Introduction

Addiction represents one of the great paradoxes of the human condition: a compulsive pursuit of connection that results in deeper separation. Beneath every addiction lies an archetypal longing—a thirst for union with what has been lost or forgotten. Carl Jung captured this truth in a 1961 letter to Bill Wilson, co-founder of Alcoholics Anonymous, observing that “the craving for alcohol is the equivalent, on a low level, of the spiritual thirst of our being for wholeness.” Addiction, from this view, is not merely a disease of choice or brain chemistry; it is a spiritual disorder rooted in alienation from the Self.

The Twelve Steps of Alcoholics Anonymous, formulated in 1939, have guided millions through recovery by offering a structured path of surrender, self-examination, amends, and service.

Though conceived in a Christian idiom, their essence resonates with the deep psychology of transformation. The Steps trace a symbolic arc—death of the ego, confrontation with shadow, reconciliation with the collective—that mirrors Jung’s process of individuation.

Unividuation, as developed in my work, extends individuation beyond the self’s personal integration into a participatory consciousness that includes community, ecology, and the sacred cosmos. It invites a recovery not only of the individual soul but of the relational field. When we interpret the Twelve Steps through this lens, recovery becomes a form of Unividuation—a re-membering of the Self within the Whole.

Step One: Surrender and the Dissolution of the False Self

The first step—“We admitted we were powerless over alcohol—that our lives had become unmanageable”—is a moment of profound ego collapse. It corresponds to the alchemical nigrado, the blackening or putrefaction of false structures of control. In Jungian terms, this is the necessary descent into the shadow that precedes transformation. Powerlessness, paradoxically, opens the doorway to authentic power—a surrender of egoic mastery that makes space for the transcendent function. In Unividuation, Step One represents the collective recognition that we cannot heal in isolation. The self’s confession of limitation becomes an archetype of communal humility: the beginning of a new relational orientation grounded in truth rather than pretense.

Steps Two and Three: Encountering the Greater Whole

Steps Two and Three—believing in a Power greater than ourselves and turning our will over to its care—represent a re-alignment with the transpersonal dimension. For many in recovery, “God” is not a dogmatic entity but an emergent relational field: community, nature, consciousness, or the living web of life. Jung viewed such surrender as the psyche’s reconciliation with the Self—the organizing totality of the unconscious and conscious mind. From the standpoint of Unividuation, this surrender marks the re-entry of the ego into participation with the Whole. It mirrors what systems theorist Gregory Bateson called the ecology of mind—the awareness that sanity and survival depend upon our embeddedness within larger patterns of relationship.

Steps Four through Nine: Shadow Integration and the Restoration of Relationship

The middle steps—inventory, confession, amends, and restitution—constitute a psychospiritual descent into shadow and relational repair. Step Four’s “searching and fearless moral inventory” invites deep introspection, an examination of the disowned aspects of the personality. In Jungian language, this is shadow work—the conscious encounter with the repressed or denied elements of the psyche.

Steps Eight and Nine transform this inner work into relational ethics. Making amends is a ritual act of Unividuation: restoring right relationship in the social field where disconnection once reigned. Francis Weller describes grief work as “apprenticeship with loss,” a communal process that re-opens the heart to the world. Likewise, amends work is a social form of grief ritual—acknowledging the wounds inflicted by addiction and transforming shame into empathy.

Steps Ten through Twelve: The Practice of Conscious Living

The final steps move recovery from event to practice. Step Ten’s daily inventory reflects a commitment to ongoing self-awareness; Step Eleven introduces contemplative disciplines that deepen communion with the sacred; Step Twelve embodies service—the outward expression of inner transformation. In Unividuation, these steps represent the evolution of consciousness from self-concern to collective participation. Service is not moral duty but the natural overflow of wholeness. The individual who has reclaimed their center becomes a conduit for communal healing. Recovery, in this sense, is the alchemy of relational transformation—the personal soul serving the greater soul of the world.

Addiction as a Collective Symptom

While the Twelve Steps address personal healing, Unividuation situates addiction within a larger cultural pathology. Our society itself is addicted—to consumption, control, speed, and separation. These systemic addictions mirror the individual addict’s psychic split. As Jung noted in *The Undiscovered Self*, the modern world’s obsession with materialism and power reflects a loss of symbolic and spiritual meaning. Recovery, therefore, must be both personal and collective. The fellowship of AA, with its principles of humility, honesty, and mutual service, models a form of *communitas*—an egalitarian spirit that arises in liminal space. Within these circles, participants experience Unividuation in action: the rediscovery of self within shared vulnerability.

Conclusion: Recovery as Unividuation

To walk the path of recovery is to participate in the archetype of return. Addiction represents exile from the Self; recovery is the journey home. The Twelve Steps trace the same psychic trajectory as Jung’s individuation, yet they culminate not in isolated integration but in relational wholeness. In Unividuation, the healing of the individual contributes to the healing of the collective; the personal story becomes a thread in the larger tapestry of renewal. Ultimately, both recovery and Unividuation affirm that wholeness is not achieved but remembered. Through surrender, shadow work, and service, the addict becomes the healer—the one who, having descended into fragmentation, now carries the light of re-membering for others. 🌈

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Living in the Shadows: Sex and Love Addiction in the 21st Century

Jeffrey Zeth, LCSW



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James began consuming pornography in his teens; it was the one place where he could be completely free from his mother’s abuse and violence. The world of pornographic fantasy was a place where he could be everything his mother told him he would never be wealthy, successful, good-looking, confident. As he got older and committed himself to a woman and a family, he found that pornography continued to be a convenient escape from the pressures of the world—until his wife found out what he was doing.

Yuri has come in because his wife has left him. His wife has left him because he cheated on her for many years, repeatedly with different women. This was not the first time she found out about his infidelity—nor the second, or the third. They have a pattern—somehow, she finds out, he promises to do better, and he remains faithful for a while. But then, after a few weeks or months, he meets a mutual friend, a co-worker, or a neighbor. They start spending more time together, and before he realizes what is happening, he and his new friend are sleeping together. These are not one-time events, but long-term emotional connections with other women, sometimes spanning years.

Before coming to our appointment, Yuri was looking up information on antisocial personality disorder online, hating himself and seriously wondering whether he is a psychopath. When I meet him, he is still consumed with this question, and is looking to me for an answer, tears in his eyes. “Am I a monster?” he asks.

Jun is a 35-year-old man from Korea, a visual artist who came to the U.S. with his girlfriend about two years ago. Within months of their arrival, he began using club drugs and having high-risk, unprotected sex with other men.

For him, the two activities go together: if he uses drugs, he is almost certain to seek out sex with other men, but he has no sexual interest in men when he isn’t using drugs. At this point, Jun is in recovery, but his career is stalled. He has been unable to find work as an artist and is not currently working on anything. To make ends meet, he works bagging groceries at Trader Joes’s.

Serial infidelity, pornography, and high-risk sexual behavior connected to substance abuse are all different aspects of a wide-ranging problem. Sex and love addiction is little-understood and under-researched, and criteria for sexual addiction can be difficult to define. A diagnostic category of sexual addiction disorder was proposed for the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) but ultimately was not included.¹ The disorder is included in the 11th edition of the International Classification of Diseases (ICD-11), where it appears as “compulsive sexual behavior disorder.”²

Because the problem varies so much in its presentation, there is no reliable way to estimate either the financial costs of sex addiction nationally, or the toll taken on quality of life and relationships. Pornography, taken alone, is a multi-billion-dollar industry, with one of the largest sites grossing almost \$450 million in annual revenue before Visa and Mastercard revoked their card-processing services.³ One study found that 46% of all men and 16% of all women surveyed reported pornography use in the week before the survey.⁴ The growth of the Internet has intensified the problem: an unlimited supply of films, offering endless


variety and catering to every taste, is available on the privacy of a home computer or smartphone. The stigma of being seen going into a brick-and-mortar “adult video store” no longer exists.

Most studies on porn addiction rely on respondents’ self-reports. (“Do you think you are addicted?”) Some have found that high religiousness or moral incongruence influences more heavily whether a patient describes his or her *experience* as addiction.⁵ If the behavior is inconsistent with one’s values, respondents are more likely to describe themselves as “addicted,” regardless of any objective criteria.

If these measures are almost wholly subjective and difficult to define with any accuracy, love addiction is even more so: like pornography addiction, most researchers on the subject rely on self-reports—on whether respondents say they have a problem or not. It’s possible, according to one study, that up to 40% of unmarried couples experience some history of infidelity.⁶ Meanwhile, serial infidelity is closely connected to three personality disorders: narcissistic, borderline, and antisocial.

So statistically speaking, Yuri was not wrong to worry about whether he was a psychopath. (He was somewhat relieved to consider the possibility that a true psychopath does not worry about whether he is a psychopath.) In looking at his history and at what he was looking to gain from his behavior, what emerged immediately was a frequent need for validation. He was looking for many of the same things James was looking for in his use of porn, but in real life: to feel powerful and virile, to be told he was good-looking and desirable. Every woman Yuri added to his “body count” reinforced the idea that he was desirable, but the feeling was short-lived. Soon enough, he would need another “hit” of esteem from another woman.

Like the above-mentioned personality disorders, addiction to substances is one of the co-morbidities closely connected with sexual compulsion.⁷ High-risk sex is sometimes, but not always, connected to the impaired impulse control and drug-seeking activities reported by addicts whose primary issue is substance abuse. But high-risk sex can also be a primary cause, with drug use as the outcome of the sexual compulsion. Drug use can often make it easier for the addict to avoid feeling the shame and guilt brought on by compulsive sex, and the values of the culture or subculture can sometimes normalize the high-risk sexual behavior.⁸ This was one of the “benefits” of Jun’s use of club drugs. The sex and drugs created a “split” in his sense of self: there was the man he was at home with his girlfriend, and the man who was having anonymous,

casual sex with men, while high. Unable to reconcile this split, a thought-feeling construct, commonly known as “imposter syndrome”, took hold. No matter where he was, whether in the club or at home, he was haunted by the feeling that, if others knew the truth about him, they would abandon him. Jun was able to stay in substance abuse recovery to look at the dynamics at play in the construct—at the self-esteem issues, the depression with anhedonia that caused him to seek out increasingly intense experiences, and attachment issues. Gradually, each piece of the puzzle became a little clearer. 

12-Step Programs

Self-help groups, which were at the forefront of help for substance disorders, also exist to meet the needs of sex and love addicts. Many were created to address issues that some members found outside the scope of Alcoholics Anonymous or Narcotics Anonymous. Some are geared primarily towards infidelity or love addiction and some towards compulsive use of pornography, masturbation, or prostitutes. Many individuals involved in these programs also attend a more traditional 12-step group, such as Alcoholics Anonymous, as well. A person seeking help in any urban area can choose the group that best matches his or her needs.

Sexaholics Anonymous helps people who feel powerless over their sexual desire. <https://www.sa.org/>

Sex and Love Addicts Anonymous is for those who are addicted to dysfunctional relationships as well as sex. <https://slaafws.org/>

Sex Addicts Anonymous focuses on sexual acting out and primarily addresses behavior, rather than desire. SAA was started by Patrick Carnes, a leading author on sexual addiction and recovery. (See “Further Reading”) <https://saa-recovery.org/>

Sexual Compulsives Anonymous is for those whose problem has a strong obsessive-compulsive component. <https://sca-recovery.org/WP/>

CONTINUED ON PAGE 24

Table I. The Proposed Diagnostic Criteria for Hypersexual Disorder for DSM-5

The proposed diagnostic criteria for hypersexual disorder, although unaccepted by the DSM, are as follows:

- A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with 3 or more of the following 5 criteria:
- A. 1. Time consumed by sexual fantasies, urges, or behaviors repetitively interferes with other important (nonsexual) goals, activities, and obligations.
 - A. 2. Repetitively engaging in sexual fantasies, urges, or behaviors in response to dysphoric mood states (eg, anxiety, depression, boredom, irritability).
 - A. 3. Repetitively engaging in sexual fantasies, urges, or behaviors in response to stressful life events.
 - A. 4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, or behaviors.
 - A. 5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.
- B. There is clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, or behaviors.
- C. These sexual fantasies, urges, or behaviors are not due to the direct physiological effect of an exogenous substance (eg, a drug abuse or a medication).
- Subtype:
- Masturbation
 - Pornography
 - Sexual Behavior With Consenting Adults
 - Cybersex Telephone Sex
 - Strip Clubs
 - Other.

Sexual Addiction Disorder—A Review With Recent Updates

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Work with Food Addiction and Unexpected Relational Effects

By Karen Kaufman, Ph.D., LCSW



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More than a decade ago, through a professional connection, I was asked to evaluate the readiness of several patients preparing for bariatric surgery. I declined to do these evaluations because I would not rubber-stamp these individuals as sufficiently informed of the risks and possible outcomes of surgery without any history of therapy or plan to begin treatment.

Before this, I had consistently observed that without therapy and the ongoing exploration of the complicated, often addictive relationship with food, the likelihood of patients gradually regaining the lost weight was high. With minimal or no change in this relationship, despite nutritional counseling and the introduction of exercise, I was not optimistic about lasting success for these individuals. The new efforts tended to be short-lived, and despite the medical risks of overeating with a surgically restricted or reduced stomach size, the former lifestyle and poor choices returned along with the weight.

In recent years, the proliferation of weight loss drugs referred to as GLP-1, initially prescribed for high blood sugar levels and diabetes, has led to extreme weight loss in individuals not only suffering from medical conditions but also those who want to utilize a seemingly easier method. Despite the often uncomfortable side effects of these drugs, the loss of appetite has made them highly desirable even when people wish to shed a small amount of weight.

An early outcome of clinical research with these drugs demonstrates benefits for other illnesses, including heart and kidney disease. Along with curbing addictive tendencies, a great advantage in their use is that many people no longer crave the sweet or highly processed foods they previously favored and are voluntarily making healthier food choices. Continued research will determine if these drugs will benefit other addictions, given the direct effects not only on the hormone that affects intestinal digestion but also on the neurotransmitter dopamine, connected to pleasure and reward.

Changed Relationships

For those who have been successful in losing and maintaining weight loss, a surprising outcome for some patients has been in the changed relationships with many of the important people in their lives. Whether spouses, children, friends or colleagues, they were accustomed to relating to an overweight or obese person who, in some cases, lost half their previous body weight and was suddenly making a strikingly different presentation.

Unlike my previous decision not to rubber-stamp readiness for surgery, when the opportunity presented itself to work with patients in therapy prior to or soon after bariatric surgery or a GLP-1 weight-loss program, I had no hesitation. I hoped to create a space for deeper self-reflection and greater insight that could assist in successful outcomes. The varied meanings assigned to food were explored extensively in therapy in terms of soothing qualities, filling voids, perceived closeness, and approval from food-addicted family members, or creating a relationship that could be controlled, as weight loss progressed.

CONTINUED ON PAGE 26

Some patients were surprised to discover that the biggest challenge they often faced was in their relationships with the closest people in their lives.

Diane, a clinical example (identifying details disguised)

Diane, a 37-year-old, White, mother of two school-age children, was married for 15 years at the time of referral, employed in a senior-level HR position in a major corporation. She had a demanding work schedule and her husband, a tradesman, worked closer to home and was able to cover the children's needs when Diane worked late or was travelling for business. Diane grew up in a chaotic home; her parents never got along and fought a lot. They divorced when she was ten years old, her sister seven, and her mother moved out of the home. Both parents were described as over-achievers and workaholics. Her mother worked in banking after attending business school when Diane and her sister were young children. Her father, the president of a national restaurant chain, traveled a lot domestically for business. He and his extended family struggled with obesity. Her mother was of average size and described as lacking in maternal, nurturing qualities. Diane felt as if she and her sister raised themselves. In Diane's words, their mother, whom they visited somewhat regularly, was never a "mommy" or a "caretaker." She also felt that both parents' difficult early lives harmed their ability to parent.

Both parents remarried after the divorce; their mother had two more children and moved with her family to North Carolina. This relocation lasted a few years before the family returned to New York. Diane and her sister continued to live with their father and an abusive stepmother, whose "paranoia" led to efforts to sever her husband's relationships with his extended family and children, any relationships that preceded her.

The stepmother demanded that the girls leave her home when Diane was in high school and the sisters had no choice but to live with their mother and her new family. Diane never fully understood what precipitated her stepmother's rejection and feared that she would lose her father if she attempted any protest over her stepmother's wishes. The sisters developed an intense mutually protective relationship that continued into adulthood.

Early Relationships with Food

The role of food in both households had been highly charged, leading to great confusion for Diane and her sister. With their father and his family, the girls received more approval for overeating, accepting second portions, whether or not they were still hungry. Their father, in a seductive manner, would invite Diane to share late-night snacks with him and this felt like an easy way of gaining his approval. She never reported any untoward behaviors, nor did she feel unsafe with him.

In their mother's home, food was more restricted and snacks were limited. At a certain point after dinner, the kitchen was closed, whether or not the growing and active girls wanted a healthy snack. As Diane reflected on her early relationship with food, she felt she was actually pushing her feelings down despite often feeling ill from overeating. She reported that the overall feeling was one of soothing. She also recognized that she was unconsciously trying to take on the role of a nurturing mother to herself in an attempt to fill the void that had always existed with her mother. She remembered the wish to hide some snacks in her bedroom but was fearful of angering her mother if they were discovered.

Diane attended an out-of-town college and never returned to her mother's home. She found employment immediately after graduation and rose through the ranks at the corporation. From the ages 18 to 29, she had two serious illnesses, which were treated successfully, but by the time of the bariatric surgery she felt "weakened."

She married soon after college, having known her husband, Mike, from the community in which she was born and continued to live with her father. They didn't have a great deal in common, but she felt some additional security and mutual understanding since they shared the same home town.

She described her marriage as close and supportive after some difficulties in their early years. At this point, tasks were shared but Diane felt there was some role reversal in terms of gender-related expectations: she had more education, higher income, managed their finances and bills, while her husband cooked and was responsible for most of the child care. Still, they felt it was a cooperative arrangement.

Prior to bariatric surgery, Diane was approximately 5'7" and weighed nearly 300 pounds. Her husband was of average height and weight. We started working together one month after the surgery, when Diane was on an extended liquid diet after a bout of pancreatitis. She was afraid of introducing solid foods after the discomfort from the illness, and was also concerned about becoming ill when she began to consider her return to work. Her surgeon tried to reassure her that her fears were normal and that she might have some difficulties introducing solids since they could cause vomiting and diarrhea until her body adjusted to the reduced stomach size. She knew that she would have to form a new relationship with food and with her own body, which would go through extensive changes, but was not confident in her ability to succeed.

Diane began to reflect more deeply on her early years and how she had buried so much of her feelings since no one was capable of emotionally supporting or nurturing her. After several months of working together, she felt as if she was finding her voice and a new sense of her own rights, and cautiously started to ask her parents questions about some of their earlier decisions. Not meeting with much resistance, she continued to make progress with both parents in their communication, even with highly charged subjects.

After the medical leave from her job ended, she was permitted to return on a reduced schedule for a short time. She was initially reluctant to request this from her manager but was becoming more confident in her right to ask for what she needed. Difficulties adjusting to solid foods ensued; she experienced what the surgeon referred to as "dumping" when sampling them and so she adhered to a liquid diet during the early months of her adjustment back to work. I suspected that much of her security with the liquid diet was also connected to her lack of trust in creating a healthier and lasting relationship with food. There would be no challenge if she continued on liquids.

In the first few post-operative months, Diane lost over 50 pounds with the goal of losing another 80 to 90 pounds. During this time, she noted that Mike's behavior was changing; he was becoming more clingy and memories of old losses in his early life were resurfacing. She was becoming more comfortable with the gradual introduction of small portions of easily digestible foods and felt more confident about her return to work. But as her appearance began to change, Mike was more possessive and insecure in their relationship, leading to conflicts between them.

Prior to the surgery, Diane avoided being photographed, so she considered it a positive sign when she engaged her children in a craft project creating a calendar with family photos that showed her progress. Diane began to explore the sources of her avoidance of recognition: her father's grandiosity and what she perceived as her mother's competition with her daughters.

She was confused by her mother's earlier wish that Diane not wear a size smaller than 12, yet the kitchen was closed to prevent excessive snacking. Diane also delved into feelings she had buried about her mother's departure from their home and her long absence during her years in North Carolina. At one point during this period, I received a call from Diane who was very upset about Mike's increasingly clingy and insecure behaviors. She felt these behaviors could harm their marriage and asked Mike to join her for her session the following day. While I would not typically change the frame of my work with individual therapy, Diane was highly agitated, and there was no time to consider a referral to a couples therapist at that moment.

Mike presented as a reasonable, caring spouse who denied possessiveness and insecurity regarding Diane's changing appearance but reported that he had initially been afraid of the potentially dangerous nature of the surgery. He claimed he was currently more attracted to her and hoped they would go out and socialize more, since prior to the surgery, she was a homebody. The couple recognized that they needed to work on their communication, along with renegotiating their marriage as Diane's physical changes and newly voiced emotional needs were altering their original contract.

Diane felt more confident in continuing to strengthen her voice, not only with Mike, but also in discussions with her father, addressing her stepmother's abuse and his lack of protection of his children. In conversations with her mother, she sought to understand her departure and absence, along with her constant criticism of Diane. These exchanges led to a heightened level of anxiety, and Diane felt obsessed with food, afraid to have preferred foods in the house, fearing a lack of control, even while knowing that overeating would make her ill.

CONTINUED ON PAGE 42

The The Addictive Brain: A Functional Psychoneurobiological Model

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



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What Is the Addictive Brain?

Addiction has traditionally been described in terms of substances or behaviors—alcohol, opioids, gambling, pornography—each with its own clinical presentation, risk profile, and treatment. This categorical approach has clinical utility, particularly for diagnosis and clinical management. However, it obscures a more fundamental observation from contemporary neuroscience: addiction is not best understood as a property of a substance or activity, but as a functional state of the brain.

Current neurobiological models conceptualize addiction as a chronic, relapsing condition marked by dysregulation across interconnected neural systems involved in reward, motivation, stress, learning, and executive control (Koob & Volkow, 2016; Volkow et al., 2016). Substances and behaviors exert their effects not simply because of their external properties, but because they engage—and progressively alter—shared neurobiological pathways. Central among these is the mesolimbic dopamine system, in which drugs of abuse increase dopamine signaling in the nucleus accumbens, a key structure in reward processing (Volkow et al., 2016). Dopaminergic activity is not limited to the experience of pleasure; it plays a central role in assigning salience, reinforcing learning, and driving behavioral repetition.

As addiction progresses, neurobiological involvement extends beyond reward systems. A widely accepted framework describes a three-stage cycle: binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation (Koob & Volkow, 2016). These stages reflect interacting neuroadaptations across major

brain systems: the basal ganglia, extended amygdala, and prefrontal cortex. Early engagement is dominated by reward and reinforcement processes; with progression, reward sensitivity decreases, stress reactivity increases, and impaired executive function. The transition moves behavior from impulsive toward compulsive patterns. A critical feature of this progression is the increasing role of negative reinforcement. Chronic substance use recruits stress-related systems, particularly within the extended amygdala, where neurochemicals such as corticotropin-releasing factor (CRF) and dynorphin contribute to dysphoric and stress-like states during withdrawal (Koob & Volkow, 2016). In this phase, substance use is no longer primarily about achieving reward; it becomes a means of alleviating internal distress. ***Behavior persists not because it produces pleasure, but because it temporarily reduces discomfort.***

In parallel, learning and conditioning mechanisms further consolidate addictive patterns. With repeated exposure, the brain's response to the substance diminishes, while sensitivity to associated cues increases. Dopamine signaling becomes increasingly linked to anticipation and environmental triggers rather than to the pharmacological effect of the drug (Volkow et al., 2016; see also Uhl et al., 2019). This shift embeds addiction within memory and associative systems, contributing to its persistence and the high risk of relapse even after prolonged abstinence.

These findings support a unifying concept: ***addiction reflects a reorganization of brain function.*** It is not reducible to any single neurotransmitter, circuit, or behavior. Rather, it represents a patterned mode of functioning—an ***"addictive brain"***—in

which reward, stress, learning, and control systems have been recalibrated to prioritize immediate, survival-based responding over integrated processing across levels.

These models describe in detail which neurotransmitters are involved and which brain areas are activated in addiction. However, this level of description does not translate into clinical work beyond pharmacological interventions. Knowing which circuits are involved does not determine how a person functions in a given moment, nor explain why individuals continue to act in ways that contradict their own knowledge and intentions. This gap requires a different approach, one that focuses on how functioning is organized.

The Functional Medicine Model: From Disease to Process

Traditional medical models are focused on identification and treatment of disease entities. Within this approach, dysfunction is defined by the presence of diagnosable pathology, and clinical work focuses on classification, symptom reduction, and targeted intervention. It has been highly effective in acute care and in conditions with clearly identifiable structural or biochemical abnormalities. However, it is less effective in addressing complex, chronic conditions in which symptoms do not map neatly onto discrete diagnostic categories. This limitation is particularly evident in conditions like addiction, where ***behavior often persists despite intact knowledge, insight, and awareness***, and cannot be fully explained by diagnostic classification alone.

The functional medicine model shifts away from a disease-centered approach toward a process-oriented understanding of health and dysfunction. Here, disease is viewed as an endpoint, while function is understood as a dynamic process unfolding over time (Bland, 2015; Jones & Quinn, 2010). It is not static; it moves in adaptive or maladaptive directions, shaped by interactions among genetic predisposition, environmental exposures, lifestyle factors, and psychosocial influences.

Rather than focusing on diagnostic labels, the functional model emphasizes the mechanisms and pathways that give rise to dysfunction. It examines how physiological processes become altered, how these changes interact and are maintained over time. This perspective is grounded in systems biology, which views health and disease as emerging from interactions across multiple levels of organization rather than from isolated defects within a single organ or pathway (Bland, 2015).

Historically, conditions that lacked clear structural pathology were often categorized as “functional disorders” and attributed to psychosomatic causes. The functional medicine model represents a departure from

this view. Advances in biological understanding and diagnostic capability have shown that such conditions often involve measurable alterations in function, even in the absence of structural abnormalities (Institute for Functional Medicine, 2011).

Clinically, this shift redirects attention from identifying the disease to understanding how the patient is functioning, what factors contribute to the current state, and which processes can be modified to restore function. This model is not defined by a specific set of interventions, but by a way of organizing clinical thinking that prioritizes causation, interaction, and change over classification.

Functional Psychoneurobiology: Extending the Functional Model to the Brain–Mind

The functional medicine model shifts attention from disease entities to processes: how dysfunction develops, is maintained, and changes over time (Bland, 2015; Institute for Functional Medicine, 2011). Applied to the brain–mind, this perspective focuses on how functioning is organized rather than on anatomical localization or discrete brain “centers.”

Functional psychoneurobiology (FPNB), as developed in prior work (Rozentsvit, 2011, 2024, 2025), examines how the brain–mind operates across levels and how this organization shapes behavior, experience, and adaptation in real time. Here, function has a dual meaning. It refers both to the unfolding of processes—how patterns of think-

““ The functional medicine model shifts attention from disease entities to processes: how dysfunction develops, is maintained, and changes over time. Applied to the brain–mind, [it] focuses on how functioning is organized rather than on anatomical localization or discrete brain “centers.””

ing, feeling, and acting develop and change—and to the clinical aim of supporting the capacity to function. The model is therefore both explanatory and practical.

The Triune Brain model, developed by Paul D. MacLean (1990), is employed here as a functional heuristic for understanding levels of processing, rather than as a literal map of discrete anatomical systems. While contemporary neuroscience has critiqued its anatomical specificity, it remains clinically useful for conceptualizing shifts in dominant processing modes. MacLean integrated evolutionary, anatomical, and behavioral observations into a coherent account of how different modes of brain activity

CONTINUED ON PAGE 30

contribute to human behavior. In this formulation, three levels are distinguished.

The **reptilian level**, associated with brainstem and related subcortical structures, is responsible for survival. It governs physiological processes, including arousal and rapid responses of fight, flight, or freeze. Its operation is immediate and automatic.

The **mammalian level**, associated with limbic structures, processes experience in terms of emotional meaning and associative learning. It shapes behavior through affect, memory, and learned patterns, much of which remains outside of conscious awareness. The amygdala, while anatomically part of this level, functions as a critical connector to survival-based processing.

The **human level**, associated with the neocortex, supports cognitive and analytical functions, including conscious thought, language, planning, and the capacity to evaluate consequences.



These are not separate anatomical compartments but levels of functioning within a unified brain–mind. Behavior is organized at the level that predominates at that moment. When the survival level predominates, responses are rapid, automatic, and oriented toward threat. When the

emotional-associative level predominates, behavior is guided by learned patterns and affective meaning. When higher-level cognitive functioning is engaged, responses incorporate analysis and evaluation of consequences.

Individuals are not fixed at a single level. There is a degree of choice—variable, context-dependent, and shaped by prior conditioning—in whether one remains at a given level or shifts toward another. The development of this capacity is central to clinical work, which involves understanding how these levels are engaged and relate to one another.

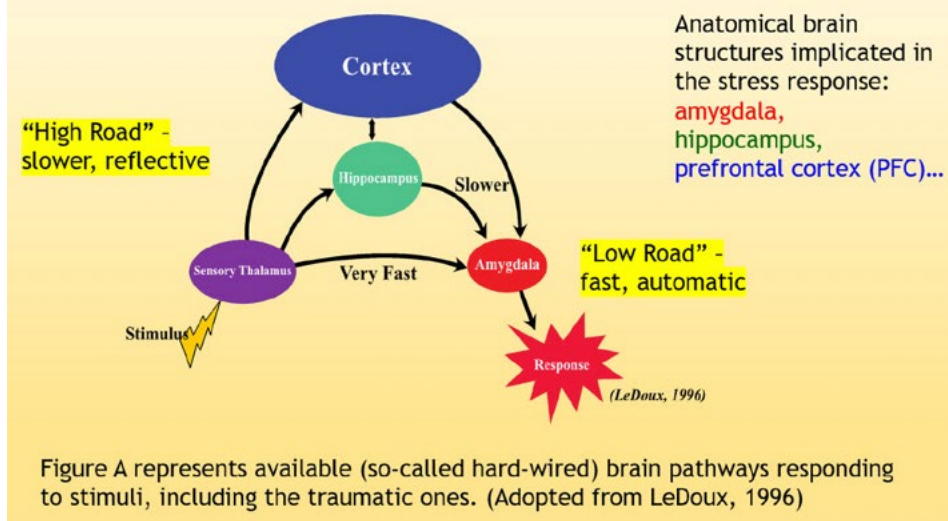
The proposed Triune Brain Plus™ extension makes explicit what is often underemphasized: the continuous involvement of the body. The autonomic nervous system, which regulates physiological states, is most directly engaged at the survival level, but its influence extends across all levels of functioning. Patterns of arousal, breathing, visceral sensation, and autonomic shifts shape how experience is registered, emotional meaning is formed at the mammalian level, and how, or whether, higher-level cognitive functions become available.

A distinction emerges between **vertical and horizontal processing**. In integrated functioning, experience moves vertically across levels, from physiological registration to emotional meaning, and to higher-level cognitive processing. The response reflects this integrated process. This distinction parallels established neurobiological formulations, including LeDoux’s (1996) description of rapid, subcortical (“low road”) pathways and slower, cortical (“high road”) processing, as well as bottom-up and top-down modes of regulation, but is framed here in terms of how functioning is organized across levels.

Under conditions of trauma and chronic or repeated stress, this vertical movement is disrupted, and processing becomes restricted to horizontal patterns, in which incoming stimuli are routed directly into fight, flight, or freeze responses. This pattern reflects a learned mode of functioning that develops early and is reinforced through repetition. In this state, higher-level cognitive capacities remain intact but are not engaged, as responses are organized at the survival level. In other instances, functioning may be organized at the emotional-associative level, where affect-driven patterns dominate while both survival appraisal and higher-level cognition are diminished or bypassed. Over time, this pattern becomes dominant, reflecting a shift from vertical integration to habitual horizontal responding. Functioning relies on what has been most practiced, so higher-level integration is less likely to engage. This organization underlies later patterns of behavior, including addictive processes. Repetition strengthens these pathways through neuroplastic change, while less-used modes of functioning become less accessible over time, consistent with a “use it or lose it” principle.

The capacity to regulate and co-regulate is not located in a single part of the brain. It arises from the coordinated activity of these levels in continuous connection with the body. When functioning is dominated by survival-level processing, behavior remains oriented toward immediate protection. When emotional processing dominates without sufficient integration, behavior may be guided by associative patterns rather than reflection. When higher-level functioning is engaged, the individual can analyze, synthesize, and respond with greater flexibility. FPNB, therefore, shifts the focus from identifying where activity occurs to understanding how functioning is organized across levels and how this organization supports or interferes with a person’s ability to respond to life. This framework is extended here to addiction and recovery processes.

Between Stimulus and Response



Understanding Gambling from a Functional Psychoneurobiology Perspective

In clinical work with individuals struggling with gambling, including years of training clinicians in gambling treatment settings, a consistent pattern emerges. A patient may describe entering a casino or betting online with the expectation of controlling how much they spend. They can articulate the risks, recall prior losses, and state specific limits they have set. Yet, within a relatively short period, this expectation becomes difficult to sustain. The individual reports a shift, in which attention narrows, emotional intensity increases, and the focus turns toward the immediate act of placing the next bet. At this point, behavior shifts into a state of urgency that is no longer aligned with previously stated intentions.

“Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and freedom.”

—Often attributed to Viktor Frankl, Rollo May, Stephen R. Covey, or B.F. Skinner

Addiction is best understood not as a property of a substance or behavior, but as a particular organization of functioning. Addictive patterns emerge when processing becomes predominantly horizontal, when responses follow well-established patterns rather than integrated processing across levels. In such states, functioning may be organized at the survival level, where immediate relief or protection dominates, or at the emotional-associative level, where affect-driven patterns guide action. In both cases, higher-level cognitive capacities often remain intact but are not engaged at the time of response. This helps explain a central clinical observation: individuals may fully understand the consequences yet continue to act in ways that contradict that knowledge. Over time, individuals may also learn to attenuate or bypass survival-level fear processing, despite retaining awareness of potential loss or harm.

This process-oriented perspective was developed in a series of clinical seminars on ADHD, PTSD, and Borderline (Rozentsvit, 2024; 2025). Patterns of nervous system overwhelm—sensory, emotional, and relational—and the dysregulation that follows require special attention. When these patterns are understood as processes rather than fixed diagnostic categories, the brain-mind reorganizes around supporting higher-level cognitive and relational capacities, allowing clinical focus to shift from managing symptoms to supporting body regulation and vertical integration of functioning.

Within an FPNB framework, this shift reflects a change in the level at which functioning is organized. Rather than progressing through vertical, integrative processing, the response becomes predominantly horizontal. In some instances, this shift occurs at the survival level, particularly when the individual experiences mounting internal tension or distress. The act of gambling then functions as a means of immediate self-regulation, an attempt to reduce discomfort or restore control. More commonly, however, functioning is organized at the emotional-associative level, when behavior is guided more by affective patterns shaped by prior experience. The anticipation of reward, the near-miss effect, and emotional salience of winning or losing create a powerful associative network. These emotional drivers can dominate the moment of decision-making, while both survival appraisal (e.g., recognition of financial risk) and higher-level cognitive evaluation (e.g., long-term relational and practical consequences) are diminished or bypassed. This does not reflect an absence of cognitive capacity; the ability to reason, evaluate, and anticipate consequences remains intact. However, these capacities are not engaged at the moment of action, because functioning is organized at a non-integrated level. This helps explain the discrepancy between what individuals know and how they act.

Over time, repeated engagement in horizontal processing reinforces this pattern. The sequence of emotional

CONTINUED ON PAGE 32

activation, behavioral response, and temporary relief or stimulation becomes increasingly automatic. At the same time, fear-based signals related to recognition of loss or risk may become attenuated through repeated override. As a result, the individual may continue to engage in gambling behavior despite awareness of its consequences.

Restoring Integration: Clinical Pathways from Horizontal Reactivity to Vertical Processing

The patterns described above are not fixed. While repeated horizontal processing reinforces automatic responding, clinical work demonstrates that functioning can shift toward more integrated, vertical processing. This shift does not occur through insight alone. It requires structured, repeated experiences that engage multiple levels of the brain–mind in coordination with the body.

One of the most widely used and often misunderstood frameworks for this process is the twelve-step model, as practiced in Alcoholics Anonymous and related programs addressing gambling, food, sex, and other addictive behaviors. These approaches are sometimes dismissed as religious or overly simplistic. However, viewed through a FPNB lens, they can be understood as structured methods for reorganizing functioning over time.

A defining feature of these programs is their emphasis on sequence. The steps are designed to be worked through in order, with each building upon the previous one, mirroring vertical integration. Early steps establish recognition of loss of control and the limits of current functioning, reducing reliance on immediate, horizontal responding. Subsequent steps engage reflection, emotional processing, interpersonal accountability, and the development of alternative responses, supporting the coordination of higher-level cognitive, emotional, and physiological processes over time.

In clinical work, including attending meetings with patients and independently, similar patterns of recognition, disruption, and reorganization emerge across individuals and settings. Despite differences in history, behavior of choice, and context, participants move through comparable phases, with functioning gradually shifting from predominantly horizontal responding toward more integrated processing. This shift is not stable. Reduced engagement, such as decreased attendance, is often associated with a return to horizontal patterns, which may manifest as relapses or substitution of one addictive behavior for another. This consistency suggests that the underlying mechanisms reflect broader principles of how functioning reorganizes over time.

The sequence becomes clearer when specific steps are considered. Step 1 establishes recognition of loss of control, interrupting the illusion that behavior can be managed through willpower alone. Steps involving reflection and interpersonal sharing engage emotional processing within a relational context. Later steps extend this process into action and introduce repeated practices that sustain awareness over time. Helping others consolidates these changes through continued engagement and responsibility.

The structure of meetings reinforces this process. Participants identify themselves in relation to the behavior (“I am X, and I am an alcoholic”) and share personal experience rather than offering advice or interpretation.

“One of the most widely used and often misunderstood frameworks . . . is the twelve-step model, as practiced in Alcoholics Anonymous and related programs addressing gambling, food, sex, and other addictive behaviors.”

This supports identification with the pattern and maintains focus on repeated engagement with the process.

The concept of a “higher power,” frequently misunderstood, functions less as a doctrinal requirement than as a mechanism for shifting the individual out of rigid self-reliance that has proven ineffective. Clinically, it reduces rigid control and allows for acknowledgment of dependence on others, process, and reality, supporting movement toward more integrated functioning.

Equally important is the role of repetition and community. Regular meetings, sponsorship, and ongoing engagement create conditions for repeated practice of alternative patterns of functioning. Over time, individuals develop increased capacity to pause, reflect, and respond rather than react.

An additional mechanism in recovery is the development of the capacity to both receive and give. Prosocial behavior, including contributing to others, is associated with activation of reward-related pathways and can be experienced as intrinsically reinforcing. Clinically, individuals who engage in helping others often report a more stable form of regulation than that associated with addictive behavior. From a functional perspective, this reflects movement from self-focused regulation toward more integrated functioning that includes relational engagement, meaning, and continuity over time (Rozentsvit, 2011).

These programs also normalize the universality of the addictive pattern. The “addictive brain” is not confined to any particular social or economic group. This normalization reduces shame and supports engagement in the process of change.

In addition to structured programs, daily practices that engage the body and mind are critical. Breathing, mindfulness, and related somatic practices influence physiological states and the accessibility of higher-level processing. Clinical tools that engage multiple levels—linking bodily sensation, emotional meaning, and cognitive reflection—can support vertical integration.

These approaches are most effective when practiced repeatedly, consistent with evidence on neuroplasticity and adaptation, as individuals learn to recognize shifts in functioning and engage higher-level processing with increasing consistency; this process can be understood as training the autonomic nervous system toward greater flexibility, expanding the capacity to remain in states in which vertical, integrative processing can be engaged (McEwen, 2007).

In parallel, recovery requires the cultivation of patterns that support sustained engagement of higher-level functioning in daily life. Reflective practices, such as journaling


“Clinical work is not limited to reducing symptoms or eliminating behaviors but involves supporting the conditions under which integrated functioning becomes increasingly accessible.”

and ongoing self-observation, and engagement in relationships and community provide opportunities for co-regulation and feedback that cannot be generated in isolation.

Creative activity, humor, and intellectual engagement can support greater flexibility in how individuals engage, reflect, and act, introducing alternative modes of meaning-making. From a functional perspective, these are components of a broader process in which individuals learn to repeatedly access, stabilize, and apply integrated functioning across contexts. Engaged together, these activities reinforce one another, stabilizing the capacity for vertical integration through ongoing movement between experience, reflection, and action. This process supports the development of self-responsibility as an outcome of increased capacity to act with awareness and continuity over time.

Together, these approaches engage multiple, inter-related levels of integration: normalization of the pattern within a social context, regulation of physiological states, and the development of higher-level, relational and meaning-based functioning. This clinical perspective is supported by empirical research demonstrating that Twelve-Step Facilitation and participation in AA are associated with sustained abstinence and improved long-term outcomes in alcohol use disorder, with similar mechanisms likely extending to behavioral addictions (Project MATCH Research Group, 1997; Kelly et al., 2020). Structured steps, repetition, relational support, and embodied practices provide multiple entry points for restoring vertical processing. They do not eliminate vulnerability to horizontal responding, but increase the capacity to recognize, interrupt, and reorganize these patterns over time.

The model presented here integrates complementary frameworks. Neurobiological models describe mechanisms and circuits (Koob & Volkow, 2016), while the functional perspective focuses on processes unfolding over time. The Triune Brain model, extended to include continuous bodily involvement, provides a way of conceptualizing levels of processing, and the distinction between vertical and horizontal organization describes how these levels interact. Together, these frameworks support a unified understanding of addiction as a dynamic pattern of functioning that can be modified through clinical intervention.

From this perspective, addiction reflects a pattern of functioning that can be reorganized over time. Clinical work is not limited to reducing symptoms or eliminating behaviors but involves supporting the conditions under which integrated functioning becomes increasingly accessible. This process does not occur through a single intervention, but through repeated engagement across levels—physiological, emotional, cognitive, and relational—through which individuals gradually acquire the capacity to act with greater awareness, flexibility, and continuity. 

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Jackson Pollock (1912–1956)

Jackson Pollock was a leading American Abstract Expressionist known for his revolutionary drip technique. He placed large canvases on the floor, dancing around them to pour, splash, and drip household paint from all angles. This “action painting” style emphasized physical movement, spontaneity, and all-over composition, abandoning traditional, recognizable subject matter for raw emotional expression.

A reclusive and volatile personality, Pollock struggled with alcoholism for most of his life. In 1945, he married artist Lee Krasner, who became an important influence on his career and on his legacy. Pollock died in August 1956 at age 44 in an alcohol-related single-car collision when he was driving drunk.

Sources: https://en.wikipedia.org/wiki/Jackson_Pollock;
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From Symbolic Expression to Neuropsychoeducation: The Evolving Work of the CCT Committee

The Committee for Creativity & Neuropsychoeducation in Clinical Practice (CCT Committee) has continued to evolve over the past year while remaining grounded in the original vision established by its longtime chair, Sandra Indig. Sandra's passing in March 2025 marked a profound loss for the Committee and for the broader clinical and creative communities she helped cultivate for decades. Her commitment to symbolic expression, interdisciplinary dialogue, community-building, and the integration of the arts into clinical life continues to shape the Committee's direction. During the past year, Committee members also worked to restore Sandra's digital and artistic presence so that her artwork and community-oriented initiatives could remain accessible to broader audiences.

Founded in 1997, the Committee originally emerged as a space where clinicians interested in creativity, aesthetics, and non-verbal dimensions of psychotherapy could think together across theoretical orientations and disciplines. Over time, the Committee's mission expanded to include Neuro-Psycho-Education: the translation of contemporary knowledge about the brain, nervous system, trauma, affect regulation, and embodiment into clinically meaningful and psychodynamically informed practice.

This integration reflects a growing recognition that symbolic life, emotional meaning, bodily experience, and neurobiological processes cannot be artificially separated in clinical work. The arts often provide access to forms of communication that precede or exceed language, while contemporary neuroscience increasingly confirms the importance of implicit memory, somatic states, stress physiology, attachment regulation, and non-verbal processing in psychological functioning. Rather than reducing psychotherapy to "brain talk," the Committee has aimed to create a bridge between neurobiological understanding and the complexity of human meaning.

In an era increasingly shaped by fragmentation—between disciplines, between body and mind, between symptom management and meaning-making—the Committee has attempted to preserve a clinically integrative perspective. We view creativity not as peripheral to psychotherapy, but as central to adaptation, symbolic processing, emotional regulation, and the capacity for

transformation. Likewise, neuropsychoeducation is understood not as a replacement for psychodynamic thinking, but as an additional language through which clinicians can better understand trauma, attachment, dissociation, resilience, and human development across the lifespan.

During the past year, Committee members organized and participated in a broad range of psychoanalytic, psychohistorical, educational, and interdisciplinary events. These included psychobiography reading groups dedicated to Ronald Fairbairn, Sabina Spielrein, Harry Guntrip, and Oliver Sacks; a Robert Jay Lifton memorial and legacy event; and collaborative psychohistorical discussions exploring trauma, violence, resilience, and contemporary

“Over time, the Committee's mission expanded to include Neuro-Psycho-Education: the translation of contemporary knowledge about the brain, nervous system, trauma, affect regulation, and embodiment into clinically meaningful and psychodynamically informed practice.”

social tensions. The Committee also supported work-in-progress meetings and interdisciplinary dialogue integrating psychoanalysis, creativity, neurobiology, history, and cultural reflection. Presentations and educational activities were offered through psychohistorical organizations, continuing education programs, and interdisciplinary clinical forums, including the International Psychohistorical Association and the International Neuropsychanalysis Association Congress.

A particular emphasis this year involved the development of educational models integrating psychoanalytic thought with neuropsychological and neuropsychiatric perspectives. Grand Round presentations and continuing education programs addressed topics such as trauma and post-traumatic growth, self-directed neuroplasticity, interoception and psychosomatics, spirituality and transcendence, and the overlapping neurobiological and

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Ozempic for Smarties: A Psychotherapist Tells the Straight Skinny

By Mary Anne Cohen, LCSW

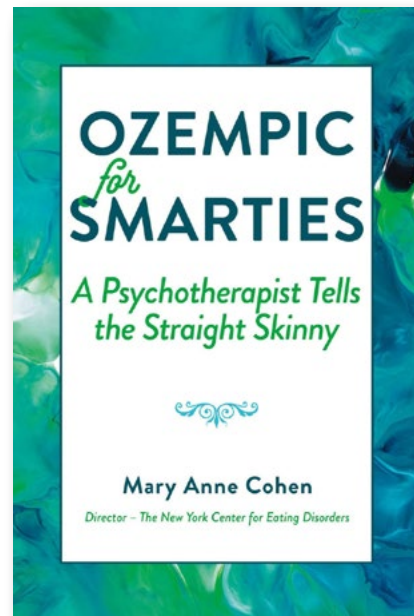
Reviewed by Karen R. Koenig, LCSW, M.Ed.

Whether we're curious about taking weight-loss drugs ourselves and wonder if they would be right for us or have clients considering them, *Ozempic for Smarties: A Psychotherapist Tells the Straight Skinny* by Mary Anne Cohen, LCSW provides the answers to their (and our) questions. Reader-friendly, warm, evidence-based, and thought-provoking, it's a welcome book amidst the angry controversy in the mental health and medical communities regarding the benefits and pitfalls of weight-loss drugs.

Cohen's goal is not to simplify the subject or take sides, but to provide a nuanced exploration of weight-loss drugs as a potential option for clients with eating disorders and weight concerns. She's not afraid to weigh in with her opinion, which is neither pro nor con, but zeros in on what would be best for individual clients. While other authors and educators have become mired in heated conflict over these drugs, Cohen's client-focused stance is unsurprising, as a major theme of her previous books and articles has been that "each person's journey is unique as a fingerprint." Through extensive use of case examples, she lets clients do the talking about what the experience of using weight-loss drugs has been for them, so readers and their treatment team can learn firsthand about the realities of taking them.

Her approach is not only beneficial to people deciding on whether or not to use weight-loss drugs, but it models what psychotherapy teaches about the dangers of having all/nothing, black/white thinking. As clinicians, we work hard to help clients learn to hold conflicting and opposing thoughts and feelings as an indicator of good mental health. That is, we encourage them to have flexible rather than rigid thinking. This book not only teaches us to be curious and provides a wide-angle view to help us consider all the facts but also encourages us to narrow our focus and zero in on what individual client needs are regarding weight-loss drugs.

Ozempic for Smarties encourages us to sidestep getting stuck in thinking one way or another by learning the facts about weight-loss drugs and melding our knowledge with clients' experience to let our—and their—thinking evolve on the subject. This, too, is what we expect of clients as



they grow mentally healthier: to use knowledge and experience to make effective choices, even if it means relinquishing old ideas and longstanding habits. Lastly, Cohen models how to be non-judgmental and compassionate during the process of fact-finding and reflection.

In this, her fourth book as an eating disorders therapist, Cohen tackles the pros and cons of taking weight-loss drugs in order to manage dysregulated eating and attain—and sustain—a comfortable weight, with a focus on physical and psychological healing, health and well-being. She covers the history and function of these drugs and their precursors, viewing them as delivering what the body lacks—similar to the use of thyroid and adrenal medications—and explores our culture's rigid thumbs' up or down approach to them. She describes the numerous health benefits of weight loss which helps readers recognize how it often translates to health gains.

At the same time, she cites medical evidence pointing to valid concerns about side effects of weight-loss medications, some of which are minor and temporary like nausea and vomiting, while others are more serious because

they may trigger complications that could damage our bodies. She also highlights the potential hazard of these drugs being counterfeit when purchased internationally or from a compounding pharmacy, their often-prohibitive cost and occasional scarcity, and the fact that we have no long-term data on their ultimate safety.

Cohen emphasizes what has been missing in society's discussion of drugs like Ozempic and Mounjaro—that we must help people heal not only their bodies, but their minds—and reminds us emotional eating can lead to unwanted weight gain and poor health. She maintains that “Eating disorder behaviors can be a way of trying to avoid psychological pain by focusing on one's body instead. This underscores how much people need to address their ‘hunger from the heart’ rather than just hunger from the stomach.”

“Eating disorder behaviors can be a way of trying to avoid psychological pain by focusing on one's body instead. This underscores how much people need to address their ‘hunger from the heart’ rather than just hunger from the stomach.”

To that end, she offers an in-depth exploration of emotional triggers leading to non-hunger eating that helps readers feel compassion for themselves and recognize how their unmet psychological needs, historical trauma, and present-day life choices drive unwanted eating. She identifies a range of emotions and experiences that cause people to turn away from feelings to avoid the pain or discomfort within and moving toward non-hunger eating, purging or starving. Yet she also stresses that “not everyone who wants to lose weight has an emotional eating problem.” Again and again, she returns to making the point that everyone is unique and that health and mental health professionals need to move from the stratosphere of debate to the down-to-earth reality of their clients' needs and challenges.

Cohen also maps out the stages a typical weight-loss drug user experiences, from the initial “life changing” high of diminished food noise to discovering past and current emotional issues that might be at play in dysregulated eating and body shame. She examines rampant weight stigma in this culture and how it not only impacts feelings about higher weight people but how the use of weight-loss drugs can be viewed as either shaming or caring for one's body. She describes who might be optimal or risky candidates for successful use

of weight-loss drugs, encourages readers to turn to science not social media for information about them, and warns against taking them in specific psychological and physical circumstances. Cohen knows her subject and wants the best for readers when it comes to making choices about weight-loss drugs.

Cohen wants us to understand the double whammy of how and why bodies become larger than we would like them to be due to the intentional marketing of certain foods to make us crave them as well as society relentlessly promoting the punishing concepts of self-discipline and will power to conquer biology. Because she seeks to give balanced information, she also explains that not everyone who is “obese” is unhealthy or unhappy about their size while stressing the strong correlation between high body weight and eating disorders.

The most hands-on part of the book is Chapter 5, “Now, Back to You: Creating Your Personal Comprehensive Strategy.” Step by step, she guides readers to making their own decision about whether or not weight-loss drugs will benefit them. This chapter is a self-help guide not only for clients but for therapists and health professionals to assist them in evaluating whether their clients would be harmed or helped by these drugs.

The first step is to find a practitioner well versed in GLP-1 to discuss dosing and side effects. Step two is to assess with a doctor or medical team whether weight-loss drugs are clinically indicated or contraindicated, and step three is to help monitor thoughts and feelings about weight loss as well as (not necessarily positive) reactions it might evoke in others. Step four is how to avoid slipping into an eating disorder as appetite drops and weight is lost. And step five is to anticipate if, how, and when to come off these drugs. Cohen stresses how these medications should be viewed as means to an end and used along with clinical and nutritional guidance and support.

By the time clients or therapists (or loved ones and valued friends) finish reading *Ozempic for Smarties*, they'll be comprehensively educated about weight-loss drugs. Rather than being swayed by hype or horror stories, they'll have the information and insight they need to determine whether or not to take them and the invaluable perspective of doing what's beneficial for their unique selves. Whatever the outcome, they'll know they made an informed decision and that's the best any of us can do. ■

Karen R. Koenig, LCSW, is an expert on eating psychology, a blogger, speaker and international award-winning author of 8 books. She has been treating dysregulated eaters for more than 35 years. Learn more about her at <http://www.karenrkoenig.com>.

Engaging Aging:

“Attuned Aging” and the Vicissitudes of Consumerism, Medicalization, and Politicization

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



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

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This article is Part II of a four-part series based on our work over the past three years facilitating Engaging Aging workshops for clinicians. Part 1, “Clinical Considerations of Late Life Paradoxes,” appeared in *The Clinician*, Summer 2025.

Introduction

Few would argue that today, aging, the process of getting older, is seen as a negative stage within the life cycle. We are taught to fear, even dread, losses and disabilities often associated with aging and to work hard to delay the vicissitudes of aging. Our current cultural climate idealizes a youthful and fit image. This idealization is detrimental across the life span and gets exacerbated as we get older. This is true for both women and men, and more blatantly for women. Patriarchy, capitalism, racism, and other dominant paradigms have a way of becoming internalized.

This article explores the power of consumerism, medicalization, and politicization on aging and offers an alternative perspective, the stance of “attuned aging” (Gitlin & Zaphiropoulos, 2015), as a counterpoint to the dominant cultural narrative.

Consumerism

In our first article of this series, we noted a twofold dilemma: the elderly must strive for an unrealistic physical appearance, but also do the impossible, become or remain young. We wrote that when asked to do the impossible, all we can feel is failure. The goal is the problem, not the person.

Advertising and marketing have created the cultural demand for a body ideal, particularly stringent for women. This ideal is even more unrealistic and stressful for the elderly since youth is the predominant demand. It is impossible to remain unaffected by the barrage of images, often fraudulent, on television, in newspapers, magazines, and of course, social media and now, AI.

The multi-billion-dollar cosmetics industry has expanded its campaign aimed at the elderly. Postmenopausal women are encouraged to purchase anti-aging products and undergo anti-aging procedures, including facelifts, nips and tucks, and even labiaplasty, to look young.

Recently, there was an advertisement for an “anti-gravity cream. This is a beautiful metaphor for how blatantly unrealistic and impossible society has made the body ideal.

Men are not immune to these pressures; witness the many marketing campaigns for medications and procedures like hair plugs to tackle balding. Nevertheless, women remain the group most inundated with a barrage of ads. The marketing strategy is to reframe aging—a stage of the life cycle—as unruly. Naturally occurring changes in human bodies are perceived as problems to be resolved. The solutions that are offered are usually costly—both monetarily and emotionally.

Furthermore, in the U.S., we are raised on the illusory notion that we are in control of every aspect of life. Our ideology says that our energy, creativity, technology, initiative, determination, and most of all, our dollars can solve all problems. We can have it all: success, and riches. We can conceive children on our own schedule. We can appear ageless. We can even avoid facing the reality that we will die someday, not usually on our own timetable.

Medicalization

Estes & Binney (1989), in their examination of the conceptual and practice aspects of the medicalization of aging, note that many more aspects of aging have come under medical jurisdiction. They note how Medicare influences the medicalization of problems for the elderly, since physicians are the only ones authorized to certify the need for care and thus, as patients are referred to services, they are seen within a medical frame. Medicalization can be said to occur on a continuum where, for example, death is fully medicalized, and illness or other physical conditions may be partially or minimally, but not totally medicalized (Conrad, P. (1992) as seen in *Medicalization and social control*, *Annual Review of Sociology*. 18:209-32).

Michel Foucault, (as cited in O’Callaghan, 2021), a French historian and philosopher, named the concept of the “medical gaze,” the power given to the medical profession that objectifies a patient by its myopic focus on body parts and symptoms. This limited focus, without regard for the whole person, and the individual’s social and cultural determinants, narrows the view of the human being and is detrimental to health and welfare.

Our society has medicalized many natural aspects of maturity, such as menopause, diminishing desire, aging skin, hair loss, muscle loss, loss of stamina, and the like. The medical field has defined aging, aging appearances, and aging desires as health issues in need of medical attention. We might note that the development of hormone replacement therapy in the 1960s resulted in menopause being framed as a “hormonal deficiency disease.”

Today, with the advent of the internet, social media, and AI, the medicalization of the natural processes of aging is ubiquitous.

On the one hand, innovation and cutting-edge treatments can prolong and improve our quality of life. On the other hand, we need to be aware of the less-than-noble influences of the profit motive in creating negative perceptions and the continued stigmatization of aging.

Racism, sexism, ableism, and classism profoundly affect people’s aging processes as well. Research shows that people who experience discrimination based on their identities (e.g., race, gender, weight, disability, etc.) are at increased risk for a range of health issues, including heart disease, high blood pressure, and depression. While the precise biological factors driving these poor health outcomes are not fully understood, chronic activation of the body’s stress response is a likely contributor. Moreover, a growing body of research connects persistent exposure to discrimination to the biological processes of aging (Cuevas, et al., 2024).

Our health care system is not immune to the prejudices and inequities of our society. Medical care in impoverished or underserved communities has been offered primarily in clinics with frequently rotating medical providers. Drawbacks of this system include the lack of continuity, relationships, and communication with the patient’s medical providers, which are imperative for good medical care.

Currently, there is a shortage of doctors and excessive waits for appointments; waits for a specialist can be upwards of nine months. If I can wait nine months, how important is it that I see a cardiologist?

Older patients using insurance providers like Medicare are canaries in the coal mine for when it comes to the current lack of access to medical professionals. We are seeing that, based on shortages of doctors, there is a move to train non-MD medical professionals to provide general treatment. While this can be beneficial in some settings, it can also present a risk of treatment becoming routinized and impersonal. From an administrative perspective, people stating that they want to speak with “their own doctor” is seen as problematic, as though a relationship with a specific doctor is unimportant.

In an environment where patients are waiting upwards of nine months to get appointments, it seems the medical industry is minimizing the value of a relationship with one’s own health provider, especially for the elderly. Older adults are statistically more likely to have multiple medical conditions and high medical service utilization. They are also at risk of isolation, less familiar with new medical technologies, and more likely to have potentially

CONTINUED ON PAGE 40

dangerous interactions from multiple medications and treatments for various conditions. Thus, a long-standing relationship with a medical provider who manages their care holistically is crucial.

Another area of systemic weakness in medical services affecting older adults is hospice care, where values related to overproviding and underproviding are nuanced and may require more individualized treatment planning than is currently covered by medical insurance. Our medical insurance is so often based on one-size-fits-all. Hospice care is available for people who decline further medical treatment, however, there needs to be flexibility and individualization in what services can still be provided. Recognition about opposing beliefs about end-of-life care needs to be honored.

People with Alzheimer's Disease and other forms of dementia frequently experience a condition called "sunsetting," wherein, as the sun sets, they become disoriented. Emergency rooms with lights blazing 24-7 and lacking any source of natural light can exacerbate this condition, sometimes irrevocably. In addition, older adults are often accompanied by other older adults when seeking emergency room care. In many metropolitan hospitals, the seating and services provided are not conducive to supporting the patient's escort.

Like Conrad, Susan Sontag, an American writer and critic, (*AIDS and Its Metaphors*, 1989 and *Illness as Metaphor*, 1978) examines the inexorable links between medicalization and social control. By denigrating aging, we recreate what Sontag called the "war" on illness. (Sontag, 1989; Sontag, 1978). Again, this is not necessarily all bad, but framing aging as something to be defeated certainly has negative connotations, especially for the human bodies experiencing this phase of life.

Politicization

Consumerism and the medicalization of the aging population are intricately related to politics. Politicization and polarization exist related to resources that support older people and promote their ability to live fully and remain integrated within their communities. Consider the continuing efforts to privatize Social Security, Medicare, and Medicaid. Private Medicare Advantage plans are being aggressively marketed to Medicare recipients. They offer all-in-one-place services but have many drawbacks, including limiting people's autonomy and ability to choose their own healthcare providers, services, and facilities.

In addition, there are more cuts in funding for not-for-profit hospitals, and cuts in funding for Medicaid, which will have a profound impact on all hospitals, whether

private or not-for-profit. These cuts in funding have led to staffing shortages. Hospitals, notably in rural areas, are closing due to a lack of funding from federal and state governments. Furthermore, many have been taken over by private equity firms that close hospitals after loading them with debt, then slashing staff and services to maximize short-term profit. This impacts everyone, particularly poor people, and especially the elderly, as they are often sicker and have trouble getting around.

In addition, as we know, many older people, couples and individuals, may require community-based home health aide services as they age. Home health care can rapidly deplete a person's or family's financial resources. Medicaid eligibility can be legally and ethically achieved while protecting the assets that people have worked for and saved for their entire lives. However, it requires considerable know-how and resources to engage an elder law attorney and make the financial plans necessary to secure Medicaid and other such benefits.

The need for home health care is increasing as the ageing population grows, but the number of caregivers is decreasing. Among the reasons for this is the impact of current immigration restrictions. Immigrants are often the people who do this work. In fact, more than a quarter of the current Long-Term Care Services and Support (LTSS) workforce is born in other countries (LeadingAge, 2019). The U.S. Department of Health and Human Services estimates that approximately 70% of Americans 65 and older will need LTSS at some point in their lives. More than half will need a higher level of care, defined as assistance with two or more activities of daily living (e.g., walking, eating, bathing) for at least 90 days (Favreault & Dey, 2016). This is another clear example of how politics is a determining force in the care of the elderly.

The president has declared that 7,500 White Afrikaners are the only people currently eligible to immigrate to the United States. At the same time, mass deportation is exacerbating the staffing shortage for the care of the elderly. Afrikaners are not typically the group that fulfills the need for home health care.

With consumerism, medicalization, and politicization of the elderly, we suppose that anxiety about meeting one's basic needs supersedes a focus inward on one's individual desires and needs. This is problematic because the elderly are not robots and have the right to age with dignity, self-determination, compassion, and respect. Subsuming resources and care for older people to the needs of the market and the state is not only disrespectful but hurts us as a society. It narrows what matters in life, creating glaucoma of the mind and heart. This communicates to older people that they no longer have purpose and

value. To younger people it communicates that a person's worth is measured in what they can contribute economically. We risk prioritizing competition over collaboration, and arbitrary measures of success over connection.

We argue for a system that allows both the open door, dealing with expectations on the outside, as well as the mirror, tuning in and honoring one's own lived experience and values. Social policies are determined by what is valued by society and promoted by our politicians. This directly impacts where tax dollars are spent.

Attuned Aging

Have your heart be where your feet are.

—PROPHET MOHAMMED

Three important aspects of Attuned Aging are: 1. Lived experience versus cultural demands, 2. Curiosity, and 3. Challenge and resistance. How do these three aspects relate to medicalization, consumerism, and politicization?

Lived Experience vs. Cultural Demands

Attunement can be defined as being aware of and attentive or responsive to something. We can look closely from an introspective or external perspective. For instance, in the process of growing old, we can think of an open door and a mirror. With an open door, we can look outside ourselves at how we are perceived or treated, what our lives are relegated to, and what is being asked of us as we age. We can look at what is required of us by the cultural mandates and the dominant gaze. As we elaborated in our first article of this series, (Kram-Fernandez & Zaphiropoulos, 2025), the dominant gaze is White, male, youth-centric, heteronormative, ableist, and educated, and driven by patriarchy, racism, and capitalism.

With a mirror, we can look inward at how we appear, feel, and what we can do, and thus focus on our own lived experience. In more modern-day parlance, the cell phone camera allows us to flip the screen to look outward, at our surroundings, or inward, at our own image. It is the ability to integrate and balance between these two vantage points that can make for a more comfortable and realistic adjustment to one's older years. It is a matter of finding one's own way and allowing for individual differences when conformity is being promoted and individuation is under attack.

The external mandate to "age gracefully" suggests that one is trim, healthy, and not in need, a consequence of the power of the dominant gaze. This gaze, coupled with the power of consumerism, medicalization, and politicization, can generate and/or exacerbate feelings of

not being "okay," not being adequate, useful, or worthy in our later years. We know from developmental theory and experience that the causes of misattunement include not being seen, not being accurately mirrored, being isolated, and being made to feel badly about oneself, one's desires and needs. Attuned aging encourages curiosity, exploration, individuation, presence, and challenge.

Curiosity

We are hard-wired for inquisitiveness; we see this in children early on. As clinicians, we know how useful it is to come from a position of curiosity, what Sullivan called "detailed inquiry," rather than from a position of assuming or adhering to the voice of the culture. However, if curiosity, that faculty of wonder, was stifled during childhood, it may be a new skill to be encouraged in ourselves and in our patients. "The beginning of all wisdom is wonder." (Socrates).

Neuroscience teaches us that when we're curious, the brain's dopaminergic system—the same one that lights up when we anticipate a reward—kicks into gear. Simply put, curiosity can make us feel good about the prospect of discovering something new. It is the lack of curiosity that can lead to misattunement.

In terms of the big picture, can we be curious about the ways that medicalization, consumerism, and politicization impact the aging population? Can we question the social justice issues and underpinnings that emerge from medicalization, consumerism, and politicization of aging?

On the individual level, in *Being Mortal*, author Atul Gawande suggests that, in the face of age-related frailty, illness, and mortality, one's focus should be on curiosity. The question to ask is, "What is most important to me right now?" This is a useful question throughout one's life but is particularly relevant toward the end of life.

The answer to the question may entail challenging the medical model of escalating interventions. For example, if walking is important, you may decide to get a knee or hip replacement. If it is not, then maybe not. This can shift the focus to meaning and desire, rather than longevity and safety. (Gawande, 2014). What is the definition of balance in attuned aging? How much striving and how much acceptance is the goal?

Listening to our bodies in an accepting way as they change with age often seems to be in direct contrast with the pressures of the culture that we discussed earlier. Every individual will encounter unique considerations and thus unique solutions. We need to explore the meanings we attach to "old" and "young." For example, what grey hair means to one person is different from what it means to another.

CONTINUED ON PAGE 42


She feared never being able to find a healthy balance with food and agreed to attend a post-operative support group available at the hospital where the surgery was performed. Since the other participants were at different stages of recuperation and weight loss, the group helped her understand her own struggles and fears of exploring her history, the removal of food as a reliable comforter, and the uncertainties ahead. It was a useful adjunct to the therapy.

Our work together spanned three and a half years, during which time she lost half her body weight and underwent painful plastic surgery to reduce the stretched skin on her body. She had to live in a tight undergarment for a long time to aid in the healing process. Conflicts continued to arise in the marriage and Mike agreed to start his own therapy.

Diane learned that he did not support this extreme physical change in her; both were more comfortable with her feeling invisible, i.e., hidden under the higher weight. He was jealous and fearful when she was not at home and became more aware of the need to explore his own early history since it was interfering with their lives.


There were many experiences of mixed messages, which were reminiscent of her childhood confusion. With Mike she struggled with guilt and regret about the surgery and felt dirty and objectified by his comments expressing compliments or attraction to her. As her clothing choices were changing as well, Mike felt threatened by other men looking at his wife.

During the months before she ended therapy, Diane reported feeling more confident regarding her voice and her rights, felt strengthened in renegotiating what both needed in the marriage, worked on needed boundaries with her and Mike's extended families, and felt more optimistic about the path ahead. She became accustomed to the style of small, easily digestible meals and was more confident in her ability to maintain this change as part of her new lifestyle.

While many people who begin a weight loss program with drugs or surgery, without the experience of deepening their insight into how they reached this point and exploring the uncertainties ahead, success with these programs may be limited or completely reversed. It is critical to understand the complex relationship with food and the many purposes it has served in the patients' lives, along with the likely changes ahead in their relationships, and the challenges of navigating a world in which they feel more physically exposed and vulnerable. Many will regain the weight to return to hiding and what felt more like equilibrium but was actually an internally chaotic lifestyle. 

Challenge and Resistance

Challenging and resisting the negative, corrosive ways the aging process is often portrayed and experienced is a moral imperative. As clinicians, we have a role in promoting awareness of key challenges experienced as we age in America: inequities; isolation; dementia; diminishing home health care services; inappropriate and unavailable housing; and the current caregiver crisis. We also have a role in helping our clients, as appropriate, promote this awareness, too. This kind of engagement and self-advocacy can be empowering and purposeful at a time when people often feel irrelevant. How much of a public stance can be taken? In what ways can the elderly feel or become encouraged to participate in the political process? Part of resistance and challenge is not just looking in the mirror but confronting the forces that impact us.

What we have termed attuned aging is both awareness and practice. Despite inevitable loss, decline, and mortality, it is possible to experience joy, appreciation, and gratitude when we have the agency to exert control over how we age. 

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psychological dimensions of ADHD, borderline personality organization, PTSD, and dissociation. These programs sought to create clinically usable bridges between psychodynamic understanding, lived experience, and contemporary neuroscience without reducing psychotherapy to purely biological language. Committee members also presented the symposium “Incubating the Future: Self-Directed Neuroplasticity and the Adaptive Mind” at the 2025 International Neuropsychology Association Congress.

The Committee’s activities also extended into publication and writing. Committee members contributed peer-reviewed articles, psychohistorical reflections, psychobiographical essays, poetry, and interdisciplinary reviews published in *Clio’s Psyche*, *MindConsilium*, *Psychology News*, and *The Clinician*. Topics included psychobiography, symbolic life, trauma, resilience, aging, neuroplasticity, women’s voices in psychoanalysis, psychohistorical responses to contemporary social conflict, and the relationship between creativity, memory, and adaptation.

At its core, however, the Committee continues to function not simply as an educational body, but as a reflective professional space. We remain committed to creating an environment in which unfinished thoughts, emerging ideas, emotional experience, symbolic communication, and interdisciplinary curiosity can coexist with scholarly rigor and clinical depth. We continue to believe that process is as important as product, and that creativity remains central not only to the arts, but also to psychotherapy, adaptation, and human survival itself.

As the Committee moves forward, we hope to continue expanding dialogue among clinicians, psychoanalysts, social workers, educators, neuroscientists, artists, and psychohistorians interested in understanding the increasingly complex relationship between brain, mind, body, meaning, culture, and human development. Museum visits and community-based programming are also expected to resume in 2026. 📍

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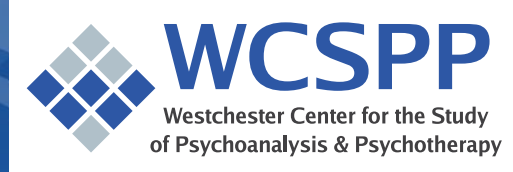


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