The CLINICIAN

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

Supreme Court Extends Confidentiality to LCSWs

State Society donated $15,000 to fund legal brief.

By Marsha Wineburgh, MSW, BCD
Legislative Chair

On June 13,1996, the U.S. Supreme Court recognized the existence of a psychotherapist-client privilege under federal law and held that this privilege specifically applied to confidential statements made to a clinical social worker in a psychotherapy session.

The Court recognized that the federal privilege of confidential communications clearly applies to psychiatrists and psychologists, extending it to protect the conversations made to licensed clinical social workers in psychotherapy sessions. These communications cannot be made evidence in federal court.

The Court also held that the confidentiality privilege is as important for mental health as physical health in serving the public good, noting that all 50 states have enacted into law some form of it. All but three states protect the social work profession. The State Society had donated $15,000 to the National Federation to fund the *amicus* brief it filed in the case, Jaffee v. Redmond, which involved an Illinois clinical social worker who refused to disclose confidential notes about the treatment of a police officer who had shot and killed a suspect.

Managed Care = Damaged Care: On May 10th, State Society members joined other health care providers and consumers from across the country for a rally in Washington D.C. to let Congress know that managed care is dangerous, to urge that it be regulated and that alternatives be found. Behind our banner (l. to. r.) are State Society Pres. Helen Krackow, Rockland Co. Chapter Pres. Fran Aquino and Staten Island Pres. Judy Weiss . Photo courtesy of Newsday

An Illinois CSW's notes

Mary Lu Redmond, the police officer in the case, was put on administrative leave after the incident and sought treatment. The family of the young man who was shot sued Officer Redmond and the city in civil court and asked that the clinical social worker testify and turn over her notes of conversations and records.

The trial judge ruled that there was no privilege between social worker and client. In addition, he told the jurors that because the social worker refused to testify or produce files they could presume that the withheld material would be "unfavorable" to Redmond. The jury awarded the family damages. On appeal, the Seventh Circuit Court of Appeals reversed the verdict, noting that all of the states have recognized some need for "psychotherapist - client privilege" and that it should include "any mental health care provider." The Supreme

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EXECUTIVE REPORT

Helen Hinckley Krackow
CSW, BCD,
Society President

The family of man and our Society family

We are blessed with the generosity of spirit of our members. They show it in many ways, great and small.

As I write this column, fog is softly drifting over Panthertail, a peak in the Blue Ridge Mountains. I am sitting on the porch swing at the summer house of my colleague, Steve McGrath, a Vice President of the Federation. Steve comes north from Florida to this beautiful spot each summer — a place where the cricket chorus at dusk is the loudest sound you will hear and where there is plenty of time to rock in the hammock and contemplate.

I have been thinking about the past year and it strikes me how greatly burdened so many of us have been. New graduates, for example, are finding work hard to come by. Clinicians who have paid their dues and established themselves now are under attack by managed care. And we "well-seasoned" clinicians are facing the issues of older age, including health worries and the struggle to remain vital.

I hear story after story of Society members facing horrible crises — the loss of loved ones or the illness of children, parents or mates. Many stories have touched me deeply. For example, one colleague lost her husband in May to cancer. Then she learned that a colleague of hers who had been very supportive of her was in similar straits — her husband was diagnosed with a disease considered incurable by Western medicine. Without hesitation, the woman joined her friend and plunged into research. Together they found alternative healing approaches and the man's health has shown some improvement.

Later in the summer, when my own husband fell ill and was hospitalized, another colleague offered support unhesitatingly, although she was grappling with her own recent personal crisis. A talented therapist, she helped me figure out a hypnosis script that I could use with my husband.

Then there was the story of one of our members, an expert in PTSD, who heard about the crash of Flight 800 this summer and drove around until she found the victims' families in a hotel near JFK airport and offered to help in anyway she could. And another of our colleagues, Roz Gold, was called to the scene to offer comfort and support to grief-stricken family members until formal crisis intervention groups were in place (please see the article by Roz in this issue.)

When the Executive Board met for a weekend retreat this summer and we set about defining our Society's mission, we realized that a special bond had grown between us. Hard times, hard work, mutual trust had forged the bond. How do we spread this sense of connection to the whole Society, we wondered. One proposal was that we set aside time strictly for social functions during the Annual Meeting; another was to build membership in the practice committees and salons and to make sure that everyone, even those in far-flung chapters, feel they are able to call a receptive colleague anywhere, anytime, for any purpose.

In fact, the more I think about this past year, the more I feel that despite the very real problems we face, we have many strengths, too. We have a level of professional expertise that is unmatched. And we are blessed with the generosity of spirit of our members. They show it in many ways, great and small— whether reaching out to help the family of man or reaching for the phone to call a colleague. This year I was the beneficiary of many of those between-sessions or late night calls. Need help with that project, a colleague would ask, or, how's your husband and how can I help? They called to talk about Society matters, or just to say hello. It made all the difference in the world.

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Haruko Brown

A fond rememberance

By Mitzi Mirkin,

State Society Executive Secretary

On June 6, 1996, after a courageous battle with bladder cancer, Haruko Brown passed away peacefully. Her life force, however, lingers in many corners of the Society, which she served actively and creatively for 23 years.

Haruko was born and raised in Seattle, Washington. Along with her family, she was interned for one and one-half years during World War II. Always a fighter against injustice, she would later lend her energies to the reparation movement for interned Japanese Americans. After moving to New York, she earned an MSW from Fordham University and several certificates from the Postgraduate Center for Mental Health. Her work in the field was mainly with the New York City Board of Education and in private practice.

She held many offices on both the Queens Chapter Board, where she served four years as President and in the State Society, where she filled both elective and appointed offices, including the chairing of several important committees. Her last State Board position was as a particularly capable and conscientious Liaison to the State newsletter. In working with other people, Haruko had a style all her own; she was firm but fair, and had the ability to focus her attention on a projected goal without missing the smallest detail along the way. She developed a unique understanding of the Society's history and structure. These qualities were most useful in formulating what may be her most notable legacy to the Society: the refining and stardardization of the Diplomate process.

On June 17, a steamy Monday evening, some of us from the Society joined a packed house of Haruko's family and friends at the Japanese American Association in New York City for a celebration of her life. People got up to speak about Haruko as the spirit moved them. Cecile Dunn, a Diplomate of the Society (as was Haruko) and a founding member, with Haruko, of the Queens Chapter, spoke about those early days. Helen Krackow recalled her last conversation with Haruko about a homesick student member from Japan and announced the Society's intention to award a prize in Haruko's honor.

It was a revelation to hear how many worlds Haruko had been a part of. There was the Japanese American Help for the Aging, where she was a volunteer, on-call social worker; the Community Conciliation Center in Flushing and the Japanese American Citizen's League, on whose boards Haruko had served; and the Asian and Pacific Islander Coalition on HIV/AIDS (APICHA), of which she was the well-loved President. Joan Pollard, a Queens Fellow and Haruko's long-time friend, remarked that everyone saw Haruko in a different way, but few knew the whole complex person.

Haruko's son, Stephen, her daughter, Leslie, her grandchildren and her brothers heard confirmation, again and again, that her life had counted for so much to so many. Passionately engaged with her family and her public commitments, she was also an adventurer who went white water rafting, a balletomane and music lover, and a marcher on Gay Pride Day.

A few weeks ago, a member of that group phoned my office for information for an article he was writing about Haruko. "I was really missing Haruko today," he said to me. I understood so well, because we are really missing her, too.

Being There in a Crisis

In the days that followed the Trans World Airlines Flight 800 explosion on July 17th, many of us were consumed by the news of the fiery crash that killed 230 people over Long Island waters. As a member of the American Red Cross' Mental Health disaster team, I was called upon a day later by Leslie O'Kane, a co-ordinator from that organization, to provide some mental health counseling to the bereaved families.

The victims families were staying at the Ramada Plaza Hotel at Kennedy Airport. I drove there and found the hotel surrounded by reporters and camerapersons. I was not able to gain entry until I was given clearance and then was escorted by a guard to the American Red Cross station. The identification tag they gave me read, "Mental Health Worker." They directed me to the main ballroom.

Round tables were set up across the ballroom floor and seated around each were people of all ages and manners of dress. The room was packed with people, yet strangely silent. It was for me a clear indication of the anguish and despair felt by these family members. I walked slowly through the ballroom, realizing that I had to come to terms with my own feelings before being able to reach out to anyone there.

Then I began. I talked to many families. It was very different from my professional craft as I know it in daily office practice. The usual intake process, for example, was not needed. In fact, all that was required was that I listen and share the pain of the distraught families.

A father blamed himself: "My frequent flier miles bought her the plane ticket." A mother cried, "I didn't take the time to say goodbye." A young man spoke about his cousin, a visitor from Italy — "My cousin trusted me. He couldn't speak English and he asked me what flight to take. I made all the arrangements. He trusted me." Many photos were shared and broken dreams were spoken of through streaming tears, both theirs and mine. Over and over these suffering people would say: "The worst thing that could ever happen, happened."

I went there to be a supportive, caring member of society. True, I am a mental health professional and trained to help people cope in times of crisis and loss. But it is also my philosophy that we are all part of the family of man and if we have the skills and the temperament to reach out to someone in psychological pain, we should do so. We will benefit, growing stronger for having made the contact. Of course, we have no easy remedies, no closure to human pain and suffering — only the work towards healing.

Why have I written this article? Because such disasters and sweeping losses are part of the course of human history, and when they occur, I think we should be ready.

Therefore, I am looking for some Society members who would be interested in becoming part of a Mental Health Crisis Committee under the umbrella of the Society. If you are interested, please call me. Leave your name and telephone number and use the code "mental health." I will then consider you part of the crisis team and will contact you to provide services in times of crisis in the community. I hope to hear from you soon.

Roslyn Gold, DSW, (718) 380-3195
(Past President, Queens Chapter)

The 27th Annual Conference

The Forgotten Father

from reports by Richard Beck, CSW & C. Toni Mufson, CSW

The Education Committee, chaired by Dianne Heller Kaminsky, created this thought-provoking conference, held in May at the New York Bar Association in Manhattan. It centered around the importance of the father in clinical work and the lives of patients. Helen Hinckley Krackow, Society President, opened the program and introduced keynoter Herb Strean, DSW, BCD, Distinguished Professor Emeritus, Rutgers School of Social Work.

Bernard Ott, MSW

David Morgan, MSW

Ronald Sunshine, Ph.D.

Lucia Imbesi, MSW

Ruth Oscharoff, MSW

Richard Alperin, DSW

George Chieffet, MSW

With his trademark humor, Dr. Strean raised serious questions about the father's role in treatment. Forty years ago, he said, he noted the absence of the father from the process. The etiology of practically every diagnostic category — the dominant mother and the passive father — must surely contribute to this absence, he thought, since fathers are reluctant to expose any passivity.

How does the father emerge in a patient's fantasy and dream life and how does he shape the superego, conscience and ego ideal? Dr. Strean explored these questions from both an intrapsychic and a societal perspective. He said, "We now know that fathering does not begin in the child's oedipal phase, and that a man's nurturing of a child at infancy is not necessarily a sign of his overwhelming wish to be a woman." But still, little is written about how the father experiences himself as the child goes through the psychosexual stages or about "the harm to the father who is unable or unwilling to nurture his child."

Emotionally inexpressive men may be defending against the burdensome myth of male superiority, through reaction formation, by viewing themselves as actually superior. Interestingly, studies by Haviland and Malatesta of the non-verbal interactions between mothers and daughters revealed the mothers give significant attention to daughters's expressions of pain and distress. Dr. Strean contends that males have a rough time in early life without such attention and they mature with "a host of unmet dependency yearnings and internal prohibitions against expressing their feelings."

When they become fathers, men may relate to their infants' dependency needs with envy, fear and feelings of helplessness leading to withdrawal. Their children are left to create fantasies of a father who is not present. Indeed, many patients seem to hunger for their fathers, Dr. Strean said. Female patients have told him they would not "hate themselves as much and would be more entitled to appreciate men and interact better with them" if they had had closer relationships with their fathers in childhood. Male patients often felt that "their loneliness and confusion regarding what is appropriate masculine behavior results from paternal neglect." These patients "do not know how to behave as men and fathers because their own fathers were in the background, amorphous and indistinct." And, he said, "It is dangerous and anxiety-provoking for many patients of both sexes to depend on a man," because of early frustration of dependency yearnings in the father-child relationship. He concluded by saying that in our work, we must not only plumb patients's anger resulting from their absent fathers, but also help them understand their fathers.

(L. to r.) Keynote speaker Dr. Herb Strean, Dianne Heller Kaminsky, Education Ctte. Chair, Helen Hinckley Krackow, Society President and speaker Joseph Giordano

Roberta Schultz, MSW and Joan V. Klein, MSW

Judith Rustin, MSW and Roberta Shechter, DSW

Photos by Jenifer B. Kaminsky

Joseph Giordano, MSW, Director, Ethnicity and Mental Health Associates, posited that race and ethnicity inform gender identity and that the meaning of manhood and fatherhood differs from culture to culture. Social workers need to pay more attention to cultural differences, Mr. Giordano said. He spoke at length of the Italian-American culture's characteristics, including the perception that the family is more important than the individual. An important value is "taking care of your own." Italian-American males function one way at home, but differently in society, where they adhere

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By Brian P. Quinn, CSW, Ph.D.

DYSTHMIA: DIAGNOSIS AND TREATMENT

Psychotherapy and medication offer patients the best hope for alleviating the suffering caused by this common, but often unrecognized, disorder.

Dysthymic patients are frequently plagued by feelings of inadequacy, guilt and shame. They often feel driven to complete long lists of largely self-imposed responsibilities. Family members may describe these patients as tense, irritable, critical and demanding. Surprisingly though, dysthymic patients have trouble being assertive when situations call for it. Their guilt makes it hard for them to set limits on the unreasonable demands or criticisms of others.

Dysthymic patients tend to be easily hurt and disappointed by family and friends. Their spouses complain they can never do or say enough to please them and may withdraw out of frustration and anger, which then leads these patients to become more irritable and depressed. Dysthymia and other mood disorders are probably responsible for a significant number of marital problems.

The absence of neurovegetative symptoms typical of major depression, the pronounced interpersonal problems and the chronic conflicts with anger can lead clinicians to misdiagnose dysthymic patients as neurotic or personality disordered. Clinicians may then mistakenly recommend psychotherapy or marital counseling as the sole treatment.

The idea that the problems could have biological roots usually has not occurred to dysthymic patients.

George sought treatment for his interpersonal sensitivity, demands for recognition, irritability, guilt and gloominess. His irritability had contributed to the breakup of his first marriage and was causing considerable strain on the current relationship. Although he was bright and showed considerable promise, his moodiness created problems with coworkers and supervisors that kept him from getting promotions. Previous therapists had given him various diagnoses, including narcissistic, self-defeating or depressive personality disorder.

Researchers have shown dysthymia to have clear genetic and biological connections to major depression. Taking a personal history from the patient who is suspected of having dysthymia — with an eye toward psychiatric diagnosis rather than psychoanalytic diagnosis alone — may reveal episodes of major depression. These typically occur at times of loss of important relationships.

Although George had never been truly incapacitated by his problems, he had overslept, gained weight and wished he were dead at times during his first year of college. This was precipitated by the breakup of a relationship with a girlfriend and by the fact that he was away from home for the first time in his life.

Similarly, taking a family history with an eye on psychiatric problems as well as family dynamics may reveal close relatives with irritable or depressive temperament or episodes of major depression.

George's mother was an irritable and gloomy woman whom he felt he could never please. He had often explained his current problems on the basis of his mother's relationship with him. His father's mother had been hospitalized for a "nervous breakdown." George described his only sibling, a younger brother, as a "malcontent." He felt his mother had "ruined" both he and his brother.

Recent clinical trials indicate that dysthymia responds well to treatment with antidepressants. Therapists need not reserve these medications for use with patients incapacitated by major depression. Patients will more easily learn effective interpersonal skills in psychotherapy once their mood instability is controlled.

George was surprised and angered when a therapist he had been seeing for a few months suggested that his problems might have biological as well as psychological roots, and that antidepressants might be helpful. He felt as if the therapist was implying that he was crazy and that he did not have a right to be irritated with people.

Dysthymic patients typically explain their foul moods and other symptoms by pointing to interpersonal problems or dysfunction in their family of origin. They seek out a therapist to help with what they believe to be psychological problems. The idea that their problems could have biological roots usually has not occurred to them. It can therefore come as quite a shock when their psychotherapists suggest medication. Therapists need to address patients' beliefs that they must be crazy, weak or inadequate if they need medication.

Environmental or interpersonal factors certainly play a role in dysthymia. But dysthymia is just as likely to be the cause as the effect of current interpersonal problems. Patients who are successfully treated with medication report that they feel much less sensitive and irritated by others. Pain associated with past hurts often fades, a phenomenon that forces reconsideration of the idea that narcissistic injury in childhood is directly connected to problems in adulthood.

George was successfully treated with Zoloft. However, the pharmacological treatment of dysthymia will not always be easy. About 20-30% of patients may need to try different antidepressants to resolve their disorder. With persistence, such treatment can help make a dramatic difference in these patients' lives. A combination of family and patient education about mood disorders, psychotherapy and medication offer patients the best hope for quickly alleviating the suffering associated with this common, but often unrecognized, disorder.

Brian Quinn has a Ph.D. in clinical social work from New York University. He holds a certificate in psychoanalytic psychotherapy from Beth Israel Medical Center. His book, Depression: A Sourcebook, will be published next spring. He specializes in the treatment of mood disorders, substance abuse and personality disorders. He is in full time private practice in Huntington.

Book Review

Fostering Healing and Growth:

A Psychoanalytic Social Work Approach

by Joyce Edward & Jean Sanville

Northvale, New Jersey: Jason Aronson, 1996.

by Carol Tosone, Ph.D.

Carol Tosone, Ph.D., is an assistant professor at NYU Ehrenkranz School of Social Work. She is also Associate Editor of Psychoanalysis and Psychotherapy, the Journal of the Postgraduate Center for Mental Health, and she is in private practice.

This is an exceptional book and a tremendous contribution to psychoanalytic social work.

Kudos to Joyce Edward, Jean Sanville, and their contributors for their pioneering work in describing the nature and scope of psychoanalytic social work practice. **Fostering Healing and Growth: A Psychoanalytic Social Work Approach** is a culmination of the dedication and efforts of the National Study Group on Social Work and Psychoanalysis, an organization formed in 1990 by the National Membership Committee on Psychoanalysis to examine the evolution of psychoanalytic thought within the field of clinical social work. As reflected in the rich theoretical and clinical interests of the contributors, the Study Group's primary goal of defining the identity of the contemporary social work psychoanalytic practitioner has been well-achieved.

It is not uncommon for social workers who have received advanced training in psychoanalysis or psychoanalytic psychotherapy to struggle with the question of their primary identification. Should they describe themselves as clinical social workers, psychotherapists, or psychoanalysts? Do they practice clinical social work, psychoanalytic psychotherapy, or psychoanalysis? While the book does not directly address these questions, it does focus on the ongoing and often ambivalent relationship between social work and psychoanalysis.

The book contributors are excellent role models for successful adaptation to this dual identity. While they work in a variety of settings and represent a plurality of treatment models, each skillfully demonstrates the value of psychoanalytic concepts in work with traditionally "untreatable" patients. These clinicians apply the "ever-widening scope of psychoanalysis" to patients who have severe pathologies, cumulative traumas, developmental deficiencies, and environmental deprivations.

To be more specific, there are 23 cases discussed, representing patients from diverse cultures, racial groups, socioeconomic levels, and sexual orientations. They suffer from modern day maladies which include addiction, anorexia, post-traumatic stress disorder resulting from abduction, rape, incest, and physical abuse, postpartum depression, physical disability, prostitution, HIV-positive and AIDS statuses, suicidality, schizophrenia, and even filicide. These presenting problems do not occur in isolation, but rather in a pattern of co-morbidity. For instance, in one case the reader encounters a young African-American woman, a recovering heroin addict who is HIV-positive and who has an extensive history of prostitution; in another case, there is a handicapped paraplegic woman whose son was placed in foster care.

These are the types of cases with which beginning social workers and social work students are well-acquainted. These multi-problem patients are seen in "front-line" settings, such as residential treatment facilities, foster care, family agencies, hospitals and outpatient clinics. Those who are new to the field of clinical social work may particularly appreciate the extensive case histories, the open and honest discussions of countertransference reactions, and the inclusion of verbatim process recordings in several of the chapters. The contributors also do a highly laudable job of modeling the ongoing processes of assessment and self-monitoring, cornerstones in the social work and psychoanalytic traditions.

Seasoned clinicians can also benefit from the detailed discussion of these cases, as well as the chapters devoted to the treatment of higher functioning patients in private practice. It should be noted, however, that several of the more difficult patients were treated successfully in a private practice setting. In fact, these authors are testament that psychoanalytic theory and technique can be fruitfully applied to patients not expected to benefit from insight-oriented treatment.

Particularly impressive is the flexible treatment parameters utilized in each case. The social work axiom "start where the client is" is evident throughout the book in all of the cases. To illustrate, in her work with victims of childhood sexual abuse, Dr. Graziano may offer an extended session or allow for supportive physical contact when appropriate. As another example, Dr. Aronson permitted a masochistic anorexic patient, who was terrified of connection to call her answering machine in lieu of face to face meetings. This intervention was employed until the patient could better tolerate the closeness of the therapeutic relationship.

A notable strength of the book is that the clinical contributors focus extensively on discussion of the vicissitudes of the treatment relationship, particularly the transference-countertransference matrix, development and maintenance of the working alliance, and course of therapy. Another significant strength is the explication and application of existing schools of psychoanalytic thought. In addition to the four psychologies (classical, ego, self, and object relations), innovative perspectives are also considered, such as intersubjectivity and the work of Matte-Blanco.

Still, other strengths are the inclusion of chapters on the history of the psychoanalytic social work, the applicability of Winnicott to an understanding of the "good-enough social worker," and the relevance of psychoanalysis for social work education. There are also well-written chapters on supervision and working with the parents of children in treatment. The book concludes with an outstanding synthesizing chapter by Dr. Sanville, followed by an abridged glossary of psychoanalytic terms by Patsy Turrini.

In summary, this is an exceptional book and a tremendous contribution to psychoanalytic social work. It is theoretically solid, clinically relevant, and can appeal to students and experienced clinicians alike. As noted in the book, the contemporary social worker must be prepared for all patients and settings. **Fostering Healing and Growth** is essential reading for those practicing in the complex and ever-changing mental health care environment. ■

MANAGED CARE VENDORSHIP

COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

We continue to identify non-reimbursers of clinical social work, either self-insured plans or benefits plans written in states without a vendorship law (requiring reimbursement for clinical social work). Then we work to get an exception made on behalf of the Society member who brought it to our attention and forward the plan to our national marketing consultant, who educates the company or plan as to the benefits of including clinical social workers (CSWS) as reimbursable providers. Our successes include Merrill Lynch, AT&T, UPS, American Cyanamid, Sony, and GE, to name a few.

We are now the Managed Care/Vendorship Committee: In an effort to address the complex issues of managed care more efficiently, it was decided at last Spring's Board retreat to approve Manny Plesant's recommendation that his committee (the Managed Care Committee) be folded back into the Vendorship Committee.

Bill numbers A.11328/ S.7553 have passed both the NYS Senate and Assembly and are awaiting the governor's signature to become law. Since he was instrumental in designing this bill, he will likely sign it without delay. This law will amend (and repeal certain provisions of) the Public Health Law and the Insurance Law in relation to regulating the delivery of managed health care. It will be a good first step in addressing some of the ills of the managed care system in NY.

What the law will do:

(Effective dates: **a= immed.; b= 1/1/97, c= 4/1/97)**

1. Sets forth detailed requirements concerning the disclosure of information by HMOs to enrollees and prospective enrollees concerning the benefits, exclusions and limitations of the HMO's products, as well as information concerning the HMO's operations. - **c**

2. Establishes minimum standards for HMO grievance procedures, including time frames, reviewer qualifications, and appeal rights. - **c**

3. Requires HMOs to provide notice of grievance determinations in writing to the enrollee, including the detailed reasons and the clinical basis for the determination.- **c**

4. Prohibits HMOs from terminating providers without cause except with 60 days notice and only on the contract expiration date (or Jan. 1 after one year on contracts without an expiration date.) - **b**

5. Prohibits HMOs from terminating or refusing to renew a provider contract solely because a provider advocated on behalf of a patient, filed a complaint, appealed a plan decision, provided information or a report to an appropriate agency, or requested a hearing or review pursuant to the provider due process section. - **b**

6. Prohibits gag clauses and contracts, policies or procedures which try to restrict providers from disclosing to enrollees information regarding their treatment, filing complaints with appropriate government agencies or advocating on behalf of their patients. In addition, these entities could not by contract or written policy or procedure transfer liability to a provider for the entity's own actions or omissions (eliminates hold harmless clauses).- **b**

7. The commissioner would be required to establish protocols to prevent disclosure to third parties and to use unique confidential identifiers wherever possible. The bill also maintains existing statutory and regulatory confidentiality provisions. - **a**

8. Establishes acceptable capacity standards for HMO provider networks or panels. - **a**

9. Requires HMOs to establish procedures for enrollees to access certain specialist care when the appropriate provider or center is not available within the network.- **c**

10. Provides for a continuity of care when, for example, a new enrollee's provider is not a member of the network in certain instances which are life-threatening, or if the patient has a degenerative and disabling condition or disease. The provider must agree to accept payment rates established by the HMO. - **c**

11. Prohibits UR agents from compensating employees, contractors or agents based on any method that encourages the rendering of an adverse determination. - **c**

12. Requires that medically-necessary emergency services are not subject to prior authorization. The bill establishes a prudent layperson's standard to determine if an emergency condition exists.- **c**

What the law doesn't do:

1. Fails to provide for an out-of network benefit for individuals covered under group health insurance plans.

2. Fails to provide for the availability of an independent, external mechanism for consumers to appeal adverse determinations by HMOs.

3. Fails to set standards for prompt payment of claims by insurers and HMOs and does not entitle consumers and providers victimized by unfair claims practices to interest on delayed claims or to sue for damages.

4. Exempts utilization review activities from the consumer protections contained in these new articles if the review is conducted by or on behalf of a self-insured welfare benefit plan, as defined in ERISA.

Although the bill isn't all that we wanted, given the current climate, which seems to protect business and consumer interests with equal weight, it's a definite improvement over having no regulation of managed care. To get a copy of this managed care regulation law, please call your state senator (518) 455-2800 or assemblyperson (518) 455-4100.■

Order this new NFSCSW brochure in bulk, and place it in your waiting areas. It is designed to educate consumers about different benefit structures (indemnity, ppo, pos, hmo) and their relationship to cost and choice. Call to order ($15 per 100) or to receive a sample. Contact Lenore Green, Rockland Vendorship Chair, (914) 358-2546.

Confidentiality Extended to LCSWs

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Court affirmed the Court of Appeals, finding that a psychotherapist-patient privilege exists under federal law and it was fully applicable to clinical social workers.

Although the majority opinion delivered by Justice Stevens decided for the federal privilege, Justice Scalia, in his dissenting opinion, attacked the expertise of social workers and pointed to the necessity for a strong scope of practice in state licensing laws for clinical social work. "A licensed psychiatrist or psychologist is an expert in psychotherapy.... Does a social worker bring to bear at least a significantly heightened degree of skill? ...I have no idea and neither does the court. It is not clear the degree in social work requires any training in psychotherapy."Jaffe v. Redmond 95-266 (1996).

Justice Scalia critiqued existing social work licensing laws, noting they are vague and concluded that the training does not compare in its rigor to the training of other experts. "Another critical distinction between psychiatrists and psychologists on the one hand and social workers on the other is that the former professionals ... do nothing but psychotherapy. Social workers interview people for a multitude of reasons." Jaffe v. Redmond 95-266 (1996). He commented that therapy is only a small part of the job of most social workers. How does one identify which social workers do psychotherapy and thus qualify for this privilege?

Clearly, Judge Scalia's comments raise a familiar and fundamental issue for the social work profession. Which social workers are trained to do psychotherapy? How do you identify them? Do our licensing laws definitively address this issue? Here in New York State, we continue to struggle with these questions are we move toward a new scope of practice statute.

Book Fair Alert

The New York State Society for Clinical Social Work and the New York University School of Social Work Ph.D. Program are holding a Book Fair featuring an exhibit of published and soon-to-be-published books by members of the Society.

Saturday, November 16, 1996
Clinical Conference
Treating the Difficult Client: Who is Difficult and To Whom?
at the New York University Loeb Student Center

If you are a member of the Society and interested in having your book on display — DO NOT DELAY
Please call Diana Hersinger of Psych Editions at 1 (800) 237-7924 as soon as possible.

Other Legislative News: Licensing update — BSWs and MSWs: Intraprofessional differences have led to several amendments to the once-agreed-upon S.4979/A.5989, a two-tier bill intended to license social workers and independent clinical social workers. Specifically, the BSW leadership has asked for inclusion as Licensed Baccalaureate Social Workers. Unfortunately, the draft they have submitted blurs the boundaries between BSW and MSW training and experience, giving no recognition to differences in education and essentially making the BSW a terminal degree. On September 21, the Exeuctive Board of the NYSSCSW voted to oppose BSW practice outside of an agency and BSW practice without MSW supervision. It endorsed licensing BSWs with the prerequisite that there be a well-defined limited scope of practice for these folks as befits the entry level in social work.

Health Care Consumer Protection Act Update: A.6800-C has died, replaced by a new managed care bill worked out by Governor Pataki (A.11328/S.7553) which, at this writing, has passed both houses but remains unsigned. This revised bill makes considerable strides in regulating consumer rights in managed care organizations, prohibits gag contracts and penalizing providers who advocate on behalf of their clients. But it fails to provide for an out-of-network benefit for individuals covered under group contracts and it fails to allow consumer to take their grievances outside the managed care organization to an independent, external agency. The Governor Pataki may not sign this bill into law. Insurance interests are fiercely lobbying against it. The Society will continue to work with other consumer groups and health care professionals to monitor and oppose any efforts to weaken this legislation and participate in drafting additional laws to strengthen consumer rights. ■

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4. **John P. Muller, Ph.D.** "Lacanian Concepts: Toward a Practical Clinical Framework" Saturday, January 11, 1997
5. **Virginia Goldner, Ph.D.** "Couples Therapy: A Conceptual Map for the Psychoanalytic Clinician" Saturday, February 8, 1997
6. **Theresa Aiello-Gerber, M.S.W., Ph.D.** "Reflections on Contemporary Adolescence: Theoretical and Clinical Considerations" Saturday, March 8, 1997
7. **David P. Celani, Ph.D.** "The Dynamics of the Battering Couple: A Fairbairian Analysis" Saturday, April 19, 1997
8. **Stephen A. Mitchell, Ph.D.** "The Contribution of Hans Loewald: A Reconsideration" Wednesday, May 10, 1997

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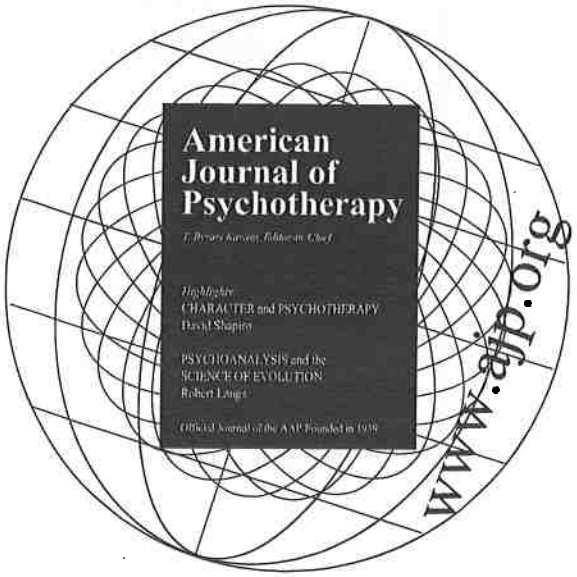

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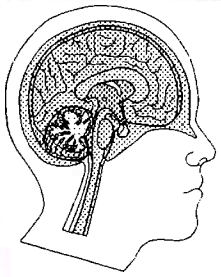

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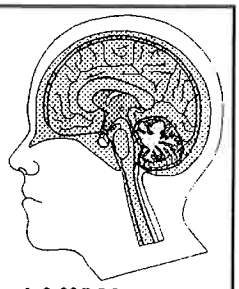

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Conference Report: The Forgotten Father

Continued from page 4

to rigid roles and avoid the appearance of femininity. In society, they must appear to be logical, rational, powerful,and self-reliant, willing to sacrifice everything to success. However, in the family, there is drama, emotionality, irrationality, reliance upon others, and work performed for the care and survival of the family, not the individual. Aggression, useful when out in society, is kept under wraps in the family, where it must not threaten the family's existence or integrity.

Toward the end of his presentation, Mr. Giordano selected four ethnically diverse men from the audience — Jewish-, Afro-, Puerto Rican- and Irish-American. Each described the differing roles for their fathers and mothers imposed by their families and society. Later in the day, several workshops and panels rounded out the program, covering such topics as transference, families in the '90s, idealized fathers, the father's role in the development of creativity and contemporary male development theory.■

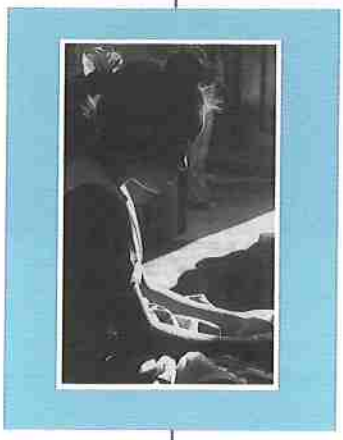
Being Different

Adoptees and the Adoption Triad by Mary G. Freeman, CSW

In psychiatrist Robert Anderson's book, "Second Choice," he reflects on his experience as someone who was adopted, and reveals that the issue was never discussed when he was in analysis on two separate occasions. His analysts viewed Anderson's adoptive parents as his psychological parents and, therefore, considered his adoption irrelevant.

"In all the years I was encouraged to say whatever crossed my mind, which I dutifully tried to do, the adoption never came up. In all the years my analysts tried to read between the lines and consider omissions, they never asked about my adoption. How could an issue of such importance remain outside the purview of a procedure designed primarily to uncover such issues?....I now view this approach to be like trying to understand post traumatic stress disorder in a Vietnam veteran without ever discussing Vietnam."

Anderson himself viewed his adoption as a secret, not even to be discussed in analysis. Many patients who are adoptees come into treatment with similar assumptions. But as clinicians we must not collude with their self-censorship. We must not avoid this important topic. Although adoption is not a diagnosis and there is no "syndrome" associated with it, it carries a powerful sense for the adoptee of being different and is a major organizer for his or her life.



Consider the implications of this special method of forming a family. Adoption begins with the birth parents, who must struggle with the decision to give up their child; it continues with adoptive parents, who build a family in a different way than most; and it culminates with the adoptee, who is part of more than one family and must come to understand and combine two parts of her/himself, two heritages. The sense of being different lasts a lifetime for all members of the triad — birth parents— adoptive parents and adoptee. The tension between the pull to normalize and the pull to acknowledge difference must be negotiated.

Therapists need to recognize that all members of the triad are present, in fact or fantasy, in each triad member's mind. Therefore, these other members should be "in the room with us" when we listen. We may choose not to mention them, but awareness will help to talk about them at an appropriate time and to incorporate them into the life story of the patient.

Adoption evokes normative and predictable developmental responses for all members of the triad. Therapists can help them address these as developmental issues and not as pathologies.

Here are some themes to listen for in one member of the triad, the adoptee:

1. Badness — Beginning at around five or six years of age, cognitive awareness of the circumstances of birth is sufficient for adoptees to recognize the differences between the way their family was formed and others. Non-cognitive, experiential awareness most likely develops even earlier. In the absence of accurate information, children devise all sorts of explanations for their adoption which often center on a presumed "badness" or defect they possess. Older adoptees may have grown up in an environment that was less open about the subject of adoption than now, and may struggle with a sense of rejection and loss which has never been articulated. The inner badness may be hidden behind compliance, rebellion or other symptoms.

2. Hypersensitivity, fear — Adoptees often develop hypersensitivity to the sadness and insecurity their parents may feel about adoption. They often tell of avoiding the subject. The family may have developed internal censorship. The child may also feel increased danger in expressing aggression or hostility towards his or her parents, because of the imagined possibility of being rejected again.

3. Identification issues — Identification becomes complicated by the "other" set of parents. In the absence of information, shreds of data are woven into material with which identification occurs. For example, the suggestion that a person was born out of wedlock may make a repetition of this scenario, an out of wedlock pregnancy, feel like it is fated, as well as being a way of forging a connection between the adoptee and birth mother. The inner dialogue might be, "My mother and I are both promiscuous."

4. Genealogical bewilderment — Adolescents tend to experience "genealogical bewilderment." This refers to a kind of identity confusion. In late adolescence, adoptees may have difficulty in formulating a vision of themselves and their lives which feels authentic. An unknown alternative looms in the background, usually unconsciously. An extended adolescence may be the result when the adoptee is unable to settle into a career or to complete a program. Straddling a dual identity is difficult, especially when one is imaginary. If the birth parents have never been seen, they exist exclusively in the imagination.

5. Feelings of loss — Feelings of loss underlie the experience of most adoptees and is seldom validated by their families or the social environment. As with other themes discussed here, these unacknowledged, hidden feelings may become inaccessible and therefore impervious to revision as the adoptee matures. The clinician's job is to help the client acknowledge any such feelings and process the information.

6. Sensitivity at different life junctures — When adoptees become parents or grandparents, when their adoptive parents die or if the adoptive parents divorce, they can experience renewed difficulties.

7. Issues in therapy — Transference may be affected by issues of adoption. For example, one patient who was an adoptee vacillated between seeing two different therapists, unaware of the connection this behavior had to the fact that she had two mothers, a birth mother and an adoptive one. Silence in therapy may mean avoiding the subject of adoption, and clinicians need to find ways to give permission for the client to open and explore the issue.

Building families through adoption is an important and rewarding resource for society, but it brings with it special concerns that clinicians must recognize.

Mary G. Freeman, CSW, is a private practitioner in Manhattan and Columbia County, . She is the Chair of the Adoption Taskforce of the Met Chapter. With other members of the taskforce, she will present a workshop on adoption at the State Society's November conference.

The 28th Annual Conference of The NYS Society for Clinical Social Work, Inc.

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Date of Conference: May 17, 1997

Deadline for submission of proposals: November 30, 1996.

Proposals should be a minimum of two typewritten pages, double spaced, and should include the following:

1. Description purpose, function and teaching objectives.
2. A workshop or panel outline and bibliography.
3. Four copies, with biography on a separate page.

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