NEWSLETTER

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Confidentiality of HIV/AIDS Related Information

Specific Rules Govern Disclosure

By Hillel Bodek, MSW, CSW, BCD

Over the past decade, the problems and needs of individuals with HIV and those with AIDS have been of increasing concern to health and mental health providers. The sensitivity of such information has led to state legislation to provide special protection of confidentially of such information. *Public Health Law Article 27-F, Sections 2780 et. seq.*

Following is a brief summary of selected provisions of this statute that are particularly relevant to clinical social workers.

HIV Testing—The statute provides that, except in limited circumstances, persons may not be tested for HIV infection without their written informed consent obtained after an explanation of the test and its purpose, the testing procedures and that the test is voluntary, the confidentiality provisions relating to HIV information, infection and AIDS; after a review of information about discrimination problems affecting HIV-infected persons, legal remedies to address these problems; and about behavior known to pose risks for the transmission and contraction of HIV infection. Also, persons must be informed that they have the option of obtaining HIV testing at a site where they may be tested anonymously.

At the time of communicating HIV test results to the person tested, the health care provider who ordered the test must provide to such person counseling or a referral for counseling about how to cope with the emotional consequences of learning the test results if positive, discrimination problems from disclosure of such information, behavioral changes to prevent transmission or contraction of HIV infection, available medical treatments and the need for persons tested to notify their *contacts.*

Confidentiality—Further, no person who obtains *confidential HIV-related information* in the course of providing health, mental health or social services or pursuant to a consent for release of such information may disclose that information except to:

a) the *protected individual,* i.e., the person tested for HIV or diagnosed as having HIV or AIDS;

b) a person to whom disclosure is authorized pursuant to a consent for release of *confidential HIV related information* executed by the *protected individual;*

c) agents or employees of a health care facility if [such] persons are authorized to have access to the facility's medical records in the normal course of their work at the facility, the facility is authorized to obtain such information and the person is either providing treatment to the protected individual or maintains/processes medical records for billing or reimbursement [sic];

d) a health care provider or health facility when knowledge of [such] information

continued on page 6

NYS Society Leads Licensing Effort

Landmark Legislation Introduced

By Marsha Wineburgh, MSW, BCD
Legislative Chair

The legislative committee of the Society has introduced landmark legislation to license clinical social work, A.12280/ S.8872. When passed, New York will join with colleagues in neighboring New Jersey, Massachusetts, Maine and Delaware who already have scope of practice statutes for the clinical social work level.

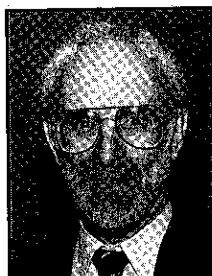
Licensing or scope of practice legislation is the most important professional recognition granted by a state government. A most stringent type of statute to ensure that public health, safety and welfare will be reasonably well protected, such legislation sets guidelines for minimum competency to practice. A State license for the clinical aspect of social work is the strongest vehicle for professional identification and distinctive public recognition. It includes in its definition of practice such words as diagnosis, treatment of nervous and mental disorders as well as psychotherapy.

In other states, the social work profession has been licensed on multiple levels. Generally, there is a license for the Bachelor of Social Work (BSW), the Masters degree (MSW) and the advanced or clinical level. Our bill focuses solely on licensing for clinical social work, defining the function and qualifications of a clinical social worker providing psychotherapy. This proposed statute enhances consumer protection by providing a clear description of responsible clinical practice, includes nationally accepted standards for education and experience, can be used to guide oversight and appropriate disciplinary action.

continued on page 4

EXECUTIVE REPORT

Growing Pains: Federation Comes of Age



I write this column less than 2 weeks after returning from the fall meeting of the National Federation. This meeting, one of the most important in the organization's history, was the third in a series devoted to the issue of how Federation should reorganize its structure to meet the demands and challenges of the '90s. The need to reevaluate its structure stems from two primary sources.

Founding State Societies

The Societies for Clinical Social Work originated within various states as small groups of concerned clinical social workers joined together to deal with issues of common concern, such as threats to their right to practice their profession. Since governmental functions such as licensing are handled on a state level, these initial professional concerns were primarily centered around the states. When Federation was formed, 21 years ago, it was just that—a federation of autonomous state societies. The states provided, and still provide, the funds to run Federation through rebates based on the number of members. State society presidents are the only voting members of the Federation board. Current issues now pertain to whether a group organized in this way can really develop a significant memberhip across the country and whether such an organization can function with the efficiency and flexibility it needs to respond to important national issues.

The new plan will foster more effective functioning.

A major organizational question arises from the development of specialty practice committees within Federation. As in state societies, these groups also wanted to respond to the needs of their membership while continuing to participate in and be represented by a strong and effective national organization. Immediate past present Adrienne Lampert had the foresight to articulate these organizationl issues and to form a task force within Federation to consider them.

Complex Issues Resolved

Needless to say, questions that arise around these complex issues are difficult and highly charged. Many of us approached this fall meeting with some concern: could problems like these ever be resolved? Federation's new president, Barbara Varley of California, led the meeting with great success. All of us who were there came away feeling much more hopeful; Federation adopted a plan to improve its functioning while retaining the essential autonomy of state societies and the practice committees. State presidents will continue to be the voting members of the Federation board, and practice committees will be able to establish themselves as tax-free corporations under the Federation umbrella. We anticipate that this plan will foster more effective functioning of Federation committees and will help in the development of membership in areas where there are not enough CSWs to form a state society.

As we in New York State enter what is likely to be one of the most difficult and challenging periods of our history, I hope that the spirit of cooperation so evident at the Federation meeting will continue and replicate. This meeting demonstrated how effectively we can function, with awareness of the mutual concerns of CSWs and appropriate respect for each others' differences.

David G. Phillips, DSW
President

In Support of Managed Care Legislation

By Mark Dworkin, CSW, BCD
Chair, Managed Care Committee

In the upcoming session (January 1993) a bill will be introduced into the State Senate by Senator Michael Tully (R). Senate Bill 583970 will have an accompanying bill in the State Assembly. This proposed legislation is intended to regulate "Private Review Agents," aka the managed care industry.

Why is legislation necessary? To "level the playing field" for consumers and providers. Currently, without such legislation, managed care companies may do business as they see fit, with no checks and balances. Practices abound that may affect the consumer and provider negatively, with little or no recourse. For example, CMG removed CSW providers who were part of an existing HMO in Buffalo because they were not part of group practices; APM of California recently reduced provider rates of social workers and psychologists; "third generation" managed care companies are expected to "decertify" as many as 50% of their existing providers; psychoanalysis as a class of therapy has been excluded in all but two managed care companies.

continued on page 7

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The Power of the Here and Now in Group Life

The Emphasis Is on Life in the Present

By Elliot M. Zeisel, PhD, MSW, BCD

This article and that by Phyllis Wright on page 5 are derived from papers delivered at the Spring 1992 Annual Meeting of the Society. The theme of the conference was "Working With Groups: Enlarging the Context of Therapy."

Carpe Diem—Seize the day.
Strike while the iron is hot.
Today is the tomorrow you worried about yesterday.
Today is the first day of the rest of your life.
Make hay while the sun shines.
I'm always ready for that part of my life that has just ended.
This is not a dress rehearsal.

These maxims, offered by group members, reflect ideas of the "here and now" in group life.

Clearly, then, the emphasis is on life in the present. To understand the power of living in the present we must consider the past and the future: what was and what will be. The past and the future bracket the present and provide a psychological framework, a backdrop for present experience. However, to live in the past is an invitation to sadness and depression, while to live in the future is a certain path to worry and anxiety. Most of us spend a portion of each day in the past or future and in the process our awareness of the present is dulled.

Group Dynamics Allow 'Gut' Reaction

Consider the difference between listening to someone report having been brutalized by an alcoholic father, and watching that same person shrink and withdraw in the face of a verbal attack by a group member. The report of his life story is experience secondhand—we have to imagine this rageful alochelic father and to conjure up the pain. In group, members are witnesses to the events; all sensory and motor systems are directly engaged. We feel the tension in the room and have a visceral response—stomachs tightening, we can actually see and feel what happened between this group member and his father as the verbal attack takes place within the group.

The power of the here and now in group life is the power to move reported experience to "in vivo" experience.

The power of the here and now, then, in group life is the power to move reported experience to "in vivo" experience. What people tell us about their experiences in the past can be made vivid and alive through the process of group treatment.

It is through our direct experience of others in group that we can best reconstruct the events that shaped them and discover how their adaptation to life is in fact a carefully crafted system for survival. Once this is understood, we can then create the climate for character change to take place. This is often best accomplished with concurrent individual analysis. We set the process in motion by establishing a group contract:

1. Arrive on time.
2. Talk about feelings and thoughts.
3. Take up one portion of the total talking time.
4. Pay the correct amount on time.
5. Maintain confidentiality.
6. Do not socialize.

Once we have in place what Dr. Louis R. Ormont calls "parameters of progress," then we can see and feel the full range of resistance. Over time, members talk about their thoughts and feelings toward people in the room and discover that that is more productive than talking only about themselves or their problems. All participants become familiar with each person's maturational needs—those emotional needs that have gone unmet. In a constructive group the members educate each other and the leader. The result—curative maturational experiences. New feelings and thoughts emerge and expand the individual's self concept and interpersonal skills. Edrita Fried once said "Resistance in group equals the forces that curb attachment to the group, that interfere with sharing experience and that undermine solidification and consolidation".

Resistance as Key to Understanding

In the modern group analytic process we adopt a positive concept of resistance, an all-embracing approach that views resistance as a key to understanding the people in our lives. The goal is not to overcome resistance, not to change people, but rather to understand. We seek to lead, not govern, and we want group members to highlight resistant behavior on their own as much as possible. Ormont in *The Group Therapy Experience* (St. Martin's Press, Jan 1992) states ". . . we are the first to see the resistance and the last to name it." Group dynamics must create an environment that is predisposed to investigation so that every facet of a resistance is made available for all members to see and understand. The clearer the understanding, the more frequently identified, the sooner the member's observing ego—which operates separate from the participating ego—will be able to see options in living rather than being ruled by unconscious process.

The therapist's first job is to identify the resistance. For example, by observing that one or more of the elements of the contract are not being fulfilled, eg, late arrival. We can intervene by consulting a group member who employs the same resistance: "John, what's your understanding of Susan's situation?"

"If I can help group members talk in the here and now the future will be taken care of and the past won't matter."

Consulting a member who has been victimized by the resistance and is supersensitive to it helps: "Sally, what are you experiencing as Renee is talking?" These interventions keep the therapist out of the center; they promote transference relationships among group members and ally us with members' developing egos. Insight doesn't count for much. It's the emotional induction and emotional communication that's curative.

To summarize: These are instances of understanding the "here and now" as a tool in the process of character analysis in the group setting—illustrations of how the here and now is used in understanding resistance and how it teaches us to live in the moment and develop respect and openness for the ebb and flow of our feeling life. To learn this frees us from holding grudges (the past), having unrealistic expectations (the future) and, finally, it frees us from a need to control those closest to us. My colleague, Dr. Ted Laquercia, put it this way: "If I can help group members talk in the here and now the future will be taken care of and the past won't matter." □

LICENSING EFFORT *(continued)*

Why do we need this legislation now?

1. At this time, there are no standards for a uniform course of professional study for the practice of clinical social work in the New York State education law.

2. Currently, there is no statutory basis that establishes standards for the practice of clinical social work and no uniform standards for supervised experience. More than 40 states recognize advanced practice levels in social work and 23 of these have a clinical social work license.

3. Existing credentials as defined by the state education law are no longer competitive. New York residents who work for self-insured or interstate companies do not have equal access to social work providers. The only credential under New York State law that allows the consumer to identify a clinical social worker is the **P** and **R** (Art. 43, 4303, Sec. 3221 of the NYS Insurance Law). This credential is not recognized by insurers of benefits packages that are outside the jurisdiction of New York State law. Consequently, coverage is limited to group health insurance plans and medical expense indemnity corporations. Common exclusions include self-insured and interstate corporations whose headquarters are outside New York State but whose divisions are within the state. These companies set their own standards for reimbursement of mental health services. For example, a United Airlines employee was denied reimbursement because his social work psychotherapist did not carry the specific title "licensed clinical social worker." The insurer was not interested in our **P** and **R** credentials, found only in New York State. The use of the title Licensed Clinical Social Worker has more far-reaching effects for consumers.

4. Licensing would ensure access to competent social work psychotherapists. Under current state education law, managed care firms can employ the least trained and most inexperienced CSWs as preferred providers. Since there are no standards for education, supervision and experience for social work providers, these organizations can hire any CSW in their search for cost-effective interventions and recommend them to their subscribers. We would require that entry level social workers be supervised by licensed clinical social workers or other equivalent licensed professionals.

5. The US Court of Appeals, Eleventh Circuit, advised that professions that were concerned about harm to consumers from unqualified practitioners prevent erosion of practice standards by seeking a scope of practice bill to define their function specifically. This recommendation followed a January 1992 decision in which Florida's title certification laws were found unconstitutional. Title certification is essentially eliminated for Florida social workers, psychologists and marriage and family therapists.

Licensing serves several purposes

1) Competency would be assured by the training and experience of the mental health professional rather than by agency oversight and supervision. 2) Standards of professional requirements and conduct would be clearly established and enforced by the State Education Department and the State Board for Social Work. This is especially relevant as the number of practitioners increases in HMOs, managed care businesses, EAPs and private practice, where supervision is likely to be on a peer review basis.

Clinical social work has a special need for credentialing inasmuch as the product of the practitioner and client interaction is intangible, interpersonal and highly specialized. A legal definition of clinical social work will create a statewide definition of advanced clinical practice so that competent and qualified practitioners can be identified.

Who will be affected by clinical social work licensing?

The current draft of the New York State CSW bill has been written to define and describe clinical social work practice in the broadest terms: ". . . the professional application of social work theory and methods to differential diagnosis, prevention and treatment of bio-psycho-social dysfunction, disability and impairment, including mental and emotional disorders and developmental disabilities." Appropriate education indicated includes a graduate degree in social work with clinically oriented course work, supervised clinical field placements *or* postgraduate education in clinical social work or psychotherapy. In addition to qualifying through an exam, three years of full-time supervised experience or its equivalent are required. (The examination will be waived for certified social workers who have met the standards for a **P** or **R** (representing 3 to 6 years of supervised psychotherapy experience.)

What about a multi-level bill?

The legislative committee of the New York Society has decided to draft legislation for that area of practice we know best—clinical social work. We have no objection to adding other levels of practice to create a multi-level bill so long as there is a level specifically for the specialty practice of clinical social work. □

Couples Group Workshop

Presenter/Report by
Barbara Greer Feld, MSW, BCD

This workshop was presented at the Society's Annual Conference in May.

This workshop discussed selection of candidates for a couples group, beginning such a group, the use of object relations concepts in couples group therapy, and the therapist's use of self in the group. The leader presented such a group as a powerful modality with which to effect change for couples. The group provides a contextual holding environment in which the couple feels free to work on their problems, facilitates each individual's empowerment and provides each member of the couple with same sex and male/female bonding. Further, projections and distortions are more readily exposed and resolved in a group setting.

In general, couples with chronic and rigidified interactions, power conflicts, blaming and projective identification work best in a group. Couples in crisis should have preparatory sessions first. The leader presented examples of four couples in a group she leads to better illustrate those who work best in these groups.

The structure of the group, fees, how to balance the group, anonymity, length of group, etc., were all discussed. The therapist's activity was addressed, especially the importance of establishing the safe holding environment, and the use of interpretations. □

Correction

The Summer issue erroneously attributed authorship to the report on "Separation and Loss in Group Psychotherapy." The workshop was presented and reported by Susan Krausz, DSW, BCD.

NYS Members Elected to NAP

Cecily Weintraub, PhD, BCD, and Adrienne Lampert, CSW, BCD, have been awarded membership in the National Academies of Practice (NAP) as Distinguished Practitioners in Social Work. Both Society Diplomates were recognized by NAP for "outstanding contributions" to the field. Formal installation took place on April 25th in Washington, DC.

The NAP comprises nine health care disciplines with equal representation. The interdisciplinary organization recognizes excellence in the practice of health care and promotes scholarly research.

Adrienne Lampert is past president of the National Federation (1990-1992) and of the NYS Society (1986-1988). She is a founding member and past president of the Brooklyn chapter.

Cecily Weintraub, PhD, BCD

Her work has focused on the advancement of social work practitioners and their ability to reach full potential as independent professionals. Her contribution to the professional organization at state and national levels has provided continued impetus for the CSW clinician.

Dr. Weintraub, a founding member of the Nassau chapter, lectures extensively and teaches at Smith College for Social Work as well as several psychoanalytic institutes; she is widely published. A consistent presenter at national clinical conferences, she is on the editorial board of *Clinical Social Work Journal.* □

Adrienne Lampert, CSW

Psychoanalytic Concepts: Applications for Group Treatment

By Phyllis Wright, MSW, BCD

Many psychoanalytically oriented therapists, trained to do individual work, often view group treatment as somehow antithetical to good treatment. We can trace the theoretical underpinnings of psychoanalytic thinking, self psychology and object relations and demonstrate how these theoretical constructs converge with group therapy. The main connection is that object relations theory and self psychology are relational, based on the dynamics between self and others, and that group psychotherapy presents a unique opportunity to work on these psychic and interpersonal issues.

Psychoanalytic Thinking

One need name only a few concepts central to psychoanalytic theory, such as transference, resistance, countertransference and the Oedipus complex to demonstrate convincingly that Freud's clinical findings and associated clinical concepts clearly pointed to problems of relatedness as central to psychopathology. However, the Freudian view of psychological life was based on the centrality of inner conflict. Freud believed that personality was formed through interaction and identification with parents but he saw this as an attempt to achieve tension reduction or drive gratification. Thus for him attachment was secondary to need gratification.

Melanie Klein was one of the first psychoanalyst–object relations theoretitions to give infant development and attachment primacy in understanding pathology and development. (The term "object relations" is an unfortunate choice in that it conjures up dehumanized images of relatedness. The current colloquial meaning is interpersonal relationships. That is, our relationship to other people.) Klein adhered strongly to Freud's basic concepts. However, her formulations about the infant's mental interactions with mother as it sought gratification shifted the focus to this much earlier and pre-oedipal stage of life and to a focus on mother-child interaction.

What became important for the object relational theorists was the primacy of object, or "other relatedness," and a view of mental life as being organized around the self and other or their representations and their relations and repetitions. According to this theory the infant's developing awareness of self takes place within the context of relationship to mother.

In sum, the shift has been from drive theory, with its focus on intrapsychic conflict, to an emphasis on relations with others and the consequent development of the self as influenced by those relations with other people.

Object Relations

Object Relations theorists have described aspects of group interaction that are clearly object relational; they include the working through of transference, which takes on a broader dimension in group because transference targets are many instead of one; the leader, group members, the group as a whole and what Ganzarian described as "the barbarians outside the wall"—that is the world outside the group.

The group can also serve as a transitional object—another construct explicated by object relations theory. In individual treatment, a patient has the undivided attention of the therapist and can reasonably expect not to be humiliated or attacked. Winnicott spoke of the evolution of a process which helps the infant to cope with the loss of the comforting object. Eventually, as the member interacts with the group, the group becomes the transitional object, that is, the comforting object, for the patient on the way to integration. Note that the object relations notion about the importance of a safe holding environment for patients is demonstrated through the vitality of a cohesive group.

Perhaps the most unique feature of group treatment is that one is immediately propelled into living out and demonstrating one's problems with others rather than just talking about them. Yet the group member can step in and out of center stage, as it were, and watch others struggle with object relations and learn vicariously.

In short, object relations theory alerts us to the centrality of relations with others.

continued on page 7

is necessary to provide appropriate care or treatment to the *protected individual* or to that individual's child;

e) an authorized agency in connection with foster care or adoption of a child; such agency shall be authorized to redisclose such information only pursuant to the provisions of Article 27-F of the Public Health Law or Section 373-a of the Social Service Law;

f) third-party reimbursers or their agents to the extent necessary to reimburse health care providers for health services; provided that, where necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider; and

g) other institutions, persons or agencies pursuant to various other specific legal exceptions provided in the statute and not enumerated.

Further, foster parents, as defined in Section 371 of the Social Services Law, or a child who is a *protected individual* may disclose information about their foster child for the purpose of providing care, treatment and supervision to the child. Also, prospective adoptive parents, as specified in Section 733-a of the Social Services Law, with whom a child who is a *protected individual* has been placed for adoption, may also disclose [such] information about the adoptive child.

Disclosure—The law requires that a consent for release of such information must be in writing, in a form approved by the Commissioner of Health. Such release shall be dated and shall specify to whom the release of [this] information is authorized, the purpose for the disclosure, and the time period during which the release is to be effective. A general consent for the release of medical or other information shall not be construed as a consent for release of [this] information unless such consent specifically indicates its dual purpose as an authorization for release of medical and other information and as an authorization for release of [said] information.

When disclosure of such information is made, the following notice must accompany the disclosed material. *This material has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.* In the event that oral disclosure is made, it must be accompanied or followed by such written notice within ten days.

It is noted that **a subpoena, even one ordered by the court, is not sufficient to authorize the disclosure of confidential HIV-related information.** The release of such information pursuant to court order would require the entry by the court of an order of disclosure, as set forth below.

Protecting *Contacts* of HIV Infected Persons—The statute permits a **physician** to disclose *confidential HIV-related information* to *contacts* of persons with HIV, that is, the identified spouse or sex partner of the *protected individual* or a person identified as having shared hypodermic needles or syringes with the *protected individual,* when a) the disclosure is made to the *contact* or to a public health officer for the purpose of making the disclosure to the *contact,* b) the physician reasonably believes that disclosure is medically appropriate and that there is a significant risk of infection to the *contact,* c) the physician has counseled the *protected individual* regarding the need to notify the *contact* and the physician reasonably believes that the *protected individual* will not inform the *contact,* and d) the physician has informed the *protected individual* of the physician's intent to make such disclosure to a *contact* and has given the *protected individual* the opportunity to express a preference as to whether disclosure will be made by the physician or to a public health officer who will disclose the information to the *contact,* which preference shall be honored. A physician or public health officer shall have no obligation to identify or locate any *contact.*

Court Authorization for Disclosure—Courts of record of competent jurisdiction may grant applications for authorization to disclose [such] information upon showing a) that there is a compelling need for disclosure of the information for the adjudication of a criminal or civil proceeding, b) that there is a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains, c) upon the application of a health officer, a clear and imminent danger to the public health, or d) that an applicant is lawfully entitled to the disclosure and that the disclosure is consistent with the provisions of the statute.

The court to which the application is made shall maintain the files relating to the application under seal, shall conduct proceedings on the application *in camera* and, where appropriate, to prevent unauthorized disclosure of [such] information, delete from court papers the name of the individual concerning whom information is sought. With limited exceptions, the law provides that such applications shall be on notice to the individual concerning whom [such] information is sought and to the person holding records in which such information is contained.

When the court grants an application to release this information, the court must limit any disclosure it does not authorize in its order granting the application for disclosure.

It is noted that health care providers who are not physicians would have to resort to these provisions and seek court authorization before notifying the *contacts* of an HIV-infected person they are treating if their patient refuses to do so. However, since the law provides that physicians, who may make such disclosures to *contacts* without court authorization, have no obligation to identify or locate any *contacts,* it is reasonable to expect that this same standard would also apply to nonphysician health care providers, who would be unable to make such disclosures to *contacts* unless authorized to do so by the court.

Immunity from Liability—The law provides that there shall be no criminal sanction or civil liability on the part of, and no cause of action for damages shall arise against any physician or his or her employer, or health care facility or health care provider with which the physician is associated, or public health officer, solely on account of a) the failure to disclose such *confidential information* to a *contact* or person authorized pursuant to law to consent to health care for a *protected individual,* b) the disclosure of [such] information to a *contact* or person authorized by law to consent to health care for a *protected individual,* when carried out in good faith and without malice, and in compliance with the provisions of the statute, and c) the disclosure of [this] information to any person or agency, or officer authorized to receive such information, when carried out in good faith and without malice, and in compliance with the provisions of the statute.

Child and Adult Abuse and Neglect—Nothing in the provisions of Article 27-f of the Public Health Law shall limit a person's or agency's responsbilities or authority to report, investigate or redisclose child protective and adult protective services information in accordance with Title 6 of Article 6 and Titles 1 and 2 or Article 9-B of the Social Services Law, or to provide or monitor the provision of child and adult protective or preventive services.

Editor's Note:

For the most part the language is the author's, as is added emphasis.

MANAGED CARE *(continued)*

The Tully bill is not a panacea, but it is a step in the right direction. Suggested revisions include:

1) prohibiting the modification of specific standards and criteria for existing treatments
2) limiting the frequency of utilization review
3) establishing rules as to how a private review agent may conduct an independent interview with a patient
4) prohibiting private review agents and/or corporations from entering into contracts in which there are financial incentives to reduce health care
5) disallowing "hold harmless" clauses
6) prohibiting refusal to any competent provider who wishes to enroll in a preferred provider network
7) protecting the provider's right to a fair and just appeal process without recrimination

This is a bill that a) psychiatry, psychology, social work, nursing and consumer groups can support; and b) will institute checks and balances on the uneven distribution of power inherent in the present system.

As social workers we face a two-pronged task: to get both a licensing bill and a managed care bill passed. The legislative committee will spearhead activity to accomplish these goals. (See page 1) That committee will need the help of every society member. To paraphrase an American leader, this is not a time to ask what your Society is doing for you, but rather what you can do for your Society. Otherwise the next question you ask may be "What will my next line of work be?" □

CONCEPTS *(continued)*

Self psychology theory, on the other hand, alerts us to the "self" and how it develops.

Self Psychology

The Object Relations theorists were limited by their inability to free themselves entirely from Freud's drive-centered theory. They could not become *self* centered enough to consider the notion of the "narcissistic" object, or selfobject, as legitimate and of central importance to the person throughout the life cycle. It is Kohut who most effectively fills this gap. In *The Restoration of the Self,* Kohut suggested that the drive model framework could not contain all the observations that his work with narcissistic patients was generating. Thus, he designated his approach the "psychology of the self," and believed that it was a novel and comprehensive system.

The patient's narcissistic needs are not seen as selfish. Rather, they are basic needs of the self in relation to self objects. These needs must be met for the patient to meet developmental requirements for self-esteem regulation and continued growth.

The therapist's task therefore is not to "catch" the patient in his/her distortions but rather to create an environment that will meet self and selfobject needs. Three such needs are conceptualized by Kohut: the need for a mirroring selfobject, an idealized parent image and a need for a twinship or partnering selfobject.

The wish to be recognized for one's unique capacities and talents is called the mirroring selfobject. The wish for harmonious merger with an idealized other who is seen as an image of calmness and strength is called the idealized parent imago. The need for a twinship or partnering selfobject refers to the formation of a link with a "partner" or buddy: mutual recognition between felt equals provides a sustenance to the self not quite offered by the meeting of needs for idealization and mirroring.

As Bacal points out, group is an ideal place for all three transferences to develop. Each can be established with various group members. It is not possible in dyadic therapy because one object, the therapist, cannot provide all three transference opportunities.

The differences in these theories have implications for how one works in group treatment. Traditional Object Relations theory envisions the therapist as interpreter, confronting defenses and working through resistances. If one is more interpersonally oriented, one conceptualizes the therapeutic situation as two coparticipants, both analyzing defenses and interpreting the experience. A Self Psychology approach sees resistance and defense as attempts to maintain self esteem and to find the needed selfobjects to fill in the structural deficits of the self. In short, one's theoretical orientation affects treatment. □

Slate of Officers

Following is the 1993-1994 slate of officers proposed by the Nominating Committee.

A secret ballot, along with a summary of credentials of each candidate, will be mailed to members not later than November 17, 1992. Members will select a president-elect, second vice president, recording secretary, and two members-at-large. All will serve 2-year terms commencing January 1, 1993. The proposed slate:

Office	Candidate
President-Elect	Helen Hinckley Krackow (Met)
Second Vice President	Uri Bergmann (Nassau)
Recording Secretary	Fred Frankel (Nassau)
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The Mid-Hudson chapter is a cosponsor for the event with Dutchess Community College, Mid-Hudson NASW and Family Services of Mid-Hudson and Harlem Valleys. The fee for the 6-hour program, which begins 9 am, is $45 for Society members, $55 for others. The full program includes continental breakfast, lunch and discussions. For additional information: Ms. Lois Stewart (914) 471-4547.

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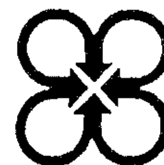

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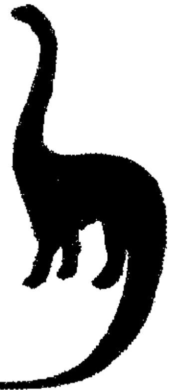

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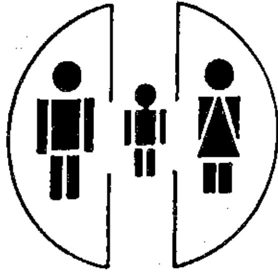

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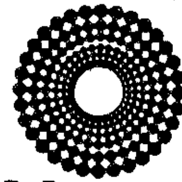

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