NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. WINTER 1986 • 1987 VOL. XVII, NO. 4

New Board Members Include President-Elect

New Position to Effect Smoother Transition

Robert J. Evans, CSW
President-Elect

Marsha Wineburgh
Second Vice President

Denise Zalman, CSW
Recording Secretary

Marcia Rabinowitz, CSW
Member-at-Large

Theda Salkind, CSW
Member-at-Large

Provision for the election of a president-elect during the second year of the incumbent president's term has been added to the bylaws to facilitate a smoother transition between administrations. The size and complexity of the Society makes this year of orientation a necessity for an incoming president. The first elected to this new office is Robert J. Evans, immediate past president of the Staten Island chapter.

"Involvement. . .on both chapter and state levels has shown how much can be accomplished when colleagues work together," Evans notes. Evans points out the active role of the NYS Society in the professional development of clinical social work and that it serves as the voice of its members to legislators as well as the business community.

In private practice, Evans is also a school social worker for the NYC Board of Education. His two-year term as president will begin in January 1988, when he succeeds Adrienne Lampert, now in the second year of her term as president.

Past president of the State Society 1980–82; member-at-large since 1984; past president of National Federation from 1982–84; Diplomate, and current state legislative chair, Marsha Wineburgh has a long record of service, beginning as a member of the original steering committee to establish the Metropolitan chapter.

As second vice president, Wineburgh plans to "continue pursuing efforts to perpetuate our position as accredited, autonomous mental health professionals." Expanding access to third party reimbursement must include review of medicaid payment which currently does not include CSWs as independent providers. Her consistent and effective efforts have been at the core of the Society's legislative gains over the past several years.

She is a former faculty member and senior supervisor, and Director, Community Services and Education Division, Post-graduate Center. Her private practice is in Manhattan.

As newly elected recording secretary, Denise Zalman seeks a more active role in shaping the future of the Society as a "professional organization which safeguards,

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Conference to Address Influence of HMOs on Clinical Practice

By Marsha Wineburgh, CSW
Legislative Chair

An all-day conference, "The HMOs Are Here! The PPOs Are Here! Critical Issues for Clinical Practice," will take place on March 14th. Jointly sponsored by the education, legislative and vendorship committees of the NYS Society, the conference will address changes in the delivery system of health/mental health care and explore the implications for clinical practice.

Fourteen million Americans have left traditional fee-for-service health care in the past six years, taking their flus, ulcers and depressions to more than 300 Health Maintenance Organizations (HMOs) across the country. No longer are HMOs and their relatives, Preferred Provider Organizations (PPOs) considered alternative sources of health care. An estimated 20 percent of our population will belong to prepaid health plans by 1993.

In this metropolitan area, the Health Insurance Plan of Greater New York (HIP), with annual revenues reported approaching $500 million, is the oldest. Mayor Fiorello LaGuardia encouraged its establishment in the late 1940s; it is second in size only to Kaiser Permanente in California.

In fact, the first HMO is said to have started in that state in 1929 when two physicians contracted with the City of Los

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EXECUTIVE REPORT

NYS Members: Stand Up and Be Counted

Since assuming the responsibility of State president a year ago, we can see progress: toward accomplishment of our five-year goals; in structuring and defining the many components of the Society; communicating regularly with members; instituting a professional public relations program; we have in place a working computer programed by Hillel Bodek and functioning well under Mitzi Mirkin's tireless effort in learning its operation. We are legislative "watchdogging" and spearheading new legislation with the experience of past efforts. The cooperation of three state committees will produce a conference on HMOs, PPOs and their effects on clinical practice (see article, page 1).

In spite of all this activity, I am consistently disturbed by the fact that the clinical social work profession is not where it could be, should be and deserves to be.

In the *New Age Journal*, November/December issue, the cover picture depicts a man holding a bank check that reads "Social Worker turned corporate exec, $150,000, more than he made in the last ten years." This lead article is entitled "Career tradeoffs—Doing Well vs Doing Good." Interestingly, the six persons interviewed were a former high school teacher, a medical researcher, a legal educator, a journalist, a producer of slide shows for non-profit organizations, and a psychologist. Not one social worker interviewed, yet our professional title associated with 'do-gooder' and used as a cover line. Why are we still trapped in this image? The article in no way diminished the profession of social work; it merely highlighted the concept that well educated professionals no longer are willing to go unrecognized and unrewarded.

We still struggle with our own identity. How often do we call ourselves by titles other than clinical social workers? We have a broad base of knowledge regarding psychosocial development with all that that implies: clinical training in human development and psychopathology, interpersonal relations and the effects of environmental and physical stress. We have professional expertise as mental health practitioners. Yet through the years this advanced specialty called clinical social work has struggled to be recognized and differentiated. I believe it is this very issue that birthed the clinical state societies, the Federation and the National Registry. Having achieved certification and mandated vendorship in this state and others, we still have not reached the level of autonomy for professional recognition. Continuing efforts will achieve this.

The big job facing us, however, is within our profession. We practice as professionals both privately and in agencies. In agency practice we are often still viewed as an adjunctive professional rather than the primary provider. We are unskilled in aggressively demanding our place in the profession, the marketplace and the public arena. This is the responsibility of each of you and all of us—to be vigilant, educated and prepared to articulate clearly your identity as a clinical social worker.

How is it possible, twenty years down the road, that there are still clinical social workers who have not heard of our State Society? Are we secretive, or is it that we have never learned how to champion our own cause? Other professions seem to have little difficulty in stating who they are, what they do, and where and how they wish to practice. And so must we.

We must forthrightly identify our profession, interest our colleagues in joining our Society, and become educated to the ways of promoting our profession. Let us make this our resolution for 1987 so that 1988 will bear our professional fruit.

Adrienne Lampert, CSW, President

CSWP

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Federation Report

Goals, Priorities Reviewed at Fall Meeting

Tri-State Collaboration Planned

San Antonio, Texas, Oct 31–Nov 2, 1986—Attending a Federation meeting as the NYS representative, one gets a perspective on where clinical social work has been, is at present and must still go. The gathering and meeting of 37 state societies, each with an agenda and representing a constituency with particular needs, proves a herculean task. It all works, however, and each representative leaves with new knowledge and a sense of accomplishment.

As outlined in the October 1985 meeting, goals were reviewed, priorities, strategies and tasks were set. These include:

1. **A strong national advocacy program** that includes monitoring legislation regarding mental health issues as well as identifying those areas of concern for future legislative and/or organizational efforts. The Federation will continue to foster and maintain coalitions/liaisons with related organizations.

2. The vendorship program will encompass **a broad marketing effort** to influence payors to include CSWs as autonomous providers of mental health services to the business community, especially in substance abuse and/or chemical dependency. The Federation will offer consultation and training to state societies in dealing with vendorship/licensure regulation.

3. A broad **promotional campaign in education** will undertake to influence schools of social work to strengthen clinical curriculums; establish working relation-

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Love, Intimacy, and the Fear of Commitment

Report by Gila Fogelman, CSW

What is intimacy? Is it opening up to a stranger you sit next to on a plane? Is it having sex with a partner you never see again? Can one be in an intimate relationship without sex? These and many more questions were raised at the day-long conference on love, intimacy and fear of commitment sponsored by the American Academy of Psychoanalysis last November.

A distinguished group of panelists, including Helen Singer Kaplan, M.D., Jean Baker Miller, M.D., and Theodore Isaac Rubin, M.D., gave brief presentations that were followed by discussion among the panelists and questions and comments from the audience. Although the discussions were stimulating, it was unfortunate that limited time did not allow speakers to elaborate on their ideas. The afternoon was devoted to workshops on topics related to intimacy.

The notion of intimacy is especially fascinating and challenging since we live in a time of alienation. Intimacy, it was generally agreed, is an experience that promotes growth and development within the context of a relationship. While the notions of love and sex appear closely related to intimacy and may be components of intimacy, they are not necessarily the most important elements. Rather, intimate relationships can be understood in a context of interactions

True intimacy can promote growth and development.

affording communication and mutually enlarging and empowering experiences. As Dr. Baker stated, "We love the people who engage with us and who feel expanded by us." The process of fostering growth and expansion happens in many relationships, e.g., mother/child or teacher/student or therapist/patient.

"Fear is at the bottom of what disturbs intimate relationships," Baker asserts. "We build elaborate systems to prevent us from developing intimate relationships." Another idea presented concerns gender differences. These stem from cultural norms, i.e., women were raised to become nurturers and encouraged to devote themselves to others; men were encouraged in self-fulfillment. Drs. Kaplan and Baker agreed, however, that, in spite of gender differences and variations in intimacy needs, men and women also need similar things: a connection that will promote growth and wellbeing.

The focus on intimacy was exploratory rather than therapeutically directed (therapeutic interventions were addressed in the workshops). In discussing technique, Dr. Kaplan agreed that, while understanding the psychodynamics in a relationship is important, what is often needed is modifying negative thoughts and feelings toward one another. She emphasized the need to deal with presenting problems before dealing with the underlying issues.

Therapists can work with couples to change negative ways of relating.

Dr. Rubin presented his theory of four types of relationships: creative, cooperative, adversarial and antagonistic. He believes there is an element of all four in relationships but what is seen more frequently reflected in society (soap operas, etc.) is the adversarial and antagonistic. In using this theory in treatment, Dr. Kaplan suggested that therapists can work with couples to help them identify and change a negative way of relating to a more effective way. For example: "What would it take to change, to make the relationship more positive?"

Dr. Ian Alger defined intimacy as a subjective relational experience in which one is trusting and self disclosing, and the response is communicated empathy. Dr. Alger maintains that four crucial elements must be present in a relationship: attachment and caring; communication; joint problem solving; and the integration of these leading to mutuality. When a couple is unable to communicate, there can be a failure in the relationship—actually a denial of problems and a lack of intimacy.

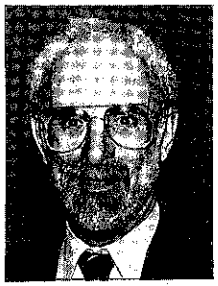
In intimate relationships people need to reach beyond self to another and provide mutual support. When love and intimacy is authentic, a mutual commitment is possible. Intimacy is a vital developmental stage in life.

Gila Fogelman, CSW, *a graduate of NY School for Psychoanalytic Psychotherapy, is on the faculty at Brooklyn Institute and is in private practice.*

A QUESTION OF ETHICS

Clinicians Should 'Collect' Directly from Clients

By David G. Phillips, DSW



A very experienced colleague recently asked for the name of a good collection agency. In reviewing the accounts of his private practice, he was dismayed to realize that current and former clients owed him several thousand dollars and that a number of these debts had been building up for a long time. He wasn't too happy with my response to his inquiry.

In the first place, I did not know of any collection agencies; secondly, I warned him that turning over the account of a client or former client to a collection agency could possibly be the basis for both a law suit against him as well as a claim of an ethical violation. It is striking that an ethical practitioner who would never reveal the names of his clients or any information about them in ordinary circumstances would consider turning over past due accounts to a collection agency.

In his excellent book on professional liability, Douglas Besharov has identified "inappropriate bill collection methods" as one of those areas of liability (The Vulnerable Social Worker, National Association of Social Workers, 1985, p. 9). As Besharov points out, many states have laws which forbid "overzealous" methods of bill collection. The professional who

A practitioner has no control over methods used by a collection agency.

employs a collection agency has no control over the methods used by that agency. If the collection agency uses methods such as abuse, threats of criminal prosecution, or disclosure of false information, the professional who employs it may also be held liable for the harassment of the client. Both the collection agency and the person or agency employing it may, therefore, be the target of a law suit if such harassment takes place. As serious as these areas of liability may be, however, they are not the only possible consequences of turning the names of clients over to collection agencies.

Both the Code of Ethics of the New York

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BOOKS

Borderline Patients: Psychoanalytic Perspectives
Sander M. Abend, M.D., Michael S. Porder, M.D., and Martin S. Willick, M.D., International Universities Press, Inc., New York, 1983, 243 pp.

Reviewed by
Rosalie Korte, CSW

Professionals at all levels of experience and training will benefit from reading this informative and well written text. The book comes out of a Kris Study Group at the New York Psychoanalytic Institute. The group's findings were presented at the Institute's monthly meetings between 1973 and 1977. The authors' theoretical point of view is ego psychological within the framework of classical Freudian theory.

The concept borderline personality as a category is examined using clinical material from four analytic cases, in which traditional psychoanalysis was begun and completed. Obviously, the data was skewed toward higher level borderline patients, since there is a consensus that the majority of borderline patients are not considered analyzable. Given that limitation, some interesting confirmations resulted from this group's in-depth examination. Most of the major "truths" of experts in the field on borderline pathology were not upheld.

Strong Identification with Disturbed Parents

The book is more valuable, and on safer ground, in my opinion, for the validations rather than for the nonvalidations posed. Findings include evidence of more severe oedipal problems in borderline patients than evidence of pregenital ones. Intense triangular conflicts are revealed and all four patients made strong identifications with seriously disturbed parents. In such identification, the patients took on sadistic aspects of their parents' personalities. Object relations were characterized by marked sadomasochistic features. Projection went along with, or was a corollary of, failure to differentiate clearly between self and object. A profound degree of narcissism showed in each patient studied—not seen as caused by failure of parental empathy or by a separate line of development from libidinal and aggressive drives. In the severe reactions to separation, the authors contend that no evidence suggested that this was due to early maternal deprivation or maternal insensitivities. The most prevalent defenses were those of projection, denial, acting-out, identification with the aggressor, the use of one drive derivative to defend against another, and sadomasochistic regression.

These patients developed intense transference reactions. There was no clear-cut disturbance in feelings of reality although there was considerable faulty reality-testing caused by serious impairment of perception, memory and judgment. Deficits in ego function were understood as being a consequence of conflict.

The Kohutians will be disappointed with the writers' presentation; the Kris Study Group seems to find nothing of value in the newer concepts or terminology, whether it be transmuting internalizations or that older devil, projective identification.

Traditionalists Reviewed

The review of the contributions of Mahler, Jacobson, Kohut, Klein and Kernberg will be welcomed by all as a worthwhile summary. Kernberg is most seriously considered for his contributions in this area. He fares not much better than Kohut, however, as the traditional analysts turn back to basics to explain that for which the newer theorists have invented new names. Technical suggestions of Kernberg, Rinsley and Masterson were reviewed, with the group's members concluding that they could not subscribe to special or specific treatment techniques as necessary for the treatment of borderline patients, nor could they implicate specific difficulties during a particular phase of development which would invariably lead to borderline disturbances. Moreover, they could not determine that preoedipal conflicts were more crucial than later ones of childhood in producing borderline pathology and could not support the idea of a greater degree of innate aggression in these patients.

No one specific treatment approach is correct in all cases

The Kris Study Group's conclusion is that the diagnosis of borderline personality is no more than a broad, loose category of character pathology, not a clear diagnostic entity with specific conflicts, defenses and developmental problems. These clinicians maintain that there is no specific etiological determinant in the development of borderline pathology. Therefore, there is no one specific treatment approach optimal in all cases. What is required is the exercise of conventional analytic skills and a thorough understanding of established analytic concepts. These must be employed with unusual tact, patience, confidence and persistence.

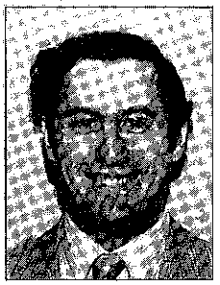
Abend, Porder, and Willick have done an excellent job of compiling the findings and summarizing the conclusions of the case material. They make it sound so simple. Why is it such hard work when one does it?

***Rosalie Korte, CSW, ACSW,** Society Fellow, is in full time private practice in Forest Hills. A graduate of the Institute for the Study of Psychotherapy, she is a training supervisor and faculty member at NY School for Psychoanalytic Psychotherapy, a member of its board of directors, the board of Psychotherapy Referral Service and of Bleuler Psychotherapy Center.*

IN BRIEF

Request for Patient Records: The Legal Obligation

By Hillel Bodek, CSW



Recently, an irate clinical social worker called me to say that the record of her treatment of a patient had been subpoenaed. She indicated that the patient had come to see her for treatment of a traumatic neurosis and was in the process of suing those allegedly responsible for the trauma. The therapist believed that it would be emotionally harmful to the patient to have the treatment record made public and protested that she would destroy her record to protect her patient rather than turn it over to the court.

Discussion with several colleagues as to how to handle such a situation resulted in the suggestion that therapists maintain one record with diagnosis and basic information and a second record that would contain information more personal in nature—and provide only the first record in response to a subpoena in order to protect patients.

As well intentioned as such zeal may be to protect the confidential nature of our treatment, the way these clinicians proposed to do so would violate both the law and the

Society's Code of Ethics.

When one party in a legal proceeding places at issue the question of his/her mental condition, such patient is generally deemed to have waived the right to assert the privileged nature of communication with mental health professionals.

Both sides need relevant information in litigation.

For instance, if a criminal defendant pleads a defense of insanity, relevant information about this defendant's mental condition must be made public. If a plaintiff in a civil matter is seeking monetary damages for emotional harm, the nature and extent of any preexisting mental condition from which the plaintiff may have suffered must be exposed. Simply put, one cannot place one's mental state at issue in a legal proceeding and then preclude the other side from obtaining information that is needed to respond fully to that issue in court.

Protection for Patients

Lawyers are permitted to issue subpoenas without prior court approval. The following procedure may be employed by clinicians and may serve both the legal obligation and the patient. If a therapist receives a subpoena for a copy of a patient's treatment record, the patient should be informed. The therapist can suggest that the patient notify her/his attorney. At this time the clinician can also write a letter to the opposing attorney (who ordered the record), indicating that, because of the confidential nature of the record, a court-ordered subpoena (one signed by a judge) is requested.

Once the therapist receives this type of subpoena (signed by a judge, with his/her title) and showing the court seal, a patient's record may be sent directly to the court.

It is the patient's responsibility to assert the privileged nature of a professional relationship.

If there is material in the record that the practitioner believes is not germane to the pending court proceeding, a cover letter indicating this can accompany the record, addressed to the court, requesting the court to examine the record "in camera" before releasing it. In this manner, the judge can review the record and redact confidential material that is not relevant to the case at hand before allowing the requesting attorney to view the record.

The patient, through his/her attorney, may also request the court not to permit release of the record by making a motion to "quash" the subpoena. If the patient is aware that the record has been subpoenaed, it is up to the patient, not the clinical social worker, to assert the privileged nature of the record as a bar to its release.

If the patient is unaware of the subpoena, a letter may be sent to the court with the record indicating that such material is protected by the therapist-client privilege (CPLR 4508), informing the court that the patient has not been informed that the record has been ordered, and objecting to the further release of such record by the court.

In responding to a court-issued subpoena, the clinical social worker's primary responsibility is as a citizen and as a licensed professional to comply with a lawful court order. Destroying a record under the misguided notion that this will protect the patient, or failing to comply fully with the subpoena by submitting only a portion of the material requested, violates the law and the Society's Code of Ethics. Such behavior can subject the clinician to criminal or civil prosecution, to disciplinary proceedings before the State Board for Social Work, and to the charge of violating the NYS Society's Code of Ethics □

A QUESTION OF ETHICS *(continued)*

State Society and the "privileged information law" for social workers in New York State (Section 4508, New York State, Civil Practice Law & Rules, Code of Evidence) define not only the obligation of confidentiality, but the circumstances under which the social worker may be released from that obligation. We may, for instance, reveal confidential information which the client authorizes us to release to those whom the client authorizes. In cases where there is reason to believe that there may be abuse and/or neglect of children, we are required to report even though the information may have been revealed in a confidential context and whether or not the client permits its release. In such a situation, as a matter of fact, the professional may well be held liable for a failure to report. There is, however, no support in our ethics code which permits us to violate our obligation to maintain confidentiality merely because a client or a former client owes us money.

Some states have passed laws which permit psychotherapists to release overdue accounts to collection agencies, but specify the steps that must be taken before referral to such an agency, and what information may be revealed. Agencies and therapists who might feel the need to use collection agencies should not automatically believe that they may do so but, at the very least, should become familiar with the relevant laws in their state. □

CONFERENCE *(continued)*

Angeles to provide health care to certain city employees for a preset fee. The growth of prepaid health plans was spurred by the HMO Act of 1973, which provided federal funding and guidelines for their development. New York, one of the first states to fully endorse the HMO concept, provided for certification of these plans in 1977. Some 1.5 million persons are now enrolled in 17 HMOs approved by the State Department of Health, including Maxicare, U.S. Health Care and Empire Blue Cross/Blue Shield Healthnet. A dozen more await approval.

What is an HMO? Basically, a combination of the traditional indemnity insurance plan (like Blue Cross/Blue Shield) and a health care delivery system, comprising four components:

1. An HMO contracts to assume responsibility for delivering a range of comprehensive health care services to its subscribers. In New York the benefits package usually includes physician care, emergency care, laboratory services, X-rays, inpatient and outpatient hospital services. Those benefits that have implications for mental health include preventive services, a limited number of visits per year for acute mental health problems, and medical care for drug and alcohol abuse.

2. A patient population voluntarily elects membership in the plan.

3. Each enrollee (or company) pays a *fixed* annual or monthly fee that is independent of the number of times the health service is used. Sometimes a small per-service fee is charged, usually not more than $1 to $5 per visit.

4. The HMO assumes part of the financial risk or gain in the provision of these services. Thus, the HMO has built-in incentives for reducing unnecessary and/or costly hospitalizations and for minimizing future demand for health care services through prevention and wellness programs.

In planning this conference, Marcia Zigelbaum, education chair, and Harry Grabarz, vendorship chair, share with me a concern for the impact of these changes on our ability to deliver quality mental health services to those enrolled in HMOs. We hope you will join us to discuss these issues.

Date: March 14, 1987
Time: 8:30 AM–4:30 PM
Place: Association of the Bar of the City of New York
42 West 44th Street, N.Y.C.
Fee: $50.00 members
$65.00 non members
$18.00 lunch (optional)

FEDERATION REPORT *(continued)*

ships with other professional organizations to promote continuing education; support educational efforts in clinical social work specialties, e.g., psychoanalysis, forensic work, etc.; explore the establishment of national standards for a doctoral degree in clinical social work; help state members to develop postmasters clinical training.

4. **A public relations program** will establish guidelines for marketing consistent with the code of ethics and increase both visibility and credibility of advanced clinical social work practice credentials.

5. **A national Federation office**, to be established by May (1987), requires an "action plan" for this project, including a description of the scope and function of such headquarters and identification of funding sources for staffing, space and operations.

President's Report

Prior to the fall meeting, Federation president Elizabeth Horton, past president Sid Grossberg and vendorship chair Gary Unruh met with representatives of NASW to explore the formation of a joint committee to establish a forum for consultation on issues that affect clinical social work. The hope is that such a group could heal the divisiveness between our two groups and work collaboratively for the benefit of the profession. The Federation board approved this liaison committee with clear limits that ensure the integrity and identity of the Federation and its objectives.

The Federation was informed of the proposed inclusion of several controversial new diagnoses in the forthcoming *DSM III* including:

a) Paraphelic coercive disorder (i.e., rapism)
b) Periluteal phase dysporic disorder (PMS)
c) Self-defeating personality disorder

The first has been dropped. A letter will be written to reflect our opposition to the remaining two and our concern that such decisions are made by psychiatry alone without input from other mental health disciplines.

National peer review, set up as a separate corporation, is not presently "doing business." Its only contractor is Norman Penner of APA, who will not sign us on since NASW will not cooperate in CSWs' being peer reviewers under the National Federation banner. President Horton, Sid Grossberg and Amy Garnett, peer review chair, will be meeting with their NASW counterparts to negotiate a solution.

Of special interest to NYS members—more than 400 members are now enrolled in the committee on psychoanalysis, and the

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FEDERATION REPORT *(continued)*

national board approved a plan to establish a national program. Credit goes to Creighton E. Rowe for his leadership and perseverance in establishing psychoanalytic practice as a modality in clinical social work.

The definition and proposed ethical standards for the practice of forensic social work were adopted. Hillel Bodek has spearheaded this effort and deserves special recognition

Report from Ken Adams, Federation Advocate, Washington, D.C.

Federation Employees Health Benefits Program (FEHBP)

All CSWs are now mandated for coverage; however, each plan has the right to impose the requirement for a psychiatrist's signature. This issue is by no means settled; a coalition of non-physician professionals is committed to attaining independent provider status.

Public Health Service

Six months ago this agency announced that all health care personnel employed would require a license. NASW urged that ACSW be the requisite credential. Through the Federation's efforts, however, it was agreed that, where a state had no licensure, an MSW plus two years' supervised practice in addition to membership in the National Registry or NASW Register would be required for employment.

CHAMPUS

One of the catchwords of the Reagan Administration's second term has been "privatization"—turning over to the private sector functions previously assigned to government, with the hope that competitive free market forces of supply and demand will more efficiently allocate scarce resources.

The latest experiment in "privatization" is the Civilian Health and Medical Program of the Uniformed Services—the huge health insurance program that provides care to six million military families and retirees. Last June the Defense Department announced its intention to invite proposals from private companies to operate the entire $1.8 billion CHAMPUS program at a fixed price contract. The contractor would be at risk if costs exceeded the contracted amount to provide the agreed-on services; if costs were less, the contractor would profit. In either case, the government's cost would be fixed in advance.

Needless to say, the large "super-med" groups are very eager about the prospect of a contract this large. Whatever group is awarded the contract will be in a position to assemble the largest single health care network in the country—hospitals, clinics, providers. Once that network is in place to serve the CHAMPUS contract, it will be available to be marketed throughout the private sector. One example of the kinds of partnerships that are being formed to share the risk and bid on this enormous contract is a consortium of the Hospital Corporation of America, Equitable Life Assurance Society and Blue Cross/Blue Shield of South Carolina (which recently informed Senator Daniel Inouye (D-HI) to assure him of their intention to fully utilize licensed non-physician providers and peer review in their delivery structure in the event they are awarded the contract).

Congress, on the other hand, is not yet prepared to endorse the notion that a governmental agency created by statute can contract out its entire function, without legislative authority from Congress. In the wake of criticism from members of Congress and some segments of industry, CHAMPUS recently retreated from its announced intention to award the contract this year. CHAMPUS now plans to proceed in three stages, with the first third in place by the end of 1987. Whether this is just a slowdown, or the beginning of a full retreat, is unclear at this point.

Catastrophic Health Insurance

Some months ago Reagan identified as a major health initiative for his second term the problem of protecting citizens from the devastating economic effects of a catastrophic illness or injury. He appointed a private/public sector Advisory Committee on Catastrophic Illness, chaired by James Balog of Drexel Burnham Lambert to solicit input from both public and private sectors and to make recommendations on addressing the problems of affordable insurance for catastrophic illness. The National Federation urged the committee to keep in mind in the design of any proposals that catastrophic mental illness is just as devastating as physical illness and not to repeat the mistake of past governmental programs which have treated mental health coverage differently from physical health. We were pleased to find that the committee heeded our request and that its initial report to the President embraced mental health needs as well as physical health. □

BOARD MEMBERS *(continued)*

publicizes and promotes the effectiveness" of its members.

Presently chair of the state referral committee, Zalman is on the faculty and is a supervisor at both Postgraduate Center and Brooklyn Institute for Psychotherapy. She is in private practice in Manhattan.

A Diplomate and charter member of the Society, Marcia Rabinowitz is corresponding secretary for the Metropolitan chapter and editor of its newsletter. In seeking to serve as member-at-large, she continues her participation on the state level, having served as membership chair and secretary.

Rabinowitz, in private practice, sees the continued effort in legislation, the "promotion of the image of the clinical social worker as defined by the Society," and maintaining high professional standards as important issues for the organization.

A founder of the Staten Island chapter, Theda Salkind served as its treasurer from 1983–86 and is now its membership chair. She has been re-elected as state member-at-large. She was chair of the arrangements committee for the Society's 1985 annual meeting and co-chairs the state's membership committee.

Salkind, in private practice, believes that the Society must try to broaden its membership base and "interpret our knowledge and skills to the consumer." □

Between the Devil and the Deep Blue Sea

Back when the hulls of ships were made of wood, sailors called the narrow space between the deep sea and the long stem-to-stern plank along the side of the ship the "devil." Here the footing was narrow, and so was the margin of choice. What a devil of a place to be!

An intensive training program in

Psychoanalysis *and* Psychoanalytic Psychotherapy

The Institute for Contemporary Psychotherapy, a non-profit organization chartered by the Board of Regents of the State of New York, is now accepting applications for admission to its 4-year Training Program.

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For further information contact:
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