The CLINICIAN

Winter 1997 Vol. 28 No. 1

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

Will 1997 Be the Year for NYS Licensing?

by Marsha Wineburgh, MSW, BCD, Legislative Committee Chair

After working together more than five years, the coalition of six social work organizations dissolved on Friday, January 10th, unable to agree on how to include the baccalaureate-level social worker in the licensing legislation. However, the leadership of the Clinical Society remains committed to passing licensing for clinical social workers.

Nearly two years ago, our Board agreed to endorse a licensing bill for the social work profession in New York State. We were joined by the State and City Chapters of NASW, the Association of Deans of Social Work Schools and the Society for Social Work Administrators in Health Care. We agreed to a single scope of practice which licensed the profession at the MSW-no-experience level of education, the equivalent of the current certified social work (CSW). S.4979/A.5989 was a two-tier bill intended to license social workers and independent clinical social workers. BSWs would be exempted from the statute, although the licensing

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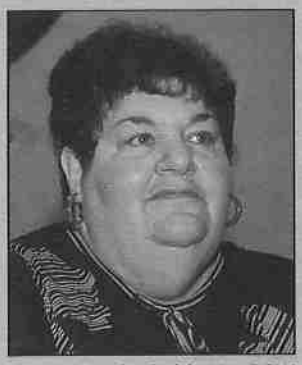
The Second Joint Conference of the NYS Society for Clinical Social Work and the NYU Shirley M. Ehrenkranz School of Social Work Ph.D. Program

Maryellen Noonan, Ph.D.



Eda Goldstein, DSW

Joyce Edward, MSW, BCD

Over 400 participants attended the second joint clinical conference of the New York State Society for Clinical Social Work and the New York University Shirley M. Ehrenkranz School of Social Work Ph.D. Program on Nov. 16th. The program "Treating the Difficult Client: Who is Difficult and to Whom?" featured two keynotes and a discussion in the morning and 16 workshops in the afternoon. The presentations by Maryellen Noonan, Ph.D., Eda Goldstein, DSW and Joyce Edward, MSW, BCD generated great enthusiasm. In addition, Helle Thorning, CSW, received an award for scholarship that was presented this year in memory of our esteemed colleague Haruko Brown to encourage the type of excellence and dedication she brought to the field of clinical social work.

Please turn to page 4 for a summary of the keynotes, the discussion and excerpts from the award-winning paper.

EXECUTIVE REPORT

Helen Hinckley Krackow

CSW, BCD,
Society President

Inaugural Thoughts

I write this to you as I am flying back from the 53rd Presidential Inauguration. An invitation for the event and other weekend activities was sent by the Presidential Inauguration Committee addressed to the New York State Society for Clinical Social Work. We can all be proud of that recognition. It is the joyous result of the long hours spent building our Society by all those on the State Board, the staff and the Chapter Boards. Finally we have achieved visibility!

The plane is just now passing over the spot where I stood to hear President Clinton and Vice President Gore swear their oaths of office. I will take this opportunity once again to swear my oath to you — that I will continue to pour every ounce of strength I have into accomplishing the mission of our Society and the Federation.

On Sunday I heard Carl Lewis, Olympic Gold Medalist, say to the audience in the Heritage Tent at the Mall, "People are always quick to tell you what you cannot do. Don't believe them. Do what you think is right. Work hard. You will get where you want to go."

As I begin my last year as State Board President and reflect on the past three years, I can see the strides we have made in getting where we want to go. For example, when I first started visiting Capitol Hill in 1993 on behalf of the Society, David Phillips had to give Congressional staffers handouts prepared by our National Advocate explaining our profession. Not any more! We are now more than just a blip on their radar screens.

It is my fervent hope for all social workers, whose profession is terribly threatened and difficult to pursue these days, that we strive to work together to secure ourselves, protect our patients and advance the parity of mental health treatment with physical health treatment. If we are allied and adhere to our shared values, we can light up those screens.

I attended the Inauguration Ball on Sunday night and networked on behalf of the Society with several legislators and colleagues from across the country. The feeling of unity of purpose was palpable. Inauguration Day, January 20th, was also Martin Luther King, Jr.'s Birthday and the celebration on the Mall became a tribute to this great leader. It brought me back to my youth and my own activist values.

I was putting myself through undergraduate school at night and working for a large corporation by day when Martin Luther King, Jr. was killed. In an effort to honor the man, I collected money from friends and wrote a passionate petition to my company's execs asking them to donate funds to the Southern Christian Leadership Conference. A firestorm erupted. The petition stirred up outrage and fear. It was stolen off my desk, a copy was sent to upper management and I was called into the Attorney General's Office to explain myself.

How did I, a file clerk, have the audacity to ask the company to support Dr. King's movement?, they wanted to know. I explained that I was doing nothing secret or subversive. And after some more questions, they dismissed me. But I learned how strong a reaction I could get with the merest glimmer of social conscience and action.

All this came back to me as I hear Maya Angelou recite a poem in honor of Dr. King and watched a light opera about the civil rights movement, followed by Peter, Paul and Mary reminding us all that "This land was made for you and me."

The mental health rights movement is not unlike the civil rights movement, with aspects of a poor people's as well as a quality of life movement. Our fight to preserve clinical social work and mental health treatment can also have great social and historical impact.

I will stop now as our glorious Manhattan Island is coming up on the horizon.■

If we work together to secure ourselves, protect our patients, advance the parity of mental health treatment and adhere to our shared values, we can light up their radar screens.

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

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PSYCHOANALYSIS COMMITTEE REPORT

By Marilyn G. Schiff, CSW, Chair

The drive to develop salons — informal groups meeting to discuss issues of psychoanalysis and psychoanalytic psychotherapy — has begun to show results. In addition, the more traditional psychoanalytic peer supervision groups have also increased. Responses to the Clinician article describing salons grew four-fold over the summer and fall.

Manhattan, where Joanne Horwitz has assumed the Met Chapter's COP leadership following Bonnie Beck's resignation, has the largest number of groups. Nassau County's Stephanie Zemon reports quite a number of ongoing groups, the result of her hard work over the years. Rockland and Westchester County Chapters are initiating new salons. Staten Island has had excellent groups meeting well before the drive to establish salons began.

Anyone wishing to join or begin a salon is invited to call your chapter COP chairperson, your chapter president or me at (212) 255-9358. Join us.

Metropolitan Chapter:
Joanne Horwitz, (212) 477-0047,
3 psychoanalytic peer groups are in place. One more, to meet in the evening, is forming. They include these groups:
1. Tuesday morning, now closed.
2. Wednesday morning, contact Rhoda Ritter, (212) 427-4942.
3. Friday morning, contact Joanne Horwitz, (212) 477-0047.
4. Evening, being formed,contact Joanne Horwitz, (212) 477-0047.

Groups open to all are:
5. Saturday a.m., monthly, contact Bonnie Cohen, (718) 601-7630.
6. Tuesday evenings, contact Linda Marx, (212) 772-6491.
7. Study group meeting every other Friday; Audrey Ashendorf, (212) 677-2132.
8. Salon, third Sunday of each month, contact Lisa Miller, (212) 496-9716.
9. New graduates will meet Mon., Tues.or Wed. evening, contact Joanne Horwitz, (212) 477-0047.

Nassau County Chapter
Stephanie Zemon, (516) 625-3927, reports current groups include:
1. Child therapy, about 15 members.
2. Family therapy, 12 to 15 members.
3. Group therapy, seeking members.
4. Three psychodynamic groups.
5. New practitioners group, run by Estelle Rauch.

Also, peer study groups may be formed soon.

Rockland County Chapter
Janet Droga, (914) 638-1412, would like to hear from those interested in forming a group.

Westchester County Chapter
Susan Freydberg, (914) 253-8144, would like to start a psychoanalytic group.■

Mentorship Program

The Mentorship Program now has 12 mentorship groups operating across the state, with five in the Metropolitan Chapter alone (the chapter that originated the program). Chapter programs welcome new members. Additionally, some chapters can provide individual mentors. Should you wish more information or to become a member of a group, please contact one of the people listed here:

Brooklyn, Marie McDermott, 718-788-5005
Metropolitan, Barbara Bryan, 212-864-5663
Nassau, Irene Schulman, 516-674-4954
Westchester, Elvira Franco, 914-948-7519
Suffolk, Terry Greenberg, 516-736-1173
Syracuse, Linda Greytak, 315-637-3747

Our experience with the program is that it is rewarding for all involved — group member, mentor leader and the chapters themselves. Those chapters not currently providing mentorhip programs are encouraged to do so.

Call for materials and information about starting a program: Barbara Bryan, CSW, BCD, State Director, Mentorship Program, 212-864-5663 email: BBryan2@AOL.Com.

Correction:

HARUKO BROWN
A FOND REMEMBRANCE

by Mitzi Mirkin

The article in honor of Haruko Brown in the Fall 1996 issue ran with omissions in the last paragraph. We apologize and reprint it here.

What a healing process it must have been for Haruko's son Stephen, her daughter Leslie, her grandchildren and her brothers to hear it confirmed again and again that the life of Haruko Kuroiwa Brown had counted for so much to so many. This person who was passionately engaged with her family and her many public commitments was also the adventurous white water rafter, the balletomane and music lover, as well as the woman who marched on Gay Pride Day to a cue from her social conscience and in support of a group about which she cared deeply (the Asian and Pacific Islander Coalition on HIV/AIDS--APICHA).

A few weeks ago, a member of that group phoned the Society office to confirm some facts for an article he was writing about Haruko. "I was really missing Haruko today," he said to me. I understood so well what he was feeling because we are really missing her too.■

JOINT CONFERENCE REPORT

The Difficult Patient

Presented by Maryellen Noonan, Ph.D.

Reviewed by Allison Gold CSW, candidate in training at NIP

Just as Anna Freud (1954) stated that "no two analysts would ever give precisely the same interpretations," it is also plausible that no two therapists would ever consider the same patient difficult in precisely the same way. This idea is the basis of a research article written and presented by Dr. Maryellen Noonan. Her research posed the question "on what basis do therapists make the determination that a patient is difficult to work with?"

Dr. Noonan's study incorporated the responses of 12 psychoanalytically-oriented clinicians with an equal number having an allegiance to a specific theoretical model. Regardless of orientation, Dr. Noonan identified that it was the patient's "inability to work psychoanalytically that was the defining characteristic of the difficult patient." This type of patient provides the therapist with a "compromised sense of professional identity." Dr. Noonan pointed out that as contemporary analytic thinking has shifted the analytic process away from the one-person model and intra-psychic conflicts to the interplay between the therapist and the patient, or the "dual person interactional model," the patient's difficulty becoming engaged in the analytic process leaves room open for the therapist to feel ineffective, incompetent and deprived of professional gratification and identity.

Conference Committee Members & speakers: (L. to r.) Co-Chair George Frank, DSW, Member Eda Goldstein, DSW; speakers Maryellen Noonan, Ph.D.& Joyce Edward, MSW BCD; Co-Chair Diannne Heller Kaminsky, MSW BCD and member Helen Krackow,CSW BCD. Members not shown: Rose Marie Perez Foster, Ph.D., Patricia Morgan Landy, MSW BCD, Richard Leonard, BA & Carol Tosone, PhD.

Taking the above into consideration, Dr. Noonan was further able to delineate that patients who manifested a "desymbolized transference" or lack of transference, resulted in their being classified as being difficult to work with. Most all clinicians agree that the transference represents a bonding between the therapist and patient. Whether the feelings associated with this bond are positive or negative is of less importance than the fact that there is any kind of a connection at all. The therapists in this study made it clear that patients who are almost unaware of their existence or related to them as an inanimate object felt as though they were lacking a specific analytic tool that would help them to effect change in the patient. This type of behavior from patients also encouraged feelings of isolation and a denial of professional validation, which in turn promoted therapists to designate this type of patient difficult. One respondent commented that if her patient showed even a hostile transference, she would have felt at least a small part of the patient's world.

It is interesting to point out that Dr. Noonan's study found that although certain diagnostic categories have been associated with the term difficult (borderline or aggressive, acting out behaviors), no specific one resulted as being definitively difficult to treat. Again, patients were only seen as difficult in the context of the interaction between the patient and therapist. With this idea firmly rooted, the notion of the therapist's own tolerance emerged, such as in the ability and capacity to deal with the patient's character and behaviors. Just as the patient brings his/her life into the relationship, so does the therapist. The degree of tolerance hinges on several factors, including personal preferences, personality characteristics and life experiences including current circumstances. One's own identification with a particular issue can enhance the treatment or hinder it, rendering the patient difficult to treat, sometimes leading to termination. If there is a "lack of fit" between the two participants and a therapist cannot find any quality that is redeeming, the therapist must rely on his/her theoretical knowledge more heavily in order to change "potentially harmful counter-reactions." In addition, Dr. Noonan commented on how most likely a therapist's choice of orientation is a reflection of what (s)he is connected to emotionally and intellectually. However, relying too heavily on theory is still not enough to help support a therapist when working with a difficult patient.

It is difficult to identify and discuss the abundant information Dr. Noonan presented in this precis. Her well-presented findings generated much enthusiasm among the conference participants. Overall, Dr. Noonan's research stressed a very important point — it is imperative that therapists try to consider seriously the needs of the patient and weigh them against their own tolerance and comfort level when accepting new patients. If this is carried out honestly and diligently, a productive course of treatment can begin. ■

JOINT CONFERENCE REPORT

Trials and Tribulations of the Therapeutic Dyad

by
Eda Goldstein, DSW

Reviewed by Josephine Ferraro, MSW, a candidate in the adult psychoanalytic training program at the Postgraduate Center for Mental Health.

Dr. Eda G. Goldstein delivered an evocative keynote presentation after Dr. Noonan and incorporated the ideas delineated in Dr. Noonan's paper. Dr. Goldstein's paper was entitled "Trials and Tribulations of the Therapeutic Dyad." It focused on the use of contemporary psychodynamic theories in dealing with obstacles in treating so-called "difficult clients."

"In the days before managed care," Dr. Goldstein began her talk, "a time I now refer to as BMC, I came across a cartoon in the *New Yorker* magazine that pictured a man lying on a couch next to a bearded older man sitting in a chair, who was saying, 'The truth is, Mr. Jones, you don't have an inferiority complex. You really are inferior.' In addition to capturing the impulse that some of us may have on a particularly hard day, this cartoon embodies a crucial perspective that has dominated psychoanalytically-oriented psychotherapy until recently, namely, that the therapist is an objective observer of the patient's personality and is more able to see the truth about the patient than is the patient himself or herself. Further, this view assumes that it is possible for the therapist to refrain from influencing how the patient behaves in treatment if the therapist remains neutral, abstinent, and anonymous and in control of his or her countertransference." The patient's role was to "cooperate with the rules of the treatment and change in accordance with the therapist's view of reality."

Who are these "difficult clients"? Traditionally, according to Dr. Goldstein, "They are described as lacking in insight and observing ego; unable to relate emotionally and to form meaningful connections with the therapist; unempathetic with and/or contemptuous of others; non-self-reflective and living in the immediacy of their experience; hypersensitive to criticism; easily rejected; impulse-ridden, chaotic, and crisis-prone; resistant to interpretation; attached to pain, suffering, self-destructive behavior..." and so on.

Contemporary techniques recognize that the traditional reliance on neutrality, abstinence and anonymity is not appropriate with many of today's clients. Furthermore, Dr. Goldstein indicated, "relying on interpretative techniques overemphasizes the importance of insight in achieving therapeutic change" and "may be experienced as assaultive, going beyond what patients are able to assimilate, or not helping clients with deficits." Rather than help clients, these techniques "repeat some of the negative or non-responsive conditions of their childhoods." Consequently, to establish a meaningful bond with these patients, therapists must become more involved in a genuine and responsive manner.

Current theories recognize the importance of "the experiential aspects of the treatment process." For instance, ego psychologists such as Greenson, and Gertrude and Rubin Blanck stress the selective use of the "real relationship" and "measured gratifications" in treating patients with less structured egos and "the potential of the therapeutic relationship for selectively replicating the growth-enhancing aspects of the parent-child relationship." Similarly, British object relations theorists, such as Winnicott and Guntrip, stressed the therapeutic "holding environment," containment techniques and the reparative aspects of the therapeutic relationship. In addition, Kohut emphasized the therapist's use of self in treatment. Dr. Goldstein also discussed the importance of using theories that take into consideration the client's "total biopsychosocial situation."

Current theories have also expanded the traditional view of transference and countertransference to encompass the recognition of "residues of separation-individuation phases," the "oscillating closeness and distancing patterns of borderline patients," the patient's "early frustrations in the mirroring, idealization and twinship needs," and the therapist's role in containing "the turbulent nature of the patient's inner life."

Dr. Goldstein described the couple as "reflecting a borderline and narcissistic pairing." Having reached an impasse . . . Dr. Goldstein considered the role of her own background, personality, theoretical bent and expectations.

Judy and Phil

To illustrate her use of contemporary techniques in overcoming treatment obstacles, Dr. Goldstein shared a case from her practice which she called "the case of double trouble." She described the couple, Judy and Phil, as "reflecting a borderline and narcissistic pairing." Having reached an impasse and challenged by the obstacles this couple presented, Dr. Goldstein considered the role of her own background, personality, theoretical bent and expectations. By examining her own response to the couple's intensely volatile and aggressive manner of relating to one another, Dr. Goldstein was able to modify her interventions and help the couple through the impasse.

In concluding her talk, Dr. Goldstein inspired the audience with her closing remarks, "There is strength in this auditorium. The importance of maintaining a strong and vital profession requires that whatever our individual pursuits, we remain identified as clinical social workers, as part of a profession in which we take pride that has devoted itself through good times and bad to ameliorating human suffering and improving the quality of life."■

JOINT CONFERENCE REPORT

Discussion: Papers by Drs. Noonan and Goldstein

by Joyce Edward, MSW, BCD

Reviewed by Richard Beck, CSW, who is in private practice with a specialty in trauma and sexual abuse survivors; and is on the faculty of the Training Institute for Mental Health, Long Island Institute for Mental Health and the Postgraduate Center for Mental Health

Joyce Edward, CSW, BCD, presented an eloquent review of Drs. Goldstein and Noonan's presentations, an example of the level of clinical excellence and reflective thoughtfulness with which Ms. Edward enhances our profession.

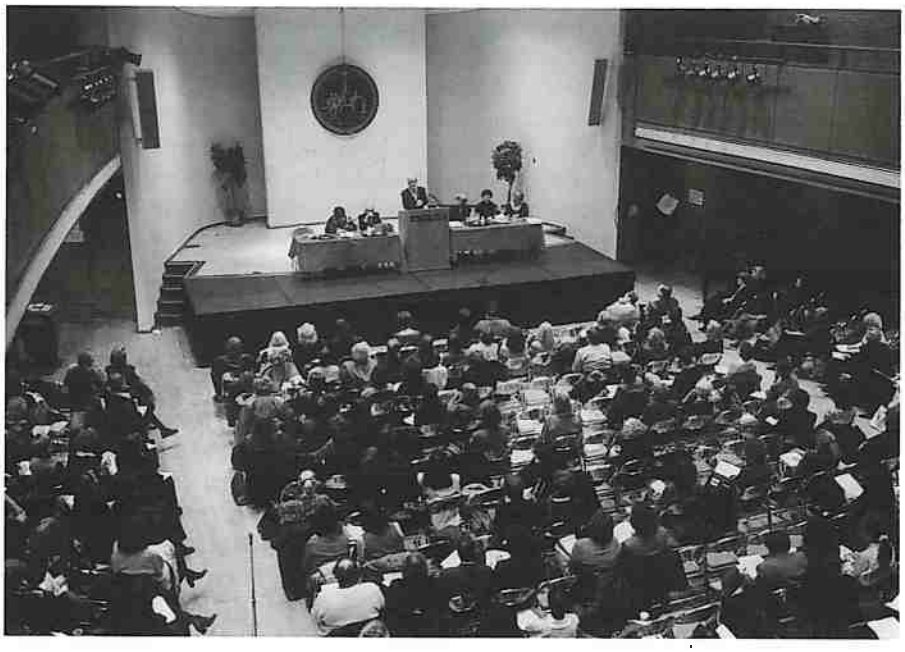
Social workers have historically been the providers of mental health services for patients we now characterize as the "difficult to treat." They previously were referred to as the "hard to reach" patients, according to Ms. Edward, and the subtle distinction between the two patient characterizations is an important one. Ms. Edward prefers the term "difficult to reach," in reflecting that "something is required of the one who strives to connect with them." In that regard, "both Drs. Noonan and Goldstein's presentations attest to this need on our parts to stretch and extend our theories, our capacities, our tolerance, our ability to fit together with another, indeed our very selves, if we are to reach certain clients."

Ms. Edward highlighted the degree to which psychodynamic and psychoanalytically oriented clinical social workers are superbly qualified for the provision of psychotherapy. Our social work training and broad knowledge base — and the value we give to the "unique needs of each individual, to meet each person where he or she is and to appreciate self determination as both a means and a goal of the treatment ('a person /situation perspective') — combined with our 'intrapsychic perspective'" — these are the "unique clinical social work qualifications." Finally, Ms. Edward states, our history of serving as advocates for our clients enables us to help people from both "the inside and the outside."

Ms. Edward described the major problems that difficult to reach patients pose for us. They include their "threat to our basic sense of efficacy, the sense of power each of us requires in order to sustain us, and the fact that these patients deprive us of a needed sense of affirmation and acknowledgement. In addition to the sense of isolation and estrangement we feel when working with difficult patients, Ms. Edward described our professional sense of estrangement considering the current attitude towards psychoanalysis as a treatment modality, and also, the toll that managed care has taken, converting therapists into "providers of services."

In addition, the advances made in theory and technique "are not without cost to us," Ms. Edward said. "No longer can we maintain the degree of conviction about what the patient requires and what the therapist knows and should do that our forbearers had when Freud was their primary guide," Ms. Edward contended.

Ms. Edward concluded with a thought provoking comment: "Our struggle to find a way to reach those clients who seem to be unreachable, our persistence and dedication to the effort, are likely to constitute in themselves one of the major contributions we make to the patients with whom we are concerned today."■



JOINT CONFERENCE AWARD

Schizophrenia and Psychotherapy: Harold Searles Revisited

by Helle Thorning, CSW

Excerpted from a final assignment submitted to NYU's Ehrenkranz School of Social Work Ph.D. Program.

While we explore new avenues for more effective medical treatments for schizophrenia, we are obligated also to focus on the subjective meanings of schizophrenia, and to enhance the quality of life for those for whom this illness has such devastating impact.

Schizophrenia is best described as a traumatic assault on the sense of self. One is struck by the strength that affected people summon every day to deal with the terrifying symptoms of this catastrophic illness, including pervasive apathy, hallucinations and delusions. Thought processes, perceptions, the ability to function in relationships — all may be profoundly disrupted. Psychoses, including schizophrenia, have often be compared to having a nightmare from which you can not wake up.

Schizophrenia is characterized as a heterogeneous illness with multiple etiologies. The neurobiological roots of the illness are better understood today than they were in the past and the search for biological treatments, with the emphasis on rehabilitation, predominates current thinking. It is thought that psychological symptoms presented in the adult patient are likely caused by biological abnormalities, and therefore they cannot be considered manifestations of, for example, regression, defenses or psychological deficits.

Indeed, the therapist working with clients with the illness is confronted with primary process thinking, the expression of infantile impulses and the loss of ego boundaries, which can be extremely frightening and disturbing, not only for the affected person but also for the therapist. Often the distorted reality presented in sessions is directed at the therapist and can evoke feelings of raw aggression and rage.

Yet, it was Harold Searles' belief that the therapist's role in the treatment of schizophrenia is pivotal if the affected person is to adapt to life with the illness. During his more than 20 years of work with patients hospitalized at the Chestnut Lodge Sanitarium, Searles (probably the most widely read and respected authority on psychotherapy with persons suffering from schizophrenia) explored the complicated dynamics of therapy with schizophrenic patients and generated important insights into the experience of the illness from the individual's subjective realm.

Searles' theory was grounded in the developmental perspective, which places the root of the psychotic and neurotic disturbance in the earliest years of life. He believed that schizophrenia exists on a continuum from wellness to neurosis to psychosis. His clinical interventions are compelling to read because he examined the private worlds of his patients with an uncanny ability to grasp the meanings of their psychotic productions.

His hypothesis was that a deep level of therapeutic interaction was vital to the therapist's effectiveness with schizophrenic patients. To achieve it, the therapist was to search for "the human essence in him[self] which is struggling against the psychopathology which besets his humanness." During the course of treatment, the therapist's own more primitive experiences and interpersonal relatedness issues that have not been resolved were likely to be revived. Only if the therapist has access to his/her capacity for primitive feelings of jealousy, fear, rage, symbiotic dependency and other affective states, could these feelings be elicited from the person with the illness and brought to awareness.

Searles believed that through the interactional process, with significant contributions by both the patient and the therapist, "even the most 'crazy' manifestations of schizophrenia reveal meaning and reality-relatedness, not only as a transference-reaction to the therapist, but beyond this, as a delusional identification with real aspects of the therapist's own personality."

Susan - A vignette

In my own practice, I developed a relationship with Susan, a 37-year-old woman who has suffered from schizophrenia since age 20. She has had a deteriorating course of illness since her first psychotic break, and

Continued on page 10

Above: Helen Krackow, Society President, (l.) presented the award for scholarship to Helle Thorning, for her paper. The complete paper and bibliography can be obtained from the author.

Helle Thorning, CSW, is the Director of Social Work at New York State Psychiatric Institute; Assistant Clinical Professor of Psychiatric Social Work, Columbia University; Doctorial candidate, NYU Ehrenkranz School of Social Work; and maintains a private practice in New York City.

Vendorship / Managed Care

By John Chiaramonte, CSW, BCD, Chair

COMMITTEE REPORT

We continue to identify, through our membership, non-reimbursers of clinical social work. These are usually either self-insured plans or benefit plans written in states without a vendorship law (requiring reimbursement for clinical social work). Our efforts on behalf of membership are twofold: we work to get an exception made on behalf of the member, and then we work to alter policy by forwarding the information to our national marketing consultant He, in turn, educates the company or plan as to the benefits of including clinical social workers as reimbursable providers.

Recently we have succeeded in altering the plans of three New York- based companies which will now include clinical social workers (CSWs) for independent reimbursement, they are: Electronics Data (138,000 insureds), Local 239 (7,000 ins.), and Spectrum for Living (565 ins.). Past successes include: Merrill Lynch, AT&T, UPS, American Cyanamid, Sony and GE, to name a few. We currently are marketing to the following companies: Arrow Electronics, Barnes and Nobel, Caldor, Hertz, IBM (non-mc contract), Iron Workers of America, Joint International Board of Electrical Workers, Mercedes Benz, Nassau Carpenters Union, PepsiCo, Sun Chemical, TGI Fridays, Unisys, Mark Hotels Inc. and Home Depot Inc.

DENIED REIMBURSEMENT?

Or, do you want to improve press coverage of Social Work Issues?

Call Your Chapter's Vendorship/ Marketing Point Person

Brooklyn	Adrienne Lampert	(718) 434-0562
Capital Dis.	John Chiaramonte	(212) 535-3839
Met	Sharon Kern-Taub	(718) 884-3355
Mid-Hudson	Marilyn Stevens	(914) 462-4178
Nassau	Fred Frankel	(516) 935-4930
Queens	Shirley Sillekens	(718) 527-7742
Rockland	Lenore Green	(914) 358-2546
Staten Island	Rudy Kvenvik	(718) 720-4695
Suffolk	Eleanor Perlman	(516) 368-9221
Syracuse	Bill Licurse	(315) 446-5175
Westchester	Anne Gordon	(914) 235-5244
Western NYS	Laura Salwen	(716) 838-2440

Managed Care Complaints

The complaints received are consistently around the impact of managed care upon patient care and upon maintaining a practice. The committee has gone to bat for several members in advocating for quality patient care. Many MCOs (managed care organizations) deny ongoing care *carte blanche* as a matter of course (long term course, that is). The more a patient needs ongoing care, the more the MCO seems to request that the treatment be curtailed. The catch-all phase, "not medically necessary," is often used whenever treatment goes beyond a certain period of time. Often MCOs will begin by requesting the clinician to reduce the frequency of contact; once that occurs, termination requests are usually not far behind.

Our success in making MCOs responsible for their decisions is based upon a clinician's willingness to take a stand and the patient's ability to confront the insurance company. We are finding that the louder a patient complains, the more likely the MCO will revisit its decision to curtail treatment. Our efforts have been given additional strength by the new NYS law (S.7553) which states, "No contract or agreement between a health care plan and a health care provider shall contain any clause purporting to transfer to the health care provider... any liability relating to activities, actions or omissions of the health care plan as opposed to those of the health care provider." This new law places liability for MCO decisions upon the MCO and gives patients grounds for a liability suit against the MCO.

The new law also raises some interesting questions with regard to many MCO contracts which have some provisions that seem to run counter to the law. However, MCOs always give themselves an out by stating in their contract, "If any provision of this Agreement is held or ruled to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force."

Make sure you know the law so that you can decipher which provisions of MCO contracts are illegal and unenforceable. To get a copy of the law, please call: 1(800) 342-9860 and ask for a copy of S7553.

Are We Part of the Problem?

According to a recent Psychotherapy Finances national survey, the mean non-managed care fee for clinical social work services is $80 per session and the mean managed care fee is $60 per session. Complaints have been flooding in regarding the lowering of fees to clinicians. The Federation has requested a meeting with Merit BC, due to their fee lowerings in the NY area. However, we are not hopeful that our protests will fall upon fertile ground. It seems that clinicians are partly to blame.

As one managed care administrator told me, "as long as we can get clinicians to work for less money, we will continue to lower the floor to see how far down we can go." In California, clinicians are working for $25 a session. In New York, we have an opportunity to reverse this trend.

As of April 1997, MCOs must have a certain ratio of clinicians to enrollees. Several companies are scurrying to increase their panels in order to comply. We don't have to help them. Unfortunately, some clinicians feel boxed into having to accept whatever managed care offers. They rely heavily upon managed care for the bulk of their practice. According to Vickie Taylor, the chair of the Federation Health Care Systems Committee, "the safest policy is to make sure you have a balanced practice mix, setting a certain percentage for managed care and the rest from other payment sources. If you choose to participate in the contract, set a goal for a certain percentage of new patients that you will accept at a discount rate, making sure your income is balanced with normal and low fees. It is also important to market your practice in traditional ways to gain referrals."

Accepting fees which are lower than the mean managed care fee may only serve to further reduce your income in the future. Each

Continued on facing page

From facing page

clinician needs to set a fee below which he/she will not accept. (Remember those MCOs that cannot enlist an adequate panel will likely take steps to entice providers to join).

Clinicians Fighting Back

Some clinicians are forming PPOs in order to compete with MCOs for company contracts. Some are looking into the possibility of forming a national union of mental health professionals (much like the podiatrists have done). Others are looking into legal solutions. Our committee also understands that anti-trust violations by MCOs have been handed over to the Justice Dept for review and action.

Many clinicians in the Mid Hudson and Rockland Chapters have contacted us and are complaining loudly to their legislators and the Department of Health about certain MCO practices such as fees lowered to $30 per session, charges of up to $600 just to gain entry to the panel and case rates of $165 per treatment course. It is important not to keep secrets when you suspect that either unethical or illegal practices are occurring. The new managed care regulation law protects those providers from sanctions who make complaints against managed care companies to the appropriate governmental agencies and to legislators.

Finally,one must question whether case rates are a direct violation of our code of ethics and as such should be termed an unethical arrangement for clinical social workers. Our code of ethics states clearly under the "responsibility to client" section, clinical social workers inform clients of the extent and nature of services available to them as well as the limits, rights, opportunities, and obligations associated with service which might affect the client's decision to enter into or continue the relationship", and "the clinical social worker terminates service to clients, and professional relationships with them, when such service and relationships are no longer required or no longer serve the client's best interests".■

REVISED MEDICARE
CLINICAL SOCIAL WORKERS FEE SCHEDULE
EFFECTIVE JANUARY 1, 1997
NEW CODES FOR 1997

CODE	DESCRIPTION	LOCALITIES		
		1	2	3
G0071AJ	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	42.33	40.80	37.28
G0073AJ	Approximately 45 to 50 minutes	65.87	63.51	58.01
G0075AJ	Approximately 75 to 80 minutes	112.46	108.23	98.40
90801AJ	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other medical or diagnostic studies; in certain circumstances other informants will be seen in lieu of the patient.)	98.01	94.63	87.06
90846AJ	Family medical psychotherapy (without patient present)	71.18	68.51	62.55
90847AJ	Family medical psychotherapy (conjoint psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated)	79.48	76.70	70.40
90853AJ	Group medical psychotherapy (other than of a multiple family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated	25.19	24.16	21.95

LOCALITIES:
1) MANHATTAN; **2)** BROOKLYN, BRONX, WESTCHESTER, RICHMOND, ROCKLAND, NASSAU, AND SUFFOLK COUNTIES; **3)** PUTNAM, SULLIVAN, ORANGE, DUTCHESS, ULSTER, COLUMBIA, DELAWARE AND GREENE COUNTIES.

PLEASE NOTE: "Interactive" codes have been left out of this schedule as they do not apply to verbal psychotherapies. For further explanation of codes and fees call Mary Cooper of HCFA (Health Care Financing Administration) Coding Section at: (410) 787-5302.

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Consumers and Consumer Advocates
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Note: Any call that is deemed to be about an immediate *life and death situation* will be referred to the medical director of D.O.H's Office of Managed Care.

To order this NFSCSW brochure in bulk ($15 per 100) to educate consumers about different benefit structures,call Lenore Green, Rockland Vendorship Chair, (914) 358-2546.

Schizophrenia and Psychotherapy

From page 7

she has been spending more and more time in hospitals. Despite attempts with many medical and rehabilitative treatments, her psychotic thinking has never cleared. A persistent delusional system often interferes with her interpersonal relationships. She is tormented by persecutory voices and paranoid ideation. Clozapin, an atypical neuroleptic medication, has helped calm her moods and thoughts, although they have not resolved the persistent psychosis. However, she is able to venture out of the hospital and is now able to consider the possibility of a reality closer to the reality of the people around her.

Susan: (smiling, seems content) I know Peter is coming tonight to get me. He is just wonderful; he helped turned off all the buttons that were bothering me. You know the bugs. I am now feeling safe again. He makes sure that they are no longer able to hear what I am doing. It is always in the radios. Yesterday with S.(another patient) screaming, I felt that they were listening to me again. They are always telling me like this "Susan you are a bitch, Susan you are no good, a whore."

"Peter" means for her the striving towards normalcy... The therapist allowed for an understanding of the delusions as having unique meanings for Susan.

Therapist: It is frightening to hear this.

Susan : Yeah, I know that people don't always believe me when I am telling them about the radios. But I know that they are there. They were put in my apartment. They also came to the hospital to put them in. For a long time I couldn't sleep. They told me that I couldn't eat and that I couldn't wash my hands. I was painting at the time; the radios told me that I shouldn't wear my shoes. Peter came and slept with me. He was a D.J., you know, in the roller skating rink. Then, when I was in Paris, and someone hit me over the head, he saw me lying on the ground. He just happened to be there, he was with the woman he married. But at the American Hospital he told me that he really wanted to be with me. He has a son now. He is 12 - 9 - 7 years old [she hesitates as she attempts to give me the age of this child]. He just wants me to be there for him, tells me that I am a good mother: "Susan come home to me," [her voice changes to that of a young child]. He is such a smart kid. Each day he reads the dictionary book and studies each page. You know a half page of the D's [letter]. [She blinks and looks away]...I can't tell you this.

Therapist: What can't you tell me?

Susan: I'm still frightened going outside.....worried about them coming after me. But now that Peter has taken care of the buttons here, I feel better. The secret police will take care of it for us. He is really a good kid. Now that Dominique, Peter's real name is Dominique...Sicilian...you know how they are...(smiling, a bit flirtatious), he is helping me with the radios. He used to be in the secret police, he has friends there. When I leave the hospital, they will look out for us. I guess he pays them some money so that they will not bother us. I think that if he doesn't show up tonight, I probably will go to the residence we talked about. Peter will make sure that the radios are all right and won't bother me. But when he comes tonight, will you come and meet with us to go over the details of my discharge? I will want to leave with him right away.

Therapist: I know that you have two plans for what you want to do, but you know I am better at working on the plan for you to go to the residence, although I understand that you also have the plan with Peter on your mind.

Susan: I know, I am afraid of going to the appointment. What if I am as afraid there as I was here before Peter helped?

Discussion

Despite her slowly deteriorating course of illness, with a fixed paranoid delusional system "untouched" by psychotropic medications and rehabilitation treatment, she is now able to engage in a discharge planning process while maintaining her delusion about "Peter". This delusion has "helped her" to combat her fear of the radios and the outside - "Peter" has become her protector.

As Searles pointed out, the individual with paranoia as the dominant mode of experiencing the outer world initially is unwavering about everything, never doubting anything. Eventually, with treatment, the person with the illness comes to believe that earlier beliefs are, as Searles stated, a "hogde-podge of the parroted." Susan's delusions are fixed, when confronted with the "truth" she becomes threatening and verbally assaultive. Susan lives chronically under the threat of persecutory figures (and radios) experienced as part of the outer world. The fragmentation of her experience is evident in the loss of ego-boundaries. The outer world and the inner world are mixed up, the loss of distinction between the present and the past, such as the persons in the present surroundings being misidentified as being persons from the past. Vivid memories from the past are experienced as being perceptions of the here-and-now.

From the beginning of her illness, she expressed paranoid ideas. As described above, radios became the main source of distress. The radios would tell her what to do, influencing her behavior and how she was to think. Searles acknowledged the concept of the *influencing machine* as introduced by Tausk in 1919 in his paper "On the Origin of the Influencing Machine." He understood this to be a loss of ego-boundaries. This complicated influencing machine, was understood as a projection of the ill person's body and as such served as externalized ego-functions. Hence for Susan, the radio is a metaphor for the most basic threat, namely, that she will "cease to exist as a human individual."

In many ways "Peter," too, becomes another form of an influencing machine. Through him she is able to establish in

Continued on Page 11

Resistance to Marketing

By Sheila Peck, LCSW

As proprietors of small businesses — and yes, those of us in private practice are indeed such proprietors — many clinicians set aside a minimum of time for marketing. Part of the reason for this is that many of us have no idea how to begin. Social work education teaches us a great deal concerning clinical matters but not much about how to publicize our services or educate the public about what we, as clinical social workers, offer.

Many of us think about marketing as if it's "manipulation." Effective promotion actually *educates* potential clients and referral sources about how we can help. We may look at the need to market as an admission of failure. In fact, it indicates that we are proud of our work and confident that what we are offering is valuable and helpful.

Private practice can feel lonely and can engender a sense of isolation and powerlessness, particularly with the encroachment of managed care into the clinical social work profession. One way to overcome this is to empower yourself by taking effective action. This means getting actively involved with marketing.

There are so many different ways to market that you can find one that fits your own talents. If you are uncomfortable at public speaking, you may be good at writing, for instance. Why not hook up with a colleague who is an effective speaker — you do the writing and s/he does the speaking? You can do this even if you don't professionally work together.

Another effective technique is to get together with a few colleagues and form a monthly marketing support group. You can give each other assignments and go over each other's plans. If you have a peer supervision group, you might incorporate a half-hour or an hour of marketing into each meeting — or set aside an entire meeting, once in a while, to deal with this challenge.

Many clinicians have found it helpful to develop a formal marketing plan. This takes some time to do, but going through the process can help you to find a direction and develop a realistic road map for expanding your practice. In essence, you'll find a starting point and an effective way of traveling down the marketing path. Such a plan will help you check how well your practice is doing and whether you are missing any significant trends. If you shudder at the idea, keep in mind that effective marketing is a win/win situation for both client and clinician. You are letting people know about a service that they can use and you are developing a client load, which will allow you to be the effective psychotherapist you have worked so hard to become.

Because we are not trained in business methods and are often taught in school that our job is to help others, not necessarily ourselves, we may be passive when it comes to practice promotion. Some of us may even experience anxiety or depression when we think about working to build our practices. Developing an effective marketing plan will give you a goal and a way of achieving it, thus helping you mobilize your resources so that you can act in a positive way.

For a copy of a marketing plan that's been developed particularly for clinicians, send a stamped, self-addressed envelope: Sheila Peck, L.C.S.W., 1010 California Place South, Island Park, New York 11558.

Schizophrenia and Psychotherapy, continued

fantasy a normal life scenario. She is able to discuss her wishes, getting married, having children, buying a house, having sex, etc. "Peter" enters into the relationship with her parents as well, as he comments on their behavior in the most loathsome of languages. Her delusional ideas also involve the fact that Peter earns more money than her parents do, and he is ready to buy them (the parents) out. Thus, her own angry, competitive and murderous feelings towards her parents are allowed a safe form of expression.

From another viewpoint, Susan's wish for "normality" has become symbolized in "Peter", a one time acquaintance. Although "Peter" is not a metaphor per se, "Peter" means for her the striving towards normalcy. We can speculate that with her illness, this metaphor has become "desymbolized," and Susan is reacting as if Peter literally exists. Searles proposes that without firm ego-boundaries, a differentiation between concrete and metaphorical thinking cannot take place. During the course of treatment, the therapist allowed for an understanding of the delusions as having unique meanings for Susan. This again made way for an exploration of alternative explanations and choices.

Susan clearly is moving towards a more integrated functioning. Searles would probably question whether Susan's ability to transition to a community residence is only seemingly a choice of sanity. From Searles' point of analysis, Susan may "only" be able to repress her psychosis. When it is subjected to repression, rather than confronted in all of its dimensions and ugliness, the resolution of the psychosis is merely superficial.

Conclusion

At this time the search for biological treatment with the emphasis on rehabilitation predominates. While we explore new avenues for more effective medical treatments, we are obligated also to focus our work on understanding the subjective meanings of schizophrenia, and enhancing the quality of life for whom this illness has such devastating impact. To this end, we need to search for ways to understand the meaning of the symptoms of schizophrenia, the content, and the experience of affect that they represent.

Furthermore, the origin of the alteration of the self experience influenced by a biological disease process needs further exploration. A dialectical perspective, juxtaposing the psychoanalytic concept of regression and the notion of the neurobiological disease process evidenced in the brain, may lead to new ways of asking questions. Given the fact that schizophrenia is seen as a neurobiological disorder affecting the functions of the ego, a person's sense of self and his/her relationship with others, future research in schizophrenia must be able to address both neurobiological and psychological aspect of this disorder.■

LICENSING IN 1997?

FROM PAGE 1

law would mandate they practice only in agencies under LSW supervision. In endorsing this bill, the Clinical Society made a major concession; in the interests of uniting the profession, we gave up our preference for a multi-level bill which would include a scope of practice for the clinical social work level of the profession. This was a difficult compromise, to which the Legislative Committee and Executive Board agreed with very mixed feelings, but it was done in the spirit of building a collective endorsement for licensing.

We opposed BSW practice outside of agencies and without MSW supervision. We endorsed licensing BSWs only with a well-defined and limited scope of practice.

Over the summer of 1996, the New York State Social Work Education Association (NYSSWEA), representing the educators of BSWs, pressed to be included as a third tier in the bill. The discussion in the coalition gradually shifted from "whether" the BSW entry level should be included to "how" it would be included in the form of several amendments to the once-agreed-upon S.4979/A.5989.

On September 21, 1996, our Board voted on guidelines for licensing the BSW level. We opposed BSW practice outside of agencies and BSW practice without MSW supervision. We endorsed licensing BSWs only with the prerequisite that there be a well-defined and limited scope of practice for BSWs as befits the entry level.

However, in the final coalition meeting, the BSW leadership continued to insist on two particular items which, in our reading, blur the boundaries between BSW and MSW practice, dissolving the differences in education between the two levels and, for all intents and purposes, defining the BSW as a terminal degree in social work. First, they wished to use the title **Licensed** Baccalaureate Social Worker, rather than **Certified** Baccalaureate Social Worker. Second, although they agreed that practice would be limited to agencies, they wanted the type and duration of supervision by a Licensed Social Worker to be determined by the (Department of Education) Commissioner rather than by the licensing statute. In effect this would create a loophole in the supervision requirement and provide that, at the discretion of the State Board for Social Work and after meeting criteria to be determined, BSWs may one day be employed without MSW level supervision.

At the final coalition meeting, no formal vote was taken on these two issues. The group seems to be split, four to two. The majority, which included the Clinical Society, the City Chapter of NASW, the Deans Association and the Social Work Administrators, favored perpetual supervision and the title "Certified BSW." The State Chapter of NASW and BSW leadership favored loophole supervision and "Licensed BSW." Both of these items were unacceptable to our Board.

Where do we go from here? It is imperative that we have a licensing bill for clinical social work in New York State and it is our reading that we need it immediately. Other mental health professions, including marraige and family therapists, are introducing their own licensing bills now. We will reconsider whether to introduce our original clinical social work licensing bill or one of the compromise bills which include the BSWs in some way and therefore may attract more intraprofessional support. The Legislative Committee and the Board will act promptly. In the meantime, you can help by sending your donations to the NYSSCSW-PAC to help us gain access to key legislators. The donation can be in any amount; usually donations range from $25 to $100 and above. Make the check out to NYSSCSW-PAC and mail it to Brian McDonald, Treasurer, 90 Gold Street, Apt. 12H, New York, New York 10038. It will be put to very good use.

Continued on page 13

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Managed Care Reform

S.7553, the managed care bill worked out by Governor Pataki, was quietly signed into law on October 9, 1996. This statute goes a long way in regulating consumer rights in HMOs and managed care organizations. Its provisions ban "gag" contracts and penalizing providers who advocate on behalf of their clients. It establishes a comprehensive set of standards for grievance procedures and utilization review and establishes due process protections for health care providers participating in an HMO network. It prohibits HMOs from contracting to transfer liability to a provider for the entity's own actions or omissions. However, it fails to mandate for an out-of-network benefit for individuals covered under group contracts and it fails to allow consumers to take their grievances outside the managed care organization to an independent, external agency. The Clinical 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. For more information, contact your chapter legislative and vendorship/managed care chairpersons. ■

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CALENDAR '97
Chapter & State Events*

Compiled By Diana List Cullen
Metropolitan Chapter President

*Subject to change. Please check for updated info.

Feb.-Mar.

2/28-3/1 Syracuse; Annual Meeting; Michelle Weiner-Davis, "Solution: "Focused Couples Therapy"

March

1 Westchester; Sat. — Speaker: Neil Skolnik/object relations
1 Mid-Hudson; Sun. — Board meeting
2 Queens; Sun.— Executive Board meeting
3 Syracuse; Mon. — Executive Board meeting
8 Staten Island; Sat. — Conference — TBA
9 Brooklyn; Sun. — Speaker: Adrienne Lampert, "What Money Means to You and Your Patient"
14 Mid-Hudson; Fri. —Social Work conference so-sponsored with NASW: John Chiaramonte & Sheila Peck, "How to Keep the Social Work Profession Alive..."
16 Suffolk; Sun. — Education program co-sponsored with local NASW: Dr. Elaine Siegel on countertransference
16 Nassau; Sun. — Board meeting
21 Suffolk; Fri. Evening — Board meeting
22 Nassau; Sat. — Education program: Carol Sussel, on object relations couples therapy

April

4 Mid-Hudson; Fri. — Board meeting
5 or 12 Westchester; Sat. — Speaker: Dr. Eda Goldstein, title TBA
6 Queens;Sun. — Speaker: Mary-Ellen Siegel, "A Writer's Workshop for Mental Health Professionals"
7 Syracuse; Mon. — Shawne Steiger & Arnold Hook, "Assessment, Early Treatment: Dissociative Identity Disorder"
11 Met; Fri. - 8:00-10:00 p.m. — Board meeting
13 Brooklyn; Sun. — Speaker: Helen Hinckley Krackow, "Mirrors of the Soul: Dehalucinated Unconscious Body Image"
20 Met; Sun. — Brunch, presentation. Speaker: Michael Adams, "Multicultural Imagination: Race,Color, the Unconscious"
20 Nassau; Sun. evening — Board meeting
20 Staten Island; Sun. — Board meeting, brunch Speaker, Stephen Baver, "Basic Clinical Concepts"
25 Rockland; Fri. — Education meeting: Harvey Siegel, CSW, "Group Therapy: The Therapeutic Value of Immediacy and Direct EmotionalCommunication"

May

? Nassau;End of year brunch party
3 Westchester; Saturday — Speaker: Faith Krasnow, "Schizoid Disorder of the Self"
3 Suffolk; Sat. — Education meeting: Susan Koschin on Bereavement
4 Brooklyn; Sun. — Season's end brunch, Linda Pizer's home; speaker TBA
4 Queens; Sun. — Executive Board meeting
4 Mid-Hudson; Sun. — Board meeting
5 Syracuse; Mon. —Executive Board meeting
9 Met; Fri.— Board meeting
16 Suffolk; Fri. evening — Board meeting
18 Nassau; Sun. evening — Board meeting

Saturday, May 17th — 28th Annual Conference

"Siblings: Impact on the Individual, the Family and Interpersonal Relationships;" Mount Sinai Hospital Conference Center. Presentations, workshops and a State Society-sponsored cocktail reception following the conference.

June

1 Staten Island; Sun. — Board meeting, brunch presentation. Speaker: Gail Grass, "Marketing Your Private Practice"
1 Queens; Sun. — End of Year General Membership Brunch
7 Westchester; Sat. — Speaker TBA,"Ethical Dilemmas in Clinical Social Work",
13 Met; Fri. — Board meeting

BOOK FAIR ALERT: Saturday, May 17, 1997
Mount Sinai Hospital Conference Center, Guggenheim Pavilion, Hatch Auditorium

The New York State Society for Clinical Social Work is holding a Book Fair at the upcoming clinical conference, "Siblings: Impact on the Individual, the Family and Interpersonal Relationships"

The Book Fair will feature an exhibit of published and soon-to-be published books by members of the Society.

If you are a member of the Society and interested in having your book on display, DO NOT DELAY.

Please call Diane Hersinger of Psych Editions at (800) 237-7924 to make arrangements.

SIBLINGS

Impact on the Individual, the Family and Interpersonal Relationships

The 28th Annual Conference of The New York State Society for Clinical Social Work
Saturday, May 17, 1997

9:00 a.m. to 5:00 p.m.
Mount Sinai Hospital
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KEYNOTES:

Joyce Edward, MSW, BCD, Distinguished Social Work Practitioner,
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