The CLINICIAN

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

Psychotherapy in Cyberspace

A therapist comes face to face with the information frontier, but not with her on-line clients.

SPECIAL FEATURE

By
Diana List Cullen, M.S.W., C.S.W.

Affordable Psychotherapy . . . was how my ad began in the now defunct *Seven Days* weekly magazine. Mine was the first of about 10 professional ads in that issue several years ago. The manager of an online bulletin board system (BBS), Thomas, saw the ad and called me. He asked if I'd like to provide therapeutic help online for the members of the BBS he managed. I had very little idea of what that meant or how it worked. We scheduled an interview.

First I learned that a BBS is like a club, except that the conversations and information are on screen. The messages and information are transmitted by a modem across telephone lines — which explains the source of "online" — and instead of a building or room, everyone's computer screen becomes the common territory. You join a BBS by paying dues for online time. You can then talk with many members at once, or confidentially with one at a time, and take advantage of any of the services offered. You can connect through the Internet to people or information all over the world. The number of people owning computers and modems using the Internet is growing.

Thomas offered me the one-to-two-hour-a-week job. He showed me a screen and keyboard and invited me to watch as he demonstrated what I would do. He typed in codes to get into the system. A welcome to the program appeared on screen and a list, or menu, of what was available. He typed in his name, as directed, and then chose "Chat" from the menu and a list of names appeared. Those were members who were also online at that moment. He typed a message to one of the people on the list, and sent it by pushing a key. A notice on the screen alerted him to a message and he pushed a key to read the incoming response. The next week I went online on the BBS.

On this particular

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IN THIS ISSUE

EXECUTIVE REPORT

Helen Hinckley Krackow
CSW, BCD,
Society President

Rethinking Our Mission

Nineteen ninety five finds the State Board of the Society reassessing the mission of our organization. We need to do this in order to be responsible and effective leaders. The social work profession has been under siege for the past few years, as you know. To work through the changes that have occurred in practice and to mobilize in the most effective way possible, the leadership needs to rethink our organizational philosophy.

This involves removing emotional log jams and forging deeper collegial relationships on the Board. The process started at our January meeting. I brought back part of an exercise used at a leadership workshop given at the full meeting of the Federation Board in Boston. We each took turns sharing our personal histories — what brought us into the field — and our own sense of mission — what we wanted to accomplish when we were just starting out as social workers. Brief as it was, the exercise was an eye-opener.

Shortly after this meeting, the Rockland Chapter held a workshop for its board on leadership issues facilitated by an organizational expert. The chapter had an enormously productive Spring as a result.

Next, our Chapter Presidents took the initiative to organize a similar workshop and invite me to attend. A clearer set of goals and action plan resulted from our discussions. Early next year the full Board will also spend a workshop day revitalizing our mission.

In general, I like to think of our Society as a receptive resource and a safe harbor, offsetting stresses by addressing the problems of our storm-tossed profession. For me, the privilege of leadership is a sacred trust. I am committed to helping advance the clinical social work profession. I would like to make a difference in my lifetime in the field of mental health. Grandiose as this goal may seem, it cannot hurt to believe that the small steps we each take can lead to a big step forward for our profession.

One day mental health treatment will be respected, not feared in American culture. One day those Americans who put 20 years into their intellectual education will not be ashamed to devote a fraction of that time to their emotional education. And one day people may understand that mental health treatment must be insured on the basis of more than just "medical necessity." Even now there are a few telltale signs that the tides may be shifting. For example, many of the legislators I visit in Washington are pleased to mention that family members or friends are either in the profession or have been treated by social workers.

> ***"One day mental health treatment will be respected, not feared in American culture."***

Oddly enough, the health care crisis may be handing us an opportunity, as professional providers and consumers are mobilizing to fight for treatment. The tea is in the harbor! Can revolution be far behind?

New Name

This issue of our newsletter, newly named The Clinician, heralds a step in fulfilling one personal mission of my presidency — to engage more of our membership in creative professional activities. We look forward to a publication that not only continues to be informative but one that encourages the developing writers, editors and journalists in our ranks.

The strength of our Society is that it is a volunteer organization. Volunteerism creates expertise, self-reliance and exposure for the contributor as well as benefiting the membership. Our members will be working with a skilled professional writer, editor and graphics expert, our new consultant, Ivy Miller. Ivy, under the direction of Sheila Peck and the Executive Committee of the State Board, will develop an active Newsletter Committee to staff the publication. ■

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SPECIAL REPORT

Mentoring Program Flourishes in Met and Other Chapters

By Barbara Bryan, MSW, BCD,
Founder & Director,
Mentor Program

Job-finding strategies, supervisory problems, clinical issues, training and career planning — these are some of the topics explored by participants in the Met Chapter's Mentoring Program. Six separate groups, led by five experienced clinicians, meet each month. About 40 mentees participate, including new social work school graduates, a few second year students and new Society members. Mentoring groups are also flourishing in Brooklyn, Nassau and Westchester.

"I lost my support system after graduation. How wonderful you are to offer one."

It was a report about the Massachusetts Society's Mentoring Program in an early 1991 edition of the National Federation Newsletter that first gave us the inspiration to launch the Met Chapter program. Massachusetts program leaders were kind enough to provide their guidance and a social work school dean of fieldwork also added encouragement. She emphasized that the first three years after graduation are critical ones for determining whether a person remains in the field. It struck us that not only would mentoring be an important service the Society could offer new clinicians, it would also provide opportunities to develop an organizational relationship with the various social work schools.

In the spring of 1991 we distributed a flier at a few schools in time for graduation and the first groups started that summer. Now we regularly send fliers to the five social work schools in the metro area and also address student groups in person. The Met Chapter group leaders are Dianne Heller Kaminsky, Helen Hinckley Krackow, Fred D. Mazor, David G. Phillips and this writer. Carol Brod leads the Brooklyn program, Kate Olshever, the Nassau program, and Elvira M. Franco, the Westchester program. Other State chapters and some in New Jersey and Pennsylvania have consulted us about setting up their own programs. We stress that the approach we use is but one of several that a chapter may wish to try.

Mentees' Responses

Here is a sampling of prospective mentees' responses to our standard screening question, "What about the program interests you?":

"At my agency I don't feel like I'm doing real social work. So I would like some expertise to rub off on me."

"After being supervised under a microscope, I am now entirely on my own."

"I lost my support system after graduation. How wonderful you are to offer one."

"The profession takes a lot of skill and time to learn. I'd like some support while I'm learning."

After participation in the program mentees wrote:

"Our discussion of my counter-transference with a case, while not easy for me, really put me back on course. The group was very supportive."

"The group's sense of humor and support was very important to me while I was learning to cope with very difficult and sometimes intimidating clients and with unprofessional staff at my agency."

From a second-year social work student: "I found it very valuable to be exposed to people who had already graduated and to get a view of the different types of agency jobs available."

And from a graduate of the program confronted with making a choice between a higher paying administrative job and a lower paying one that offered a good clinical training opportunity: "The group was very helpful to me at a time in my career when I really needed to share my thoughts and feelings about the possible direction I might take in my future clinical training and professional career."

About 90% of the mentees choose to become members of the Society. Many take an interest in the educational offerings of the Met chapter, such as the brunches, specialty committee meetings and conferences.

Mentees are not the only ones who benefit. Mentors say they enjoy being provided with a window on the world of today's social work schools, job market and agency practice. They also have the satisfaction of knowing they have made a positive impact on the professional lives of the mentees.■

Barbara Bryan is in private practice and has been on the faculty at New York School for Psychoanalytic Psychotherapy Institute and the Hunter College School of Social Work postmasters program.

START A PROGRAM

If you would like information about the program, please contact Barbara Bryan, (212) 864-5663.

This is the first in a series of articles. In the future we will cover such topics as: mentoring as seen through the eyes of the mentee, a mentoring meeting close up, different styles of mentoring, and how to get publicity.

VENDORSHIP COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

The Vendorship Committee continues to receive calls from members regarding problems with reimbursement and managed care practices. Our recent marketing/pr mailing has been successful, if the amount of calls is any barometer. For example, in the last six months we've received calls from members who were terminated from managed care panels with no offered reason or explanation (EMHC, GHI); one member who was being denied reimbursement because CNA, a self-insured plan, mandated that a psychiatrist supervise clinical social workers; several members who were not receiving payment for services rendered even though their services were pre-authorized; and several members who were denied entry to managed care panels, as well as those excluded from reimbursement by self-insured plans, namely, Stop and Shop (MD supervision), Ironworkers of America and Hotel Employees and Restaurant Union.

The Committee was successful in getting one member back on GHI and another back on EMHC. We also interfaced with CNA to get them to agree to have a psychiatrist approve the treatment as necessary and essential, instead of mandating ongoing supervision in order to allow clinical social work reimbursement. Additionally we have assisted members in their efforts to deal with the problems of managed care in some companies. We have also forwarded the aforementioned self-insured plans which do not recognize independent clinical social workers for reimbursement to our national marketing consultant for more intensive marketing. (Our consultant is also in contact with AT&T about the updating of their new benefit package. We are hopeful that clinical social workers will be included as reimbursable independent providers). This year alone, our national society's marketing efforts have netted over 160,000 insureds now able to be reimbursed for clinical social work services; we continue to market social work inclusion to 66 self-insured companies nationwide.

Managed Care Issues

We received complaints on two other fronts. One was on a start-up HMO, MDLI, which was reported to be excluding social workers from investing (this was referred to the proper authorities to determine the legality of such a practice). The other was questions on a sub-group of Oxford called CHCS. This is an interesting organization which gets referrals from Oxford and subcontracts them out to out-of-panel clinicians for significantly less than what Oxford pays its panelists. Many members complained of the $40 reimbursement, but it is all legal, and you can choose not to be on the panel.

The amount of complaints we've received on GHI seems to give credence to the idea that this company is in internal chaos. OTR's being lost, contradiction and misinformation seem rampant. Look for major changes and layoffs at EMHC. Word has come to us that Blue Cross will be contracting out its mental health managed care to another company.

We have forwarded complaints of fee reductions for clinical social workers by AETNA (Human Affairs International) and the General Motors Co. (Cigna). Representatives of our national organization have met with GM and Cigna in Michigan to clarify policy and begin a dialogue. Our Federation president has been in contact with the national leadership of NASW in order to coordinate a response to AETNA's recent fee reductions.

Don't sell your shingle yet! Our illustrious legislature has several managed care regulatory bills on the floor which go a long way toward protecting consumers and providers alike from negative managed care practices. Please see the Legislative Report in this issue. ■

The Vendorship Committee has two new members

Bill Woolis, CSW, will be assisting the Committee in his role as our managed care consultant. Bill has worked in a large managed care company and is helping us traverse the sometimes user-unfriendly barriers of managed care.

Alice Garfinkel, CSW, will be assisting Vendorship in her role as our Medicare Consultant. She knows the Medicare system quite well and has already proved a great help to many members.

Medicare Telephone Claim Entry System
by Alice Garfinkel, Medicare Consultant

Medicare has established the MTCE, Medicare Telephone Claim Entry System. It enables providers to enjoy the benefits of submitting Medicare claims electronically. It is a "quick and easy" way to submit Medicare claims by using a touch-tone phone. Medicare says that "the MTCE system was designed for providers who submit a low volume of claims (less than 100 per month)." To get more info and the package to get started, contact Mr. James Bavoso at Medicare Professional Relations at (212) 476-4935.

From the National

As of January 1, Merrill Lynch, Northwest Airlines (pilots, flight attendants), Standard Registry, NIBCO (of Virginia), FERMCO and Central Benefits included clinical social workers as reimbursable independent providers.

Denied Reimbursement?

Or, do you want to improve press coverage of Social Work Issues?

Call Your Chapter's Public Relations, Marketing or Vendorship Rep/Chair

Brooklyn	Lesley Post (718) 399-6476
Capital District	John Chiaramonte (212) 535-3839
Met	Sharon Kern-Taub (718) 884-3355
Mid-Hudson	Marilyn Stevens (914) 462-4178
Nassau	Fred Frankel (516) 935-4930
Queens	Shirley Sillekens (718) 527-7742
Rockland	Lenore Green (914) 358-2546
Staten Island	Rudy Kvenvik (718) 720-4695
Suffolk	Dorothy Sokol (516) 493-0918
Syracuse	Pat Demyan (315) 476-4274
Westchester	Anne Gordon (914) 235-5244
Western NYS	Laura Salwen (716) 838-2440
STATEWIDE	Sheila Peck (516) 889-2688

REPORT
by Marsha Wineburgh, MSW, BCD, Chair
LEGISLATIVE COMMITTEE

Social Work Licensing Bill Introduced (A.5989-A/S.4979)

On March 7, 1995, Assemblypersons Catherine T. Nolan (Queens) James F. Brennan (Brooklyn) and Samuel Colman (Rockland) introduced our social work licensing bill in the New York State Assembly (A.5989-A). Senator Thomas W. Libous (Broome, Tioga, Chenago) introduced the bill in the Senate on May 3, 1995 (S.4979).

For the first time since the Clinical Society Legislative Committee began working on this project more than five years ago, licensing legislation, which is fully supported by the social work community, has been introduced into both houses of the legislature.

Our next step is to attract as many legislators as possible to co-sponsor this bill. The greater the number of co-sponsors, the greater the demonstration of support for our bill.

Toward this end, your chapter legislative chairperson will be visiting local legislators in their home offices to educate them about the social work profession where necessary and to ask for their support for our bill. It is vital that Clinical Society members who have a relationship or contact with local legislators call their chapter legislative chairperson immediately to help strategize this campaign. Please see accompanying box for information.

The Legislative Committee is working collaboratively with other professional social work organizations to make the widest statewide search for support. Once the cosponsors have been identified we will ask you to then write to your local representatives thanking them for their sponsorship. We will also be looking for endorsements from business, other professional individuals and groups as well as social agencies and psychotherapy institutes.

Stay tuned.

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Chapter Legislative Chairs

Brooklyn	Geri Ness (718) 789-6739
Met (Bx, Man)	John Chiaramonte (212) 535-3839
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Buffalo	Laura Salwen (716) 838-2440
STATEWIDE	Sheila Peck (516) 889-2688

Legislative Update

Managed Care Legislation:

The NYSSCSW is actively supporting S.4188 (Velella, Hannon)/ A.6800 (Grannis, Gottfried), an act to amend the insurance law and the public health law to establish standards for the quality of care consumers receive from manage care plans, provide consumers with the information they need to make informed decisions or challenge unfair determinations, and to set uniform standards for certain problems areas which frequently result in disputes between consumers, providers and managed care plans. There has been an intensive campaign, highlighted by a Health Care Bill of Rights, to support these bills for quality and choice.

This is one of several bills which have been introduced this year. Best information indicates that none will pass this year. However, next year is an election year and those who know believe some managed care reform will be passed.

Toward this end, we need documentation about managed care abuses.

If you have an experience which will demonstrate the need for reforming managed care, please — sit down and write a description of what has happened to you or to your patient. Send your story to:

Marsha Wineburgh,
263 West End Avenue, #1F,
New York, New York 10023.

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Psychotherapy in Cyberspace

From Page One

BBS people use pseudonyms, familiarly called "pseudos," rather than their real names. Thus, for example, one might "talk" with Navajo, lizard, stockings, Sittin down, fox, Lost in LA, Today's in, or R. Some choose ordinary first names for their pseudos or names of fictional characters and celebrities whom they admire or identify with such as King Arthur, Mame, etc. regardless of whether the gender is the same as their own.

Pseudos give people the freedom to reveal, in the safety of being unknown and unseen, problems they have not talked about with anyone else. In a way, I am pure self-object.

Beyond the pseudos, identification of the state or country from which the person is talking, and the soundless monochromatic words on screen, I am deprived of the usual data. There is no voice — sound, timbre, rhythm, or dynamics; no manner of dressing or indication of personal care; no eyes to connect with or avoid mine; no body language or direct perception of physical attributes. Further, since the encounter is a dialogue, I must respond to each message. I cannot nurture a silence waiting for something to be revealed by the client. Occasionally a member gets anxious if he/she feels I am not responding quickly enough. That can happen particularly if I am carrying on more than one conversation at once, as often occurs. The reaction is useful in understanding the developing transference.

The particular BBS on which I work is organized so that I must respond in the order in which messages appear. There is also a limit to the length of the message. All conversations are confidential and private. Further, although members use pseudonyms, they know my real name. In addition, they are provided with a brief bio including my accreditation. A legal disclaimer is added.

I decided early on that I would rather risk someone having a good laugh at putting one over on the therapist than risk disbelieving a legitimate story...

When I first started "talking" online, I was more formal and, I assume, somewhat stilted. One young paranoid woman from Sweden abruptly stopped talking with me. I sent a message asking her what happened. She accused me of sounding like a textbook (probably a bad one!). I paid attention and started to respond more conversationally.

One of my primary principles is to treat every inquiry or comment as if the person were presenting an actual problem and situation. I decided early on that I would rather risk someone having a good laugh at putting one over on the therapist than risk disbelieving a legitimate story and concern. I also thought that if someone were making up a story, it was likely to be a metaphor for more than the person was conscious of, so it might have some unconscious use even then.

One person, "Madame Ann," described and reported on a complex family and relational life that took me quite a while to begin to doubt. It was at first a fairly consistent, good story. Even then, in case there were any truth in any part of it, I simply said after about five weeks that I was a bit puzzled, that some of what I was hearing was a bit confusing. After an amusing dialogue, the saga ended and I never heard from Madame Ann, my pseudo for her pseudo, :-), again.*

Face-to-Face

Sometimes members are interested in sexual talk and stimulation. I usually disengage from those conversations. However, sometimes what seems like sexual provocation may be the entry to a legitimate issue. One man from Texas asked if I were interested in cunnilingus. With questioning and dialogue it turned out to be an important issue in his marriage and what it meant for him. Further, I learned that he was in therapy and had been embarrassed to talk about it with his female therapist. Our discussion broke the ice and, as I encouraged him to do, he was able then to bring it up in his therapy. One woman from Italy, after telling me a sexual secret of which she was deeply ashamed, sent me E-mail saying that simply telling me had given her the first relief she had had in years. She added that when she got up the courage, she would try to work with me face-to-face.

As for face-to-face, only two people have ever come in to see me and only one continued as a client. Pseudos give people the freedom to reveal, in the safety of being unknown and unseen, problems they have not talked about with anyone else. In a way, I am pure self-object, with unlimited possibility for fantasy. However, because the safety of the transitional space of the screen allows people to reveal secrets about their inner and private lives early on, they get to some issues more quickly than is often the case in person. In consequence, they do not want to see me or, rather, be seen by me. The reality of the meeting can feel threatening. On screen they have much more control. Further, choosing a therapist introduces a more socialized selection process, rather than simply discovering and talking with an unknown therapist online. Early on, quite a few people — primarily from New York but also one each from France and Italy— made appointments for in-person therapy for which they did not show up. Only once did someone manage actually to call to cancel. Thus,

*I "smiled" in that sentence. Turn the page to see it. It's called an emoticon. Online: the :-(indicates a frown, a wink shows up as ;-) and surprise as :-o. I was once given a rose, ----'----,---@ and another time a tulip, ---'---,---C.

now when anyone suggests they might want to see me, I let them know I'd be pleased to work with them and would be happy to explore the possibility. I also tell them that the transition from talking online to being present in person can be difficult and explain why. We talk about it and I encourage them to think about it before making an appointment, and offer to discuss it with them in a telephone conversation. I let them know that I will be glad to continue talking with them online or see them in person, as they choose. Then, in the most likely case that they decide against in-person psychotherapy, they feel freer to continue talking online without any embarrassment or hostility.

I have referred people to other psychotherapists and clinics, as well as simply suggesting and encouraging psychotherapy when it appears appropriate. However, few follow up that I know of and those who say they have found psychotherapists on their own. Only a few let me know when they find someone. Once, inadvertently, I learned when one person called a clinic to which I had referred her. In another instance, a woman was in therapy with the same therapist as her husband and her stepchildren. She gradually let me know she felt uncomfortable about it. I urged her to bring it up with her therapist. She did, and still felt uncomfortable. We explored her concern and she finally decided to terminate with that therapist. She found someone else on her own.

Online work can enable people to explore . . . without being judged. They can . . . look at their behavior and explore around it as one does a sculpture, giving distance for self-observation.

Crisis Intervention

Crisis intervention seems to be effective online. One woman was having difficulty making love to her husband after she gave birth to their first child. We dealt with that, exploring her feelings and what sexual behavior meant for her under those circumstances. We "talked" for about four online sessions. Months later she came back online to thank me and let me know that with my help she had gotten past being stuck and she and her husband were doing well together. Another woman was struggling with whether and how to reveal a physical disability in a budding online relationship.

The bulk of the presenting issues concern relationships. However, other issues and personality disorders that appear include depression, paranoia, sexual fetishes, gender confusion, and work — in general, whatever one finds in working with clients in person. One deeply paranoid young woman talked with me over a period of three months. I do not know if it was useful to her beyond the conversations themselves. Our online dialogues ended about a year ago. The longest I have worked online with someone has been over a year and a half. The person was a woman who had had a long-time satisfying therapy experience years before. That helped her make good use of our conversations. As we continued to talk and she felt safe, she told me her real name and other identifying information.

Is It Psychotherapy?

The question most asked by both colleagues and people on the BBS, of course, is whether work online is psychotherapy. It would be unwise to underestimate the importance of what one learns in person that one cannot learn online with the limitations of the screen and the anonymity. The dynamics of the in-person interactive process itself are missing. But what online work can accomplish is to enable people to begin to explore their own thoughts and feelings without being judged. They can then begin to look at their behavior and explore around it as one does a sculpture, giving distance for self-observation.

Online I use customary techniques: mirroring, questioning from a not-knowing place, active listening, clarification, education, occasional interpretation and confrontation and, sometimes, practical suggestions.

Because I encounter words on screen only, my sensitivity to style as a communication itself and subtle changes in patterns of "speaking" has been heightened. It has enhanced my awareness in my in-person work as well. Knowing what a word means to the "speaker" is particularly crucial where the communication is words on screen only. As a result, I tend to ask about the meaning of more words than I might in person. Also, I explain what I am doing whenever it seems appropriate.

There is a small but growing group of psychotherapists who use the Internet to talk with each other and clients by E-mail, as well as through the immediacy of a BBS. Research is being conducted on the uses of E-mail in psychotherapy. I believe that there is unquestionably a useful and important role, though limited, for psychotherapeutic work on the computer, whether E-mail or bulletin boards. It can open a door for people who would not ordinarily reach out for help. It can also introduce the process to some so that they will be more likely to make use of psychotherapy in the future.■

Diana List Cullen, M.S.W., C.S.W., is in private practice in New York City. She is also president of the Metropolitan Chapter of the State Society for Clinical Social Work.

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FRONTLINES

■ BROOKLYN CHAPTER

Social Workers Crucial in Treating Learning Disabled

by Maura McDermott *(Freelance Writer)*

The diagnosis of "learning disabilities" is an umbrella term for diverse, overlapping conditions that adversely affect a normally intelligent person's ability to learn. In fact, the diagnosis is often based on what the child is NOT, Donna Arking, ACSW, explained at the Brooklyn chapter's May 7 meeting entitled "(Some of) What Clinical Social Workers Need to Know about Learning Disabilities."

If the child is not functioning optimally yet is not retarded, emotionally disturbed, lacking in opportunity, or otherwise impaired, learning disabilities are a likely diagnosis. Illustrating with the film "F.A.T. City," Ms. Arking said the disabilities now are commonly held to be neurological, rather than psychological or environmental, in nature. However, certain myths persist such as the mistaken belief that children outgrow their disabilities. While there are many effective ways to compensate for the disabilities, the disorder itself is life-long.

The lively meeting, at the home of chapter co-president Marie McDermott, emphasized two points: Given the complexity of the brain's mechanisms, there is still much to be discovered about learning disabilities, and clinical social workers have a vital part to play in their disgnosis and treatment.

Because the brain is still largely uncharted territory, clinicians must rely on phenomenological data of functional impairment, rather than on direct observation of neuronal circuitry. And there is a great deal of comorbidity. Rarely is an individual afflicted by only one discrete learning disability. Disabilities are common in reading, writing, mathematics and in other areas, including social maturity.

Normal childhood developmental issues are often complicated by the neurological disorder. Learning disabled children are often "difficult babies," according to Ms. Arking. Early failures in self/object experiences, poor mirroring, and affect misreading on the part of the infant are common, and can lead to serious psychological conflicts in later life. These initial blows contribute to the depression, low self-esteem, anxiety and other psychiatric problems that afflict the learning disabled at three-to-five times the normal rate.

The social worker's role is threefold. First, to take a complete family, academic and vocational history. Second, to refer the individual for educational, psychological, neurological or even medical evaluation. Third, to help the family process the difficult feelings that arise as the diagnosis is determined.

Given the multidisciplinary nature of these disorders, the social worker can resolve treatment conflicts or avert competition among professionals. Finally, the social worker, in advocating for the learning disabled, is best equipped to remain attuned to the individual's deficits in information-processing and tailor the methods of intervention accordingly.

■ SYRACUSE CHAPTER

by Linda Greytak, President

The Syracuse chapter is working towards its annual meeting, September 22, with a sought-after speaker, Leigh McCullough-Valiant, who presents nationally on dynamic short-term therapy. The new executive board takes over at that time; the new president will be Judy Crosley, who represented the chapter at the winter state meeting.

Also in chapter news is its first annual scholarship. To build a stronger relationship with the Syracuse University School of Social Work, and to recognize and encourage a second-year student in the field of mental health who shows both need and merit, a scholarship was awarded at the school's convocation.

The chapter has joined the Coalition of Mental Health Professionals and Consumers, Inc. and is working towards improvements in managed care. Many members are organizaing their own managed care corporation in central New York, with practitioners from as far away as Binghamton, Ithaca, Watertown and Utica. Legislatively, we are working towards passage of the social workers' licensing bill. One of the chapter's quarterly private practice meetings was about learning to lobby. Other topics have included managed care, record keeping, testifying and legal liability. Future topics of the bi-monthly educational meetings will be services for the elderly, metaphors in child therapy, anxiety education groups and treatment issues of African-Americans.

■ QUEENS CHAPTER

by Ira Frankel, President

The Queens Chapter had an active year providing continuing education for its members. Among the stimulating topics and their presenters were: assertive practice building techniques with Sheila Peck; surviving in the evolving managed care system with John Chiaramonte; current legal and ethical dilemmas in clinical practice with Hillel Bodek; and a legislative update with Marsha Wineburgh. The lectures were all well attended.

The Queens Chapter is in the forefront of clinical research awareness through its Research Committee Program. The chapter's Empirical Clinical Practice Study Group met monthly to discuss Single-Case Research Designs. This material is becoming more essential for practitioners who have to demonstrate that their interventions actually produce desired outcomes with individual patients. The study group is looking for more participants and is planning to link up its activities with those of the State's Research Committee, chaired by Jacinta Marschke.

At the chapter's annual membership brunch April 2, Roslyn Gold received a service award for her tenure as immediate past president.

■ WESTCHESTER CHAPTER

by Joan Elkin, President

This year the chapter has established book awards at Columbia University School of Social Work and Fordham University Graduate School of Social Service, two schools which have complete masters degree programs in Westchester. The student recipients demonstrated outstanding achievement in the study and practice of clinical social work.

The chapter is open to feedback, recommendations and new ideas as it works to hold onto important professional values in the face of major changes in the political climate, in the complexities of client populations and in the delivery of social and mental health services.

■ SUFFOLK CHAPTER

By Laurie Rosen

"Personality Disorders and Their Treatment" was Morton Kissen's topic at an April 2 seminar sponsored by the Suffolk chapter. Dr. Kissen described how to conceptualize the diagnostic categories in spite of managed care's emphasis on Axis I diagnoses. He also raised challenging questions about personality disorders.

The chapter has formed a Mentorship Group for recent MSWs and second-year MSW students. Its monthly meetings will focus on negotiating the workplace and networking. The chapter also hosts Friday afternoon luncheon-meetings every quarter to get member input and to encourage participation. For information, contact president Margaret Loughran, (516) 821-2958.■

CLINICIANS, COMPUTERS & CYBERSPACE
Part One

By Sheila Peck, CSW

A little more than eight years ago I would have been struggling to get this article written by hand or on my geriatric IBM electric typewriter. Today I'm using my computer. Like a good friend, and barring power failures, my Mac is always there for me.

A little more than eight years ago, after struggling to collect the figures preparatory to doing our tax return, I told my husband, who works on mainframes (the big million dollar computers), "I'm getting a computer so I won't have to go through this next year." (We do our own taxes, although now we use software for the accuracy and neatness attributes it offers.) He laughed and predicted I would play with it for a while and then let it drop. After all, what could I use it for besides letter-writing and taxes? Even so, on May 15, 1987, I became the proud parent of my first cute little Macintosh Plus computer. It had a tiny screen, a clunky printer, and a minuscule 20 Megabyte hard disk (by today's standards, tiny). The whole set-up (which is still operative and which I view as a kind of souvenir), including some software, cost me more than twice as much as my current higher-speed, 14" color monitor with ink jet printer with modem, CD-ROM and a much larger hard drive.

Enough technicalities! So what has all this done for me in my practice? And how might this interest those readers who are "technologically challenged"? How can all this help a clinician in private practice? Please review the list at the right.

Ready-Made Report Formats

Of course it takes work to begin, but for simple word processing, it's not much more effort than it would to fill out a complex application to belong to a managed care panel or write a long Outpatient Treatment Report (OTR) .

One way I use my computer to advantage is to enter the format of the OTR into a permanent file in my word processor. Then I write the initial OTR. Later, when it's time for the next one, I make a new copy and address the goals I presented initially with updates. I outline the new material in a box and, at the top, address a note to the utilization reviewer that "new material is indicated by a box" and send the whole thing in. It saves the reviewer the trouble of looking at old reports and makes it clear, by boxing new material, that you're doing an effective job (if you are) by addressing relevant goals. If you'd like a sample, let me know and I'll send you one.

Using this method, I've received several compliments from peer reviewers along with thanks for making their job easier. And it's no extra trouble for me. One caveat, however: make sure you really do add *new* information. Several clinicians have been caught merely rearranging old material. In addition, I use my software to print out attractive envelopes for mailing out my OTR's, with a graphic near the address. I have no proof for this, but I usually get reimbursed fairly quickly, which I attribute to the fact that my envelopes stand out. In general, my reports look professional and get noticed in a positive way. And yours can, too. Your computer will make all your record keeping much easier. You'll just keep track of everything on the computer—*but—you must make sure you back up your work!* It should become automatic. ■ **[Part Two will appear in the Fall issue.]**

Here are some of the things I do with my computer (besides play):

(1) Keep all client financial records and notes (later on you'll read how this helps you with insurance claims.)

(2) Keep track of banking and print out both business and personal checks each month. When it's tax time, we transfer tax-related information to tax software (and you can, too) and print out the return;

(3) Send out all billing to clients;

(4) Print out insurance claim forms and matching envelopes;

(5) Write effective outpatient treatment reports.Also,

(6) Make sure outgoing mail from my office looks good (especially since I have a terrible handwriting) and is reasonably error-free. You cannot know that I just typed "cannot" as "canot". That's because my spell checker spots an error, makes suggestions for changing it, and lets me fix it with a tap of a finger. The same software even checks my grammar or uses a built-in thesaurus;

(7) Publish two reasonably professional-looking newsletters, one for the Coalition of Mental Health Professionals and Consumers and the other, "The Session," a marketing and practice-building newsletter for clinicians;

(8) "Talk" to people all over the world on the Internet (that's what "Cyberspace" means). In addition,

(9) Have board meetings on-line, "attended" by 12 people, while the computer automatically keeps a log of everything "said";

(10) Design brochures and write press releases for other clinicians;

(11) Produce flyers for the Society and the Federation;

(12) Research the Internet's data banks for clinically relevant articles and data (I recently read one article about research showing mild depression was helped by some new computer software which seemed just as effective as "live" sessions);

(13) Advertise the State Society for Clinical Social Work on a variety of computer billboards (it's free).

And finally, (14) subscribe (also free of charge) to several "news groups" all over the world on a variety of topics of interest to me (at last count there are over three thousand of these); and

(15) Make travel and hotel reservations for business (and pleasure trips).

One way I use my computer to advantage is . . . for OTRs. I've received compliments from peer reviewers along with thanks for making their job easier. And it 's no extra trouble for me.

Sheila Peck, CSW, is a psychotherapist in private practice, chair of the Society's Public Relations Committee and newsletter liaison. She trained in family therapy and sports psychology and served as a mentor at Empire State College. She offers seminars and consultation in public relations and practice-building.

Please Note: How to Write A Press Release, slated to be the topic of this month's Practical Practitioner, will run in a future issue of *The Clinician.*

A Brief Note On Transference In Daily Life

by Roberta Ann Shechter, DSW

Family Fantasy in the Workplace

The Dilemma

Her eyes were luminous with tears. She brushed thick brown curls from her forehead and sobbed into slender, cupped fingers, nails bitten to the quick. In a voice filled with anguish she said, "All I did was work, from the morning through the night. I ate at my desk. The computer keys felt like parts of my body: 10-hour days, 12-hour days, 16-hour days . . . nothing was ever enough. I gave him my all, and he still wasn't satisfied. I didn't mean to lose the documents. Really, I didn't! He screamed at me, 'Oh my God, not again, leave!' And he pushed me out the door. I can still feel his pointed finger in the small of my back. He wouldn't listen. I want to die!"

I listened and wondered. Was this woman describing her boss or lover?

Theoretical Framework

Like a petri dish in a microbiology lab, the workplace is a medium for live drama. Work is a central human endeavor. The average adult spends up to 80% of his or her waking hours at work.[1] Time spent in the workplace promotes emotional closeness. Personal and professional identifications develop among colleagues. Hostility and conflict are, nevertheless, unavoidable. According to Sigmund Freud (1930), "no other (activity) of life attaches the individual so firmly to reality (and) community."[2] Karl Menninger (1942) viewed work satisfaction as an essential ingredient in a harmonious life.[3] Problems at work often lead people to seek psychotherapy. They may have difficulty completing tasks, getting along with office mates, following the directions of a supervisor, carrying forward an appropriate share of responsibility on a work team.

The most common office illustration of family fantasy is the secretary who has been given the role of a favored daughter or abused wife by her employer.

Psychoanalytic theory deepens our understanding of workplace problems. In close daily contact with others at the office it is natural to seek the satisfaction of libidinal longings, the fulfillment of one's need for love and security. Libidinal fulfillment can take many forms. Praise from others for a job well done builds our sense of competence and gratifies normal narcissism. Conversely, libidinal frustration perpetually threatens. Criticism can be deflating and trigger unbridled fury at self and others. The intensity of these experiences is based on family fantasy.

Family fantasy is a form of transference that is bounded to the workplace. A family fantasy occurs when an individual invests a current work relationship with the feelings, thoughts and expectations that were once reserved for the significant objects of childhood.[4] When a family fantasy unfolds, the ego defense of displacement is operating. The past is alive in the present. A family fantasy can cloud perception, encourage unrealistic expectations of others, and lead to irrational decision-making. The most common office illustration of family fantasy is the secretary who has been given the role of a favored daughter or abused wife by her employer. If the secretary meets the demands of this role, she is participating in her employer's family fantasy. She may also be enacting a family fantasy of her own. In middle-management we find a unique form of family fantasy, the executive in search of a mentor. This mentor is a longed for father or mother figure, without whom the executive's career feels rootless and directionless. If a mentor is found, the executive may have a sudden, unexplained adolescent-like need to rebel and reject guidance. In short, family fantasy can be constructive and/or destructive. It gives shape and substance to our deepest longings, wishes, and fears.

Roberta Ann Shechter, DSW

Case Examples

I recently did psychotherapy with a company owner whose family fantasy triggered anxiety that led to a destructive leadership style.[5] I learned, in the course of doing an intake, that my patient was preoccupied with worry about high staff turnover at her company. Rumination about this concern kept her awake at night and flooded her daytime thoughts. She complained of overwork. All business decisions, no matter how minor, required her approval. All managers and line staff, approximately 30 people, were connected by intercom to her office. Workers at every level of her sales organization could be audio-monitored anytime. She listened to telephone calls to be certain that they were business related. When an offender was caught in the act of "stealing time," the phone call was disconnected and a reprimanding memo was sent before closing. My patient found her need for vigilance draining. Still, she was too fearful of being let down by others to loosen the reins. Her behavior provoked the abandonment that she feared. Harassed employees quit after only a few months on the job.

My patient's behavior was based on the repetition compulsion, an unconscious need to treat others in the present as she had been treated in the past. Her hostile behavior replayed the painful experiences of childhood — pain suffered at the hands of an

Roberta Ann Shechter, DSW is a Certified Psychoanalyst in private practice in New York City; an Adjunct Assistant Professor at Hunter College School of Social Work; and Associate Editor, Journal of Analytic Social Work.

invasive, hypercritical, controlling mother. Working through the pain of that early time became the focus of a lengthy therapy.

A disabling family fantasy can gain its strength from a friendship that predates a business relationship. My patient Jim came into treatment complaining of depression, "everyday is grey, the same." In our second session he wondered aloud if he should "dissolve my partnership with Harry . . . buy him out." Jim was the co-head of a small investment firm that "would make big money if it was run my way." This business was founded on the strength of a long-standing friendship. Jim met his partner Harry while they both attended business school. "Harry was a risk taker then. He had a great imagination. He encouraged me to join forces with him. Our basic business concept was his idea. We met our wives at the same party. Our children are close in age. We have the same concerns in life. We use to think alike about most things. It is different now, especially in business." His sense of history with Harry fomented guilt in Jim. He felt guilty when he found himself questioning Harry's business practices. Jim said, "Harry lacks vision and the courage to expand our operations. But, I feel like we are brothers as much as business partners. Not to trust Harry's judgment feels disloyal. Perhaps, I should hold myself back and not push for change. But if I do that, we will eventually be bankrupt."

The torment of Jim's family fantasy is based on personal history. In displacement, Harry is a brother. The youngest of seven, Jim was the only "achiever" in his family. Graduation from college and movement into a profession left his working class siblings behind. He said, "My brothers, to a man, work on father's fishing boat. The income is seasonal and meager. They bitch, but I'm the only one who has left." Punishing guilt and accompanying depression were experienced in that earlier separation. These feelings were replayed in Jim's brother-like partnership with Harry.

In conclusion, the unconscious is timeless. The past and the present come together, stimulated by workplace anxiety, in a form of disabling transference called family fantasy. The meaning of family fantasy can be uncovered in psychotherapy, and the conflict at its core resolved.■

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L. to r., William R. Felts, MD, NAP President, inducts new social workers Golnar Simpson, DSW, David Phillips, DSW, Alice Medine King, CSW, Edna Roth, PhD, Co-Chair and Betty Jean Synar, MSS, Chair.

Two Inducted into National Academies of Practice

Two State Society members, Past President David Phillips and Alice Medine King, were inducted in March as Distinguished Members of the National Academies of Practice (NAP). The NAP is comprised of nine academies, dentistry, medicine, nursing, optometry, osteopathic medicine, podiatric medicine, psychology, social work and veterinary medicine, each comprised of 100 members who were judged by their peers to have made enduring contributions to their fields.

Alice Medine King, CSW, MCSW, BCD, of Great Neck, is a private practitioner of psychoanalytical developmental psychotherapy and a faculty supervisor and member of the board of New York School of Psychoanalytic Psychotherapy. She is on the advisory council of the Managed Care Committee of the State Society, Board member of the Committee on Psychoanalysis of the National Federation and Co-Chair of the Legislative Committee of the Coalition of Mental Health Professionals and Consumers. She received a Masters degree in Psychology from the University of Michigan and MSW from Adelphi University School of Social Work, and is a graduate of the Institute for the Study of Psychotherapy.

David G. Phillips, DSW, State Society President from 1992 to 1994, received his Doctorate degree in Social Work from the Adelphi University School of Social Work and a Certificate in Psychoanalysis and Psychotherapy from the Postgraduate Center for Mental Health. He is currently a Supervising and Training Analyst at that center, an Adjunct Associate Professor at the Wurzweiler School of Social Work, Yeshiva University, and in the private practice of psychoanalysis, psychotherapy and couples therapy in New York City. He was a member of the New York City Task Force on Ethics which contributed to the current revision of the Code of Ethics of the NASW and, later, Ethics Chair of the State Society, where he drafted the first Code of Ethics. He has written and taught on various legal and ethical issues and is co-editing a book with Dr. Richard Alperin on the impact of managed care on the practice of psychotherapy, to be published by Brunner/Mazel.■

MANAGED CARE COMMITTEE REPORT

by Emanuel Plesent, Ed.D, CSW, BCD, Chair

Focus on the State Level

With the demise of National Health Care Reform, it is clear that our efforts must be focused on the New York State level. With the change in State government, our tasks regarding legislation become more important, yet more confusing.

- We continue to attempt to coordinate with other organizations such as the Coalition of Mental Health Providers and Consumers and the Alliance for Universal Psychotherapy. Managed care companies continue to consolidate and merge.
- The prediction of the imminent demise of the solo practitioner has had a mid-course correction. The replacement by group practice in our field has hit some bumps and snags.
- Reports challenging the financial benefits of managed care are beginning to appear.
- Strong legislation, referred to as the Health Care Bill of Rights, regulating HMOs, is being introduced in the State Senate and Assembly. It is being proposed with a broader coalition of physician, provider and consumer support than previous efforts. Quoting from one newspaper, "pressure seems to be building among lawmakers to get this State more actively involved in insuring the quality of care patients receive and doctors provide in the burgeoning managed care industry."

The power of our efforts can be measured by the extremely strong and antagonistic response by HMO and business representatives. They voice dire warnings about the AWP (Any Willing Provider) provision. I believe a POS (Point of Service) requirement might be more acceptable and accomplish many of our goals.

No, we're not dead yet, but we must keep eternally vigilant. Closed panels have been a major problem. We have answered many members' calls and given much advice and support concerning managed care companies. Members seem greatly appreciative of this service. However, many of their problems stem from "not playing by the agreed-upon rules," for example, very late filing of OTRs, not filing them at all, or not keeping accurate records of the number of allotted sessions.

Though we may disagree with the whole procedure, if we play the game we must play by the rules. We still have the option of private contracting (although this is under attack also).

In general, communication has continued between the Legislative, Vendorship and Managed Care sections. Vendorship efforts have increasingly been in the managed care area, as that is the direction of insurance coverage. We also continue to be closely involved in one of the first regional health alliances in the U.S., the Long Island Association Health Alliance. Our voice for appropriate mental health services has been heard. It remains to be seen what will be the result.■

Managed Care Companies

Several colleagues have asked which managed care panels to join. The current situation is that many panels are closed. There are two newsletters which give monthly updates on openings as well as other valuable information. They are: Psychotherapy Finances, (407) 624-1155 and Practice Management Monthly, (800) 578-5013.

The following are the 10 largest managed care companies and their phone numbers. Most are not expanding networks now. But the list is dynamic. Panels open, panels close, waiting lists are formed. Also, phone numbers change and mergers occur. Please let me know of additional information you may have.

Value Behavioral Health	(800) 338-7485
Medco Behavioral Care	(800) 999-9772
Human Affairs International	(801) 268-0553
Green Spring	(800) 788-4005
United Behavioral Systems	(800) 551-7413
First Mental Health	(615) 256-3400
MCC Behavioral Care	(800) 926-2273
Family Enterprises	(414) 359-1040
US Behavioral Health	(800) 333-8724
Occupational Health Servs.	(800) 541-3353
OTHER COMPANIES ARE:	
Prefer'd. Mental Health Mgt	(800) 776-4357
Options Mental Health	(800) 854-1133
Multiplan	(212) 780-2047
Integr'd. Behavioral Health	(800) 395-1616
CMG Health	(410) 581-5000
Com Psych	(312) 245-2699
Pru Psych	(713) 276-3921
Choice Care-Long Island	(516) 694-4000
GHI-BMP	(212) 501-4447
BX-BS Mental H'lth. Choice	(800) 362-8344
Oxford Health Plans	(800) 666-1353
Consulting H'lth. Care Sys.	(212) 874-3696
Managed Health Network	(800) 541-2381

ETHICS & PROFESSIONAL STANDARDS

by Hillel Bodek, MSW, CSW, BCD, Chair

COMMITTEE REPORT

Medical Insurance Fraud

As chair of the Society's Committee on Ethics and Professional Standards, I receive a number of questions regarding medical insurance reimbursement. Over the past several years, an increasing number of these inquiries disclose practices which constitute insurance fraud. It is quite distressing that many practitioners are seemingly blind to the fraudulent nature of their conduct and its potential serious impact on their patients and on the public image of their profession.

Section 176.05 of New York State's Penal Law defines a "fraudulent insurance act" as committed when a person, "knowingly and with intent to defraud presents, or causes to be presented, or prepared with the knowledge or belief that it will be presented to or by an insurer or purported insurer, or any agent thereof, any written statement as part of, or in support of .... a claim for payment or other benefit pursuant to an insurance policy .... which he knows to: (i) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto." Committing insurance fraud can lead to state criminal charges for larceny, federal criminal charges for mail fraud, civil suits, and charges of professional misconduct brought by the New York State Education Department. These can result in incarceration, fines, civil monetary penalties and loss of licensure.

> It is easy to rationalize insurance fraud . . . because it benefits patients by allowing them to obtain therapy they might otherwise not be able to afford. . . . However, this noble end can be accomplished honestly by therapists . . .

The most common type of insurance fraud is billing for services that were not rendered. This doesn't merely include billing for extra sessions in addition to those provided. It also includes billing an insurance company for missed sessions. Although one may bill a patient for missed sessions if they have informed the patient, in advance, of their policy to do so, insurance companies only reimburse expenses for services rendered. ***When a patient misses a session, no service was rendered and submitting the cost of such missed session to the insurance company for reimbursement is a fraudulent act.***

A second, increasingly pervasive type of insurance fraud, occurs when a practitioner bills for services that are not covered and disguises this fact by describing those services ambiguously. For instance, most medical insurance policies limit coverage to clinically necessary treatment of mental disorders. As such, most do not provide coverage for marriage therapy. What some practitioners do is describe such service as "psychotherapy" and list a DSM-IV diagnosis of "dysthymic disorder" or "generalized anxiety disorder" on the insurance claim. This is misleading. The practitioner should describe the service as what it is, "marriage [or conjoint] therapy," and list the diagnosis that reflects the focus of their clinical attention, "partner relational problem (v61.1)."

Another situation in which this problem occurs is when a practitioner who is treating a child sees the parents to discuss the child and bills the session as therapy for the child or a parent, or sees an adult patient and has collateral contacts with the patient's family and bills that as therapy for the patient or family members. Practitioners should bill such services as rendered for the child as the patient and should describe such services accurately as, "conference with child's parents incidental to child's treatment" or as services rendered for the adult patient that should be described accurately as, "consultation with patient's family" or "explanation of results of evaluation or other data to family or other responsible persons" and/or "advising patient's family how to assist patient."

Yet another situation in which this problem arises occurs when a practitioner is treating a family and bills the sessions as therapy for one member of the family, often until that person's coverage runs out, after which the family sessions are then billed as therapy for another family member. Such services should be billed as "family group therapy" and the fee for each session divided equally among the family members attending. Accurate diagnoses should be given for each family member. If the focus of the family therapy is primarily for treatment of a parent-child or other family problem, that problem should be listed as the primary diagnosis and the appropriate V code from the DSM-IV utilized.

A third type of insurance fraud, a variant of the second, occurs when a practitioner describes a service as for the treatment of a physical disorder rather than a mental one in order to get around an insurance policy's lower reimbursement rate for and annual limitation on mental health benefits. For instance, a practitioner bills half of their sessions as psychotherapy for treatment of anxiety and half as biofeedback/hypnosis for stress reduction, or bills for a psychotherapy session and for a session of biofeedback/hypnosis on the same day when these were provided as part of a combined treatment of the patient's emotional disorder during the same session. ***It is essential that the services for which a claim is made be fully, accurately and unambiguously described on the insurance claim form, that the diagnoses listed represent the focus of the practitioner's intervention, and that claims for services be attributed accurately to the patient(s) to whom they relate. In that manner, the insurance company can then knowingly process the claim and accept or reject it depending upon the terms of the insurance policy.***

A fourth type of insurance fraud, increasingly common among social workers, occurs when an eligible provider [one with the "R" endorsement on their license] signs an insurance claim for services rendered by a practitioner whose services are not eligible for reimbursement. ***An insurance claim form should be signed only by the practitioner who provided the services listed thereon.*** If a practitioner who is not eligible for insurance reimbursement is being supervised by a practitioner who is eligible, ***the supervisor may write a cover letter, to be attached to the claim, indicating that the services rendered on the dates listed on the claim form were provided under their supervision and explicitly stating that they did not provide the services in question.*** Remember that as opposed to a consultant, a supervisor is one who takes personal professional responsibility for the professional actions or failures to act of the supervisee.

A fifth type of insurance fraud occurs when a practitioner increases their submitted, though not actual fee for services, in order to take advantage of a patient's insurance. For instance, a patient has a policy that provides for 50% reimbursement of the practitioner's "reasonable and customary fee" and does not impose an annual maximum. One practitioner informed me that what she did was bill $180 a session, thereby having the insurance company pay 50% of that, the $90 that was her usual and customary fee. In her defense she noted that,

(Continued on page 16)

PUBLIC RELATIONS COMMITTEE REPORT

by Sheila Peck, LCSW, Chair

1. The National Federation (of Societies for Clinical Social Work) has approved the funding for the proposed media guide and we're formulating more specific concepts to include in it. So, we are soliciting further ideas from YOU, please. What do YOU want national and local media to know about our profession and ourselves?

Also, we have the following specific needs:

- Clinical "success" stories (no names of clients, please).
- Information as to what your "special expertise" might be and whether you have made any media appearances in a professional capacity. Many programs prefer people with some experience, although it's not entirely necessary. Nevertheless, I'd really like to have this on file — and only one person has, so far, responded to this request. Does that mean we have nothing to offer? I particularly hope the clinical committees (hypnosis, psychoanalysis, family, group, etc.) will be part of this.
- Clear photographs, candid or posed, of social workers at work.
- Publication titles by Society or Federation members.

2. In response to a call from a member who read about it in the recent mailing sent out by Federation, we recently followed up a letter she wrote to Art Ulene of the *Today Show*. In the course of a segment about eating disorders, Ulene omitted clinical social workers from his discussion of where to get help.

3. Another member called with a complaint about the recent PBS program, *Divided Memories*, stating that she thought the few social workers appearing on the program were chosen irresponsibly and did not present an accurate representation of our profession. We've received transcripts of the programs and will soon be going through them in order to be able to respond appropriately.

4. We are writing a letter to the *Oprah Winfrey Show* complimenting them on changing the title in a recent broadcast about the misplacement of foster children from "Are Social Workers Guilty?" to "Are Caseworkers Guilty?". It's my understanding that NASW worked hard on this. Our Society needs to be heard, too.

5. We have sent several letters of appreciation to television programs who have presented clinical social workers as guest experts.

Please continue to tell us about any negative media references or omissions about clinical social work. And send us those media kit data, too! Call or fax me, Sheila Peck, at (516) 889-2688 or write me at 1010 California Place South, Island Park, NY 11558; e-mail Sheila2688@aol.com.■

Zero-to-Five Mentoring

At the recent meeting (May 3-7, Washington, DC) of the National Federation of Societies for Clinical Social Work, an ad hoc group, the Zero to Five Committee, was formed under the leadership of Betty Phillips of Connecticut, president-elect of the Federation. Zero to Five is intended to address the concerns of MSW graduates, beginning immediately after they leave school and extending until they are ready for the BCD exam, or five years after graduation.

Specifically, the committee decided to create a multi-faceted mentorship program to offer to all State chapters that do not already have one. The New York Society and other states that have an active mentorship group will serve as models for helping Zero to Five begin this work.

Plans were made to implement one or more courses for the Zero to Five population, starting with development of an eight-session workshop to be given by mentors to deal with the synthesis of social work theory with actual cases which "mentees" will bring to the workshop.

The Federation Committee will offer State groups information, support and guidelines for developing mentorship programs of their own. Since we in New York have such an active program, Society President Helen Hinckley Krackow offered some the material that Met Chapter currently directs toward second year students and graduates of social work schools to serve as a model for other groups. Helen also told the group about our Bulletin Board initiative, which is managed by Barbara Bryan of the Met Chapter.

In addition, Sheila Peck, Public Relations Chair, will be working with Betty Phillips to write a letter to state presidents telling them about this new program and offering help in publicizing it. At the next Federation meeting, in Seattle at the end of September, a workshop on the topic will be offered to all the presidents.■

Ethics & Professional Standards

COMMITTEE REPORT

Insurance Fraud

From Page 13

"everybody does it. My analyst did it for me. Otherwise, I wouldn't have been able to afford twice a week sessions."

A sixth form of insurance fraud, a variant of the fifth, occurs when a practitioner consistently fails to collect the coinsurance and deductible amounts from a patient. In such instances, the fee the practitioner lists on the insurance claim is not their actual fee for the service, since the practitioner is accepting the insurance company's payment, which is only a percentage of the fee they list on the claim, as payment in full for the service. There are ***few***, ***rare***, situations where a practitioner who doesn't have a general policy of waiving collection of the coinsurance and deductible amounts ***might*** appropriately accept the insurance company's payment as payment in full. These would include a situation where the cost of billing for coinsurance would exceed the amount of the coinsurance or ***a very unique*** situation where a practitioner charges the insurance company their ***usual, standard and customary fee***, and waives collection from a patient of the coinsurance because of the particular patient's ***indigency***, not merely financial hardship.

In several states and under the Medicare program, consistent failure to collect coinsurance and deductible amounts may result in criminal prosecution. (Continued on page 18)

The Rockland County Chapter
of the
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OLGA SILVERSTEIN, MSW

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Medical Insurance Fraud

From page 16

Alarmingly, reflecting a serious problem with the ethical foundation in some of our colleagues' professional development, many of the practitioners with whom I spoke who engage in insurance fraud were able to rationalize it as acceptable for a variety of reasons. These rationalizations include, "everybody does it," "psychiatrists and psychologists do it so why is it wrong when we do it?" "clinical social workers won't be able to compete with psychiatrists and psychologists if we don't do it," "it helps the patient by increasing the number of sessions they can afford," "the insurance companies should cover these services anyhow," "making the patient pay for a missed session is part of the therapy, so it should be covered," "it doesn't hurt anyone," and "nobody will know." Aside from the fact that engaging in insurance fraud is illegal, unethical and may lead to criminal, civil and administrative sanctions against the practitioner involved, there are other reasons to avoid scrupulously such conduct.

First, such behavior detracts from the respect others have for our profession and impacts negatively on our struggle for professional recognition. Second, ***insurance fraud, just as any other so-called "white collar crime" is not a victimless crime.*** It results in increased insurance rates and decreases in insurance benefits. Third, and most important, ***by engaging in insurance fraud together with a patient, the practitioner harms the patient.*** Such practitioners involve patients as partners in a criminal act that can result in the patients incurring criminal and civil penalties. And, such practitioners indicate to their patients that it is acceptable to engage in antisocial behavior and dishonesty.

It is easy to rationalize insurance fraud as acceptable because it benefits patients by allowing them to obtain therapy they might otherwise not be able to afford or which they could only afford with some hardship. However, this noble end can be accomplished honestly by therapists adopting a sliding fee scale or referring such patients to practitioners who do. The bottom line is that what insurance fraud really accomplishes is increasing practitioners' incomes at the expense of their professionalism while undermining their therapeutic efforts to facilitate patients' development of healthy ego functioning.■

The CLINICIAN

How the Newsletter Got Its New Name

Late last year this newsletter ran a contest requesting a new name for itself. The Clinician, simple and eloquent, was Carl Bagnini's winning entry. Honorable mention goes to Suzie Jary, Robert Schore and Susan Solomon, who submitted fine alternatives.

We congratulate them all and proudly present them to you.

The Winner

Carl Bagnini, CSW, BCD, Nassau Chapter:

Carl is a Diplomate in the State Society. He is Assistant Director of the Family Therapy Training Program of the Long Island Institute of Psychoanalysis in East Meadow, where he teaches object relations family therapy and supervises candidates. Carl has a certificate in Family Therapy at the Long Island Institute and at the Manhattan Center for Modern Psychoanalytic Studies. He has been in study groups for eight years with faculty from the Washington School of Psychiatry's Object Relations Family Therapy Program, including Jill and David Scharff. He has presented on Couple and Family Therapy for the State Society Annual Conference twice and at other chapters, as well as in Toronto. He is also an associate editor of and writes on analytic couples therapy for the Long Island Psychoanalyst, his institute's newsletter. In private practice in Port Washington, Carl leads object relations supervision groups and treats individuals, couples and families.

"Succeeding in clinical practice still requires the basics," Carl said, "a good heart, a well informed intellect, family and friends who care, excellent training, an eye for the absurdities of life, a competent therapist, the desire to do the work well, and health. We are an honorable profession going through difficult times." He advises, "Keep the faith, and multiply the good object."

Honorable Mention

Suzie Jary, MSW, Met Chapter:

Suzie has been a member of the Metropolitan Chapter of NYSSCSW for one year, and is active in the public relations committee and the Mentor Group Program. She received her MSW from Hunter College two years ago and worked in outpatient mental health clinics before taking her current position at Career Transition For Dancers, where she provides vocational and supportive counseling to professional dancers at a point of career change. She was a musical theatre dancer for 14 years and performed on Broadway.

Susan Solomon, CSW, BCD, Westchester Chapter:

"Coming up with a possible name for this newsletter intrigued me. I love to play with words and revel in those moments of therapeutic work when the client's choice of words leads to the heart of the matter. Family therapy, marital counseling and supervision comprise over 50% of my practice," Susan said.

"I would like for there to be a project that sponsored our finding the words — a slogan — to convey the essence of our clinical process. After all, if GE can bring good things to life, why can't we declare how we uniquely use ourselves to bring good lives to people?"

Robert Schore, CSW, Rockland Chapter:

Robert Schore retired in 1991 after 26 years as a social worker with the New York City Schools, the last five in High School Clinical Services. However, the free time he thought he would have in retirement has been elusive, what with adjunct college teaching and a part-time private practice in his West Nyack office. He also serves as an Impartial Hearing Officer in disability hearings, studies piano, and has lately been preparing for a "ham" radio license exam. Bob also tries to participate in meetings of the Rockland Chapter.■

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