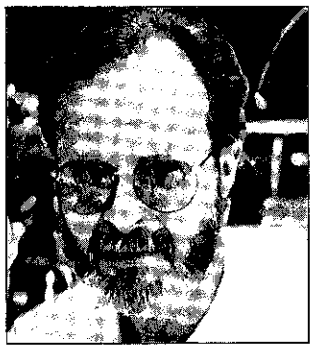
NEWSLETTER

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC. SPRING 1993 • VOL. XXIV, NO. 1

President-Elect and Officers Chosen

Helen Hinckley Krackow CSW, BCD—Met



Uri Bergmann, CSW, BCD Nassau

Dianne Heller Kaminsky, CSW, BCD—Met

President-elect Helen Hinckley Krackow, CSW, BCD, believes the Society "is the single most important vehicle" for building and developing the clincial social work professional. A member since 1981 and a Fellow since 1985, Helen has been active on almost every chapter committee.

During her tenure as president of Met chapter since 1990, membership has increased by almost 250 and the chapter has initiated a mentor program for graduate social work students. She believes this consistent experience provides a "rich understanding of what is needed to run a professional organization."

Her work on the state level includes lobbying in Albany for the "R" credential. She was also the first liaison for the Society with the New York City Coalition for Women's Mental Health.

Helen is a graduate Fellow of the Institute for Research Hypnosis. In private practice in Manhattan, Helen's credentials extend to forensic clincial work. She reiterates, "If we do not regulate ourselves . . . someone else will define the scope of clinical social work practice."

Uri Bergmann, CSW, BCD, second vice president, joined the Society as a Fellow in 1989 and was member-at-large for 2 years, 1990-1992. He has been active in the education committee and serves currently as vice chair of the managed care committee; his plan is to continue to focus on legislative efforts in the regulation of the managed care industry.

In private practice since 1983 in Smithtown and Seaford, Uri is pursuing a doctoral degree at Adelphi University; his professional expertise includes hypnosis and pain management.

He believes strongly in licensure for clinical social work and will work with the legislative committee toward this end.

Dianne Heller Kaminsky, CSW, BCD, is a Diplomate and currently heads the education committee. She has served as chapter member-at-large and as vice president of Met chapter for 8 years. She helped develop the mentor program for recent graduates.

Dianne is a faculty member and supervisor at Postgraduate Center and serves on the training and evaluation committee of the adult therapy psychoanalytic training

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National Plan to Include Mental Health Services

News From the Front

By Marsha Wineburgh, MSW, BCD
Legislative Chair

The good news appeared in *The New York Times* March 16th: the White House Health Care Task Force planned to include mental illness coverage in the nation's new health care plan. There was even recognition of the ongoing discrimination against mental illness by private insurance policies. A wide range of mental health services are being considered for coverage including the treatment of severe mental illnesses, alcohol/drug abuse and treatment for children. Mental health coverage alone,

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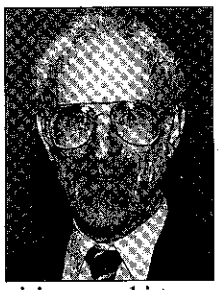
EXECUTIVE REPORT

When We Were Very Young . . .



At this year's Annual Meeting, scheduled for May 8th, we will be both looking to the challenges of the future in presenting a major program on managed care and its impact on clinical practice, and recognizing our history as we mark the 25th anniversary of the New York State Society.

Attending the first meetings of the group that evolved into the Clinical Society, I was beginning my second year of psychoanalytic training at the Postgraduate Center for Mental Health. The creative and forward looking people who convened these meetings were angry that social workers seemed to occupy the lowest position at every facility; they felt that they were not well represented with regard to their specific interests and issues—either in the workplace or in the legislative arena. They had learned that a small group of California social workers with an interest in direct practice had joined together and were able to defeat pending legislation in that state that would have been devastating to their right to practice. When the New York and California groups made contact, they originated the concept of a national organization of social workers with a primary interest in direct practice.

By means of certification, we thought the struggle for recognition had been won. It was just the beginning.

In the fall of 1968, as this group began, New York's certification law for social workers was about 3 years old, and we were still delighted at being one of the first states in which social workers had achieved some kind of legal recognition. We thought that the struggle for legal recognition was over—unaware that, indeed, it was just beginning. We had no idea that certification was just a step along the way and that some day we would have to work even harder to achieve licensing for clinical social work to be able to effectively protect both our right to practice and the public from unqualified practitioners.

When this group began to meet, only Federal employees had insurance coverage for outpatient psychotherapy, and this benefit had not yet started to become available to workers in the private sector. Insurance coverage for outpatient treatment was still a foreign concept and none of us could have imagined that social workers would ever be able [allowed] to diagnose a patient, sign an insurance form, and have the patient receive reimbursement for the treatment received.

Social workers in this type of setting, such as the group that formed the Society, were then referred to as "psychiatric" social workers. This term denoted both their major area of interest and their domination by the medical profession. The terms "clinical" social work and "clinical" social worker, with all that they imply, evolved later. This small group that began to meet 25 years ago thought that they were just working to get a better break for social workers with practice interests who worked in psychiatric settings; as forward looking as they were, they could not have known that they were actually taking the first steps in the founding of a new profession.

David G. Phillips, DSW
President

Society Marks 25th Year—1968-1993

The NYS Society marks its 25th anniversary this year. Do you remember the early years? The earliest days?

We would welcome your memories—the Fall issue will commemorate this Silver Anniversary.

Clinicians Urged to Prepare for Change

Managed Care: Adapt or Fight?

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

This time of economic and political turmoil in health provokes a degree of suffering and "angst" for all of us, to a greater or lesser degree. No one knows what the outcome of this crisis will be. What we do know is that change is inevitable. The Society will advocate for necessary legislation (See Fall 1992 *Newsletter,* "In Support of Managed Care Legislation," page 2.)

Will we all have to join together in group practices in order to survive? Clinical social workers must become educated, flexible and ready for change, however that may

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IN BRIEF

Clinical Documentation and Recordkeeping

CSWs Must Keep Accurate Files

By Hillel Bodek, MSW, CSW, BCD

Clinical documentation and recordkeeping are familiar agency practices. Clinical documentation and recordkeeping, however, is often overlooked by clinical social workers in private practice.

This is Part 1 of two on this topic

The Rules of the Board of Regents define unprofessional conduct by a health care professional to include, "failing to maintain a record . . . which accurately reflects the evaluation and treatment of [each] patient. Unless otherwise provided by law, all patient records must be retained for at least 6 years, [including] obstetrical records and [those] of minor patients, and until 1 year after the minor patient reaches the age of 21 years" (8 NYCRR 29.2 [a][3]). In *Suslovich v New York State Education Department, et. al,* 571 NYS2d 123 (A.D., 3 Dept, 1991), the court affirmed an earlier finding that a psychologist whose patient records consisted of copies of insurance claim forms and the notes he kept in his mind, violated this regulation; the court upheld the suspension of the psychologist's license for professional misconduct, noting that "[t]he purpose behind the requirements [for proper recordkeeping] is in part to ensure that meaningful information is recorded [should] the patient transfer to another professional or the treating practitioner . . . become unavailable." 571 NYS2d at 124.

Private practitioners are required to keep "hard copy."

Clinical documentation and recordkeeping, often viewed as a chore and yet another burden heaped upon health care professionals, serve several important purposes, equally applicable to private practice settings as well as agencies. Seven key purposes of clinical documentation serve to:

1. **document professional work**—to record what was done, by whom, to whom, when, where, why and with what results; to document diagnosis and assessment, treatment/services provided and the patient's clinical course;
2. **form the basis for organization and continuity of care**—to record clinically meaningful information for the practitioner to rely on later to refresh memory of crucial events in treatment, the patient's response to treatment, problems experienced, key historical facts and collateral contacts; to provide a basis for self-supervision and reflection on the patient's clinical course and progress;
3. **establish a base for subsequent continuity of care by other practitioners**—to provide appropriate data regarding evaluation, treatment, progress in and response to therapy, treatment planning/goals and problems to subsequent practitioners, who will have the data to provide continuity of services to the patient;
4. **provide risk management and malpractice protection**—proof of informed consent for treatment, release of records, etc; documentation of the nature of the professional relationship and duty owed with regard to the patient; support of professional decisionmaking, problems encountered in working with the patient, supervision/consulation obtained, professional response to crisis/special situations; support for the adequacy of the clinical assessment, appropriateness of the treatment/service plan and the application of professional skills and knowledge; substantiation of the services provided and of the results of such services;
5. **comply with legal, regulatory and institutional requirements**—compliance with recordkeeping requirements of the NYS Education Department, specific programs (e.g., JCAHO) and payors (e.g., Medicare, Workmen's Compensation, Medicaid, etc),
6. **facilitate quality assurance and utilization review**—record professional activities, purposes and results; document appropriateness, necessity and effectiveness of services provided; documentation of the need for further treatment/services or to support termination of such services; facilitate supervision, consultation and staff development; improve the quality of services by identifying problems with service delivery so that effective corrective action can be undertaken; provide data for educational planning, policy development, program planning and research;
7. **facilitate coordination of professional efforts**—to facilitate communication between members of the treatment team to assure coordinated treatment/service delivery.

Good clinical documentation 1) provides relevant information in appropriate detail, 2) is organized with appropriate headings and logical progression, 3) reflects the application of professional knowledge, skills and judgment in services provided, 4) is concise, 5) serves as support, 6) uses relevant direct quotes from the patient and other sources, 7) distinguishes clearly between facts, observations, hard data and opinions, 8) is consistent, and 9) is written in present tense.

Part 2 will discuss the essential components of an initial assessment, key elements of an appropriate progress note and the role of clinical documentation in assuring quality clinical social work services. □

Practice Committee in Clinical Hypnosis

An ad hoc practice committee on clinical hypnosis has been approved by the board of the Society, to be chaired by William Ballen.

Increasing recognition of clinical social workers as competent hypnotherapists has fostered interest in this modality. Clinical social work has taken its place with medicine, dentistry and psychology in its use of hypnosis as a therapeutic tool. The diplomate status has been offered by the American Hypnosis Board for Clinical Social Work for the past 3 years and qualified clinicians are welcome to apply as full members to the Society for Clinical and Experimental Hypnosis.

The committee will focus on educating the professional and lay communities about hypnosis and its use in various practice settings; it will provide individual and small group supervision and networking opportunities. □

Queens Celebrates 20th

Past presidents of Queens chapter who received Certificates of Appreciation include, left to right: Shirley Sillekens, Allen A. DuMont, Joseph A. Ventimiglia, DSW, Cecile S. Dunn, DSW, Robert P. Galardi, Consuelo V. Alsapiedi.

The Queens chapter celebrated its 20th anniversary February 28 at the Sly Fox Inn in Jamaica. Chapter President Roslyn Gold was the chapter's host for the event, which included a gala brunch and awards to the chapter's past presidents. Roslyn welcomed members and guests, including Society President David G. Phillips, DSW, and President-Elect Helen Hinckley Krackow.

Speaking about the contributions and leadership that Queens chapter has provided over the years, David Phillips presented to each past president a Certificate of Appreciation from the chapter. Past presidents who were honored included Cecile S. Dunn, DSW, Robert P. Galardi, Haruko Brown, Consuelo V. Alsapiedi, Shirley Sillekens, Allen A. DuMont and Joseph A. Ventimiglia.

—Report by Joseph A. Ventimiglia, DSW

CLINICIANS URGED *(continued)*

manifest. As a television character says, "Denial is not just a river that flows through Egypt."

A national Managed Health Care Congress, meeting in Washington in April, will bring together a variety of groups. Insurance companies, managed care organizations, group practices and health care providers will lay out these issues for discussion.

Issues facing us as practitioners seem overwhelming; however, each chapter has a managed care committee, and members are urged to get involved. Chapter committees help members to deal with problems posed by managed care. The Annual Meeting May 8 will address the many issues inherent in managed care: "Negotiating the Maze of Managed Care."

Members can also join the Coalition of Mental Health Professionals and Consumers headed by Society member Joyce Edward. Although this is a regional group whose efforts are not connected with the Society, the Coalition's efforts include meeting with state and national representatives, collecting data and advocating for mental health care delivery to remain a private arrangement between clinician and patient. For additional information: P.O. Box 412, Great Neck, NY 11021.

Become active. Participation is empowerment. Be ready for change. □

PRESIDENT-ELECT *(continued)*

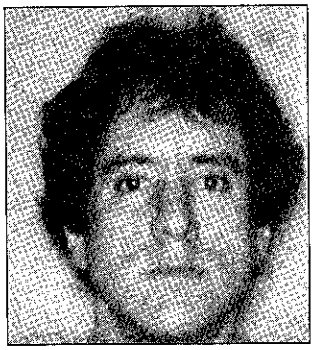
program, on the professional board and on the executive committee of Postgraduate Psychoanalytic Society. She is also coordinator of group supervision at Training Institute for Mental Health and in private practice.

As member-at-large, Dianne remains "dedicated to the advancement and development of excellence in clinical social work education."

Jeffrey Bryan, CSW, BCD
Nassau

Jeffrey Bryan, CSW, BCD, member-at-large, has been a Fellow since 1988. In addition to private practice in Plainview, his work in four mental health centers provides special experience in family treatment and has "informed me of the issues and problems facing practitioners."

He brings a "desire to protect our interest and promote the advancement of our individual and collective needs."



Fred G. Frankel, CSW, BCD
Nassau

Fred G. Frankel, CSW, BCD, member-at-large, has been serving as recording secretary in addition to his efforts in public relations and vendorship. A Fellow since 1984, he has been coordinator of the Annual Meetings in 1989 and 1990 and has served for the past 2 years as second vice president for the Society.

He believes that this organization must continue, via its committees, to ensure heightened awareness of clinical social work. Fred is in private practice as well as on the staff at Queens Psychiatric Center.

BOOKS

The Bad Object: Handling the Negative Therapeutic Reaction in Psychotherapy

By Jeffrey Seinfeld
Jason Aronson Inc.; Northvale, New Jersey; London, 1990, 319 pages

Reviewed by
Diana List Cullen, MSW, CWW

In *The Bad Object,* Seinfeld brings a new dimension to the theory and treatment of the negative therapeutic reaction in psychotherapy. His thesis is compelling and unfolds beautifully, although sometimes confusing in its complexity. He begins by providing a clinical picture of the bad object based on an historical overview of the object relations literature, and the negative therapeutic reaction, referring particularly to H. Searles.

Creating a Dynamic Interactive Theory

The heart of Seinfeld's thesis is a synthesis and extension of the theories of Fairbairn and Jacobson. Seinfeld combines the static representational elements primarily from Jacobson and the interactive dynamics of Fairbairn. He thus creates a dynamic interactive theory in which the elements are good and bad representation units of self and object, good and bad external objects, and action among and between them.

In addition, Seinfeld confronts the apparent dichotomy between the theory of "structural deficit [deficit of positive self and object representations] and conflict [the bad object situation] . . . contend[ing] that the negative therapeutic reaction *always* involves both. . . ." With the structural deficit, the bad object and self representation unit are the dominant pair, actively reinforcing each other. They may be acted out or projected. Seinfeld, in a personal communication, says they are "like silly putty," able to be thrown anywhere either whole or in fragments. If the bad object representation is projected onto another or others, the negative self will be acted out. If the negative self is acted out, the bad object will be projected. External objects often match the bad object or self representation, disguising the projection.

Moreover, Seinfeld's model incorporates conflict within the framework of the deficient personality structure. The bad object actively rejects not ony the good external object, as Fairbairn theorized but also, says Seinfeld, the *internalization* of a good object. Seinfeld also articulates how the structurally deficient personality struggles between a wish for fusion, with an accompanying fear of violation, and a wish for separation, with the accompanying fear of abandonment.

Working Through

Building on the treatment literature, particularly H. Searles, Seinfeld identifies four stages in working through the negative therapeutic reaction: 1) out-of-contact (when the psychic worlds of the patient and therapist are totally different); 2) ambivalent symbiosis; 3) therapeutic symbiosis; and 4) resolution of symbiosis. One of the most important aspects of his conception is that ambivalent symbiosis reflects a positive step in treatment. He sees this phase as the period when the patient begins to internalize the good object and self. In so doing, s/he projects the bad object onto the therapist in order to separate from that representational unit. In the next stage, that of therapeutic symbiosis, the bad object is no longer projected onto the therapist but onto all other external objects. "The all-good, comforting, and nurturing self and object unit temporarily dominates psychic life . . . reinforcing the internalization of the positive self and object unit." In the final resolution of the symbiosis, the patient "will have the opportunity to repossess and integrate the bad and good split-off object relations unit."

The author delineates a new way to conceptualize and work through the negative therapeutic reaction

Seinfeld provides a review of Freud's famous case of Dora in light of his conceptualizattion, as well as case examples of negative therapeutic reaction of both children and adults. In the case of a 9-year-old boy, Seinfeld describes the treatment in the ambivalent symbiotic stage. The boy initiated a game of catch with Seinfeld and acted out the rejecting and controlling bad object, ordering Seinfeld around, denigrating Seinfeld's ability to catch and throw, accusing him of being stupid and inattentive. In following the boy's instructions, Seinfeld took on the projection of the negative self but performed neutrally so as to ensure its being perceived as a game. Over time, the nonretaliatory and gratifying behavior of the therapist enabled the boy to expose his true vulnerable self and develop and internalize a good self and object.

The boy's needy, vulnerable self had been hidden within his acting out of the bad object. Seinfeld points out that if he had stopped in resentment at being treated like a "slave," he [Seinfeld] would have been acting as the original external bad object which had not been able to respond to the boy's vulnerability and needs. Seinfeld points out that vulnerability appears with the beginning of autonomy and, therefore, meeting dependency needs frequently serves autonomy.

Seinfeld's model incorporates conflict within the framework of the deficient personality structure.

In his book, the author sprinkles literary, religious and philosophical references to clarify and enliven his theory. For example, he refers to "theological prescientific terms," saying that the patient acting out or responding to an internalized bad object would have been said instead to be "possessed."

Seinfeld's book delineates a new way to conceptualize and work through the negative therapeutic reaction. The book is written well and sensitively, and is an important addition to the theoretical and clinical literature.

Diana List Cullen, MSW, CSW, maintains a private psychotherapy practice with individuals in Manhattan. She runs a support and discussion group for grandparents. She does volunteer work at the Booker T. Washington Learning Center in East Harlem and is currently membership chair for the Metropolitan chapter.

Call for Workshops

Please submit proposals for workshops and seminars to be included in the Fall/ Winter 1993 continuing education program brochure. Proposals should include:

1. Description purpose, function, and teaching objectives
2. Course outline and bibliography
3. Copy of instructor's curriculum vitae
4. Publicity flier (see format of Spring brochure). Indicate dates, frequency of sessions, length of time per session, and suggested fee per session.

Submit by June 1, 1993, to: Dianne Heller Kaminsky, Chair, Education Committee, 65 East 96th Street, 1C, New York, NY 10128. □

however, does not assure consumer access to care and treatment unless such coverage also guarantees choice from a range of qualified providers, including clinical social workers. Freedom of choice would ensure access to mental health care particularly among the underserved populations often served by CSWs. Such choice also fosters greater competition among qualified providers.

If *The Times* story is accurate, where is the Task Force headed? Whether it is "managed care" or "managed competition," how are patients to be protected against the abuses of managed care practices? Which professions will be approved as qualified providers? Will it be the four licensed core disciplines: psychiatry, clinical psychology, psychiatric nursing and clinical social workers? In New York State at this time they are certified only as MSWs with no experience (NY State Education Statute).

The National Federation has submitted a position paper to the White House Health Care Task Force as well as to key members of Congress, documenting the qualifications and contributions of the clinical social work profession. Here in New York we have been asked to distribute the paper to our Congressional representatives as soon as possible. The State Society is actively following the lead of the Federation as the reform health care package takes shape and the issues affecting clinical social work become clearer.

The Society's bill (A. 2240) has been reintroduced by Assemblywoman Catherine T. Nolan from Queens.

Meantime, in New York State, the legislative committee has reintroduced our single level licensing bill for clinical social workers, A.2240. Assemblywoman Catherine T. Nolan, Queens Democrat, is our lead sponsor. Legislative chapter chairs have been educating and recruiting local legislators as cosponsors for this bill, now awaiting introduction in the Senate.

Although the State Society has sought cooperation and welcomed multi-level licensing suggestions from other professional groups, the State chapter of NASW has recently decided to oppose a licensure bill. The legislative committee encourages all members to write to the appropriate city or state NASW chapter and urge them to support a multi-level licensing bill to include the clinical social work level of the profession.

Additional Legislation Pending

S.2018—New York State Senators Spano, Lack, Larkin, Marchi, Sheffer II, Velella, and Volker have introduced a bill to establish standards and procedures for utilization review for the treatment of mental illness. This bill is intended to protect the public by assuring adequate safeguards and restrictions on the conduct of private mental health agents who review treatment for mental illness.

S.2351/A.3935—Senator Volker (Buffalo) has reintroduced legislation to amend the criminal procedure laws to include qualified social workers as psychiatric examiners. This legislation is important in our plan to gain parity with other core mental health disciplines.

S.1416—Senators Spano, Libros, Skelos and Volker have introduced legislation to create a fifth profession of Mental Health Therapy. The practice of psychotherapy would be limited to this group and the currently recognized four core disciplines.

A.591—Assemblyperson Gantt has introduced legislation to amend the judiciary law to exempt certified social workers as jurors. Don't hold your breath. □

LETTERS

Managed Care: Hazardous to Health

To the Editor:

When I received an MSW in 1974, psychotherapy was clearly dominated by psychiatry; their practitioners were seen as the experts in this form of treatment.

The very fine psychoanalytically oriented mental health clinic that employed me was staffed largely by MSWs. Many of these psychotherapists were highly experienced or were in psychoanalytic training; they were knowledgeable and competent. When they had difficulties with a client, however, they anxiously consulted one of the psychiatrists. This surprised me since the social workers were usually more knowledgeable and experienced than the young psychiatrists they consulted. Puzzled by their behavior, I investigated our profession's history to determine where this subservience originated. From my research and analysis *(Clinical Social Work Journal,* 1977), I concluded that this behavior stemmed from a poor professional self-image, and that social workers behaved obsequiously toward psychiatrists because they were *grateful* that they were *allowed* to practice psychotherapy. This attitude not only proved destructive to the social work profession, but also limited our helpfulness to clients.

Since that time, due to the assertive efforts of the National Federation, our situation has changed dramatically; we have made great strides in achieving autonomy and parity with psychiatry and psychology. Once again, however, we are facing a dilemma that could undermine our autonomy, competence and effectiveness. The culprit is big business in the guise of managed care.

The objective of managed care is to contain costs, not to improve mental health care.

Managed care, a rapidly growing national trend, will have great impact upon future practices. While in New York State only 25% of the population is covered by managed care companies, in other areas of the country such as Washington, DC, enrollment has reached 80%.

The objective of managed care is to contain costs, not to improve mental health care. The therapist must justify treatment as a "medical necessity" that focuses upon functioning and symptomatic behavior rather than emotional distress. Short-term therapy of less than 20 sessions is advocated,

Lost is the right of client and therapist to determine parameters of treatment.

as well as medication for clients failing to respond to this treatment model. Reviewers liberally cite research to validate their position, totally disregarding the clinician's experience with the client. Lost is the right of client and therapist to determine whether treatment is necessary, how it should be conducted, and the privacy and confidentiality necessary for its success. Refusal by a clinician to follow established procedures may prove detrimental to his or her practice.

As Dr. Karen Shore, noted expert on

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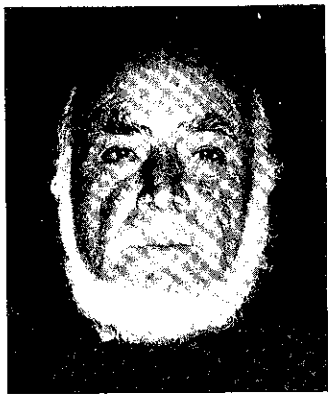
LETTERS *(continued)*

the task force on managed care of New York Psychological Association, informed the advisory council to the Society's managed care committee, "The managed care industry knows that the vast amount of personnel needed for utilization review is expensive, so their plans for the future are to eliminate the need for utilization review by eliminating from their networks all therapists who are not compliant and do not conform to their practice guidelines. They expect to eliminate 30 to 50% of all network providers."

We must do everything we can to help regulate and change managed care. We do not have to feel *grateful* that they have *allowed* us to be providers in their networks; this is a repetition of our past. Since managed care might very well prove hazardous to our health as well as to our clients, let us act immediately!

Richard M. Alperin, DSW

Richard M. Alperin, DSW, is chair, committee on psychoanalysis, State Society, and member of the advisory council, managed care committee.



NAP Elects Society Member

Bernard Frankel, PhD, BCD, has been awarded membership in the National Academies of Practice as a Distinguished Practitioner in Social Work. Formal installation took place in Washington, DC, last spring. This news was inadvertently omitted from our feature in the Fall 1992 issue.

Dr. Frankel, in private practice in Manhattan, is a consistent presenter at national clinical conferences, conducting workshops and seminars in group, marital and family psychotherapy. His current interest is in group modalities for the chronically mentally ill. He is certified as a clinical social worker and a psychologist.

A clinical professor of psychology and supervisor in the postdoctoral program in psychoanalysis and psychotherapy at Adelphi University, Dr. Frankel is a Distinguished Faculty member at the Center for Advanced Group Studies. He is a past president of the Eastern Group Psychotherapy Society and a Fellow of the American Group Psychotherapy Association. □

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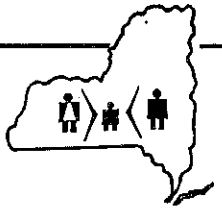

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