NEWSLETTER

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC. FALL 1994 • VOL. XXV, NO. 2

Clinical Social Work Licensing Bill Amended

Scope of Practice Covers Entire Profession

By Marsha Wineburgh, CSW, BCD
Legislative Chair

In 1993, the NY Society introduced legislation to license the clinical social work level of the social work profession in New York State. The bill is designed to stand alone or to be integrated into a multi-level bill reflecting other tiers in the profession, similar to that enacted in New Jersey.

We have sought the cooperation of other social work professional organizations for many years on this legislation, including the state and city chapters of NASW, the deans of schools of social work and the State Board for Social Work. This past spring, in cooperation particularly with the city chapter of NASW, the legislative committee has adopted a new approach to licensing which meets the general and specific needs of the profession as well as providing consumer protection. Unlike our original bill, which focused solely on a scope of practice for clinical social work, this amended version describes a single scope of practice which encompasses the entire profession. It has two levels: one for all MSWs, which requires supervision and practice within a facility—Licensed Social Worker. A second level, Licensed Clinical Social Worker, applies to those MSWs with 3 years of facility-based experience. This level permits practice in any setting without supervision (i.e., private practice).

The language describing the scope of practice is both broad and specific, including aspects of social work function that are endemic to practice. Our Federation lawyer, Kenneth Adams, has counseled that if we have the opportunity to include specific areas of practice such as psychoanalysis, hypnosis and behavioral therapy, it is best to do so.

The state chapter of NASW has opposed this bill, asking that worker's compensation benefits be paid for clinical social work psychotherapy. One argument was that the bill favored only one group of the profession and that all social work services should be reimbursed by workers' compensation. Objections seem to reflect old ideological differences between clinical and generic social work interests. There appears to be a bias against securing the clinical functions of the social work profession in the legislation.

In addition to the need for consensus on our legislation, an even larger issue is brewing around licensing psychotherapy in New York State. If passed, bill A.2240-A would make it illegal for anyone who is not a clinical social worker or a social worker in a facility to provide psychotherapy unless such person is exempted from this law. All licensed mental health practitioners are automatically exempted. But lay psychoanalysts, marriage and family therapists, mental health counselors and others who are currently practicing would be unable to continue to deliver psychotherapy services unless they were exempted. In our legislation, we have found a way to allow some of these as-yet unrecognized groups to continue to practice. No legislation would ever pass if it disenfranchised people from earning a living.

It is unclear whether New York State wishes to exercise any control over the practice of psychotherapy. There is absolutely no consumer protection currently from anyone who calls him or herself a psychotherapist. The issue of who can practice psychotherapy is intimately tied to any licensing legislation because licensing describes function—what professionals do. Only those who qualify can do it. □

Annual Conference: The Nature of Change

"The Nature of Change in Psychotherapy: Multi-Model Approaches to Treatment" is the topic of the Society's 26th Annual Conference, to take place Saturday, November 19. Keynote speakers are Margaret G. Frank, MSSW, BCD, program coordinator, Advanced Training Program in Child and Adolescent Therapy, Boston University and president-elect, National Committee on Psychoanalysis; and Beverly Winston, MSW, BCD, adjunct assistant professor, New York University School of Social Work; consulting psychotherapist and research associate, Beth Israel Medical Center. Louise Crandall, PhD, BCD, New York Freudian Society and adjunct faculty member, New York University School of Social Work, will serve as Discussant.

A series of panels and workshops will take place during the afternoon.

The Society will recognize successful Diplomate candidates, those members who have made outstanding contributions either to the Society or to the field of social work.

Sponsored by the education committee chaired by Dianne Heller Kaminsky, CSW, BCD, this year's conference provides a focus to examine the various aspects of change, now under challenge by the concept of brief psychotherapy. The all-day event will be the first to be held independently of the business meeting and will take place at the Association of the Bar of the City of New York, 42 West 44th Street. □

EXECUTIVE REPORT

Health Care Reform: Let Our Voices Be Heard

Dear Colleagues:

This is the most beautiful place to write an executive message—overlooking the lake at the Stockbridge Bowl watching the wind move through the fir trees. Strains of Verdi, Mussorgsky and Brahms still ring in my ears. The perfect end to a difficult summer—the summer of our discontent if you will. I refer to our agony over national health reform. Questions abound. Will mental health services be included and to what extent? Will social workers be included as providers? Will the level of mental health care that has been suggested in some plans be drastically cut if employers are mandated to pay for insurance? Does Congress understand providers' difficulties with poorly run managed care? What will happen when managed care is part of national law?

At this point in late August it is difficult to know the answers to anything. Both Houses of Congress are still meeting. Through my work with the advocates of the National Federation, the Coalition for Mental Health Providers and Consumers and the Alliance for Universal Access to Psychotherapy, I have been staying abreast of developments—faxing members of Congress about our interest in inclusion of "point of service" and "any willing provider" provisions in whatever bill emerges. Many of you sent telegrams to our legislators. Your support of this effort is greatly appreciated.

Our work on national health reform has taught us many lessons about politics and building a grass roots movement. We need to become educated participants in the political process. Our profession is being reshaped by both government and business interests. Any national health reforms will be administered through the states; both the Gephardt and Mitchell bills allow the states options in establishing their own health reforms. Once the battle is over at the federal level, it will begin at the state level.

We need to think though the pros and cons of various options such as a single-payer system. We need to think through the results of legislative reforms we decide to support. Much of what we learned in our social work policy courses will come in handy—policy changes that seem wonderful can have disastrous ramifications. We all remember that when Governor Rockefeller's administation legislated stiff sentences for drug dealers, children were drafted to sell drugs on the street.

We need to become educated participants in the political process. Our profession is being reshaped by both government and business interests.

On a concrete level I want to encourage you all to write to your legislators. Congress is greatly influenced by the response of its constituents as well as lobbyists in the controversial issues surrounding national health reform. If Americans can so effectively impact on national legislators, New Yorkers should be able to influence Albany. The Society's board will be considering offering training on how to become politically effective; we will continue to offer the choice of sending prepared telegrams at key points. If you send your own telegrams, Western Union is prepared to match your ZIP Code with the appropriate legislators. Letters of course are the least costly method of communication. The greatest cost is to remain passive. Grass roots means all of us! This is an election year; it is not too late to have an impact on pending health care reform. We have been dazed, depressed and overwhelmed by the changes that have crept up on us. Action counteracts depression. Let us act!

Helen Hinckley Krackow, CSW, BCD
President

Newsletter Head Steps Down

Haruko Brown, CSW, BCD, the Society's *Newsletter* consultant and one-person committee since 1989, has stepped down. The *Newsletter*—and its editor—owe her a debt of gratitude.

Her clear thinking, objectivity and creative approach to both editorial and production dilemmas made the job easier and more agreeable. Her skills, warmth and humor will be sorely missed.

Sheila Peck, CSW, is the new consultant for the *Newsletter,* beginning with this issue. She heads the Society's public relations committee. Welcome aboard.

Alyce J. Collier
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Advertising for Spring 1995 issue due February 1.

All advertising must be camera ready.

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Mana

By John A. Chiaramonte, CSW, BCD
Vendorship Chai

NATIONAL

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A Sense of Vulnerability for CSWs
NYNEX

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amendment in writing would not be offe
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is up; providers who received notice t
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until the contract expiration date to resc
their refusal to sign and to agree to
amendment. If they sign the agreement t
will then continue on as providers. W

Major Corporations Urged to Include CSWs As Providers

Managed Care Networks Reveal Goals for Subscribers, Providers

By John A. Chiaramonte, CSW, BCD
Vendorship Chair

NATIONAL

Self-insured companies/unions presently being marketed for clinical social work inclusion on behalf of New York by the Federation's new marketing consultant Gary Unruh (formerly of NICSWA) include Arrow Electronics, AT&T, Nassau Carpenters Union, Merrill Lynch, International Brotherhood of Electrical Workers, International Brotherhood of Teamsters, and Barnes & Noble, which will be asked to delete the required MD letter of reference.

A Sense of Vulnerability for CSWs

NYNEX

Several members expressed concern about NYNEX's recent request for its panelists to sign an amendment to their contracts to allow either party to terminate the Mental Health Care Network Professional Services Agreement without cause by giving at least 60 days' written notice to the other party. This would allow NYNEX to sculpt its 5,000-provider member panel before legislation becomes law that would prohibit such dismissals.

Stephen Tiwald, the vice president of networks and consulting at Health Direct (the Chicago firm hired by NYNEX) denied any effort to sculpt the panel. He stated that the sole purpose of this amendment was to give NYNEX and its providers increased flexibility at a time when both national and state insurance laws may be changing. NYNEX's panel has been closed since June '93. To keep a uniformity of contract throughout the NYNEX system, those who did not fully agree to the amendment in writing would not be offered contract extensions when their contract year is up; providers who received notice that their contracts would not be extended have until the contract expiration date to rescind their refusal to sign and to agree to the amendment. If they sign the agreement they will then continue on as providers. While he believes that NYNEX will continue to offer the present panel as an option in its benefit plan, Tiwald notes the possibility of the corporation's contracting a package out to a more "managed managed mental health care" organization and offering incentives (lower co-pays, increased benefits) for its members to join.

> **GOOD NEWS!**
> Effective August 1, 1994, the State Health Benefits Program of New Jersey, which insures 320,000 employees and has a total enrollment of 900,000, recognized clinical social workers as reimbursable mental health providers. The inclusion amendment reads "licensed" social workers; we hope that states with certification only will be acceptable as well.
>
> **AND**
>
> Commonwealth Edison dropped its MD supervision requirement for clinical social workers effective September 5, 1994.

Oxford Health Plans

The issue at hand was the institution of the Resource Based Relative Value Scale (RBRVS). This scale sets a differential payment for psychiatrists (100%), psychologists (75%), and clinical social workers and psychiatric registered nurses (65%).

Douglas Anderson, manager of physician reimbursement, stated that Oxford instituted the RBRVS method of differential fees "in order to have a fee foundation that made sense and was fair". Most managed care companies have some sort of leveled fee schedule, and Medicare's use of the RBRVS method was pivotal in Oxford's decision to use it. He also stated that, should the Medicare percentages change, Oxford would likely follow suit. "The best way to effect change in our rate differentials would be to lobby Medicare to alter its rate differentials."

Providers who are not part of the Oxford network can receive out-of-network reimbursement if their insureds choose the point of service "freedom plan," which allows for choice outside of the panel but includes a deductible and a larger co-pay. Anderson noted that, like Medicare, Oxford will be adopting a regionalized payment schedule based upon practice costs. See table.

Manhattan Region Fees

MD: $115	PhD: $86.25	MSW: $74.75
	Patient half: $43.13	Patient half: $37.38
	Oxford half: $36.66 (–15%)	Oxford half: $31.77 (–15%)
Total: $115	**Fee received: $79.79**	**Fee received: $69.15**

Empire Mental Health Choice (EMHC)

The issuance of some 60-day notices of termination from the EMHC network prompted several inquiries. In the shadow of these notices, members have asked about the request from EMHC that providers submit the Quality Based Network Management (QBNM) Provider Practice Questionnaire and the Outpatient Treatment Clinical Outcome Summaries. Could a "wrong answer," e.g., using a dynamic rather than a behavioral treatment approach, result in EMHC's exercising the termination clause in the contract (Section X A)? Also, members believe that EMHC, like other managed care companies, was sculpting its panel before legislation is passed that would prohibit panel discharge for other than proven malpractice or fraud.

Joan Cerniglia made it clear that EMHC

continued on page 8

New Alliances Forged in Managed Care Issues

By Emanuel Plesent, EdD, CSW, BCD
Chair, Managed Care

We are all subject to a raised anxiety level as we experience the encroachment on mental health services of the increased movement toward managed care. Every aspect of our profession is under attack. Decreasing per-session limits and/or reimbursement, as well as inequities in fees among other mental health professionals and clinical social workers—are factors added to the issue of interference with the client-provider relationship. Utilization review methods and imposed judgments upon our work with clients become additional abuses. We will focus here on what your Society has been doing and urge all members to become doers.

We have joined with other professional organizations in cooperating and coordinating efforts in several areas:

1. Cosponsoring educational meetings for mental health professionals on how to better deal with managed care and how to move toward a practice with less involvement with managed care.
2. Cosponsored a program directed at the business purchasers of health insurance.
3. Ongoing work with the NYS legislature to urge passage of the Tully and Gottfried bills to regulate Managed Care and Utilization Review.
4. Harnessing efforts of the National Federation in both protesting specific moves being made by managed care companies and advocating for appropriate mental health services in the national health care reform proposals.
5. Urging all of our members to contact their legislators with our concerns and coordinating efforts within our own State Society. A joint meeting was held recently of the managed care, vendorship and legislative committees.
6. Testifying at the NYS Assembly Committees on Insurance and Health (see Spring 1994 *Newsletter*).
7. Participated in the National Mental Health and Managed Care Alert. Although numbers of our members sent telegrams and letters putting forth our views to federal legislators, this response from our membership could have been greater.
8. Meeting with many legislators in Washington, DC, to convey our message. Society President Helen Hinckley Krackow and other members, and representatives from National Federation and related organizations made this special trip.
9. The Nassau chapter has joined the Long Island Association (the largest business association on Long Island), gained membership on its health committee, and is attempting to influence the direction of the recently created L.I. Health Alliance (a health service purchasing group based on the concept proposed by President Clinton). This is a joint effort with other mental health professional associations.
10. Cooperative regional interdisciplinary programs are being carried forward in the Albany, Long Island and Rochester/Buffalo areas.

Remember the adage. There are three types of people: Those who make things happen; those who go along with what is happening; and those who say "What happened"?

We must be part of the group that **Makes Things Happen.** □

JOINT CONFERENCE

Family Therapy: Beyond Divorce

Report by Al DuMont, CSW, BCD

On Sunday, May 1, 1994 the Queens and Nassau chapters and the society's family practice committee cosponsored a conference, "Beyond Divorce: Treating the Transitional Family". Presenter Robert Eigen, CSW, BCD, director of family therapy at Peninsula Counseling Center, pointed out that although "divorce is a wrenching event for *most* adults, for *all* children it is not a single event, but one that goes on for a lifetime".

Eigen emphasized the importance of the therapist's active use of self in working with transitional families. Information and guidance can serve to reorient family members thrown off balance by a breakup. They can help to "normalize" disconcerting thoughts, feelings and responses, thus promoting adaptation.

He suggested that, while it may be tempting to get lost in the juicy details of the marital conflict, it is more important to seek out and explore the responses of the child. Too often the parent, preoccupied with his/her own concerns and feelings, fails to recognize the effect of the marital breakdown on the child. The child is in shock from the event and/or worries about further upsetting the custodial parent and perhaps losing him/her too. Interviewing the child in the presence of the parent, without interruption, the therapist models for the parent how to engage the child—promotes greater sensitivity to and awareness of the child's reactions and facilitates communication.

The therapist models for the parent how to engage the child.

Eigen also discussed various techniques in working with remarried parents, including use of the genogram and family sculpting. He stressed the importance of a sound parental condition and maintenance of generational boundaries for the child's optimal growth and development. In working with divorced parents he tries to help them focus on what is best for the child.

He concluded by citing the work of the Vishers, who have identified five factors remarried parents found most helpful from family therapy: 1) Personal and family validation; 2) the therapist's knowledge of step-families; 3) normalization of the family's experience; 4) education as to what to expect; and 5) the strengthening of the couple relationship. □

Al DuMont, CSW, BCD, is founder and past head of the family practice committee.

BOOKS

The Selling of the DSM: The Rhetoric of Science in Psychiatry

Stuart A. Kirk and Herb Kutchins

Walter de Gruyter, New York, NY, 1992
304 pages

Reviewed by
Marsha Wineburgh, MSW, BCD

The recent publication of *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*[1] once again raises the question about the limitations of this ubiquitous assessment tool. In their book *The Selling of the DSM: The Rhetoric of Science in Psychiatry,*[2] Stuart A. Kirk and Herb Kutchins, both social workers, make a convincing argument for their primary criticism of the *DSM*: the serious problems of reliability and validity. Despite the marketing claim that it is reliable, research and subsequent analysis have failed to demonstrate this.

The book describes the work of a small group of research psychiatrists who attempt to identify a nosology—a systematic classification of disease—that would tie more closely the specialty of psychiatry to the scientific community of medicine. With crisp, comprehensive clarity, the authors track the development of a flawed research assessment device and its effective marketing as the primary tool for categorizing mental illness and associated issues.

> ***In what way is an instrument, primarily developed for research purposes, applicable to clinical practice?***

A Questionable Diagnostic Aid

Basic questions are raised about this diagnostic aid that have been ignored in the rush to adopt each edition of the *DSM* as the primary basis for evaluating patients. For instance, in what way is an instrument, primarily developed for research purposes, applicable to clinical practice? What is the essence of the limitations of the actual research tool? What is mental health? What is normal behavior? The newly published *DSM-IV* has an additional 25 research diagnostic criteria, narrowing even more the scope of what is considered normal human behavior.

At the same time Kirk and Kutchins are quite respectful of the scientific and professional imperative of psychiatry to have a classification system of mental disorders, they are also cognizant of the political and economic benefits for the American Psychiatric Association as the developers of this nosology. The APA's commitment to identify categories of illness in a meaningful way is commendable. Such a rational diagnostic classification system can be used as a rationale for treatment planning, delivering new services, assessing mental health needs of communities and assisting with the allocation of limited resources. However, the APA also seeks to maintain and restore its credibility and control of its domains by using the power of psychiatric nomenclature as the foundation of psychiatric power and influence. Kirk and Kutchins report that when the American Psychological Association raised questions about several issues in the *DSM* draft report, they were rebuffed, dismissed and ultimately challenged to create their own open classification system. Neither psychology nor the social work national professional organizations have the resources to develop their own nosology. We will have to find other ways to challenge psychiatry's control of the classification system.

> **DSM *is the standard required to demonstrate medical necessity and to qualify for reimbursable psychotherapy services.***

Insurance Reimbursement and DSM

Kirk and Kutchins, who have published extensively in the areas of diagnosis and reliability, are in an excellent position to suggest areas of controversy. In 1988, they published the results of an outstanding national research survey of clinical social workers which was designed to determine how extensively the *DSM-III* was used in social work practice. More than 88% of the respondents were engaged in direct clinical practice. Of these, 81% indicated that insurance reimbursement was the most important reason for using the *DSM.* Findings also revealed that a number of social workers rejected the medicalization of emotional problems of living and having the *DSM* place medical labels on psychosocial problems. Too many problems of childhood were considered pathological. Diagnosis was not related to treatment planning. Individual differences were obscured by the *DSM* and the nosology was of no help in understanding marital and family problems.[3] This important survey identified the major problems and abuses we are seeing now, 6 years later.

The *DSM* and its revisions are the popular diagnostic tool in the mental health field. It is the standard required to demonstrate medical necessity and to qualify for reimbursable psychotherapy services. The case for the importance of a classification system for mental illness is obvious and that is certainly, in part, why the field has embraced these particular manuals so eagerly. What is not common knowledge is the limitation of this classification system. Kirk and Kutchins have made a valuable contribution to educating the mental health field about these limitations.

1. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: American Psychiatric Association; 1994.
2. Kirk SA, Kutchins H. *The Selling of the DSM.* New York: de Gruyter; 1992.
3. Kutchins H, Kirk SA. The Business of Diagnosis: DSM III and Clinical Social Work. *Social Work.* 1988; 33:215-220.

You Name It!

After these many years of ***NEWSLETTER,*** Society members want a proper name for their publication. So—switch into creative mode and send in your ideas for an appropriate/original/catchy/sensible (?) name. As many as you wish. The deadline for entries is December 31, 1994. Final decision will be made by the Society's board.

The winner's prize? Your profile published in the *Newsletter.*

Please send all entries to the editorial office—See page 2 of this issue.

Panic Disorder or Heart Attack?

Chest pain, shortness of breath, dizzy spells—all of these symptoms can be warning signs of heart disease. But these symptoms can also result from sudden attacks of anxiety and panic, feelings that almost all of us experience from time to time but that some people experience frequently and for unknown reasons. This condition goes by names such as "phobic anxiety" and "panic disorder" and affects as many as one out of every 20 people. Not surprisingly, people with panic disorder often worry that their symptoms are caused by heart disease, and these patients account for about one out of every 10 patients seen by cardiologists.

Of course, people who have spells of anxiety are not automatically protected from heart disease. Many people have both panic disorder and cardiovascular problems—and recent data raise the question of whether these two types of conditions contribute to each other. That heart disease might encourage the development of panic disorder comes as no surprise, since any chronic medical condition can raise anxiety levels. But can the opposite occur? Can panic and phobias cause heart problems?

In fact, evidence of an association between phobic anxiety and fatal coronary heart disease first emerged from a 1987 British study of nearly 1500 healthy middle-aged men; those with indications of panic disorder had an elevated risk of dying from heart disease. Further support for such a theory was recently provided by a long-term Harvard study of 51,529 male dentists, veterinarians, pharmacists, and other health professionals in 1986. Participants in this Health Professionals Follow-up Study are sent questionnaires every two years in order to update information.

Although the cause of this association is unknown, these data strengthen the link between the head and the heart and indicate that physicians and patients should not dismiss panic attacks lightly as episodes without long-term health consequences. President Franklin D. Roosevelt might have been wrong when he said that we have nothing to fear but fear itself. (Excerpted with permission. *Harvard Heart Letter*, Sept 1994.) □

NYS Member Recognized by NAP

Marsha Wineburgh, CSW, BCD, has been recognized as a Distinguished Practitioner of the National Academies of Practice (NAP) in Social Work. She was inducted in April of this year in Denver, Colorado. NAP is a multi-disciplinary organization comprising nine professional health care disciplines whose members are nominated based on outstanding contributions to the profession.

Marsha is past president of both the National Federation (1981-1983) and the New York State Society (1980-1981); she is currently first vice president of the Society. She has served as chair of the legislative committee since 1983. She is a former member of the examination committee of the American Association of State Social Work Boards.

Marsha has been a leader in introducing and working to secure passage of the NYS vendorship bill; the legislative committee initiated and pursues licensure bill for CSWs in New York State; she was also in the forefront in the fight for parity.

She was a member of the original steering committee to establish the Met chapter. A Diplomate of the Society, Marsha is currently a doctoral student at Wurzweiler School of Social Work, Yeshiva University. She is in full-time private practice.

CSW Press Kit Coming

The public relations committee is beginning work on a press kit to help educate the media about clinical social work and the people who practice it.

They are asking for "success stories" from clinicians to counteract the chilling stories about so-called social workers seen in the media. They don't expect you to break confidentiality, but if you have any work of which you are especially proud and can tell about it, please let the committee know. The press kit should be completed in early '95. Any suggestions for the kit are welcome.

Call or FAX Sheila Peck at (516) 889-2688 or send material to 1010 California Place South, Island Park, NY 11558.

GARDEN OFFICE
Manhattan—52nd St. East. Psychotherapy office, very attractively furnished, overlooking private garden, doorman building, available several days a week. (212) 355-4250

Plainview
CSW needed to treat patients. Fee for service. Member HMOs required. Send resume and list of HMO participation to: Dr. Aronowitz, 146A Manetto Hill Road, Plainview, NY 11803

Roslyn
Part-time space available in quiet, attractive psychotherapy suite with private bathroom. Excellent location. (516) 365-1741

Throgs Neck—Psychotherapist P/T
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Beautifully decorated suite available part-time: 240 East 76th Street, great neighborhood, near transportation. Private waiting room and consultation room with analytic couch. Doorman building. Private entrance with video security system. Call (212) 988-9602

Odds 'N Ends

The Suffolk chapter will hold a seminar entitled "The Sexual Dimension in Psychotherapy: Transference and Countertransference." Guest lecturer will be Herbert S. Strean, DSW, renowned author and clinician. The event will take place on Sunday, December 4, 1994 at the Marriott Hotel in Melville. Call Laurie S. Rosen, MSW: (516) 864-1469.

In "Groups Dealing With Managed Care" (Spring 1994 *Newsletter*, page 6) a small alliance, now dissolved, had been formed in the Capital District. For further information about managed care activities, call Betsy Owen, CSW, BCD: (518) 482-4278.

"The Friday Night Group" (Spring 1994 issue, page 2) has been renamed: Alliance for Universal Access to Psychotherapy.

The Practical Practitioner: How to Treat "Managed Care Anxiety"

By Sheila Peck, CSW
Public Relations Chair

The Disorder

An excerpt from DSM-IV states: ". . . this category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific Anxiety Disorder. . . . [it includes] clinically significant phobic symptoms. . . ." This describes "300.00, Anxiety Disorder NOS". A new syndrome has arisen recently that affects psychotherapists in general and clinical social workers in particular.

Let's call it "Managed Care Anxiety (MCA) and suggest it be assigned a DSM code of "300 Oh!-Oh!" which is the way many clinicians are reacting to the advent of managed care. MCA is characterized by resistance, feelings of helplessness, teeth-gnashing, outrage and an intense longing to return to the "good old days" of indemnity health insurance. Another clinical symptom in this syndrome is *amnesia*, specifically connected to those so-called "good old days". Sufferers of MCA seem to have forgotten that 10 or 12 years ago most CSWs received NO payment from insurers, whether indemnity or managed care. Those of us who practiced back then—before so-called parity—received NO money in the mail. Our clients paid it all. Some of them could have chosen therapy with psychologists or psychiatrists, all of whom were eligible for vendorship. They elected us. We survived. All of us who started out then and are still in practice now survived. And so, we hope, did our clients.

In fact, if you go back 20 years, much health insurance didn't cover in-office doctor visits. The patients paid for it. (Of course professionals kept their fees lower, too, so care was more affordable.) As a result of this amnesia and other symptoms of MCA, many clinicians are suffering. How can we help? Is there a "therapy" for this emerging syndrome?

The Treatment

Treatment for MCA is multi-pronged. First, let's remember that managed care helps remind us we still have options; in the currently improving economic situation many people have discretionary income. Some of them are spending these funds on health care. They seek chiropractors, acupuncturists, podiatrists, massage therapists, homeopaths and other such practitioners, most of whose services require repeat visits (as does psychotherapy). Insurance, managed care or otherwise, rarely covers such modalities. Yet people who want and need these services find the money to pay for them. So clinicians should re-remember that our skills are necessary, too.

Another part of treatment for MCA is to decide that we can live with or without managed care. It's a choice. Some clinicians ask anxiously, "But how will I get referrals if I'm shut out of panels?" The development of marketing skills is an excellent tranquilizer. Although I'm on several panels, most of my referrals come from other sources: former clients, professional affiliations, personal contacts, and from letting the general public know about us. Referrals from managed care organizations often arise because I'm one of only two practitioners in my zip code. That's marketing—which they don't teach in social work school.

Remember also that if an already existing client gets switched in mid-therapy to a panel of which you are not a member, there are many creative arrangements to keep working with that client if both want to continue. I have never stopped seeing a client for this reason, and I don't directly know of any therapist who has. Remember discretionary income.

If you love your work—and most clinical social workers do—keep in mind that marketing is part of the job. AND IT ALWAYS HAS BEEN, even in those "good old days". Learn how to do it as a part of "taking responsibility for yourself," that wonderful phrase we're telling our clients they need to act on.

Do the burdens outweigh the rewards of the work (and not just financial ones)? If your answer is truly "yes," then it may be time to think about changing careers. If not, keep rewarding yourself. Remember, "Managed Care Anxiety (300. Oh!-Oh!)" is a perfect diagnosis for brief therapy treatment. □

UPDATE

Group Practice Committee

Report by Phyllis Mervis, MSW, CSW

In 1991 Maria Warrack, CSW, BCD, approached the Society's education committee to suggest group psychotherapy as the theme for its next clinical conference. The 1992 Annual Meeting took as its theme "Working With Groups: Enlarging the Context of Therapy." The event was well attended. (Report in Summer 1992 *Newsletter*). Subsequently, this committee continued to work on establishing a respectable as well as visible position for group psychotherapy practitioners in the Society. The next task was to assist with the development of regional chapters which meet regularly to help members with professional development.

In 1994 Phyllis Mervis, MSW, CSW succeeded as chair of this committee. Under her leadership the committee plans to expand its activities. To further encourage and support members who are practicing group psychotherapists and to increase their visibility to the whole membership, a roster of active groups is being developed, to be distributed to Society members. The committee is currently developing a survey to capture the relevant information for the roster. Anyone interested in joining this committee and assisting with this project is welcome. Call Phyllis Mervis at (212) 369-8879.

MAJOR CORPORATIONS *(Continued)*

strives to tailor its panel to meet its business needs. Therefore, panel downsizing (they term it "right sizing") is effected on an individual basis rather than wholesale efforts. Reasons for termination from the panel may include provider saturation, noncompliance with EMHC protocols and/or failure to provide proof of licensure and liability insurance. Moreover, the use of the QBNM initiative is an effort to determine quality, effectiveness and efficiency. Cerniglia acknowledged that some patients will need more intensive, longer term treatment. "We don't want to micromanage or review every case with our providers. Therefore, it is important for us to know the quality of care received. One of the ways to determine that quality is to review the treatment outcome summaries sent to each panel member." If a provider did not submit these forms, EMHC would not know about the panelist's work and that nonsubmission of the forms could influence the decision to retain the provider on the panel. She reiterated that EMHC's primary goal is to implement the best provider match. EMHC panelists can request new forms by calling 1-800-626-5907, ext. 1834. □

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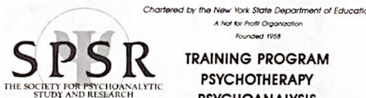

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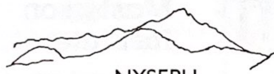

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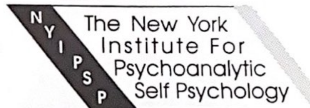

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