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

Sibling Relationships Explored at the 28th Annual Clinical Conference

The May conference, "Siblings: Impact on the Individual, the Family & Interpersonal Relationships," held in New York City and chaired by Dianne Heller Kaminsky MSW, BCD, drew over 200 participants. Keynotes are reviewed here.

Impact of Sibling Relationships on Development and Psychic Experience

KEYNOTE BY JOYCE EDWARD, C.S.W., B.C.D.;
Summary by Roxandra Antoniadis, Ph.D., C.S.W.

The power of rivalry, envy and hatred between siblings, so fixed an element in our conceptualization of family since the archetypal disposition of Cain toward Abel, dominates much of the psychoanalytic thinking on sibling relationships. While literature and history are filled at least equally with quite opposite and far more subtly differentiated examples of sibling interaction, it is only in the last fifteen years or so that the complexity of these relationships, including their libidinal aspect, has approached the forefront of our research.

In the introduction to her keynote presentation, Joyce Edward cited portraits by Austen and McCullers in fiction and such real-life affectional bonds as those sustained by the Van Goghs, the Huxleys, and the Kiplings. A brief review of some of the more salient reports by contemporary

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2nd Annual Conference Review

Sibling Triangles

KEYNOTE BY JUDITH GILBERT KAUTO, MSW
Reviewed by Josephine Ferraro, CSW

Judith Gilbert Kauto of the Center for Family Living delivered a rich and evocative presentation which focused on the importance of triangles in sibling relationships. Using the film, I Never Sang for My Father, and her own personal family history, she demonstrated how triangles complicate the relationships between caring siblings.

Ms. Kauto discussed how early loss on two generational levels, in terms of alcohol abuse, emotional cutoffs, significant shame, and the role of the male child in restoring the family's respectability, affect sibling relationships in the film I Never Sang For My Father. The film demonstrates how unresolved emotional issues surface for the siblings after their mother dies. In the first segment of the film, Gene and Alice reminisce about the past. The segment closes with a quiet scene of Alice and Gene each lying in their former childhood beds the night before the mother's funeral. In the second segment of the film, there is an emotional explosion between the siblings and their father. It is evident that the ghost of their mother still exerts a powerful influence in the triangle between Alice and Gene, and their father, Tom.

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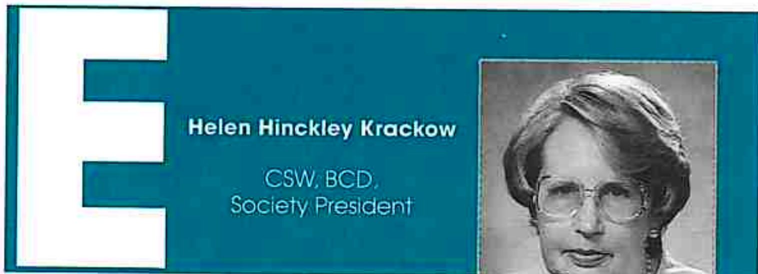

Helen Hinckley Krackow

CSW, BCD,
Society President

My dear colleagues:

I bring you important news regarding our Federation's progress this summer in securing the field of clinical social work on a national level. In these next few years mental health practitioners will need the representation and protection that the Clinical Social Work Federation (CSWF) offers even more than we have in the past. Clinical social workers need a strong national presence as our nation considers such changes as medical savings' accounts, single-payor coverage, and as our citizens are threatened with national healthcare data banks. It is important to that our Society members in New York State understand the mission of the Federation and know about its initiatives.

Through the efforts of Federation President, Betty Phillips, and our national legislative chair, Denny McGihon, CSWF has secured a social work seat on HCFA, the Health Care Finance Administration. HCFA sets the Medicare rates and, therefore, can and has been used by the managed care industry to set the reimbursement rates. NASW who has had the seat to date will have the seat as observer. Influence here and in other national health care committees is vital to the survival of clinical practice.

The CSWF is also participating in a survey that has been developed by the American Medical Association (AMA) to determine the "relative work value" of the new psychotherapy codes used in Medicare billing. It is vital that our organization participate. Research surveys have been sent to a random sample of Federation members.

The professional standards of the Federation are being revised to guide clinical social workers on the ethics of practice in the climate of managed care. These should be published shortly.

The Federation has mobilized an evaluation of and response to the Model Practice Act of the American Association of State Social Work Boards. Much of this bill was acceptable but there was an alarming blurring of the boundaries between baccalaureate social work and clinical social work that went unchallenged by other social work organizations.

These are just four of the accomplishments of the Federation in the last six months. They show its progress in fulfilling its mission. As a reminder to all members its mission statement is as follows:

To promote excellence in Clinical Social Work practice through the development and advancement of the profession for the benefit of clients and clinicians who serve them by:

- Advocating on behalf of members of the state societies with the federal government and other national organizations.
- Assisting state societies in education, marketing, reimbursement, research image building, promoting standards, and competence, legislation and regulation, and related areas at the state and national level.
- Providing the means for clinicians with common interests to work collectively on a national level; and
- Providing information to and advocacy for client populations who need and can benefit from clinical social work services;
- So that the practice of clinical social work is enhanced as an independent and economically viable profession.

I, as President of the New York State Society for Clinical Social Work, can assure our members that the CSFW is actively fulfilling its mission. The organization deserves our acknowledgment, support and gratitude.■

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Mitzi Mirkin Honored

At the June meeting of the State Society, a presentation was made honoring Mitzi Mirkin, Executive Secretary, on the 20th anniversary of her dedicated service. "Mitzi does so many jobs for us intelligently and with a smile, and usually before we think to ask," Sharon Kern-Taub, CSW, BCD, State Membership Chair, said. "She is also the one person who knows nearly everything that has happened in the organization for the last 20 years, and nearly everyone. She is a great asset and a dear friend to us." A gold bracelet was presented to Mitzi as a token of appreciation.

MANAGED CARE & VENDORSHIP

John Chiaramonte, CSW, BCD, Chair

COMMITTEE REPORT

The Managed Care/Vendorship Committee has received numerous member complaints of improper practices of managed care companies and continues efforts to persuade various (member reported) self -insured companies to alter their benefit plans to include clinical social work reimbursement. .Regarding the latter, the following companies which do not recognize clinical social workers for reimbursment and are currently being marketed by the committee for benefit inclusion are: Bear Stearns, Chemed Corp., Ford Motor Credit Co., IIT Research Inst., Pepsico, Sun Chemical, The Mark Hotels, TGI Fridays, UIDC and Unisys.

Examples of three complaints from membership are:

- that Vytra formed a new provider network (Vytra/VBH) which replaced the Vytra/Options panel. They requested V/O providers terminate with their patients and send them back to the company for reassignment to the new panel. This new panel is smaller and accepts a reduced fee. Certain groups are soliciting Vytra/Options providers to be included in the new provider group (Vytra/VBH) if the clinician joins their group (fees for joining are from $500-$1000). The committee has forwarded these complaints to the DOH, the Attorney General's Office and the Public Advocate.

- that CMG (which represents various HMOs in NYS) is requesting clinicians to mail in complete medical charts for an in house quality review and scoring for "quality assurance". This request seems clearly contrary to the NYS law S7553, and this was documented and forwarded to the DOH, Att. General's Office and the Public Advocate for their investigation. Clinicians should be warned that to blindly follow the request of a managed care company in violation of the rights of your patient, could leave the clinician facing a professional ethics violation as well as malpractice liability.

- that various MSOs (managed service organizations) are in practice violating the NYS law against fee splitting. These companies typically contract with a variety of HMOs to provide for mental health services, and then proceed to enlist a provider panel. However, they usually take a portion of the managed care per session fee (sometimes up to 35% and even 40%) for their administrative fees. The DOH, Att. General's Office and the Public Advocate have been asked to investigate these practices.

BE PART OF THE SOLUTION: SHOULD YOU ENCOUNTER THE PROBLEMS LISTED ABOVE, OR OTHER LIKE PROBLEMS WHICH MAY BE IN VIOLATION OF NYS LAW, PLEASE CALL AND HAVE YOUR PATIENTS CALL. GOVERNMENTAL AGENCIES RELY UPON CONSUMER COMPLAINTS TO BEGIN INVESTIGATIONS. THE LARGER THE OUTCRY, THE QUICKER THE ACTION.

- **THE NYS DEPT OF HEALTH MANAGED CARE HOTLINE: 800- 206-8125**
- **THE NYS ATTORNEY GENERAL'S HEALTHCARE HOTLINE:888-692-4422**
- **THE NYS PUBLIC ADVOCATE'S OFFICE: HEALTHCARE COMPLAINTS: 212- 669-7606**
- **THE CLINICAL SOCIAL WORK FEDERATION'S HOTLINE: 800-270-9739**
- **TO GET A COPY OF NEW YORK STATE LAW S.7553 CALL: 800-342-9860**

NEWSFLASH: THE VENDORSHIP/MANAGED COMMITTEE IN COLLABORATION WITH THE STATEN ISLAND CHAPTER SOCIETY PRESIDENT, JUDITH WEISS, HAS ASSISTED LOCAL 1199 IN THEIR EFFORTS TO DEVELOP A NEW BENEFITS PLAN FOR MENTAL HEALTH. THE NEW PLAN, SOON TO BE ANNOUNCED, WILL OFFER AN ENHANCED BENEFIT PACKAGE WHICH WILL ALLOW ENROLL-EES ACCESS, CHOICE, CONFIDENTIALITY AND QUALITY CARE. IT WILL NOT FALL UNDER MANAGED CARE AND IS BY OUR ESTIMATION A QUALITY BENEFIT PACKAGE WHICH ACCENTS CARE WHILE CONSIDERING COST. LOOK FOR THE ANNOUNCEMENT OF THE PLAN IN OUR NEXT *CLINICIAN.*

NEWSFLASH: The New York State Society for Clinical Social Work's Vendorship/ Managed Care Committee has actively joined with the Alliance for Universal Access to Psychotherapy, the National Coalition of Mental Health Professionals and Consumers, and the American Association of Private Practice Psychiatrists in an effort to interest the Justice Dept. and the Federal Trade Commission to open an investigation of the managed care industry. These clinical organizations have been concerned about what appears to be collusive actions on the part of the managed care industry. These actions have seemed aimed at establishing (minimal) standards and measures for the delivery of mental health care, and having achieved that, have sought some legitimacy for these standards. The allegations that we are making suggest that there may be violations of the Sherman Antitrust Act with regards to various illegal and anti-competitive practices.

EDITORIAL by John Chiaramonte

Acceptance of Low Fees Is Not the Solution

As the marketing co-chair for the Clinical Social Work Federation (formerly the National Federation of Societies for Clinical Social Work), I receive numerous phone calls from clinicians around the country complaining about the problems of managed care. Clearly, the system is flawed and as such, cannot last. Yes, managed care companies will tell you ad nauseam that they are here to stay, but more and more that feels like propaganda instead of reality. Thirty-nine states have passed legislation to regulate managed care and there is now a strong push in Washington to legislate national regulations of the managed care industry. Additionally, there is a move to stimulate the Federal Trade Commission and the Justice Department to open up investigations of the industry on allegations of fraud and conspiracy regarding Sherman Antitrust Act violations. More importantly, the press and the public are not enamored of managed care. This is evidenced by the fact that, last year, the most sought after benefit plan was the point of service option, which allows insureds the option to choose a provider or hospital outside the managed plan(NYT 8/17/95).

Which way New York goes regarding managed mental health care depends upon how clinicians deal with the system at hand. For example, a recent call from my Kentucky marketing point person related that Greenspring was calling up clinicians urging them to send back their applications and assuring them of acceptance. It seems that clinicians, as a whole, banded together to refuse to accept the poor fee schedule Greenspring had set up. There was a month-and-a-half wait for patients to be referred to a therapist. An opposite example is in California. There, clinicians, feeling that they had no choice, accepted whatever the managed care companies offered. Currently, the fees in California (which have continually declined) are some of the lowest in the nation, with clinical social workers receiving $20 and $25 per session (and, in some plans, lower).

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FAMILY THERAPY

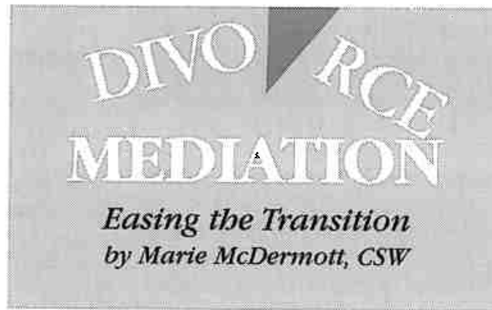
BARBARA FELD, CSW, BCD, Chair

COMMITTEE REPORT

The Family Therapy Committee has spent this past year networking and supporting the heads of the various chapters' family study groups in building and expanding their groups. In addition, we planned the Family Practice panel on Sibling issues for the annual conference. The Nassau chapter's meetings are held on a monthly basis. Contact Marcia Leeds at (516) 868-0523 if you are interested in joining. Anyone interested in joining family study groups in Rockland, please contact your chapter president; and in Mid-Hudson, contact Yasuko Hatano-Collier at (941) 297-1739.

Westchester family practice group meets on the first Saturday of each month at 9:00 a.m. at the County Mental Health Association in White Plains. All clinicians working with couples and families are invited for peer supervision. Contact Susan Gombos at (914) 693-3611 if you are interested. The Metropolitan Chapter continues to hold meetings on the third Sunday of the month from 11:00 a.m. to 12:30 p.m. at 1150 Fifth Avenue, Ste. 1C. We have been reading about various topics of interest to us and inviting guest speakers. The September and October meetings will feature a discussion of sexual problems and couples therapy. Contact Barbara Feld at (212) 410-3680 if you are interested.

If you are a member of the Queens, Suffolk, Staten Island (Bronx or Riverdale are members of the Met chapter, but might prefer their own study group closer to home or office), please contact Barbara Feld at the number above, or your chapter president if you are interested in forming a study group in your chapter. In addition, we are interested in more members as representatives of their chapters, on the state level. Being on this committee would give you the opportunity to have input and promote family practice issues and concerns on the state level. We are very interested in your concerns and support.■



Easing the Transition

by Marie McDermott, CSW

When a couple has irreconcilable diferences, divorce mediation can help them through the difficult decisions they will face. The adversarial process of the law often exacerbates problems, but divorce mediation helps couples and families heal. It is the most humane way to navigate one of life's most stressful experiences.

The behaviors that result in an acrimonious, self-destructive divorce are often the same ones that wrecked the marriage in the first place. When marriages begin, they seem to offer an opportunity for healing to each partner. But, as object relations theorists tell us, there is not as much free will involved in choosing a marriage partner as we would like to think. The selection is mostly an unconscious process — in an attempt to heal ourselves, we unconsciously choose someone who has the qualities which we have cut off in ourselves. The man who has not allowed himself to express feelings because of family prohibitions will be attracted to the woman who expresses feelings with abandon. The woman who has been taught to be self-effacing will be attracted to the man who lets the world know what his strengths are, often in a way that does not help him to achieve his goals.

The tasks of divorce include coping with intense feelings, looking to the future, developing new capacities and supporting children in their developmental tasks . . .so they can go back to just being kids.

At first these differences are exhilarating. One partner enlivens the other; one shores up the other's boundaries. In the early, romantic phase, both partners feel whole, euphoric and each idealizes the another, much like a very young child idealizes his parents. However, what attracts one person to another may lead them to hate the other later on. Suddenly, the spontaneity of the woman that seemed so refreshing now looks crazy; the self confidence of the man that was empowering now looks grandiose. Each partner begins to hate the prohibited part of him/herself now apparent in the other.

If the relationship is to be successful, each partner must grow to allow that hated aspect of the self to become integrated within the self. The man who views the expression of feelings as "wimpy" must learn to be aware of his feelings and verbalize them. The woman who was never taught to think before acting must learn to reflect upon her feelings and then decide how or if she will express them.

This growing and stretching within the relationship is a painful process, but one that all couples must go through. When a marriage partner reconciles with the split-off parts of him or herself, childhood wounds begin to heal. Some couples can achieve this on their own, while others require the help of couples therapy. Those who do not negotiate this difficult phase of a relationship will reexperience the trauma of childhood and will want to escape from the pain it causes. The grim statistics are well known — about half of all marriages end in divorce.

Tasks of Divorce

For those couples that choose to leave the marriage, it is crucial that they complete certain "tasks" of divorce in order to move on with their lives and, hopefully, enter more fulfilling relationships in the future. The tasks are these:

First, coping with the intense feelings that accompany divorce — guilt, anger, humiliation, paranoia, greed and fear. Despondency, depression and sadness are also commonplace. The adversarial legal system reinforces them, intensifying a person's regression. But divorce mediation, properly conceived, can block regression by supporting adult ego functioning and problem solving and empowering the parties. Mediation allows for ventilating and interferes with many projections. By structuring problem solving, it enables each partner to work with the other. Divorce mediation also involves grief work, which allows healing to take place.

The second task of the divorcing couple is to change focus from the past to the future. Because each spouse will play a much smaller role in the other's future, the future must be defined without constant reference to the other's perceived deficiencies or defects.

Placing blame for the demise of the marriage or nursing bitterness over past offenses or infidelities is understandable, predictable and normal in divorce, but it slows the needed transition to a new life. The mediation process itself can counteract this tendency. When a mediator shows faith in a couple's ability to mediate, a kind of spiritual healing takes place, as it does in couples therapy when the therapist's empathy toward each spouse is internalized. Each partner then will try to forgive the other — if only for the relief from bitterness and angst he or she will feel as a result. The mediator who is even-handed and empathetic toward both allows each to listen to the other in more neutral terms. A new kind of relationship begins to emerge. For example, divorcing parents redefine themselves — no longer "losers" in marriage, each now considers the other "my child's other parent." No longer failed ex-spouses, they are becoming successful co-parents.

The third task is to develop new capacities and skills. Women and men have different developmental tasks to perform. For example, during the marriage, women usually play the dominant role in maintaining intimacy with and emotional connection to others, including friends and family. Therefore a major risk for men who divorce is emotional disconnection. They often need to broaden their parental skills and emotional repertoire.

On the other hand, women who have been at home caring for the children will need to comfort them as they tighten the family budget, obtain career counseling and prepare for a job hunt. The woman, whether she has been earning an income or working at home, must embrace change not only as inevitable, but as something in which she takes a pro-active role.

The unfortunate fact is that second marriages have a much higher

The 29th Annual Conference of The NYS Society for Clinical Social Work

SUGGESTED TOPICS:

- Addictions
- Family Secrets
- Sexual Abuse
- Patient-Therapist Secrets
- Adoption
- Sex
- Money
- Infidelity
- Divorce
- Eating Disorders
- Therapist's Illnesses
- Illness in Patient or Family
- Confidentiality

SECRETS & LIES:

Fantasy, Reality, Intrapsychic & Interpersonal Dimensions

CALL FOR PROPOSALS:
We are looking for proposals for workshops and panels from all modalities -- individual, group, family -- as well as from all theoretical orientations. The focus should be on secrets and lies and how they affect us intrapsychically, in the family and interpersonally.

Proposed Date of Conference: May 16, 1998

Deadline for submission of proposals: November 30, 1997

Proposals should be a minimum of two typewritten pages, double spaced, and should include the following:

1. Description purpose, function and teaching objectives.
2. A workshop or panel outline and bibliography.
3. Four copies, with biography on a separate page.

Mail to:
Dianne Heller Kaminsky, CSW, BCD
Chair, Education
1192 Park Avenue, 4E
New York, NY 10128
[212-369-7104]

rate for failure than first ones. Incomplete developmental work during and after the first divorce accounts for much of that failure.

Children's Tasks

Most important of all these considerations is the effect of divorce on children. Judith Wallerstein has alerted us to the long-lasting impact on children of divorce in her book, *Second Chances.* Parents must help their children complete their own set of developmental tasks and make peace with their changed circumstances.

If the children are not helped, the problems that result can include acting out, poor school performance and depression. These problems will make their parents' and their own lives more difficult. The entire family begins a downward spiral.

The developmental tasks for children of divorce are to acknowledge the marital rupture and give up denial and hopes for a reunion. In addition, they must separate themselves from parental conflicts and resume their usual activities. They must, as much as possible, leave the divorce for their parents to handle and go back to just being kids — learning, having friends and fun. This takes time to achieve and they must have support and encouragement from their parents to do it.

Children must come to terms with the many potential losses caused by the divorce including:

- The radical loss of one parent (who moves out of the home) and the partial loss of the other (who assumes added work and financial burdens).
- Loss of a familiar family structure.
- Moving from the family home, neighborhood, friends or school.
- Loss of a familiar lifestyle, income level and extended family relationships (grandparents).

The mediator intervenes on behalf of children to create a consistent, predictable presence and involvement by both parents that helps children reconcile themselves to these losses.

The fourth task is resolving anger and blame. The cooling of a child's anger and forgiving of his or her parents for the losses suffered usually comes with increased maturity and with the help of both parents. However, when parents harbor anger, continue to fight or badmouth each other, the child's resolution of his or her anger and/or guilt is made more difficult. And when the children are involved in their parents' bickering, their ability to develop respectful relationships with the prospective new mates of their parents is diminished.

The fifth task for the child is to develop hope about relationships. This usually will not be achieved until late adolescence or young adulthood. It is a task that takes time and also requires parental support. It will help if the parents each develop good romantic relationships.

Support Adult Ego-Functioning

Accomplishing these tasks of divorce is so difficult because of the divorce-induced regression that interferes. People who are usually generous and caring, during a divorce become greedy, envious, hateful, frightened, dependent and/or vengeful. Parents who have been loving, competent and child-centered, suddenly cannot stop doing things that hurt their children. Mediation can help to block this regression and support adult ego functioning.

Take the example of "equitable distribution," a concept that arises during divorce. Equitable connotes "fair" to the average person. Fairness and sharing are learned through interactions in childhood with siblings. Therefore, feelings of "sibling rivalry" may be stirred up during discussions of equitable distribution. A knowledgeable mediator will approach the matter much differently than a lawyer would. Lawyers "dig in" on their client's behalf, taking a strong position, arguing and making concessions only when absolutely necessary. A woman says to her husband, "I get the house or there will be no divorce." His retort is, "You sell that house or I'll see you in court." The lawyers struggle until a compromise is reached.

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(In divorce) people who are usually generous and caring become greedy, envious, hateful, frightened, dependent and/or vengeful. Parents who have been loving . . . suddenly cannot stop doing things that hurt their children. Mediation can help to block this regression and support adult ego functioning.

The Therapeutic Language of Hypnosis

On March 19, 1997 the Hypnosis Practice Committee of the State Society sponsored its 2nd annual conference: The Therapeutic Language of Hypnosis. The all-day conference, which drew more than 180 social workers, psychologists and other professionals, took place in Manhattan. A riveting keynote address was given by Dr. Kay Thompson, D.D.S., who is internationally known for her work on the language of hypnosis. Dr. Thompson was a student of the late Milton Erickson, M.D. for 28 years. She provided a wealth of information on hypnotic technique, the construction of therapeutic metaphors and use of body language. Her creative uses of hypnosis with dying patients were particularly inspirational. Following Dr. Thompson's address was a panel response which featured Helen Krakow, CSW, BCD, Society President; Susan Dowell, CSW; Kent Jarrett, CSW and William Ballen, C.S.W.. Following lunch and a film about Dr. Erickson, there were four afternoon workshops ranging from beginners to advanced, and to close the day ,there was a wrap-up and group induction by Dr. Thompson.

In his opening remarks, William Ballen, C.S.W., founder and chair of the Hypnosis Practice Committee, said that there is a need for hypnosis to be integrated with and grounded in theory; he pointed to the tendency for training programs to overteach hypnotic inductions while neglecting to provide students with a solid theoretical base to work from in guiding the clinical uses of hypnosis. He presented his relational model of hypnosis, which is rooted in contemporary relational psychoanalytic theory and three hypnoanalytic case studies which illustrated how hypnotic techniques can be developed and used with patients who function on strikingly different developmental levels: a neurotic-range woman struggling with her essentially competitive strivings; a borderline pedophilic man with a highly discontinuous, fragmented identity and a narcissistic, alcoholic man with a life-threatening psychosomatic condition which was treated with hypnosis prior to the initiation of hypnoanalysis

In her well-attended workshop The Language of Couples, Jane Parsons-Fein, C.S.W. illustrated through lecture and videotaped clinical material how hypnotic understanding can be used to work with couples and families. Parsons-Fein teaches how to diagnose mutually-induced pathological states of interaction in couples that stem from their respective families of origin. She demonstrated how the clinician can use that understanding to de-hypnotize or

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A. The Widening Scope of Hypnoanalysis

by William Ballen, CSW, Chair

The changing visions of treatment espoused by many contemporary psychoanalytic authors provide innovative ways of conceptualizing trance as a relational process. In psychoanalysis, the contemporary trend has been away from the classical emphasis on objectivity, clarity and insight to giving primacy to the patient's need to generate experience felt as authentically and distinctively her own. (Mitchell, 1993). What is most significant, in this view, is the primary importance assigned to the patient feeling valued and cared for in a relationship of mutuality with the analyst which eschews classical notions of neutrality and abstinence. This radical shift from an emphasis on understanding to experiencing in psychoanalysis has given rise to the need for techniques which are intrinsically different from the techniques of the classical model. The selective inquiry into what patient and therapist feel about and mean to each other is a theoretical modification that implies the need for therapists to interact and intervene with their patients in more flexible, opened-ended, experientially-oriented ways.

Perhaps the central point of convergence between contemporary psychoanalysis and Ericksonian and permissive schools of hypnosis is the preeminent role of affective experience and imagery. According to Aron, affects are "at the center of the psychoanalytic theory of motivation and at the core of human subjectivity and intersubjectivity". (Aron, 1996) For many patients, hypnosis enables them to quickly identify their feelings with greater clarity and immediacy than they do in the waking state. Where necessary, hypnotic suggestions can also be given to tune down

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B. Language and Mind/Body Communication

by CSWs Susan Dowell and Marie McDermott

Hypnotherapy has been called a tool for transformation. It can be utilized to access problem solving skills, resolve impasses, retrieve memories, work through traumas and enhance ego strengths. With increasing emphasis on time effective therapy, more and more clinicians are becoming interested in learning how to integrate hypnosis into their psychotherapy practice.

But effective hypnosis requires a solid groundwork in theory and practice and the maintenance of clear ethical standards. To that end, the American Society of Clinical Hypnosis has established national standards for training and certification.

The two hour workshop which we offered at the State Society Conference on the Therapeutic Language of Hypnosis, was designed to introduce participants to important hypnotic concepts such as ideomotor phenomenon, hypnotic language and imagery.

The process of hypnosis, has often been compared to accessing right brain function, where the world is understood in metaphoric terms, where consciousness is not limited by ordinary categorical thinking, and where there is more direct communication of mind and body. This conceptualization served as the underpinning of the workshop.

Marie McDermott taught participants to create their own Chevril pendulums and use them to discover the potentialities of mind/body communication. Chevril pendulums, along with finger signaling are forms of ideomotor signaling utilized to facilitate communication with the unconscious mind. Through the use of imaginary magnets, participants also had the chance to

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wake people up to the "negative trance states" that they induce in each other. She teases out "invisible patterns" and then works with them.

Kent Jarrett, CSW led a workshop in which he spoke about how hypnosis provides new and interesting ways to understand the relationship between patient and therapist. How does the patient tell her story? How does the therapist hear the story? He illustrated his work with case material and included a practica for dealing with treatment issues including: borderline processes, the difficult patient, eating disorders, and living with AIDS.

The Introductory Workshop was facilitated this year by Susan Dowell, C.S.W. and Helen Krackow, C.S.W. Participamts were taught some basic skills for inducing and working with hypnotic states, discussed various theoretical approaches, assessment and treatment planning with hypnosis and took part in a supervised practicum. ■

SAVE THE DATE

The Society's 3rd Annual Hypnosis Conference, The Hypnotic Relationship: Perspectives from Theory and Practice, will take place March 15, 1998 in New York City. The keynote speaker will be Erika Fromm, PhD, an internationally-recognized psychoanalyst and hypnosis researcher. A prolific author, Dr. Fromm's books and scientific papers have become classics in the field. She has served as the clinical editor of the International Journal of Clinical and Experimental Hypnosis and as president of the Society for Clinical and Experimental Hypnosis. Among her many scientific honors, Dr. Fromm received the American Psychological Association (Division of Psychoanalysis) 1985 award for Outstanding Contributions to Psychoanalysis and, in 1986, the award of the Society for Clinical and Experimental Hypnosis for Best Clinical Paper.

C. The Hypnotic Language of Couples

by Jane Parsons-Fein, CSW BCD

"Couples develop skill in putting each other into negative trance. They then reinforce the sometimes elusive themes of families of origin, which each partner brings to the relationship. In this workshop, we will use hypnosis to dehypnotize; we will use hypnotic language to take the power out of negative suggestions; we will tease out these invisible patterns and work with them."

Parsons-Fein opened the workshop with an overhead of Rodin's "The Kiss" followed by a New Yorker cartoon of a disenchanted married couple and asked the question, "How did those people get from all the hopes, wishes, dreams, passions of the first couple to the resigned automatic tension-filled relationship that are often illustrated so aptly in the New Yorker?"

A process occurs which goes back to mind sets learned from the family of origin. Milton Erickson recognized that when people move into the state of consciousness which he called trance, they receive suggestions on deeper levels than conscious awareness. They are imprinted by the language of the people they are closest to and for whom they have the deepest feelings. These imprints occur all the time in families because children learn unconsciously, spending 85 - 90% of their time in trance. In life after childhood, people continue organizing their personalities, their physiology and their life choices around these imprints.

Each member of a couple brings the family of origin into the marriage - the myths and messages that were communicated from the unconscious of their parents. The family unconscious, or the family trance is the context in which our rhythms, movements, attitudes, values and behavior choices are shaped. In our intimate relationships, even in the workplace, we recreate the family context over and over again to maintain the familiar (family-iar) experience of ourselves.

As each member brings his/her unique family trance into the marriage, the couple embarks on the unconscious adventure of inviting the partner into it. Using unconscious inductions we shape each other to answer the needs which were never fulfilled in the family of origin.

When working with couples, it is important to track how people put each other in trance and to identify the family trance

Continued on page 9

D. Stories

by Kent Jarrett, ACSW

The overriding goal of this workshop was to position hypnosis as a bridge between the opposing narratives of current, managed-care and managed-cost treatment, and the traditions of process-oriented analysis.

In the first part of the workshop, I presented a short paper that applied White and Epston's explication of Michel Foucault to outline the knowledge/power analogies of hypnosis. I showed how hypnosis has been transformed from a one-person, abreactive system to a utilization model within a two-person field. Foucault's "normalizing gaze" was contrasted with Levenson's idea of "soft eyes."

During a demonstration, I illustrated the co-constructed meaning of therapist and patient, as Spence describes it, by using the Adlerian technique of eliciting early recollections. Winnicott's idea of therapy taking place in the overlap of play, as amplified in his discussion of "the squiggle game," becomes a useful metaphor for the modern use of hypnosis within a narrative context and a relational mode.

A case presentation sought to show this relational aspect when hypnosis is used as a narrative technique. The five-year treatment of a young man who had AIDS was then presented. The workshop members were invited to imagine the therapeutic encounter as I told the "story" of the treatment and presented two scripted, hypnotic inductions: one written by the therapist for the patient, the other written by the patient for the therapist.

The workshop ended experientially, as I used a quote from Christopher Bollas to describe the goal of a mutual trance exercise: "Perhaps there is a special form within each of us for the perception of this type of communication. Maybe we have a special ear for it, as we may have for music. If so, then we are capable of a kind of spiritual communication, when we are receptive to the intelligent breeze of the other. . ." ■

Kent Jarratt, ACSW, in private practice in Manhattan, is affiliated with NIP as Director of Hypnotherapy Services and with the Center for the Study of Anorexia and Bulimia as an associate therapist. He is also a staff consultant for the Lesbian and Gay Community Services Center, serves on the Executive Board of the New York Society for Milton H. Erickson Hypnosis & Psychotherapy, and coordinates monthly presentations of the Hypnosis Practice Committee. For bibliography and/or more information on this workshop, contact him at 15 Charles Street, Suite 1C, New York, NY 10014.Phone: 212-741-7744.

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affective intensity, unmanageable symptoms or transferential reactions that may be harmful to the patient or the treatment process. (Brown & Fromm,1986) In most cases, the richness and vividness of imagery that accompanies affective experience in hypnosis tends to amplify the significance and meaning of the person's experience.

Trance States

I find it helpful to view states of consciousness or what might be called trance-organizations as the central structures of mind. Trance-states fluctuate frequently during everyday experience; the spectrum of possible trance-organizations are linked to numerous subjective and intersubjective variables. Nevertheless, each distinct mental state is bound and grouped together by structures of mind, having their own identifying component parts. In other words, every trance-state is a unique composite of affective, cognitive, sensory-perceptual, psychophysiological and relational correlates. I find it useful to think of trance-states or trance-organizations as the largest units of psychological experience, each distinct trance-state having multiple individual and relational functions. From a one-person psychological perspective, trance-states have a binding, organizing function – they hold together clusters of adaptive and maladaptive aspects of personality. Pathological trance-organizations hold together symptom clusters and pathological aspects of personality. When they are altered, either through planned hypnotic suggestions or by the more unconscious influences of the hypnotic relationship, the effect is that distinct pathological states are interrupted, loosened and resynthesized with other states. The possibilities for a deeper and expanded re-organization of emotion, cognition, memory, as well as mind-body dimensions is greatly increased by the altered state of hypnosis.

At the heart of a contemporary understanding of the therapeutic action of hypnosis is the increased psychic mobility that takes place in hypnosis. Increased psychic mobility enables vacillation between past and present; conscious and unconscious; activity and receptivity; observation and experience; enhanced memory or amnesia; and mind-body. These are the sine qua non characteristics of hypnosis which constitute its usefulness in psychotherapy and psychoanalysis. (Brown & Fromm, 1986)

An inherent feature of the relational model is the inevitability of unconscious mutual influence and mutual regulation between patient and analyst. (Aron, 1996) From a relational perspective, it is neither possible or desirable for the therapist to be "neutral". Something is *suggested* to the mind, especially the unconscious mind of the patient through every action and inaction of the therapist and well as through every verbalization and silence; each person's associations are inevitably shaped and co-created through interaction with the other. Suggestion in this broadened sense is the way in which hypnotic suggestion can be thought of today. Suggestion, like its heir apparent, interpretation, requires a readiness to receive on the part of the patient; there needs to be an ego-syntonic susceptibility not only to hear something new, but to respond in new ways as well. Hypnotic suggestions that do not consider the patient's readiness to respond are likely to be rejected much in the same way that poorly dosed, worded, or timed interpretations are.

Relational Perspective

Hypnosis from a relational perspective takes its shape and form from the meaning of the relationship in which it takes place. Minds primarily seek other minds, and in this process, patients and therapists are continually inducing various states of consciousness in each other. Of course, we all vary in our individual ability to experience hypnosis. However, one's potential for creative restructuring through therapeutic trance can truly come to life only within the configurations of relationship, and never through standardized individual measures of hypnotizability alone. [For a review of empirical studies in the social-psychological approach to hypnosis which supports a relational view, see Spanos and Coe in Fromm and Nash, 1992]. Therapeutic hypnosis is the transition from habitually restricting or pathological states of awareness to more expanded , adaptive states that are usually "altered" from the person's habitual range of experience. Transitioning between states of consciousness can be compared to turning the ring of a kaleidoscope – a subtle turn can result in a completely new and different configuration of contours, shapes and colors. Similarly, a reorganization of ideas, memories, fantasies, affects and self and object representations takes place when the "dial" of therapeutic hypnosis is gently turned. Changes occur in the structure and meaning of affects, conflictual-ideas, fantasies, memories and object relations when transitioning from state to state. The component parts of a state are subordinate to and determined by the *states* to which they are bound.

Clinicians at Hypnosis Conference: Back, L. to R. , Joan Kuver, Helen Krackow, Marie McDermott, William Ballen, Kent Jarret Front, L. to R., Ellen Thorne, Kathleen Friend, Susan Dowell

In summary, at the conference several beginning tenets of a hypnoanalytic model of practice based in contemporary relational psychoanalytic theory were presented. The relational perspective has illuminated the intrinsic processes of mutual-regulation, mutual-suggestion and mutual influence that seek to forcefully direct the human interpersonal encounter. These processes reveal the rudimentary hypnotic nature of inter-human unconscious communication. The work of hypnoanalysis consists in amplifying and utilizing these processes and, in concert with the patient, discovering newly created and more elevated mutual aims. ■

Ref. : Aron, L (1996). A Meeting of Minds: Mutuality in Psychoanalysis (p. 120). NJ. TheAnalytic Press.; Brown, D. & Fromm, E. (1986). Hypnotherapy and Hypnoanalysis (p. 175). Hillsdale, NJ: Erlbaum.; Erickson, M., Rossi, E., (1979). Hypnotherapy: An Exploratory Casebook (p. 3). NY: Irvington.; Mitchell, S., (1993). Hope and Dread in Psychoanalysis (p. 24). NY. Basic Books.; Spanos, N., & Coe, W., (1992). Contemporary Hypnosis Research. E. Fromm & M. Nash (Eds.). NY: Guilford.

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HYPNOSIS: B. Language & Mind/Body Communication . . .

experience a hypnotic induction and involuntary movement.

Susan Dowell discussed some of the potentialities of language and imagery in hypnosis. She focused on the role of imagery in evoking feelings and accessing associations. Through the use of a simple induction, participants had the chance to see how easy it was to evoke somatic experiences such as thirst, taste, temperature changes and smell.

The possibilities for identifying patients primary sensory modes of communication was also discussed. Although it is frequently out of conscious awareness, many people organize their speech patterns and thoughts, with emphasis on one specific sensory mode. Often there is a disparity between the therapists and patients preferential sensory mode. While the lack of recognition of this disparity may be the source of many impasses, the ability to recognize this and communicate in a parallel mode, greatly facilitates therapeutic rapport and possibilities for meaningful hypnotic communication.

For example, those individuals who organize their thinking in the auditory mode might use such phrases as *I hear what you mean* or *that sounds right.* People who think in a visual mode use such phrases as *I see what you mean, that looks right* or *I get the picture*; while those with a kinesthetic orientation might say things like *that feels right* or *I'm touched by what you say.* Individuals whose language is based on taste words might say things like *that is hard to swallow* or *that left a bad taste in my mouth*; while people with a cognitive orientation would say such things as *I know what you mean, I get the idea* or *that figures* .

A case example was given to illustrate the potentialities of identifying and using these language modalities as the basis of hypnotic communication. An anorexic patient who strictly forbade any discussion by the therapist of her eating habits used language which was overflowing with food words. She talked about things *being hard to swallow, people being biting, chewing her out, leaving a bad taste in her mouth.* As she worked on other issues, hypnotic interventions were peppered with such phrases as *discovering her tastes, taking in only what was good for her, not swallowing ideas she didn't want, learning how to have nourishing relationships.* The shifts in her eating habits, as well as her relationships, became obvious over a few months.

A case was also described to illustrate how the recognition of an individual's sensory mode, could enhance insight. In this example, the prior therapy had been stalled because the situation had been misdiagnosed as resistance. The patient was a 30-year-old musician who processed information in an auditory mode and had a great deal of difficulty identifying and describing even the simplest of interpersonal exchanges. When put into trance, he was asked, using open eye hypnosis, to create a percussion piece of music which described a family interaction. He was to pick different objects in the office to represent different family members. In composing this piece, he began to recognize how much more he knew about his family interaction, than he knew he knew. For example, he could recognize who was in harmony with whom, who overrode or interrupted whom, or who had a completely separate melody . Once he was able to do this, he was able to translate this awareness into spoken language. It was very ego enhancing for him to realize that he had a whole repository of information to draw upon.

In summary, this two-hour beginning workshop gave participants a chance to experience hypnotic phenomenon and get an introduction to some of the theory underlying this powerful approach.

Clinicians interested in getting further training may contact CATCH, the Center for the Advancement of Training in Clinical Hypnosis at (212) 531-1332 to receive a calendar of hypnosis training in the metropolitan area.■

SUSAN DOWELL, CSW is an approved consultant for ASCH, and President of CATCH, the Center for the Advancement of Training in Clinical Hypnosis. She has offices in New York City and Westchester. This fall, she will be offering ACSH approved courses in Introductory and Intermediate Hypnosis as well as a Saturday training workshop in the use of Hypnoprojectives. She runs regular supervision groups and is available by appointment to meet with clinicians interested in receiving approved consultant certification for ASCH membership.She can be reached at (212) 864-4171 or (914)738-9360.

MARIE McDERMOTT, CSW is an approved consultant for ASCH (the American Society for Clinical Hypnosis) and Vice President of CATCH, the Center for the Advancement of Training in Clinical Hypnosis. She is Director of Hypnosis and Hypnotherapy Training of the Brooklyn Institute for Psychotherapy, which offers ASCH approved class in hypnosis. She is in private practice in Brooklyn. She can be reached at (718) 787-5005.

HYPNOSIS: C. Hypnotic Language of Couples . . .

Continued from page 7

themes as they repeat themselves over and over again. If you miss a theme once you can be sure it will come up again. That is the nature of negative trance; it repeats itself.

It is important to remember that the more intense the feelings the deeper the imprint. Conscious understanding of this is important, but not as important as knowing how to shift out of the negative trance. Since our feelings and our unconscious learnings are experienced throughout our bodies, shifting our physiology out of negative trance state is essential for the couple to transform old patterns.

In discussing how to shift couples out of their negative hypnotic induction loops, Parsons-Fein pointed out the importance of chunking sequences down, of breaking them into smaller parts, going meta (helping them step back and access their positive hypnotic abilities thereby shifting them physiologically) reframe the parts moment-to-moment, and always have the self esteem of each partner in mind. Parsons-Fein described 25 hypnotic tools we can use, discussed the importance of language, voice tone and physiological tracking, hypnotic anchors, and family rituals in everyday living. She stressed the importance for therapists to remember that once a couple can experience therapeutic trance together something new is added to their experience of each other. She then gave a demonstration of working with a couple using Ericksonian hypnosis and the Satir Model. ■

JANE PARSONS-FEIN, C.S.W.,B.C.D.,D.A.H.B., will be conducting a 10-week advanced training for Ericksonian professionals in Erickson/Satir approaches to working with the hypnotic language of couples. It will be on alternate Friday mornings, 10 am to 12 noon beginning October 17. Enrollment is limited.

Ms. Parsons-Fein, who recently resigned as NYSEPH Director of Training to become Director of the Milton H. Erickson - Virginia Satir Training Institute for Psychotherapy and Hypnosis, Inc. (MEVSTI), is continuing her Satir Model 10-week Fall Training for Ericksonian professionals:- 10:00 am to 12:00 noon on alternate Friday mornings beginning September 26, 1997. Enrollment is limited.

She is conducting a Satir Family of Origin Workshop with Stephen Adler, Ph.D., November 8th and 9th, and will continue on a January weekend and again on an April weekend.

Ms. Parsons-Fein, who is now Secretary Treasurer of the American Hypnosis Board for Clinical Social Work invites interested social workers to consider applying for Diplomate Board Certification by the American Board of Clinical Hypnosis, Inc., which is endorsed by SCEH and ASCH and is the most advanced competency certification in clinical hypnosis.

For more information, please contact Jane Parsons-Fein at:

Tel.: 212-873-4557; Fax: 212-874-3271; Email: Janepars@aol.com

Keynote: Sibling Triangles: Roadblock to Emotional Connectedness, from p. 1

Following the viewing of the film, Ms. Kauto provided some treatment recommendations to improve the sibling relationship between Alice and Gene so that they can be emotionally supportive of each other to deal with the grief and loss of their mother. Specifically, she proposed that the siblings would need to work through their feelings about parental favoritism, and other related childhood issues so that they could become a united force in dealing with their aging father's safety and personal well-being. Furthermore, in order to develop a mosaic of their siblinghood, Ms. Kauto recommended that they would need to make commitments to a connection with each other, a working relationship with their sibling's spouses and children without getting caught in triangles.

In the last segment of her presentation, Ms. Kauto disclosed a personal example of sibling triangles using her family history with her older brother. The triangles were defined with her mother and her brother, Jerry, as a team with Jerry as her mother's favorite, and Ms. Kauto on the outside of that team, loved but not as valued. Ms. Kauto speculates that she might have been on the outside because she was her father's favorite, and neither her mother or brother received as much attention from him as she did. Over time, the triangles did not change until her father died; her mother and brother became closer, causing her to feel even more left out.

According to Ms. Kauto, when her brother died last year, she was catapulted into a process that provided her with the impetus to open up and explore positive feelings for her brother and other personal feelings that, until then, had not been accessible to her.

The audience was visibility moved as Ms. Kauto closed her presentation with poignant words from her brother's eulogy which she concluded by saying, "To know what you stood for and valued makes me proud and to remember who we used to be together warms my heart." ■

Joyce Edward Judith Gilbert Kauto

Photos by Veronica Ryan Silverberg, MSW, CSW, and Sandra Indig, CSW

Keynote: Impact of Sibling Relationships on Development, from p. 1

analytical researchers yielded, among other considerations: Parens' view of the sibling as a "'bridging' object to the other-than-mother world;" the developmental line in sibling relationships tentatively proposed by Leichtman and others; and the oedipal-like sibling relationships that exist relatively independent of the oedipal parental triangle as observed by Sharpe and Rosenblatt.

Edward's paper centered on a case study detailing the impact of a patient's affectional and sexual strivings for her brother. If the sibling relationship was not, Edward emphasized, the primary one for her patient, it was nonetheless significant to a "multiply-determined development, personality, and life." The paper delineated in particular its signal contributions to her relational capacities, "her choice of a love object, her sense of her self, and her pathology." While envy, rivalry, and hatred of her brother did in fact play an important role in her development, Edward focused especially on how the patient used negative object representations to defend against the loving feelings she experienced as far more threatening.

It was not until about a year and a half into the treatment that the older brother of Edward's patient, a professional woman of 35, entered the consulting room and took his place among the invisible company of familial and collegial relations already resident there. While his arrival was precipitated by more frequent telephone contact with his sister occasioned by the imminent needs of their elderly father, it was Edward's announcement of forthcoming vacation plans that provided the context for a series of five sessions revolving around the sibling relationship. During the first of these, Edward becomes aware of herself as the brother in the transference.

The series begins with the patient's comparison between herself and her brother and Edward; she experiences herself as dull and boring and the other two as exciting and interesting. In four of the sessions, the patient recounts incidents which reveal the brother's warmth, generosity, and positive regard with respect to his sister. Over the course of these sessions, the patient progresses, with Edward's interventions, from heated denigration of these acts as manipulative and cavalier, to gratitude and appreciation, and finally to the understanding that her negative feelings constituted defenses dating from childhood against her affection and longing for him. Indeed, in the final session outlined by Edward, the patient, overcoming agitation and embarrassment, relates a sexual fantasy of painful domination which she associates to her brother. There ensues an acknowledgment of identification with the characters and story of George Eliot's The Mill on the Floss, in which an estranged brother and sister are described as reunited in death following a desperate rescue attempt, when both are drowned by a flood. The fantasies of rescue/childbearing and death/intercourse entertained by the patient through her recollection of the novel, which she had read as an adolescent, again pinpoint her erotically-toned feelings toward her brother.

A further outcome of these sessions is the patient's speculation that the distancing of which she angrily accused her brother is his own protective measure against similar feelings for her. Additionally, she comes to appreciate that the victim role she assumes with colleagues and acquaintances, which has deprived her of friendships and job satisfaction, is a derivative of her entrenched attitude toward her brother: "the defense of focusing on negative self and object representations had become characteristic of her, seriously compromising her self view and her social relations." Especially noteworthy is her growing recognition over time that both her sexual difficulties and problems centered upon childbearing stem, at least in part, from her confusion of husband with sibling.

In her discussion, Edward offered reasons, consistent with the criteria of Sharpe and Rosenblatt, that the brother was an erotically-loved person in his own right and not, at least in the sessions summarized, a displacement figure for the patient's parents. Chief among these is that oedipal issues surrounding the latter were revealed through other defenses and examined on their own in the consulting room. Edward did note, however, with reference to the patient's primary objects, that narcissistic injury incurred by deficient parenting was greatly exacerbated by disappointed love for her brother, given especially that the child experiences in the sibling a greater possibility of oedipal wish fulfillment. Edward also raised the question, again citing Sharpe and Rosenblatt, of why the patient did not use the defense of repression. If according to Edward, the answer is still unclear, what is certain is that she derived considerable masochistic gratification from her defense of choice, as well as partial release from responsibility for forbidden desires.

In considering her patient's early ego development, Edward hypothesized that her brother probably contributed positively, first by supporting the separation-individuation process from an overly dependent mother and later by spurring his sister to her own achievements. Whether the latter , however, were induced by envy or by love is difficult to gauge, according to Edward.

In her final remarks, Edward expressed the conviction that work relating to her patient's interpersonal and intrapsychic relationships with her brother was "a useful component of a multi-faceted treatment." She concluded with the hope that our continuing explorations of the singularity and effects of sibling experience would serve to "broaden our therapeutic range."■

ROXANDRA ANTONIADIS maintains a private practice in Manhattan. She holds a Ph.D. in comparative literature and presents workshops on symbols of the self from a Jungian perspective.

THE PRACTICAL PRACTITIONER

Getting Paid

By Shelia Peck, LCSW, Chair, Public Relations Committee

The Clinical Social Work Federation has an e-mail discussion group on the Internet. Recently one of the questions which arose was about the best way to collect overdue fees. Lawyers? Collection agencies? Letters? This article is adapted from my response to this question. The suggestions I make are solely that — suggestions. I'm not a lawyer and am speaking only from my own experience.

Mental health clinicians have a peculiar problem when it comes to trying to get paid — whatever we do becomes part of the therapy and, if the client is continuing in treatment, has to be dealt with. The whole process affects transference/countertransference and is far less clear-cut than a merchant trying to collect an overdue bill. Yet, we are entitled to be paid for our services. It's just that every decision we make to facilitate our being paid has an impact on the therapy.

Because the writer of the e-mail on the internet discussion group asked about collection agencies specifically, let's start with that, though this should only be considered as a last resort. If you've sent letters and made phone calls, you might then consider that route. If you do choose this method, talk to the person who'll be your "agent" and try to make sure that your client will not be harassed. This isn't always easy to do, particularly since the only way that most such agencies make their money is through a percentage of what they collect. So it behooves them to be rough and tough, particularly for larger amounts of money.

And remember — they usually get from a third to a half of the bill. So, if your client owes you $200, you may only see as little as $100, even if the collection is successful. And some agencies won't bother with small amounts. Here's a *caveat* — when you are interviewing a potential bill collector, you might notice that s/he is asking questions which seem as if they have more to do with YOU then your client. This may be true. Collection agencies try to keep a database on *anyone* in case they ever need it in the future. Even you.

Some clinicians feel like turning overdue bills over to a collection agency violates confidentiality. It's my opinion that with an ethical agent, this is no more true than if you have an office assistant who makes collection calls. But, if you're concerned, check with an attorney. In any case, I advise that you only use someone who has been recommended by a colleague.

Speaking of attorneys, why not hire a lawyer to write letters to your clients who are overdue instead? You can usually arrange this at a set minimal fee, and this is sometimes enough to get the job done. It would be far more polite (and you'd be able to keep whatever payment your client ended up sending). Sometimes lawyers are willing to write up a template for you to send, in the lawyer's name, to any client who is overdue.

Also, you might consider small claims court. The clerk of the court helps you fill out the minimal paperwork and you don't need an attorney. In many states you can sue for up to $5000. If you have a legitimate claim, you'll have a good chance to win. In some states, including New York, you and the debtor can agree to arbitration (from which there is no appeal), which is quicker and just as fair as a trial. If you do go to small claims court. here's a piece of advice which came in handy for me when I used it in another kind of case. Remember that even if you win, you still have to collect. This is done in a number of ways in different jurisdictions. It's not always so easy to do. You have to find an asset on which to levy once a judgment is made. So try to remember the name of the client's bank so that a levy can be made on it if you win; otherwise, you might not have a place from which to get the funds even if you have a judgment. Various states and cities have different rules on this. If you go to small claims court, ask the clerk how collections are made when you're filling out the papers.

I would, though, recommend the lawyer letter route. It's the one least likely to engender more bad feeling and it gives you more of a chance to preserve the therapeutic relationship. And it's often effective. Most importantly, you, the clinician, can minimize this problem all by yourself. Don't let clients pile up bills. It can wreak havoc, countertransferentially speaking — and it really can interfere with, interrupt or prematurely end the therapy. I tell my clients, in advance, that I don't want this to happen, so except in a few circumstances, I ask that they "pay as they go." I believe this is the best way to take care of yourself and your clients.

To join the Clinical Social Work Federation mailing list online, go to the website at http://www.cswf.org and follow the directions about joining. Or, e-mail John Augsburger (VA), at JohnA1212@aol.com and ask to be included.

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Editorial

Continued from page 3

It is my opinion that accepting fees lower than what you feel you can live with is a prescription for disaster. Managed care companies will tell you that, once they are able to cover their costs and make a profit, they will then increase the fees to a level which is reasonable (sort of like profit-sharing). However, history teaches the lesson that this is highly unlikely to occur. You probably have noticed that managed care fees, which at one time approached the national clinical social work mean fee of $75-$80, have spiraled downward, first to $70, then $65, then $60, and now there is a push by managed care to offer $50 fees and sometimes lower. Interestingly enough, some clinicians in harder-to-refer-to areas have, when they refused to participate, been offered higher fees to see managed care patients.

Beware of those companies and intermediary companies which offer discounted fees. Some MSO companies offer fees which, on average, are 35% lower than the already reduced managed care fees. It is highly likely that, if you accept fees which are lower than you feel comfortable with, the fees offered will continue to get lower (remember California). Unfortunately, many clinicians feel boxed into accepting whatever fees are offered, fearing that if they refuse, they will eventually have no patients to see, period.

I firmly agree with Vickie Taylor, the chair of the Federation's Health Care Systems Committee, who states, "the safest policy is to make sure you have a balanced practice mix, setting a certain percentage for managed care and the rest from other payment sources. If you choose to participate in the contract, set a goal for a certain percentage of new patients that you will accept at a discount rate, making sure your income is balanced with normal and low fees. It is also important to market your practice in traditional ways to gain referrals."

The country is beginning to get wiser and wiser and is starting to scream for quality care over cost redirection (it is fast becoming cost redirection, not cost savings). As you are able, help facilitate the change from a system which can abuse to one which provides quality mental health care at reasonable cost. The longer com-panies which make a profit off the backs of clinicians are allowed to exist, the longer it will take for the change to quality healthcareto occur.■

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In contrast, a mediator might ask the woman, "What do you want to get from ownership of the house?" She might answer, "It's in a good neighborhood, where the kids can get a good education and continue with their current school activities." The mediator might then ask the man, "Why is the sale of the house so important to you?" And he might answer, "I need the cash from the sale to put a down payment on a coop that I found at an excellent price." Armed with this information, the mediator would help them work out a truly equitable solution, one in which both spouse's needs are met. The mediator would encourage both of them to bargain from their actual self-interests, not from pre-established positions.

Brainstorming always plays a large part in the mediation process. The ground rules are that any idea the partners think of should be shared; every idea should be added to the list to be discussed; no idea can be dismissed out of hand by the other party; and, no one can criticize an idea or merely explain why it won't work.

Reframing is as much a part of the mediator's repertoire as it is a therapist's. For example, the husband might say, "The children need a father," and the wife might say, "The children need a mother." The mediator would say, "I assume they need both of you."In an adversarial divorce, there might be a custody fight. But mediators do not talk of custody, a word commonly used when a prisoner is remanded — to the "custody" of the sheriff. Do we really mean that the child is to become a prisoner? Or is the mother to become the "custodian," the father a "visitor?" Should everyone now be redefined in roles other than their traditional ones within the family?

In a divorce there must be two co-parents, both involved in parental decision-making. When a woman has been staying at home to take care of the children, a mediator will work to help her establish ways to earn a decent living. A mediator will also help the husband understand that if he will help his ex-spouse get career training or education, he will be rewarded when she contributes more to their child rearing expenses.

The Non-initiator

The decision to divorce is rarely mutual. Usually, one spouse, after ruminations and often a long period of marital discord, concludes that he/she can no longer tolerate the painful marriage and seeks divorce. The initiator has a psychological advantage over the non-initiator. Despite his or her ambivalence, the initiator has probably already mourned the relationship's demise, developed alternatives, or at least the image of what they might be, and has "tried on" the role of divorced person. Very often they have already begun to separate their social lives and revamp careers, and in some cases, they have found a person who provides intimacy and emotional support. For most initiators, divorce represents a substantial improvement in their lives.

The non-initiator is at a psychological disadvantage. Though probably aware of problems in the marriage, surprise or shock at the

Continued on page 16

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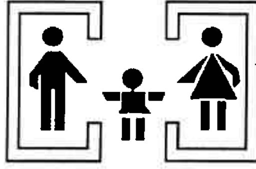

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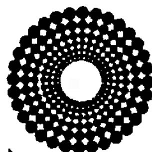

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other spouse's decision will often be the non-initiator's response. If he or she does not want the marriage to end, the divorce is a nightmare.

Feelings of betrayal and abandonment, rage and panic, and a deep sense of humiliation and rejection, abound. The non-initiator will plead, offer to "change" or agree to long-rejected couples therapy. But the efforts will be futile if the initiator really wants to leave the marriage. For most non-initiators, divorce means that life will worsen due to a loss of status, economic security, identity, contact with children or loss of a place in the community. There is little motivation to adapt to divorce.

Whether the couple will be able to achieve the developmental tasks before them is often determined by whether they choose the adversarial method or divorce mediation. Only the mediator can address issues at the start of the process that will help the non-initiator move beyond the role of the victim and stop seeing the initiator as the villain. In an adversarial divorce, the non-initiator is often vulnerable to wanting the lawyer to "rescue" him or her from the "villainy" of the other spouse. The vindictiveness of the non-initiator may enrage the other spouse, cauterize his or her guilt and set up tit-for-tat battles that arrest progress and lock the family in limbo.

Successful divorce

A successful divorce, one that in five years finds the family members thriving, is rarely the product of an adversarial legal proceeding. The win/lose premise of litigation makes cooperation difficult. When settlements are finally hammered out, they are often based on grudging concessions rather than affirmative agreements. That is why about half of all settlements break down within two years of the divorce and the clients return to court for further litigation.

In fact, almost all aspects of the adversarial divorce interfere with the working-through process that is needed. For example, lawyers may advise men to remain in the marital home to promote a custody fight which will intimidate the wife. This obviously interferes with the separation process, one which must occur to facilitate adaptation to the divorce. Conversely, they may advise wives who have not been earning an income to refrain from seeking a job in order to ensure a larger settlement. This obviously interferes with the wife's ability to start a new life.

After divorce, the couple's economic status will almost certainly slip. Since most families consume between 95% to 105% of their net income living in only one household, creating a second means adding 30% to 40% more to the family's expenses. A divorcing couple must decide whether they will follow a course of deficit spending or initiate spending cut backs. The latter choice is the only healthy one. However, if the non-initiator harbors resentment and refuses to make a choice, the battle could be dragged out for years.

In fact, the non-initiator usually sets the tone for the divorce. It can be an orderly process, in which family members grieve, but then move on, if the non-initiator can manage his or her feelings. If not, it becomes the "War of the Roses." The former couple must embrace the need to change spending patterns and family roles. But the legal system teaches silence where communication is needed and stasis where change is needed. It promotes a conservative route where people must take risks. Mediation, on the other hand, requires direct communication between spouses. Mediators provide the model for and extensive practice in problem-solving that can establish a working relationship between the post-divorce parents. The emphasis is on reconciling the interests and needs of the parties, rather than on vindicating them in a court of law. Mediation is pragmatic, not abstract, and that helps to reduce anger. The process usually takes two to three months, not two to three years, as is typical in the adversarial proceeding. And mediation can cost as little as 10% the cost of the conventional divorce.

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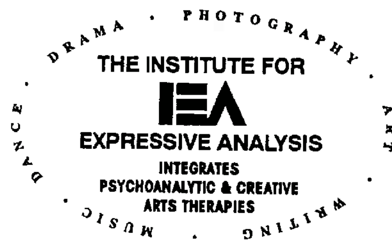

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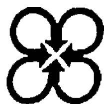

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