NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. SUMMER 1986 • VOL. XVII, NO. 2

Spring Federation Meeting

Tri-State Program Planned for '87

Forensic Definition Established for CSWs

Report by Adrienne Lampert, CSW
NYS President

A good deal of the energy on the Federation level is expended on providing guidelines to develop licensure bills; to achieve mandated vendorship on the national and state level; to maintain communications among states; to share information; to promote the professional image of the CSW; to interface with government and appropriate professional organizations.

Vendorship

This committee is active:

1. Developing guidelines for licensure and vendorship bills;

2. Lobbying (for CSW inclusion as independent providers) with large hospitals which have formed partnerships with insurance companies to provide medical insurance.

3. Disseminating results of the NIMH/McGuire Study, 1982, which evaluated the impact of "Vendorship for Social Workers on Use and Cost of Ambulatory Mental Health Services." Using information from Blue Cross/Blue Shield over a 3-year period, 1980-1982, involving some 29,314 subscribers, the study revealed:

—no significant increase in utilization;
—no significant increase in overall mental health costs;
—a reduction in service delivery and billings by psychiatry and psychology.

The bottom line: Mandated vendorship for CSWs *does not increase costs* and offers the consumer freedom of choice.

This leads us into NY State's visit to the Hill to enlist the support and co-sponsorship of NY representatives for the ERISA (Employee Retirement Income Security Act) bill. This bill is to ensure and protect the consumer's right of freedom of choice regarding providers in those states with mandated vendorship—to plug loopholes such as self-insured companies and policies written in another state to avoid individual state mandates. We visited the following NYS representatives: Rangel, Downey, McGrath, Owens, Molinari, Kemp and McHugh. We were well received, and have an agreement from Congressman Owens of support and co-sponsorship.

Peer Review

This committee functions:

1. To provide the necessary services and serve as standard bearer for peer review in clinical social work;

2. To establish criteria for selection of peer reviewers;

3. To publish peer review manual;

4. To train peer reviewers;

5. To develop marketing procedures.

Forensic Clinical Social Work

This committee, with 8 states represented, established a clear definition of forensic clinical social work. The committee is charged to:

—disseminate definition of forensic clinical social work;
—finalize standards for practice;
—contact American Academy of Psychiatry and Law to share information;
—work with Ken Adams, national advocate, to seek joint action with NASW regarding CSW standards;
—contact National Registry with regard to potential certification of experience and credentials of forensic CSWs.

National Registry to Develop Qualifying Exam

The registry will now be known as the National Board of Examiners in Clinical Social

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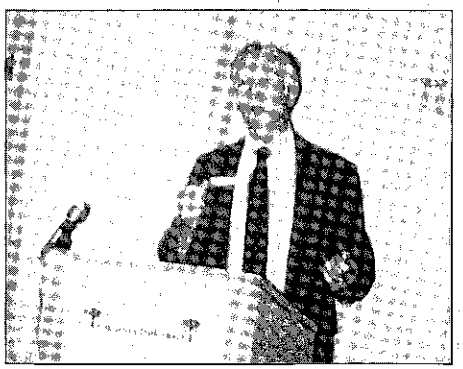
Philip Johnston Addresses Annual Meeting

Clarifies State Board Procedures

Report by Phyllis Gordon, CSW,
and Harriet Wald, CSW

The NYS Society's Annual Meeting took place at the Gramercy Park Hotel in New York City on Saturday, May 17. About 100 members socialized, brunched and learned the "state of the society" from members' reports and the "state of the 'R'" from the featured speaker.

Philip Banner, member-at-large from Brooklyn, acknowledged Theda Salkind's planning for the meeting. He introduced board members and guests: Harriet Wald, Hillel Bodek, Maria Warrack, Crayton E. Rowe, Jr., Marsha Wineburgh and Theda Salkind; and Mr. Philip Johnston, executive secretary of the State Board for Social and for the State Board for Clinical Practice.



Philip Johnston, State Board for Social Work

Beginning his address, Philip Johnston, MSW. who has occupied his position at the State Board since its inception 20 years ago, reviewed the history and responsibilities of

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EXECUTIVE REPORT

For CSWs, Identity=Commitment

We as individuals create organizations. As our environment becomes increasingly "high tech," we sometimes find we're cut off, we lose perception and understanding of this activity and why we do it.

Many individuals—volunteers, all—have with great dedication, interest and fortitude created our New York State Society into a very special professional organization. It truly represents us as well educated, well trained mental health providers ready to serve the community. Our accomplishments are manifold. The volunteers of the past—members with a mission—have helped us achieve certification, then parity; helped us educate ourselves; most importantly, they have ensured and guaranteed respect for the professionalism of the clinical social worker. They reflected for all of us a commitment to our maturing organization; and with them we formed collegial relationships.

We are now 1550 strong and look forward to 3000 or more. Each member has the potential to assure continued growth. Your energy and interest are vital; there is still a long way to go. We must continue to be the initiators and watchdogs of both national and state legislation. We must be involved in education—from schools of social work to the most advanced training. We must be knowledgeable in newer, more complex issues: vendorship, peer review, HMOs, PPOs. We must also be prepared to be entrepreneurial professionals.

The only way to ensure these goals is through active participation—by each of us on the chapter and state level. My own experience in volunteering time to our Society has truly enriched me. My identification as a clinical social worker has been clarified, enhanced and assured.

In a world filled with computer numbers instead of names, fast food and bits and bytes, identity feels safe, warm and comforting: a sense of "belonging." At the same time, your contribution provides the Society with its identity—expanded yet unified. The affiliation is mutually beneficial.

Make this the time you attend a chapter meeting and lend your energy to your New York State Society community. Make a commitment and identify yourself.

Adrienne Lampert, CSW
President

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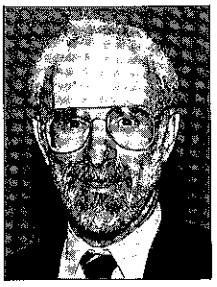
A QUESTION OF ETHICS

Informed Consent: Cornerstone of Professional Responsibility

By David G. Phillips, DSW



Under common law, any uncontested touching constitutes a battery, even if that touching takes place for the purpose of rendering medical care. Thus physicians, particularly surgeons, have practiced with the obligation to obtain the patient's consent before proceeding with treatment. Consent, however, consisted merely of the patient's agreement to what the doctor proposed to do—even if what was proposed was not entirely clear to the patient.

In the 1950s and '60s a series of cases challenged this traditional practice. Courts began to hold that a patient's simple consent to treatment was not sufficient to protect the doctor. Gradually, the courts began to require an "informed consent" and to create a body of decisions that defined that concept. Among issues that have been resolved: treatment *without* any consent or over a patient's objection may constitute a battery, *whether or not it causes harm to the patient.* Treatment which follows *inadequate* consent may properly be considered as a form of malpractice if it is determined to have caused harm to the patient.

A patient's "informed consent" to treatment must include sufficient knowledge to offer such consent.

The basis for the legal doctrine of informed consent is the moral principle which holds that it is *prima facie* wrong to force individuals to act against their will—a principle which is most clearly embodied in our adherence to the value of self-determination.

In spite of our emphasis on self-determination, it is questionable how far we have come in developing a social work doctrine of informed consent. It is still true, for example, that many field instructors supervising social work students do not encourage, and may even forbid their supervisees, to tell clients of their student status. Withholding of such information constitutes a clear violation of our own standards of practice. A client may well be harmed because he or she was not informed of this limitation. There might, for example, be a deterioration in the client's condition caused by the student's sudden and unanticipated termination. In such a case, there would be clear grounds for an action based on the negligence, and it may well be the supervisor who would be held to be the negligent party.

Do social work practitioners see the obtaining of informed consent to treatment as one of their professional responsibilities? If a clinician has a psychodynamic orientation, does he or she inform a prospective client who suffers from a presenting symptom of phobias that behavior modification techniques have shown better treatment outcomes with this condition? In most instances, needless to say, a client will not be sufficiently

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JOHNSTON *(continued)*

that body. The Board was established ". . . for the purpose of assisting the Board of Regents and the state education department on matters of professional licensing, practice and conduct."

The Board of Regents selects the executive secretary (who must have an MSW degree) as well as the State Board members.

The State Board's functions include:

1. Developing statewide examination for licensure of CSWs;

2. Acting on matters of professional misconduct (through its Office of Professional Discipline);

3. Advising the education department of the state on issues facing the profession;

4. Establishing standards and evaluating experience for third party reimbursement.

Johnston observed an anomaly in this professional body in that CSWs may hold limited licensing to cover that period between completion of credentials for practice and taking the qualifying exam.

In terms of qualifying criteria, Johnston hailed the NYS licensing law, passed in 1965, as one of the most significant pieces of legislation both for CSWs and for consumers. It mandates an MSW from an accredited school of social work and qualification through examination. And, because of the state's stringent qualifications for CSWs, there is little or no reciprocity with other states unless a clinician can prove eligibility. Currently, because of diverse standards among states in the evaluation of social work practice, no national CSW exam exists. As the national organization, the American Association of State Boards for Social Work could establish this goal.

PHOTOS: PHYLLIS GORDON, CSW

Socializing at Annual Meeting: Crayton E. Rowe, Jr.; Charles E. Smith; Maria Warrack

Johnston acknowledged the extensive role played by the NYS Society in the formation of the AASBSW.

Mandatory credentials notwithstanding, no hard and fast differences are discernible between certification and licensing. Johnston observed that licensing may pertain to the use of a title rather than to a particular function. For CSWs licensing or certification involves the use of "Certified Social Worker" as a title (as well as the evaluation of education, experience and ability to practice). No reference is made to function or actual practice modality.

Since all CSW candidates must pass a state test, of particular interest was clarification of the methods for developing certification exams. In June each year some 150 questions are withdrawn from a "bank" of questions. State Board members take the sample exam, discussing and deciding on each question. If answers to a question seem very diverse or if there is not a consensus as to a "correct" answer, that question is not used. Johnston recognized the assistance rendered by Society members in developing test questions.

Israel Cohen, Gemma F. Colangelo

Johnston's closing comments concerned the state of the "R". To qualify under the 6-year rule, 4,000 CSWs requested applications; of those, 3,000 have been processed and, to date, 2,500 have been approved. He noted certain problems, which have been the cause of processing delays. Among them:

1. Applicants do not read the applications carefully;

2. Applicant's and supervisor's informa tion do not agree;

3. CSWs are the only group that accepts supervision by other disciplines. These professionals (from other disciplines) must be qualified; it takes time for the Board to verify the credentials.

Following Johnston's presentaiton, first vice president Harriet Wald read a prepared statement by Society president Adrienne Lampert, who was unable to attend. Committee reports followed (see June President's Letter for full coverage). □

Q & A

Following are samples of questions asked by members, and Philip Johnston's replies:

Q. Doesn't the right of privileged communication between therapist and client become violated when we fill out insurance forms—especially those that ask for a great deal of detailed information?

A. A client has released everything when he signs an insurance form. It is therefore recommended that the therapist give only what is needed in response to inquiries from insurance companies.

Q. What happens if we are beyond the stage where we require supervision, or if some of our supervised experience was gained before we received our MSW? Would it be possible to qualify under the six-year law?

A. Unsupervised experience will not be counted and the six years with experience must be post-MSW.

Q. How do the insurance companies know which practitioners are qualified under the six-year law?

A. The State Board has publicized this information and updates it periodically. Newly approved psychotherapists can be verified by insurance companies through an "800" telephone number which the Board has set up for that purpose.

CONFERENCE NOTES

Westchester's Spring Institute

Social Work as an Art Form

Report by Phyllis Gordon, CSW

The Westchester chapter's Spring Institute, "Clinical Social Work as an Art Form," took place in April. Three speakers, from different vantage points, conveyed their shared belief in the importance of creativity as an integral part of psychotherapy. Phyllis Gordon and Sue Solomon co-chaired the event.

The keynote speech by Max Siporin, DSW, professor of social work at the School of Social Welfare, State University of New York at Albany, set forth his ideas on broadening our conventional therapeutic interactions to include the use of fantasy, imagery and metaphor. For example, as therapists, our understanding of what clients tell us is important, but it is also important that we demonstrate to our clients that we do understand. Siporin suggested that we make use of metaphors to promote consensual meanings and avoid misunderstandings.

The case presentation by Keith Schenenga, CSW, illustrated the positive results to be derived from the use of imagery and metaphor in conjunction with psychoanalytically oriented psychotherapy techniques. Schenenga, currently at a family agency, had been on the staff at residential treatment agencies for children. By coincidence, therefore, he worked with his client, Michael, in two different treatment settings.

Michael was an adopted child, scapegoated and rejected when his younger sister was born; she became his mother's favorite and sole interest. At 15 Michael was admitted to a residential school on a PINS petition. In their relationship Schenenga's empathic acceptance created an atmosphere in which Michael was able to develop trust in the relationship. Michael shared his metaphorical descriptions of his experiences: that he was always on camera as an actor in a movie; that he approached life as he would a team sport. Over a period of years patient and therapist found it helpful to allude to these fantasies, which diminished in importance as Michael's sense of himself and coping abilities improved. Their use of this material enhanced communication and served as a bond between them.

The third speaker, Emily Shachter, CSW, is in private practice; a recent director of the child and adolescent division of Rockland County Community Mental Health Center, she is adjunct associate professor at the New York University Graduate School of Social Work Post Masters Certificate Program. Shachter discussed societal changes that impact on the therapeutic relationship and call for creative responses by the therapist. After more than 20 years in the field, she finds that psychotherapy is more accepted now and that a broader range of people enter therapy (possibly due to reimbursement). She finds herself on a first-name basis with many of her clients, which would have been "unthinkable" during her early years in practice. Shachter's presentation included examples of the types of changes she has encountered in practice over the years.

Reflections on her presentation were that, after decades in the field, we should try to keep pace with the times without compromising our social work values and principles. There is a delicate balance between maintaining a professional stance and relating in a meaningful way to a new generation of clients.

In addition to timely and provocative discussions, the presenters exhibited an openness in sharing thoughts and experiences. It was easy to identify with each speaker and to expect that this identification will add another dimension to practice. □

Symposium: "Psychoanalytic Process and Technique"

Report by Susan Zuckerman, CSW

An overflow crowd filled the new Lincoln School on Saturday and Sunday, April 12 and 13, when the New York Center for Psychoanalytic Training (NYCPT) and the Society for Psychoanalytic Training held their 11th annual symposium. Within the framework of "Psychoanalytic Process and Technique," the meeting explored the three phases of work in psychotherapy: beginning treatment; middle phase; and termination.

Reuben Fine, Ph.D., director emeritus of NYCPT, opened with a provocative talk on "Why the Difficult Patient is Difficult." The 'whys' include those patients who 1) may overemphasize their own reality while insisting that the therapist is divorced from reality; 2) want to resolve an intolerable life situation by leaving (patients who don't want to analyze but want to *do* something); 3) put up a 'false front' and withhold vital information from the therapist (attends sessions regularly but insists he/she has nothing to do with the psychotherapeutic change process).

Fine noted that overwhelming countertransference with these difficult patients involves a sense of hopelessness, fear of abandonment by patients and feelings of anger and incompetence.

Workshops

Fittingly, "Countertransference and Its Effect on Technique" was the name of a workshop led by Norman Shelly, who observed that the therapist's neutrality is a myth derived from a medical model which posits that one person is ill and one person cures. Shelly envisions a much more interactive, dynamic process in which there is psychic growth for both analyst and analysand.

Another aspect, sexual transference and countertransference, was the focus of a workshop by Sandra Bragman Lewis, MSW. Lewis began with a broad definition of countertransference—not only is it our counterreaction to the patient's transference, but all our theorizing, analyzing and discussing is also part of the countertransference. Rather than engage in a debate over whether preoedipal patients can have sexual transferences, she suggested we think of sex in a more general way. Lewis reminded us always to explore what the patient means by sex—often it is not what the analyst assumes. The *leitmotif*, reiterated here, was the analysis of the patient's unconscious and an awareness of resistances and defenses.

Herbert Strean, DSW, NYCPT director, addressed "Patients' Marital Conflicts" in his highly entertaining workshop. Strean noted that married people often turn spouses into parents, and this precludes intimacy; people recapitulate their psychosexual development in the marriage; chronic complaints about a spouse are always unconscious wishes of the mate (these same complaints show up in transference); whenever the patient wants to change the modality of treatment, there are unresolved transference issues.

Day 2

During Sunday's presentations, in her well-argued paper, Judith Pekowsky, MSW, explored the defensive and adaptive aspects of masochistic/sadistic transference reac-

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FEDERATION *(continued)*

Work and will develop through examination a national standard of advanced competence to establish clinical excellence for CSWs in the health care delivery system. National Registry, 1025 Dove Run Road, Suite 108, Lexington, KY 40502.

Psychoanalysis

See article below.

Education

All states are asked to submit a list of educational programs.

We discussed with New Jersey and Connecticut the possibility of a tri-state educational program in 1987. The Connecticut board has already approved this idea.

There was discussion around the states establishing training institutes for CSWs which would be staffed by CSWs. Illinois and California have such institutes.

National Office

There was agreement that a national office with an executive director is indicated. However, disagreement arose as to combining the functions of executive director and lobbyist in one person. A task force will continue to study this problem and present again at the October meeting.

We should all feel proud of New York State's contribution to the Federation board. We have two chairs: Hillel Bodek, forensic clinical social work; Crayton E. Rowe, Jr., psychoanalysis; three past presidents: Crayton E. Rowe, Jr., Nancy Palazzola, and Marsha Wineburgh (who served two terms). I foresee a continued close working relationship for NYS with Federation which can only enhance the clinical social worker on the state and national level. □

Psychoanalysis: National Membership

Members of the New York State Society may now join the National Federation's newly organized committee on psychoanalysis, which is now a national membership committee.

This national membership organization will function in a similar manner as Division 39 for psychologists in that it will provide CSWs with a national voice in the advancement of psychoanalytic theory and practice. It is open to all members of state societies which are members of the National Federation.

For further information:
Crayton E. Rowe, Jr., MSW
230 West End Avenue
New York, NY 10023

Events Calendar

August 4-8 . . . . . **4th Annual Seminar: Stalemates and Difficult Encounters**
Institute for Contemporary Psychotherapy
Drs. Paul and Anna Ornstein
Bridgehampton Tennis and Surf Club
Information: Deborah Rothman 212-595-3444

September 19,20 . . . . . **Psychotic Systems: A General Model—Clinical Applications**
Ackerman Institute
Mara Selvini Palazzoli, MD
Roosevelt Hotel, NYC
$135, early; $150, after Aug. 1.
212-879-4900

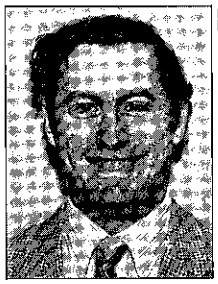
October 24 . . . . . **Freud: The Original Systems Thinker? Systems Theory Meets Psychoanalytic Theory**
Canterbury Group Family Institute
Great Neck, NY $75.00 516-829-6920

November 15, 16 . . . . . **Clinical Controversies and the Interpersonal Tradition**
The William Alanson White Institute
Roosevelt Hotel, NYC
$140, 2 days; $80, 1 day
212-873-0725

IN BRIEF

Forensic Clinical Social Work: Definitions and Responsibilities

By Hillel Bodek, MSW, CSW



Recently, a judge showed me a presentence mental health evaluation (by a social worker) of an adolescent criminal defendent who had been found guilty of robbery. The report noted that the defendent had been evaluated several years ago at a psychiatric clinic, at which time the determination was that he did not suffer from any significant psychopathology. The evaluation report failed to note, however, that, after treating the defendent and his family for several months, the clinic had decided that he did suffer from significant emotional problems and had recommended residential placement. Failing to disclose this information to the court, the social worker proceeded to recommend the defendent's release on probation.

A brochure recently published by a group of human service professionals indicated that forensic social work involves "the application of scientific principles and practices to the judicial adversary process, *where the specially knowledgeable social work practitioner plays an adversary role"* (italics supplied).

These two examples highlight a common serious misperception by social workers of their proper role when providing an expert social work opinion in the court.

The National Federation recently adopted a definition of, and drafted standards for, the practice of forensic clinical social work. It is defined as "the application of clinical social work theory, knowledge, skills and expertise to address clinical questions that arise with regard to the resolution of legal issues."

Advocacy Not Appropriate

Advocacy is often an appropriate social work function. However, when clinical social workers provide expert opinions as part of a legal proceeding, their primary client is the legal system, and their primary obligation is to maintain the integrity of the legal process. In such a situation it is the function of the attorneys, not the clinical social workers, to advocate the best interests of the parties.

When providing an expert opinion, the forensic clinical social worker should not play an adversary role. A clinical social work evaluation and expert testimony for legal purposes should be carried out impartially. The opinions rendered by CSWs should depend solely on the data obtained as a result of their professional evaluations and should not be affected by the source of

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ETHICS *(continued)*

knowledgeable to inquire. These may not be questions that practitioners are accustomed to thinking about, but the doctrine of informed consent requires that clients be told of the risks and benefits of the proposed treatment *and* of alternative treatments.

As health care professionals in one of the most sensitive disciplines, these issues are particularly relevant. For clinical social workers, committed to patients' self-determination, such considerations are crucial.

Advertising Rates/Sizes

Size on Page	Measurements	Cost
½ page (hor.)	7¾" x 4⅞"	$250
½ page (vert.)	3¾" x 10"	$250
¼ page	3¾" x 4⅞"	$125
⅓ page (vert. col.)	2⅜" x 10"	$165
½ column (vert.)	2⅜" x 4⅞"	$ 85
½ column (hor.)	4⅞" x 2⅜"	$ 85

All ads must be camera-ready.

Classified: $1 per word, minimum $30, prepaid.

Advertising for the 1986 issues is due March 1, June 1, September 1, December 1.

IN BRIEF *(continued)*

the request or the source of payment. Although clinical social workers may advance and defend their opinions (objectively arrived at), they should strive to assure that their objectivity is not compromised by the adversarial nature of the legal process.

To avoid compromising treatment relationships—and to achieve the desired impartiality of forensic evaluations—it is strongly advised that CSWs not accept the role of evaluator for a current patient. Nevertheless, when clinicians are requested to provide expert testimony about one of their own patients, such testimony must remain as impartial as possible. Clinical social workers must exercise a heightened awareness so as not to entrap themselves in the "hired expert witness" process often seen in the courts.

To establish criteria for the practice of forensic work, the National Federation has formed a forensic committee. The New York State Society also has such a committee. Any state member who provides this type of service or who is interested in this area of practice is invited to join the committee. Please write to me at 135 East 50th Street, Suite 102, New York, NY 10022. □

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CONFERENCE

Friday and Saturday • September 19, 20, 1986

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A CLINICAL CASE SEMINAR

- Based primarily on participants' case presentations.
- This seminar offers the opportunity to discuss treatment cases from several psychoanalytic perspectives (developmental, self psychology, and object relations theory).
- 12 sessions, starting October 1986.
- Specific attention will be given to the process of diagnosis and choice of interventions in "difficult" and "stalemated" cases.

Faculty:

- **Joan Klein, C.S.W.**
  Private practice of psychoanalysis and psychotherapy. Graduate and member of I.S.P. and the New York Freudian Society. Faculty and supervisor, N.Y.S.P.P.; N.P.A.P.

- **Robert Clark, Ph.D.**
  Clinical Psychologist in private practice. Supervisor, Ramapo Counseling Center. Formerly Deputy Director of Childhood and Adolescent Division of Rockland County Mental Health Center.

For more information contact:

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SYMPOSIUM *(continued)*

[illegible] is her borderline female patient. She noted that her patient's depression could be viewed as a last resort to safeguard the object and the self from aggression.

A lively debate ensued between the self-psychological and more classical theorists during the workshop "The Obsessional Personality: A Narcissistic Perspective," conducted by David McIsaac, Ph.D. with discussion by Harvey A. Kaplan, Ed.D. Kaplan agreed that McIsaac was an empathic and thoughtful therapist who had helped the adolescent boy described in his paper; however, he disagreed that Kohutian principles had led to the successful resolution of the young boy's symptoms.

Susan Zuckerman, ACSW, CSW, is a psychotherapist at St. Luke's-Roosevelt Hospital Center in Manhattan in the adult outpatient psychiatry unit. She has a private practice in Manhattan and Brooklyn and currently serves as co-chair of the Brooklyn chapter referral service.

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