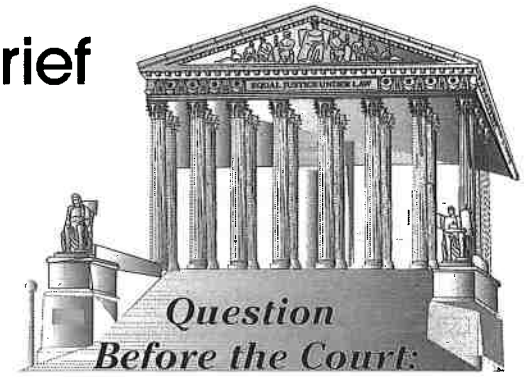
The CLINICIAN

Winter 1996 Vol. 27 No. 1

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

State Society Funds Legal Brief in Supreme Court Case



Are Clinician/Patient Communications Confidential?

FEATURE

By
Marsha Wineburgh, MSW, BCD
Legislative Chair

On November 18, the Executive Board of the State Society voted to make a gift of $10,000, with the possibility of $5,000 additional support, to help fund an Amicus Brief for the Supreme Court hearing on clinical social work confidentiality. An occasion to support a crucial issue as fundamental to the practice of clinical social work as the confidentiality of patient communications rarely appears. This gift ensures that the National Federation will be able to fully participate with the finest legal representation in this most important case, *Jaffee V. Redmond.*

The Supreme Court of the United States has agreed to decide whether psychotherapists can be forced to testify or provide other evidence about patient communications in federal court cases. All 50 states have adopted some form of protection for confidential information between psychotherapists and their patients; all but three states protect the social work profession. If the high court concludes that there is such a shield against forced testimony, the justices will also have to determine whether it extends to non-medical psychotherapists including social workers.

Jaffee v. Redmond is a case which involves an Illinois clinical social worker who refused to disclose confidential notes about the treatment of a police officer who had shot and killed a suspect. Following the incident, Mary Lu Redmond was put on administrative leave and sought treatment. The family of the young man sued the officer and the city in civil court and asked that the clinical social worker testify and turn over her notes of conversations and records. The trial judge ruled that there is no privilege between social worker and client. In addition, he told the jurors that because the social worker refused to testify or produce files they could presume that the withheld materialwould be "unfavorable" to Redmond. The jury awarded the family damages. On appeal, the Seventh Circuit Court of Appeals reversed the verdict noting that all of the states have recognized some need for "psychotherapist-client privilege" and that it should include "any mental health care provider." The Supreme Court is deciding whether a psychotherapist privilege exists and whether it should include "any mental health provider." The brief was due to be filed on January 2, 1996.

Although persistent efforts were made to include all relevant clinical social work organizations in one joint effort, at this time, the National Federation and the National Association of Social Workers are participating in our brief. Efforts were being coordinated with a number of other groups that were planning to file supporting briefs, including the federal government, the American Psychiatric Association, the American Psychological Association, the American Psychoanalytic Consortium, the ABE Board, AASSWB, the Employee Assistance Professionals Association, the ACLU and the Bazelon Center for Mental Health.■

IN THIS ISSUE

EXECUTIVE REPORT

Helen Hinckley Krackow
CSW, BCD,
Society President

Multiply and Prosper

These are difficult times for our profession and for all Americans. Many of our members are threatened with diminishing practices as the marketplace changes. In the insanity of this unraveling American economy, we must turn anxiety into action. We do well as a Society, but we must do better.

As I begin my second term as State President, I want to thank all our members who have helped build and strengthen the Society. I deeply believe that the Society can provide the protection our members so desperately need. This Society stands for enhancement of the clinical social worker and the field of mental health treatment. But we must grow and harness our potential.

My main goal in the next two years is to build membership and help more of you to take active roles. We must bond together as a functional family to meet a life crisis. There is so much to be done. All of us who do the work of the Society are rewarded with personal and professional support. We are the first to know about changes in the mental health marketplace and to conceive solutions in our "think tank."

Many thanks are due to the members of the State Board, who give so many hours of thoughtful work. Board meetings are usually exhilarating and enjoyable (all of you are welcome to attend at any time). The Chapter Boards and the chairs of the State and local chapters are also due our gratitude, as are those who work on conferences, workshops and newsletters, building our knowledge base and the quality of our writing. All of you who help build the Society in unofficial ways should not escape notice and praise. Every time you enlist a colleague in membership or pass the word along about our work, you help the Society and the field survive.

I begin my second term as State President with gratitude to all members who have helped me build and strengthen the Society in the past two years. My fervent wish for the new term is that we multiply and prosper. Help me make it so.■

At the Oct. 27th conference in NYC of the National Membership Com. on Psychoanalysis in Clinical Social Work.. (L.to r.) Carol Greifer, Conf. Dir., Keynoter Hon. Karen S. Burstein, Margaret G. Frank, Pres., NMCOP, Fed.Pres. Chad Breckinridge & Soc.Pres.Helen Krackow.

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

The Clinician is published three times each year by The New York State Society for Clinical Social Work, Inc.
Society Phone: 1 (800) 288-4279.
Editorial Office: 21 East 22nd Street, New York, NY 10010. (212) 533-7381.
Editor: Ivy Miller.
Society Editorial Consultants: CSWs Sheila Peck, Lesley Post and Carolyn Colwell.
Deadlines: January 10, April 5 & September 1.

THE 1996 STATE BOARD

EXECUTIVE BOARD
President, Helen Hinckley Krackow, CSW, BCD
* First VP, Allen A. Du Mont, CSW, BCD
Second VP, Dianne Heller Kaminsky, CSW, BCD
Recording Secretary, Sheila Peck, CSW
* Treasurer, Stephen M. Baver, CSW
Immed. Past Pres., David G. Phillips, DSW, BCD

MEMBERS AT LARGE
Neil J. Cervera, Ph.D., BCD
* Janet T. Droga, CSW
* Joan Elkin, CSW
* Sharon Kern-Taub, CSW
Emanuel Plesent, Ed.D., BCD

CHAPTER PRESIDENTS
Brooklyn: Marie P. McDermott, CSW; Henni Fisher, CSW, BCD; & Ninnette Setton, CSW, BCD
Capital District: No president
Metropolitan: Diana List Cullen, CSW
Mid-Hudson: Karen P. Whitton, CSW
* Nassau: Estelle H. Rauch, CSW
Queens: Ira Frankel, Ph.D.
Rockland: Frances Aquino, CSW, BCD
Staten Island: Judith M. Weiss, CSW, BCD
* Suffolk: Leona Duffy, CSW
* Westchester, June Tu, CSW
Western NY Contact: Laura V. Salwen, CSW, BCD

COMMITTEE CHAIRS
Education: Dianne Heller Kaminsky, CSW, BCD
Ethics/Forensic: Hillel Bodek, CSW, BCD
Family Practice: Barbara G. Feld, CSW, BCD
Group Psychotherapy: Phyllis Mervis, CSW, BCD
Hypnosis: William M. Ballen, CSW
Legislative: Marsha L.Wineburgh, CSW, BCD
Managed Health Care: Emanuel Plesent, Ed.D., BCD
Membership: Sharon Kern-Taub, CSW
Public Relations: Sheila Peck, CSW
Psychoanalysis: Marilyn G. Schiff, CSW
Research: Jacinta Marschke, Ph.D., BCD
Vendorship: John Chiaramonte, CSW, BCD

[**Executive Secretary:** Mitzi Mirkin]
* Newly elected

MENTORSHIP PROGRAM

Professionalism and Laughter: One Mentee's Experience

By Mary Anne Sessler, C.S.W.

I remember seeing the signs posted for the Clinical Social Work Society's Mentorship Program as I approached completion of my Master's degree. At that time, I immediately rejected the idea of being part of a new group. I felt too emotionally and physically exhausted from the demands of graduate school to join anything. There was a part of me that just wanted to be left alone. The only thing that I really wanted to add to my schedule was professional employment in clinical social work and I felt anxious about the interviews I had attended.

Before I knew it, almost two years had gone by. I felt alone in my work and confused about further professional development. A therapist encouraged me to join the Society and seek out a mentor group. I feel very grateful for that suggestion today.

The Mentorship Program is an invaluable source of support, guidance and inspiration for clinical social workers. Participating in monthly meetings with an experienced mentor and five to eight other CSWs has greatly aided in my professional growth.

During these monthly meetings we network for employment and referrals, present case material, receive excellent clinical supervision, offer peer support and exchange information about institute training and workshops. All of this is accomplished with a high degree of professionalism and *laughter*!

Also, mentoring extends beyond the group experience. This past summer, I encountered a problematic case in my clinic work. A friend in the field suggested that I consider legal advice. The attorney I phoned reacted with alarm and recommended an expensive consultation.

After calming myself, I decided to seek a second opinion and reached out to my mentor. One phone call and ten minutes later, I was provided with an outline of the necessary steps to take, received clarity regarding my role and experience a much-decreased anxiety level. I feel very grateful to be a member of a mentor group and cherish my membership in the Society.■

Mary Anne Sessler, a mentee of President Helen Krackow's, is a graduate of the Hunter School of Social Work and on staff at Greenwich House Counseling Center, a substance abuse treatment center.

FOR INFORMATION please contact Barbara Bryan, State Director of the Mentoring Program, at (212) 864-5663.

Group Practice in New York State

by Betsy Owens, CSW, CAC

Practitioners pursuing their livelihood through managed care need to be aware of the issues involved in forming professional group practices. New York State regulates these group formations via the business and education laws. Prior to the passage of limited liability corporation laws, education law prohibited fee-splitting between professions, i.e., group practices with psychologists and social workers forming partnerships. Ironically, fee-splitting for business expenses was and is permitted within an individual profession (via PC's and partnerships, as described below.) This is more ironic when one considers that many public agencies *require* interdisciplinary teams. Following are the general legal implications for the formation of group practices:

Sole Proprietorship: As a sole proprietor, one person owns all the assets of a business. The sole proprietor is liable for all of the obligations of the enterprise and is responsible for his/her own malpractice. Income is reported under Schedule C. ***Practice Implications:*** Safe and simple. Raising capital for new projects or winning capitated contracts may be a problem.

General Partnership: This is defined as "an association of two or more (partners) to carry on, as co-owners, a business of profit." Each partner has the power to bind the partnership, and all partners are liable for all the obligations of the partnership. Each partner is liable for malpractice covering him/herself, his/her employees and those providing service in the name of the partnership. Income is taxed to the individual partners. ***Practice Implications:*** To protect yourself, you should have confidence in the business and ethical integrity of your fellow partners. You may be responsible for their debts.

Registered Limited Liability Partnership: A recent development was the passage of legislation which enables the formation of interdisciplinary groups. Registered LLPs are owned by general partners and each partner is only responsible for the obligations of the partnership which each: a.) assumes or b.) incurred prior to registration as a partner. Each partner is liable for his/her own malpractice and any employee under his/her supervision or control. Income is taxed to the individual partners.

Practice Implications: This is currently one of the few options in New York State in which interdisciplinary practitioners can form a business relationship (physicians excluded). There has been a boom in this type of group because, as the name implies, there is "limited liability" for co-owners' debts. If you put one dollar into the corporation, that is the limit of your obligation should the enterprise fail. LLPs are common in other states.

Professional Service Limited Liability Company: This differs from the above in that it pertains to unincorporated organizations, as opposed to partnerships, and in that interdisciplinary practices are prohibited. Members are only liable for unfunded contributions, their own malpractice and that of any employee under their supervision or control.

Professional Services Corporation (PC): This is defined as an artificial person or legal entity created to carry on a profession. Shareholders are not liable for corporate debt unless assumed. Each shareholder is responsible for his/her own malpractice and that of any employee under his/her supervision or control. Interdisciplinary practices are prohibited. ***Practice Implications:*** There is double taxation, both as a corporation and in personal income returned to shareholders.■

Betsy Owens, CSW, CAC, is a private practice social worker in Albany. She functions as both a solo practitioner and a member of a limited liability corporation.

The intent of this article is not to promote any form of group practice, but to highlight the differences within the State. Anyone interested in forming one of the above groups should contact an attorney and accountant for professional advice.

Family Secrets

by Susan Gombos, MSW, BCD

Susan Gombos, MSW, BCD, is the Chair of the Westchester Chapter of the Family Practice Committee. She maintains a private Practice in family therapy in Scarsdale, and consults to the New York City school system. She serves on the boards of the Westchester Chapter of the State Society and on the Gifted and Talented Development Center at Iona College.

Why is it important to talk about family secrets? When you work with a family that is keeping a secret, you can feel the tension in the room, and the treatment often goes nowhere. When there is a secret, destructive behavior repeats itself across the generations, behavior such as out of wedlock childbirth or suicide in midlife. Stigma and shame are powerfully driven by secret keeping.

Evan Imber-Black, in the book she edited, *Family Secrets*, has provided the most comprehensive look at the clinical questions and issues raised by family secrets yet written. In this article, I will use her insights to examine the purposes that secrets serve in families, the symptomatology and some clinical interventions.

How do secrets shape relationships?

According to Imber-Black, secrets are systemic phenomena. "They are relational, shaping dyads, triangles, hidden alliances, splits, cut-offs, defining boundaries of who's "in" and who's "out," and calibrating closeness and distance in relationships. Certainly the questions, 'Who knows the secret?' and 'Who does not know the secret?,' orient us to the ways secrets affect relationships."[1]

In families where secret-keeping is common, triangulation can occur and family members may attempt to protect each other by carefully guarding the flow of information which they find threatening. Intergenerational loyalties are often shaped by the secrets. At the same time, otherwise unexplainable behavior, such as delinquency, extramarital affairs and refusal to seek treatment for serious illness, may result from secret keeping. Secrets limit the search for alternative, appropriate solutions to problems. In addition, the repetition of destructive behaviors may actually represent metaphorical attempts to disclose the family secret.

"Since the presence of a toxic secret can disallow discussion in many areas, a family's ability to solve problems or to confront normal developmental issues may be seriously impaired."[2] For example, an eight-year-old girl I saw in treatment became school phobic and no longer wanted to attend classes. Her mother was keeping the secret of her older brother's incarceration for drug dealing and instead told her daughter that he had gone away for a while. The mother was often depressed and tearful and the girl felt that it was necessary to stay home and take care of her mother.

I encouraged the woman to tell her daughter the truth. When the secret was finally revealed, the girl's response was to deal with the reality of the situation — she asked to visit her brother in jail. The mother sought psychotherapy for her depression and the girl returned to school.

Often secrets are not about current issues, but hidden family history. Secrets shape not only relationships, but inner lives. The secret-keeper thinks "If you knew the truth, you would not accept me," while those kept in the dark grow worried and confused. The reservoir of shame grows. Therapists are aware that low self esteem, anxiety, anger, depression, alienation and feelings of inferiority are symptoms of shame. Shame can be well masked and maintained through our loyalty to the family rules.

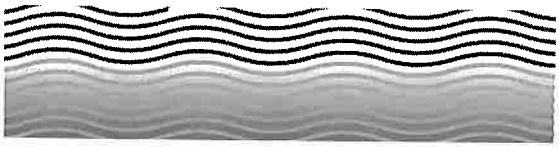
Shame also leaves its marks in lack or fear of intimacy, perfectionism, or self-defeating behaviors, where one partner is overresponsible, and the other underresponsible. The classic example is the overresponsible child in the alcoholic family who attempts to mask the family dysfunction by doing too much, thus permitting the alcoholic member to underfunction.

The keeper of a secret has the illusion of power; those who do not know are often confused and anxious, lose their sense of trust and often blame themselves for the trouble they are in. In searching for a way to explain the inexplicable, private beliefs, myths and fantasies are created. These often get acted out through symptomatic behavior and become a metaphor for the concealment of the system. For example, an adolescent boy trying to break through the veil of secrecy in his family may be arrested for breaking and entering houses. Therapeutic interventions can focus on making the metaphorical statement explicit.

Secrecy vs. privacy

An important therapeutic issue is how to distinguish between secrecy and privacy. A guideline that I use is the concept that "what is kept secret often engenders shame, while truly private matters do not. Secrets are often connected to fear and anxiety regarding disclosure, while privacy implies a certain zone of comfort, free from the unwanted entry of others. Therapy itself is an arena where the experience of an umbrella of privacy can often be sufficient to enable the opening of painful secrets."[3]

The positive and appropriate use of secrets can be seen in the preservation of cultural traditions and as a strategy for validation and for resistance when people's survival seems threatened. It is extremely important for the therapist to understand that secrets need to be seen contextually. Information that should or should not be kept secret shifts according to cultural and societal mores. Issues such as illegitimacy and homosexuality were once considered very shame-



ful. The silence has since been broken on these and other issues such as alcoholism, abortion, adoption and gay rights. Currently, however, many families with a member who is HIV positive keep it a secret because of the fear and stigma associated with this disease.

Cultural norms once made shameful secrets out of too many issues. But many clients now struggle with an equally rigid assumption, fostered in part by the media. It is the belief that revealing secrets, no matter how, when or to whom, is morally superior and automatically healing. I feel that the saturation and exploitation of sensitive information, which generally does not get processed after the initial and often dramatic disclosure, whether in a weekend workshop or on network television, can be extremely damaging. It can desensitize the public, even to such tragedies as incest and murder, when talk show hosts interview the victims endlessly.

Treatment issues

Secrets are one of the most common causes of therapeutic impasse as they block a therapist from knowledge that is essential to understanding and resolving a core problem. The therapist is often treated as an outsider, or many be invited into a secret but rendered ineffective, as when the therapist is forbidden to discuss it with others. Triangles in the family that are shaped by secrets are thus replicated at the family-therapist level.

The initial step in intervention is finding out where in the system the secret is located. Is it within one person or within a dyad, keeping other family members on the outside? Once the location is found, the therapist needs to explore how the secret currently maintains and protects relationships. For example, not revealing to a child that he has been adopted may spring from the fear that the child will someday leave home, search for his or her birth parents and abandon ties to the adoptive parents.

The therapist needs to guide the family toward the understanding that secret-keeping blocks honest communication and maintains high levels of anxiety. The revelation of a secret should come in the middle or toward the end of treatment, not at the beginning. The family needs to develop a solid relationship with the therapist based on trust in order to take a risk which could powerfully change the way the members relate to each other. Once the secret is revealed, the therapist needs to help the family reorganize itself in a more functional way so that the secret loses its destructive influence.

It is important to keep in mind that secrets regarding family violence need to be revealed very carefully, to protect the most vulnerable family members.■

1 Evan, Imber-Black, ed. Secrets in Families and Family Therapy (New York: Norton and Company, Inc., 1993) p.9.
2 Ibid, p. 13
3 Ibid, p. 19 [Bibliography available from author]

SUNDAY BRUNCH WORKSHOPS

Sponsored by the Hypnosis Practice Committee of
The New York State Society for Clinical Social Work, Inc.

*

Sunday brunches are held from 10:45 a.m. to 12:45 p.m. at

The National Institute for the Psychotherapies
330 West 58th Street, Room 204.

*

Meeting space donated by NIP through its Hypnotherapy Service. Please call the individual presenters to reserve a space and confirm the workshop. For general information contact:
Kent Jarratt, ACSW
(212) 741-7744

*

FEBRUARY 25, 1996
Hypnosis and the Family Trance
Jane Parsons-Fein, CSW
(212) 873-4557

*

MARCH 24, 1996
The Hallucinated Body Image
Helen Hinckley Krackow, CSW
(212) 683-1780

*

APRIL 21, 1996
Self Hypnosis
Anne Tully Ruderman, CSW
(914) 472-3162

*

MAY 19, 1996
Sexual Abuse Survivors
Marie McDermott, CSW
(718) 788-5005

*

JUNE 9, 1996
Hypnosis With The Spiritually Oriented Client
William Ballen, CSW
(516) 889-0706

Book Review

by Simcha R. Goldberg, CSW

Dance and Other Expressive Art Therapies: When Words Are Not Enough
New York. Routledge 1995

Edited by Fran J. Levy with Judith Pines Fried and Fern Leventhal

In the last half of the 20th century, the central preoccupation of psychotherapists shifted dramatically from a search for theoretical systems of explanation to a search for the ability to dialogue therapeutically with clients.

It is no accident, as Dr. Fran Levy points out in her fine introduction, that the modality of dance therapy began in the 1940's. This was about the same time that such pioneers as Milton Erikson and Jay Haley were beginning their efforts to push theory from its place of centrality. Levy's subtitle, When Words are Not Enough, expresses the theme of this expansive, ambitious work.

A glance at the table of contents gives the reader an idea of the book's scope. It catalogues creative, integrated and therapeutic interventions for a wide range of issues, such as multiple personality disorder, trauma, abuse, addiction, mood disorders and autism.

Fran J. Levy, MSW, Ed.D., is a member of the Staten Island Chapter.

Levy's article, Nameless: A Case of Multiplicity, launches the collection. Nameless is an awkward and sad little girl who emerges from Rachel, a 28-year-old professional, through a drawing of a frightened child in a sailor suit. The questions Levy addresses include: how do we increase the depth of communication between therapist and patient and how do we create an expressive environment that affects the whole person? Drawing is a modality she strongly favors with both adults and children. The wonderful thing about drawing, she tells us, is that it can lead into a story and dramatic play. The arts and play can become creative and expressive parts of the therapist-client interaction. In fact, Nameless was not the only other "self" to emerge from Rachel and mature through creative expression over a 12-year period.

SIMCHA R. GOLDBERG, CSW, has a private practice on Staten Island and is associated with H.I.P. Mental Health Services. He is a board certified hypnotherapist and a member of the Society's Committee on Hypnotherapy. His practice specializes in the treatment of mood disorders.

Treating Anxiety

Susan Kierr's piece "Treating Anxiety: Four Case Examples" begins with brief explanations of the origins of anxiety based on psychodynamic, behavioral, cognitive and biochemical theories. It demonstrates very effectively that no single approach is sufficient to treat the clients discussed.

Terry, Kierr's first case, learned through dance and drama to behave as if she were self-assured and assertive. She glided between rows of supportive dancers and was helped "to speak" with her whole body. In the case of Adele, Kierr used visualization and movement to reassure her and support her efforts toward separation-individuation.

Adele's image of a park with a mother and baby deer comforted this hyper-anxious client. While this particular image surely represented unmet early childhood needs, Kierr did not address this directly. Instead, she followed Adele's imagery. Images of her husband waiting for her in a restaurant soon replaced the deer image. The combined use of imagery and movement strengthened Adele's ability to cope with her intense fears of being abandoned.

The author concludes with the cautionary point that although the various approaches may be taught separately in our training, we need to remember that, in reality, clients "cannot be divided into separate parts."

As a practitioner who enjoys working with teenagers, one of the very first articles I read in this volume was Diane Duggan's piece "The 4's: A Dance Therapy Program for Learning Disabled Adolescents."

Duggan's article discusses the developmental issues of adolescence, as complicated by the problem of learning disabilities and impulse control. No where in the human life cycle are dynamic forces more graphically illustrated than in the adolescent "dance" between separation-individuation and attachment-dependency. If this were not confusing enough, the youngsters presented by Duggan also have difficulties that are neurologic in origin, making it especially difficult for them to organize themselves intellectually and expressively.

Duggan describes the establishment of a powerful "holding structure" through the medium of group dancing, particularly a certain rhythmic pattern. This pattern captured the youngsters' attention and gave vent to their complex drives.

Duggan integrates her knowledge of teen culture, developmental psychology and dynamic theory in her approach. She has a clear passion for dance and a genuine concern for her kids.

These are only three of the 16 colorfully written chapters, all on different patient populations and all with many case illustrations.

My guess is that there are two ways in which you will choose to use this book: you will read it once and find reinvigoration in the richly layered work of the master practitioners presented in it.

And, you will keep it on your office shelf, together with the half-dozen other dog-eared reference works to which you continually return.■

COMMITTEE REPORT

Help Us Decide Which Paths to Explore

With the onset of managed care and accountability, proliferation of treatment models, and universal desire to demonstrate that social work intervention is effective, social workers have become more interested in clinical research.

In response, several members of the Society have been meeting to explore the possibility of organizing a research committee for the Society. This effort has resulted in the presentation of one panel discussion, held at the annual meeting in 1994. The panel reviewed some of the current research related to clients diagnosed with Depression, Schizophrenia, Panic Disorders and Borderline Personality Disorders.

The present committee, including Joe Ventimiglia and Ira Frankel from Queens, Bobba Moody and Ellen Leukens from Metropolitan and Cindy Marschke from Mid Hudson, has been exploring future directions. We'd like to share with you some of the suggestions that have been offered and stimulate your interest enough to consider joining us on the committee.

It has been suggested that the committee initially focus on developing educational programs on research in clinical practice. Activities might include: conferences which review current literature and research on specific client populations, practice models or outcome studies; a mentoring program for MSW students; teaching workshops on current research methods applicable to practice; and/or a research column in the newsletter to review studies, answer clinical research questions or explain design and methodology.

We have a hunch that there might be a lot of interest in workshops about the ins and outs of publication and/or which provide on-going support during the process. If we could increase members' confidence in their ability to write and their knowledge of the publication process, we believe more clinical articles and related research would be generated and ultimately published.

A major research project would be overly ambitious for a volunteer committee, but it would be possible to pursue some descriptive research using existing data sources (membership profiles) to support members' projects through small grants, and to sponsor informative programs about grant writing and funding resources.

The committee will be brainstorming at our next meeting.■

The next meeting will be at Bobba Moody's home in Manhattan on Sun., March 24th, from 10:00 a.m. to 12:30 p.m. We welcome all members and hope to have representatives from Brooklyn, Buffalo, Capital District, Nassau, Rockland, Westchester, Staten Island & Suffolk. Please call Bobba at 212-260-6081 or Cindy Marschke, at 914-255-5466.

The Hypnosis Practice Committee of the State Society presented its first full day conference, "Using Hypnosis in Psychotherapy," on Nov. 19th to 160 participants in New York City. Committee Chair William Ballen introduced the keynote speaker, Daniel Araoz, Ed.D., noted author and chair of the Dept. of Counseling & Development, C.W. Post Center of L.I. University.

Dr. Araoz contrasted traditional and new hypnosis and credited Milton Erickson, M.D. with creating the bridge from the more medically oriented, directive traditional approach to the more client centered, indirect, newer method which stresses using material presented by clients in session. A panel discussion followed, moderated by Helen Krackow, President of the Society, and including panelists Bill Ballen, Susan Dowell, Marie McDermott and Jane Parsons-Fein. They ranged over such issues as training, application to various modalities, formal and informal inductions and hypnotic transference.

Beginning, intermediate and advanced workshops were offered in the afternoon by many of the panelists, as well as by Anne Tully Ruderman and Kent Jaratt. Marie McDermott began the intermediate group with a demonstration using ideomotor signaling and conversation while the subject was in trance. Participants then followed an exercise which demonstrated the value of hypnotic technique in working through unresolved grief. Ms. Ruderman concluded with a group induction focused on accessing strengths and resources in order to achieve personal goals.

Evaluations and feedback from the conference were so positive, the Committee has begun planning a second annual conference. (Please see Sunday Brunch announcement on P. 5.)

by Joan Kuver, ACSW, Nassau Chapter

Note to Readers
Due to space limitations, various articles were held for future issues. They include the Practical Practitioner piece on press releases by Sheila Peck, and a book review by Laura Salwen.

"The practice of psychotherapy should be interesting, appealing and charming"
-MILTON H. ERICKSON, M.D.-

NYSEPH

The New York Milton H. Erickson Society for
Psychotherapy and Hypnosis Training Institute
Chartered by the New York State Board of Regents

Comprehensive Training Program
in Ericksonian Hypnosis and Psychotherapy

This is a 5 part, 100 hour program, meeting 2 hours a week. Emphasis is on ongoing supervised practice, on demonstration, and on refinement of a wide range of hypnotherapeutic techniques.

The course is open to health care professionals with graduate degrees and to students in accredited graduate programs.

Classes start in February and September. We welcome your inquiries and applications. Please contact Jane Parsons-Fein at (212) 873-6459 • Fax: (212) 874-3271

HYPNOSIS FOR PAIN AND STRESS MANAGEMENT

20 hour specialty training in hypnosis for pain and stress management. Meets 2 hours per week. Open to all nurses and health care professionals. 20 CEU's approved. Classes begin in February.

Call Dorothy Larkin, MA, RN, CS 914-576-5213.

W illiam
A lanson
W HITE
I NSTITUTE

CHILD AND ADOLESCENT PSYCHOTHERAPY TRAINING PROGRAM

- ☆ **A three-year program including course work, field placements, individual and group supervision, and training experiences in the Institute Clinic.**
- ☆ **In-depth coverage of normal development and developmental difficulties and the full range of disorders and contemporary issues.**
- ☆ **Based on the need to study and treat children and adolescents individually and in their social context.**
- ☆ **Open to Psychologists, Psychiatrists, Social Workers, and qualified professionals in related fields.**

For more information or to request an application, please call or write:

Jacqueline T. Ferraro, D.M.H.,
Director of Admissions, CAPTP
William Alanson White Institute
20 West 74th Street

The Society of
THE NEW YORK SCHOOL FOR
PSYCHOANALYTIC PSYCHOTHERAPY
AND PSYCHOANALYSIS

Spring Scientific Meeting

Sunday, March 10, 1996
The New York Hilton
Avenue of the Americas at 53rd Street

Gerald I. Fogel, M.D.

"INNER GENITAL SPACE IN MEN: WHAT ELSE CAN BE LOST IN CASTRATION"

DISCUSSANT:
Steven Ellman, Ph.D.

WELCOMING REMARKS:
Charles Rosen, C.S.W.
President, Society of NYSPP

Registration and coffee: 12:30 pm
Conference: 1:00 to 4:30 pm

For information and brochures call:

212-595-4674

SUPERVISORY TRAINING PROGRAM

A one-year training program in supervision of the psychoanalytic process, consisting of:

- ✓ weekly didactic seminar
- ✓ weekly group supervision
- ✓ practicum with assigned NIP candidates

Open to graduates of recognized postgraduate psychoanalytic programs:

- ✓ Psychologists
- ✓ Social Workers
- ✓ Psychiatrists

For additional information please contact
Clair Arditi, Coordinator (212) 996-5357

NIP

THE NATIONAL INSTITUTE FOR THE PSYCHOTHERAPIES
330 W. 58th St. New York, NY 10019 (212) 582-1566
Chartered by the Board of Regnets of the University of the State of New York

NYCPT NEW YORK CENTER FOR PSYCHOANALYTIC TRAINING

MANHATTAN
HUDSON VALLEY
LONG ISLAND

Psychoanalysis is not just one more approach to psychology and the social sciences, any more than being just "one more" kind of therapy. It is the best basis for an all-embracing science of man, just as it is the best basis for all psychotherapy.

Dr. Reuben Fine, Founder of NYCPT

THREE-YEAR PROGRAM IN PSYCHOANALYTIC PSYCHOTHERAPY

SIX-YEAR PROGRAM IN PSYCHOANALYSIS

NYCPT MEMBERSHIP ASSOCIATION Upon graduation, an environment for on-going professional development and active participation in NYCPT and the broader psychoanalytic community

NYCPT CONSULTATION CENTER Founded in honor of Reuben Fine (1914 - 1993), the Consultation Center offers patient referrals for psychotherapy and psychoanalysis to NYCPT candidates. Upon graduation, patients are transferred into one's private practice.

NYCPT CANDIDATE ORGANIZATION with active representation on the Board and all committees involved with the functioning of NYCPT

ADVISORY SYSTEM to help guide candidates through the program

WORKSHOPS, SYMPOSIA, STUDY GROUPS, SCIENTIFIC MEETINGS AND PROFESSIONAL PUBLICATIONS

NYCPT, founded in 1963 for the advancement of psychoanalytic training and thought, is chartered by the New York State Board of Regents and is a Member Organization of the Council of Psychoanalytic Psychotherapists. Courses are taught from a sound base of Freudian theory with full recognition and integration of the widening scope of psychoanalysis.

For further information, call 212-757-9200 (Manhattan and Hudson Valley) or 516-466-4333 (Long Island).

Classified Advertisements

End Computer Anxiety: Expert in applications for psychotherapy practices will help you select and use the system & programs you need to run your practice. Call 212-594-6531.

Managed Care Blues? Working harder, lower income? Consider an opportunity to enhance health & vitality with income potential between $2,000 — $5,000 per month within a year through part time efforts. Call for information packet: 800-927-2527 X8872 (VM)// 617-864-9107 (#92178).

Office, Manhattan: East 30's. Furnished, high floor, doorman, shared waiting area, kitchen and bath. Available March 31st, Tu., Wed., Fri. (2 day minimum). Call: 212-679-5245.

For Sale: Analytic couch, rust and cream tweed fabric, 35" X 98" (can double as twin bed). Very good condition. Call Barbara Pichler, 914-478-4942.

Eating Disorder Supervision Group: Focus will be on intensive psychoanalytically oriented psychotherapy for patients with anorexia nervosa, bulimia & compulsive eating. Fridays, 9:30-11:00 a.m. Dianne Heller Kaminsky, CSW, BCD, Senior Psychoanalyst, faculty member & supervisor, The Center for the Study of Anorexia and Bulimia; 65 E. 95th St., NY; 212-369-7104

Benefit From Hypnotherapy Certification

Good for Patients - Good for your Practice

- ☑ 21 hrs. of training flexibly arranged
- ☑ Third party payors refer to Specialists
- ☑ Credibility in Hypnosis Advertising Works
- ☑ Publicize your affiliation with our Institute in your advertising
- ☑ Be included in a provider directory being marketed to managed care companies along with outcome research showing the effectiveness of hypnosis for DSM IV disorders.

THE INSTITUTE FOR HYPNOSIS RESEARCH
Chartered by the Board of Regents of the University of the State of New York

FOR MORE INFORMATION CALL:
William Ballen, C.S.W.
Director of Clinical Services
(516) 889-0706

ICAPP

INTERNATIONAL CONFERENCE FOR THE Advancement of Private Practice In Clinical Social Work

35th Annual Clinical Conference
"ISSUES OF INTIMACY"

Sunday, July 14 - Thursday, July 18th, 1996
Hamilton Princess Hotel, Bermuda

Workshops will be offered: 8:30 AM-Noon (CEU's available)
Afternoons free for exploration or group planned trips.
Registration Fee:
ICAPP Member: $195 Non-Member: $215
Early Bird Registration April 15: Deduct $25
Make checks payable to ICAPP
Mail to: ANNE EVANS
14 Wilde Road, Waban, MA 02168
Tel # (617) 969-8968 • Fax # (617) 969-0106
For Information In Canada:
Contact Dr. Margaret Rodway 403-220-6710

POSTGRADUATE CENTER FOR MENTAL HEALTH

124 East 28th St, NY, NY 10016

FAMILY AND COUPLES THERAPY TRAINING PROGRAM

The Psychoanalytic Institute of the PGCMH offers a unique two-year program of training for candidates interested in developing an integrative approach to the treatment of families and couples.

The program includes courses, clinical experience and supervision which combine object relations theories, developmental theories and family systems. Patients may enter the candidate's private practice upon certification.

NOW ACCEPTING APPLICATIONS FOR 1996-1997

Please Join Us For Our EVENING OPEN HOUSE Wednesday, May 8, 1996 8PM-10PM

Please contact: Registrar, Postgraduate Center for Mental Health, 124 East 28th Street, NY, NY 10016. (212) 576-4168.

POSTGRADUATE CENTER FOR MENTAL HEALTH

124 East 28th St, NY, NY 10016

Applications are being accepted for the following training programs in 1996-1997 :

- Adult Psychoanalysis and Psychotherapy
- Child and Adolescent Psychotherapy
- Analytic Group Therapy
- Family and Couples Therapy
- Supervision of the Psychoanalytic Process
- Introductory Program in Psychoanalytic Psychotherapy
- Pastoral Counseling

Please Join Us For Our EVENING OPEN HOUSE Wednesday, March 20,1996, 8pm-10pm and our TRAINING DAY Saturday, April 27,1996 9am-3pm

FOR INFORMATION CONTACT:
Paul Stark, Ph.D., Dean of Training
(212) 576-4168

METROPOLITAN CENTER *presents*

Object Relations Training Programs

For 1996

✓ **Individual & Couple** One year, twice monthly program for individual & family therapists interested in learning about Object Relations theory and practice.

Includes a variety of settings:

- **Small group supervision.** An ongoing case presentation by one student.
- **Didactic and clinical seminars.** Develop the therapist's theoretical framework and clinical understanding. Theorists studied: Bion, Klein, Fairbairn, Guntrip, and Winnicott.
- **Large group consultation.** Case observation based on students' cases.
- **Group process.** Small groups help the student integrate the day's events.

Faculty
Justin A. Frank, MD, of Washington School of Psychiatry
Hannah Fox, CSW, BCD

Guest Faculty
Washington School of Psychiatry
Tavistock Centre London

Guest Lecturers
NYU School of Social Work
Jeffrey Seinfeld, Ph.D.
Judith Siegel, Ph. D.

✓ **Klein/Bion** Ongoing monthly program studying the psychoanalytic theories and techniques of Klein and Bion.

CALL FOR BROCHURE

METROPOLITAN CENTER FOR OBJECT RELATIONS THEORY & PRACTICE
333 West 56th Street Apt. 1D New York, New York 10019
Voice: (212) 307-7217 - Fax: (201) 837-0148

ADVANCED INSTITUTE FOR ANALYTIC PSYCHOTHERAPY

Chartered by the Board of Regents of the State of New York

Serious programs for the serious candidate that provide thorough training in a clinically and professionally rich environment.

Certificate Training Program in Analytic Psychotherapy

- Contemporary Analytic Theory and Technique
- Individual Supervision
- Clinical Case Seminars
- Advanced Courses in Theory and Technique
- Eclecticism in the Psychoanalytic Approach

Two Year Training Program in Child and Adolescent Psychotherapy

- Classes in theory and technique
- Individual Supervision
- Clinical Experience with children and adolescents

Our programs provide qualified applicants with opportunities for paid treatment experience.
We also welcome the non matriculant.
STARTS MARCH 6, 1996: THE BORDERLINE PATIENT

CONTACT: **Eleanor F. Light, PhD., Director (718)739-7099**
178-10 Wexford Terrace, Jamaica Estates, NY 11432

Affiliated with Advanced Center for Psychotherapy
Affiliate of Council of Psychoanalytic Psychotherapists

Do You Wonder...

- *If mediation is appropriate for your separating/divorcing clients?*
- *If mediation can work in cases of high conflict?*
- *If mediation really saves time and money for families in transition?*
- *How to make an informed referral to a mediator in your community?*

The New York State Council
On Divorce Mediation

For a free directory of New York State mediators or for more information, write or call:

The New York State Council on Divorce Mediation
666 Old County Road/Suite 705
Garden City, NY 11530
800-894-2646

Training Institute for Mental Health

Chartered by the Board of Regents of the University of the State of New York

Psychoanalysis and Psychotherapy

Now Two Comprehensive Training Programs!

- ◯ Psychoanalysis and Psychotherapy
- ◯ Psychoanalytic Psychotherapy

Choose the program that best meets your needs and interests.
Both are thorough and realistic four year part-time training programs that integrate traditional and contemporarypsychoanalytic theory.
Fellowship covers the full cost of supervision and tuition.
Supervised clinical practice begins in the first semester.
Private practice encouraged and supported by referrals.
Credit given for previous analysis and/or coursework.
Active Psychoanalytic Society and Therapist Council.
Opportunities for advancement within the Institute after graduation.
Social workers, psychologists, psychiatrists and nurses are eligible.

Inquire about our other training programs in:

Group Psychotherapy

Psychotherapy with the Generations of the Holocaust & Related Traumas

Supervision of the Psychotherapeutic Process

Contact: Howard Kogan, M.S.W., Director of Training
Training Institute for Mental Health
40 East 30 Street, New York, NY 10016-7377
(212) 889-0870

The Making of a Psychoanalyst

The Westchester Center for the Study of Psychoanalysis and Psychotherapy

Chartered by the State of New York in 1974, the Westchester Center provides formal training in psychoanalysis and psychotherapy. The faculty represents a range of contemporary psychoanalytic approaches.

PSYCHOANALYTIC TRAINING: A four-year curriculum for psychiatrists, psychologists and social workers designed to enhance psychotherapeutic skill and psychoanalytic knowledge through personal analysis, intensive supervision, coursework and clinical experience.

THE PROSEMINAR: A one-year program that provides an overview of psychoanalytic theory for professionals who are interested in deepening their clinical and theoretical understanding or for those who may wish to pursue psychoanalytic training but lack the necessary prerequisite experience.

(All courses are conducted on Tuesday evenings in Westchester)

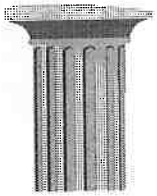
OPEN HOUSE

Saturday, March 9th, 1996
9:30 a.m. - 12:30 p.m.
Family Service of Westchester
1 Summit Avenue, White Plains, NY 10606

Presentation on the Impact of Psychoanalytic Training on One's Personal and Professional Life

Call **914-946-9462** for information

FOUNDATIONS IN HYPNOSIS



For More Information: call:
Susan Dowell, C.S.W.
(212) 864-4171

Workshops in Beginning, Intermediate & Advanced Clinical Hypnosis & Case Supervision

New York City & Westchester

New classes beginning in February & March

LOCATIONS:

350 Central Park West #6B
New York, NY 10025
(212) 864-4171

142 Montery Avenue
Pelham, NY 10803
(914) 738-9360

SPONSORED BY CATCH
Center for the Advancement of Training in Clinical Hypnosis

BRIEF HYPNOTHERAPY: THEORY & PRACTICE

A CONFERENCE
With Daniel Brown, Ph.D.

April 27 & 28
(Saturday-Sunday)
Loews new york Hotel
Lexington & 51 Street
New York City

For more information call:
Daniel Brown,Ph.D & Associates
(617) 621-0809
or CATCH (212) 531-1322

SPONSORED BY:
The Center for Integrative Psychotherapy

local hosts: CATCH
(Center for the Advancement of Training in Clinical Hypnosis)
CATCH

Registration Form

DATE_____

NAME _____

DEGREE_____DAY PHONE_____

ADDRESS_____

_____

TUITION: $ 240
SEND FORM AND WORKSHOP FEE TO:
Daniel Brown,Ph.D.& Associates
The Center for Integrative Psychotherapy
75 Cambridge Parkway
Cambridge, MA 02142

ETHICS & PROFESSIONAL STANDARDS

by Hillel Bodek, MSW, CSW, BCD, Chair

COMMITTEE REPORT

Clinical Documentation and Recordkeeping, Part II

The first part of this series discussed the legal requirement for clinical recordkeeping, the seven key purposes of clinical documentation and the nine elements of good clinical documentation. This second part of the series will address the essential components of an initial assessment, the key ingredients of a good progress note and the role of clinical documentation in assuring quality clinical social work services.

The Society's definition of clinical social work states, in pertinent part, that, "clinical social work practice methods and approaches include . . . differential diagnostic assessment and treatment planning . . . implementation of appropriate assessment-based treatment plans, including brief and long-term psychotherapy with individuals, couples, families and groups, habilitation, crisis intervention, hypnosis, biofeedback, patient education and client-centered advocacy . . ." Professional practice standards require that clinical social work treatment must be based on a proper differential diagnostic assessment and must be implemented in a planned manner with identified goals, methods, time frames, and criteria to measure its efficacy and appropriateness.

Elements of an Appropriate Initial Assessment

An initial differential diagnostic assessment, which may be abbreviated or elongated depending on the circumstances of a particular case, provides the basis for the development and implementation of the treatment plan. As with any other area of clinical practice, lack of a proper clinical assessment is likely to result in less than optimal and, perhaps inadequate or inappropriate treatment. Thus, the failure to conduct an appropriate differential diagnostic assessment is a serious deviation from the standard of care owed by a clinical social worker to a patient. The conduct and documentation of a proper initial assessment, includes:

A. identification of the referral source(s), gathering information about the background and reasons for the referral and assessing the patient's response to and expectations with regard to the referral;
B. defining the presenting problem(s), both in the patient's own words, as well as in terms of the clinician's perception of the presenting problem(s);
C. detailing the history and clinical course of presenting problem(s), and the details of services and treatment the patient has sought or received to deal with that problem;
D. gathering relevant history [family, medical and psychiatric, substance abuse, educational/occupational, interpersonal relationships, etc.] and material from the patient and from collateral sources, in appropriate detail, by topic, identifying the sources of such historical information;
E. describing the clinician's observations of the patient(s), interview data, mental status examination and material received from collateral sources;
F. detailing prior clinical services, the background and reasons therefore, the results of such services and the reason(s) for termination of those services;
G. making a differential assessment - a bio-psycho-social diagnosis, 1) in functional as well as diagnostic terms, 2)distinguishing between observations, hard data and opinions, 3) supporting generalizations and conclusions, and 4) determining the degree of confidence in the assessment;
H. developing an initial differential treatment/service plan with identified goals, methods to be used, time frames and standards to measure treatment progress in functional terms, with a rationale for prioritizing of treatment goals and for the choice from among various treatment alternatives and strategies;
I. assessment of prognosis with supporting rationale; and
J. describing the patient's response to the assessment and to the proposed treatment plan and, if the patient agrees to proceed with that plan, obtaining informed consent for implementation of that plan.

Elements of a Proper Progress Note

The ongoing provision of clinical social work services should be documented, keeping in mind the seven key purposes of clinical documentation and nine elements of good clinical documentation set forth in the first part of this series. Depending on the evolving circumstances of each case, certain purposes of documentation will be more crucial than others at various points in treatment. For instance, if a patient's mental status deteriorates and he/she becomes threatening, the purpose of carefully documenting the clinician's professional response and clinical decisionmaking and the purpose of risk management/malpractice protection will predominate. In a case where a patient who has significant medical, family and mental health problems is being served by several different professionals, documentation geared toward the purpose of coordination of professional efforts will predominate. A proper progress note, which need not be particularly extensive, in most cases merely several sentences, should include:

1) the date of the contact,
2) description of the type of contact (i.e.; in person, telephone),
3) indication of who initiated the contact (i.e.; regularly scheduled session, phone call by patient's family, inquiry from another clinician/service provider),
4) statement of where the contact took place (i.e.; office, if a home visit - the address visited, if by phone - the phone number called),
5) indication of who was involved in the contact (i.e.; patient, family, other clinician, family friend),
6) a description of the themes of the contact,
7) details of any new significant history obtained,
8) details and description of relevant problems newly identified,
9) details and description of relevant significant new events,
10) description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances,
11) statement of what was accomplished in the session,
12) statement of what wasn't accomplished in the session that needs to be followed up on,
13) details of obstacles noted to progress in treatment, if any, and a plan to address these, and
14) description of a plan for further care, changes in treatment plan/goals, if any, and reasoning to support these, particularly when in response to crisis situations or special/markedly changed circumstances.

Writing up appropriate initial assessments and proper progress notes requires thought and reflection. Having to prepare proper clinical documentation serves an important role of helping assure quality patient care by making clinicians think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their patients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential to a clinical social worker's professional development, to the maintenance of his or her professional skills and to the provision of high quality clinical services. Rather than viewing clinical documentation as a meaningless chore that consumes precious time, clinical social workers should view it in this light, as a form of self-supervision that is an essential element of their professional practice and of their provision of quality clinical services.■

Part III will address how to deal with concerns regarding the confidentiality of clinical records.

The ABCs of Membership in the New York State Society for Clinical Social Work

Advance your skills, practice and the profession as a whole. Avail yourself of the latest clinical techniques and theories at workshops, courses and seminars. Advocate for mental health care reforms and support the Society's lobbying efforts in Albany and Washington for licensing, insurance and parity, among other issues. Ally yourself with the leaders in your field.

Benefit from educational and mentoring programs, chapter and state newsletters, the Clinical Social Work Journal, malpractice insurance, help with insurance reimbursement and vendorship efforts. Build professionalism with information on ethics, legal issues, technology and research. Bolster your practice, even in the toughest economic climate, with tested strategies.

Challenge yourself to consult, write, teach, mentor, supervise and lead in a supportive environment. Choose from among many chapter and statewide groups, including peer study and supervision groups and committees organized around your professional interests. Cultivate a broad-based network and lasting friendships.

Join the organization committed to you, the clinician:
The New York State Society for Clinical Social Work, Inc.
Call 1-800-288-4CSW (4279) for information.

New York State Society for
Clinical Social Work, Inc.
350 Fifth Avenue, Suite 3308
New York, NY 10118

Address Correction Requested

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

BULK RATE
U. S. POSTAGE PAID
NEW YORK, N.Y.
PERMIT NO. 9513