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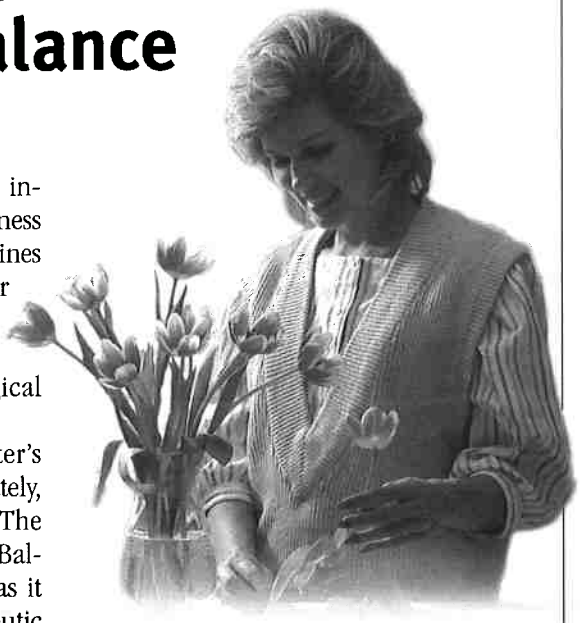
THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

The Psychodynamics of Hope: A Delicate Balance

Keynote by Roberta Ann Shechter, DSW
Reviewed by Maryellen Noonan, Ph.D.



Our therapeutic marketplace is increasingly dominated by business interests. Managed care guidelines and agency policies impinge on our work with clients...We are told to limit our sessions to no more than 30 minutes and to alleviate psychological symptoms... in less than 20 weeks."

Thus began Dr. Roberta Shechter's stimulating, provocative, and ultimately, hopeful presentation. Her paper, "The Psychodynamics of Hope: A Delicate Balance," was indeed timely, focusing as it did on the role of hope in the therapeutic situation. In the best of times clinical work is profoundly difficult, but maintaining hope while external forces negate, restrict, and minimize our efforts is an even more challenging task. Dr. Shechter's discussion of the psychodynamics of hope was scholarly and accessible; equally important was how the material resonated with her audience. Utilizing interviews with 10 clinicians, Dr. Shechter examined how practitioners maintain a sense of optimism in their work, both in terms of the clinical situation itself and in relation to external forces, such as policies and procedures, which are beyond the clinician's control. The forthright descriptions provided by her respondents exemplified the thoughtfulness, self-awareness and commitment that clinicians bring to their work.

SPECIAL FEATURE
Joint New York Society and New York University Conference

Although hope is implicit in our work, it is seldom written about or explored — we simply take it as a given. Dr. Shechter, using the words of her respondents, defined hope as expectation and optimism, the expectation that positive change can occur and the belief that it will occur. But as Dr. Shechter rightly suggested, hope is no simple matter. One of the many paradoxes of our work is that, to be truly hopeful, the clinician must be able to tolerate the opposite. The capacity to relate to and tolerate the despair, tragedy, and psychic pain of others is vital to the success of our therapeutic endeavors.

But by what process does this occur? In Dr. Shechter's words, "Tolerance ex-

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EXECUTIVE REPORT

A Shot Across Our Bow

By Allen A. Du Mont, President

THE CRISIS precipitated by the drastic cut in fees by Magellan is a clarion call to battle, a shot across the bow of clinical social work and the other clinical professions. Few of us can go on thinking that accommodation to the status quo will ensure our survival, that we will be allowed to provide a high level of care as "partners" with managed care, that we will be able to earn a modest living in the service to others.

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Executive Report

By Allen A. Du Mont, CSW, BCD
Society President

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Managed Care has told us otherwise: it plans to grow rich at the expense of consumers and professionals alike. We must rise to the challenge and carry on the war on many fronts. Some of us are fortunate enough to be able to refuse participation on managed care panels and to reach those able to pay for their own psychotherapy. For many of us that is more of a goal toward which we strive, currently serving a population heavily dependent on insurance reimbursement. Some of us discount our fees, if necessary, and others find creative ways to finance the therapy. Some of these solutions are well described in Dana Ackley's *Breaking Free of Managed Care,* which is an excellent resource for anyone seeking emancipation from the yoke of what has been called "Mangled Care." This subject will also be addressed early this Fall in a half day course offered by the Society and Sheila Peck, our Public Relations Chair, who has lectured extensively on this subject.

Much of what we can do to help ourselves is to educate our clients about some of the abuses and problems of managed care: the threat to confidentiality; the denial of access to unused benefits; the micromanagement of the therapy by a third party unfamiliar with the client and the situation; insistence on use of medication to reduce or supplant psychotherapy; limited access to professionals outside the panel; documentation of provider treatment patterns and other behavior according to a "managed care friendly" standard; and exile to a "reserve" status when termination with causecannot be made legally.

Other professional organizations can be helpful in educating the media and the public about these problems and can help us reach a wider audience if we pool our resources. We will be reaching out to these organizations in this effort and will support the work of the National Coalition of Mental Health Professionals and Consumers (NCMHPC), which has written a Mental Health Consumer Protection Manual and is sponsoring Rescue Health Care Day to take place on April 1, 2000, which will be aimed at stimulating a national dialogue on managed care.

Every day that passes makes the public and our public officials more aware of how managed care uses the ERISA laws (originally designed to shield employee benefit plans from frivolous but crippling lawsuits) to escape legal responsibility for medical decisions in denying and restricting appropriate care. As a "Time" magazine article (February 1, 1999) points out, you can sue almost everybody, including the President, "but most Americans can't sue their health insurer." We must build on this growing awareness and lobby for the patient's right to sue.

John Chiaramonte, Chair of our Managed Care Vendorship Committee, acting on behalf of the Society and our members, has referred the matter of the Magellan cuts to the State Attorney General for investigation of possible violation of the Sherman Anti-Trust Act. While professionals are barred from combining to set acceptable professional fees (because that would be a monopoly and a restraint of free and competitive trade) HMOs are controlling the marketplace by restricting access of consumers only to those professionals willing to accept lower fees.

The White Paper developed jointly by the Alliance for Universal Access to Psychotherapy and the NCMHPC and presented to the Department of Justice in 1998 identifies this practice as a monopsony, which is also a violation of the Sherman Anti-Trust Act. On this basis the National Coalition is planning to file a lawsuit which the Society and all of us should support. Currently before Congress is the Campbell bill which would allow professionals to bargain collectively and to correct the imbalance in negotiation with the insurance industry. We were alerted to this bill by the OPEIU-Guild so that we could assist in lobbying for its passage.

We are also exploring what other legislative and political remedies may be possible on the federal and state level, utilizing the influence and power of the OPEIU-Guild and the AFL-CIO.

There is much work to be done; there are promises to be kept to our clients, our profession and to our ideals; and there are miles to go before we sleep.■

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Guild Update

by Helen Hinckley Krackow, CSW, BCD, Guild Treasurer

Our attorneys, lobbyists and Clinical Social Work Federation officials and Guild President, Luba Shagawat have met three times in January and early February with the national lobbyists of the AFL-CIO. The purpose of these meetings was to plan strategy regarding the initiatives in health care legislation that we wish the AFL-CIO lobbyists to take on in behalf of clinical social workers. The CSWF expects Congress to enact quite a bit of health care legislation this year. Concerns expressed cover such issues as confidentiality, mergers of managed care companies, lowering of fees, anti-trust issues and databases. Specific areas covered were discussions regarding Magellan's recent lowering of fees, the Patient's Bill of Rights and the skilled nursing facility bill. The CSWF is interested in supporting Representative Campbell's HR. 4277 regarding anti-trust relief for professionals. He is quoted as stating:

"I introduced federal legislation to allow health care professionals to present a united front when facing a single entity like an HMO...I oppose the idea that the insurance industry deserves its own exemption from anti-trust laws."

The AFL-CIO lobbyists actually brought this vital legislation to our attention, proving how valuable the contribution of the Guild is to clinical social work.

Donations Given to Support Consumer Protection

The State Board of NYSSCSW has voted to give the National Coalition of Mental Health Professional's and Consumers, Inc. a donation of $2,000 to support two important projects in 1999. These projects are Rescue Health Care Day and development of a manual entitled *Mental Health Consumer Protection Manual: A Guide to Solving Problems with Insurance and Managed Care.* The National Coalition is organizing hundreds of health care groups across America to have a national day of protest against business dominated health care. The day of teach-ins and protest will take place on April Fool's Day in the year 2000. The MH Consumer Manual will be used to develop a network of volunteer consumer advocates to give specific information to help consumers defend themselves against mistreatment by managed care. Our Society wants to support the voice of consumers in changing our health care system into a system where choice, confidentiality and quality are considered above business and investment interests.■

Vendorship & Managed Care

LETTER TO THE STATE ATTORNEY GENERAL

By John Chiaramonte, CSW, BCD, Chair

1/18/99
Mr. Eliott Spitzer
NYS Attorney General's Office

Dear Mr. Spitzer,
We thought it important to let you know about the outpouring of concern that we have received from our membership throughout New York State. As the largest clinical social work membership organization in the state, NYSSCSW is in a unique position to reflect the concerns of healthcare professionals statewide. We are quite concerned that federal and state anti-trust laws are being violated and by this letter are requesting that you investigate this matter.

By way of background, Magellan Behavioral Health Company ("Magellan"), which has acquired Merit Behavioral Care ("MBC"), CMG Health, Green Spring Health Services and Human Affairs International, has sent out notices through Merit Behavioral Care (see enclosures) to the mental health professionals of Empire Blue Cross and Blue Shield ("BC/BS") advising that psychotherapy reimbursement rates are being reduced as of January 1,1999. Clinical social workers, who provide the majority of mental health services in New York (over 60%) are the hardest hit with a reduction in fees of 27% (from $63 to $45). Further, Magellan informed its MBC clinical social work professionals that they would also be bound to accept the $45 rate for any Empire Blue Cross members in their indemnity plan. Moreover, it advised that Medicare clients would also be reimbursed at the $45 MBC rate rather than the amounts set by the Health Care Financing Administration ("HCFA") for such services, namely up to $74.95 in New York State for 1999.

Clinical social workers, who provide the majority of mental health services in New York (over 60%) are the hardest hit with a reduction in fees of 27% (from $63 to $45). Further, Magellan informed professionals that they would also be bound to accept the $45 rate for any Empire Blue Cross members in their indemnity plan.

Eventually, I did speak with the Northeast Regional Director of MBC, Cynthia Cangemi, who told me that with the company's current combination of panels, MBC feels that it already offers sufficient mental health coverage to its subscribers. She also told me that MBC will monitor the resignation rate of professionals and if too many resign, they will recruit more clinicians. She did not seem at all concerned that the plan might lose many experienced clinicians or jeopardize the continuity of care so important to the provision of mental health services. She further informed me that several more HMOs and other health care plans in New York are planning to cut psychotherapy fees in 1999, citing as an example Value Behavioral Health's (Value Options) and Cigna's recent reduction in fees for NYS.

The calls I have received from our members indicate that many New York clinical social work professionals are deciding either to resign from the panel or to refuse to accept new patients from the MBC plans. In either case, enrollees of the BC/BS plan and others will have fewer and fewer seasoned psychotherapists available to subscribers — by location, specialty, or both. Therefore, the quality and the access to these plans will likely be reduced even as premiums charged remain the same or increase. Clinicians throughout the state have said that they would be unable to maintain a practice profit above their overhead if they agree to accept these fees, yet many feel that they have no choice since so much of the behavioral mental health market is controlled by a few very large companies (of which MBC is one).

I am gravely concerned that this consolidation of managed care plans and the resulting diminution of reimbursement will spread to all plans... There are already several plans in NYS which appear to offer mental health benefits, however, in reality, such treatment is extremely difficult to access...We are concerned that such reductions could be part of a larger plan to force down the fees of mental health professionals and to limit access to qualified professionals in some collusive and anti-competitive manner (see enclosed *The New York Times* article of 1/13/99). If true, quality of care would be substantially reduced.

We hope you will review this situation as soon as possible with special focus on possible anti-trust violations regarding collusion and anti-competitive practices — before more damage is done to the citizens of our state. ■

Attention Medicare Providers

If you haven't used your Medicare Provider number for billing a patient for the last three years, there is a possibility that the number may be terminated. To verify that the number is still active and to update your provider file, call (516) 244-5151 in all counties except Queens. For Queens Medicare providers, call (212) 721-1300, ext. 335 and speak to Ms. Santano.

Vendorship & Managed Care

COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

This has been a very busy period for the VMC Committee. Clinicians have been calling at a record rate with complaints, such as: MBC placing clinicians on "reserve status" (no further authorizations) without notifying them; delayed payments well beyond the 45 days allowed by NYS Insurance Law; Oxford telling a clinician to refer her patient to a group and terminate individual treatment or they will cease her mental health reimbursements; Metro-Health denying further psychiatric treatment for an enrollee because she was in more than once-a-week in treatment; VBH requesting that the clinicians send in "all of their progress notes" for review before they will allow further ongoing treatment authorizations; clinicians being asked to pay money ($95) to sign up for Integrated Health Inc. in FL. However, the most frequent complaint was on the recent fee reductions from Blue Cross, Merit Behavioral Care, Value/Options and MCC (Cigna).

Regarding these fee reductions, the most member response and outrage came from Magellan's lowering its Merit Behavioral Care contracts (including Empire Blue Cross) to a $45 fee, for code 90806 (indiv., 45 minutes). [Even clinicians in the South and Mid-West don't see fees below $55 as a rule].

Many clinicians have signed off this contract and many others have called to ask our advice as to whether they should sign off. We understand, from speaking to M.C. representatives, that a clinician can sign off one plan while remaining on other M.C. plans. For example, one could sign off of the Blue Cross plan while remaining on the AT&T plan, which pays an $80 fee rate. We also understand that M.C. is prepared to solicit new panelists if their panel is markedly reduced by clinical social work terminations and they were not able to refer patients with consideration to location and specialty. We were informed by M.C. officials that, with the merger of several plans through Magellan, M.C. feels that it has an ample panel and will not be faced with a shortage of clinicians.

This trend is not a surprise to our committee. Over a year ago, we were informed by several different M.C. plans that (to paraphrase)," We intend to do in New York what we did in California." In California, fees are often $25 and even lower for 90806 managed care reimbursement. We have written a letter on behalf of our membership to the N.Y.S. Attorney General (see page 4) asking that he investigate whether any anti-trust laws have been breached.

Currently, though most of us feel that we are often helpless and our practices are hurting with regard to managed care, it is managed care which is hurting and will continue to resort to any means possible to stay afloat. Most plans are losing money yearly and most are increasing their premiums to employers and enrollees (by at least 10%). Many self-insured companies are reviewing their plans with the idea of taking back the reins of their benefit plans from MCOs (managed care organizations) in order to insure cost savings and quality care. Wall Street seems to be divesting itself of managed care products, and the brokers to whom I have spoken are steering their clients away from health care stocks. It appears to this clinician that managed care, as we know it, is undergoing a crisis of sorts. Some MCOs have filed for bankruptcy.

We have recently been informed of a situation in which B.A. (Benefit Plan Administrators) in Nassau County is reported to be over $50 million in debt in a two year period of operation. Furthermore, there are serious allegations of wrongdoing by the past head of the Republican Party in Nassau in facilitating B.A.s takeover of the Nassau County Civil Service Employees contract from United Health's Empire Plan. With that changeover, clinical social work fees went from $67 for 90806 to $55 for out-of-panel, and $40 in-panel. As a result, both the FBI and the U.S. Attorney's office have begun an investigation.

I am hopeful that our affiliation with OPEIU will hasten managed care's demise, especially in view of a new trend — that many unions (most of which are self-insured) are beginning to design their own benefit packages in competition with managed care. Some are even offering their packages beyond their own membership (e.g., Local 1199).

Should you have a complaint regarding insurance reimbursement or a managed care issue, feel free to contact your local VMCC representative (see chart) for assistance. Additionally, please let your elected representatives know when you have a problem.■

For assistance with an insurance or managed care problem, call Vendorship/Managed Care Committee Representatives:

BROOKLYN	ADRIENNE LAMPERT	718-434-0562
CAPITAL & UPSTATE	JOHN CHIARAMONTE	212-535-3839
METROPOLITAN	SHARON KERN-TAUB	718-884-3355
MID HUDSON	MARILYN STEVENS	212-873-1714
NASSAU	FRED FRANKEL	516-935-4930
QUEENS	SHIRLEY SILLEKINS	718-527-7742
ROCKLAND	BETH PAGAN	914-353-2933
STATEN ISLAND	RUDY KVENVIK	718-720-4695
SUFFOLK	ELLIE PERLMAN	516-368-9221
SYRACUSE	GARY DONNER	315-488-1884
WESTCHESTER	ANNE GORDON	914-235-5244
WESTERN NEW YORK	LAURA SALWEN	716-838-2440

On Saturday, November 14, 1998, New York State Society of Clinical Social Work and the New York University Shirley M. Ehrenkranz School of Social Work Ph.D. program presented its third joint clinical conference entitled: "Loneliness, Isolation and Disillusionment: Creating Hope and Connection in the Therapeutic Relationship." It was co-chaired by Eda G. Goldstein, DSW, and Dianne Heller Kaminsky, MSW. The keynote presentations were: "The Dialectic Between Social and Personal Despair," by Jeffrey Seinfeld, Ph.D. and "Psychodynamics of the Clinician's Hope: A Delicate Balance," by Roberta Ann Shechter, DSW; Eda G. Goldstein, DSW, was the discussant. The morning presentations were followed by a choice of 16 workshops in the afternoon. The day was a huge success with an attendance of over 350 people. All proceeds will be used for scholarships for students in attendance at NYU who are also members of the Society.

Creating Hope and Connection in the Therapeutic Relationship

Discussant Eda G. Goldstein, DSW

Reviewed by Josephine Ferraro, CSW

Josephine Ferraro, CSW, is a EAP Specialist in the NYC Employee Assistance Program and is a Candidate in the Adult Psychoanalytic Training Program at the Postgraduate Center for Mental Health

As the discussant for the two compelling keynote presentations by Jeffrey Seinfeld, Ph.D. and Roberta Ann Shechter, DSW, Dr. Goldstein, professor and director, Ph.D. Program in Clinical Social Work, NYU School of Social Work, eloquently synthesized the concepts of the clinical implications for treating persons whose schizoid personalities are reinforced by societal alienation, and the psychodynamics of the clinician's sense of hope in the daily work with clients.

As she discussed Dr. Seinfeld's presentation, Dr. Goldstein spoke passionately about "the day to day conditions of life to which too many of our clients are exposed—conditions in which they witness and experience violence, illness, addictive behavior, and death, sexual and physical abuse and neglect, family breakdown and geographic dislocation, homelessness, discrimination, racism, and other forms of societal oppression." In addressing the challenges that clinicians face today, Dr. Goldstein discussed the impact of the shortages of treatment programs and "mechanistic behaviorally oriented programs and time limited treatments that do not embody a conception of the human relatedness essential to the helping process." She also reminded us that "as social work professionals, we have to be concerned about the treatment services that are necessary to help such individuals, how to make our voices heard about providing such services, and how to work within the constraints of the present delivery system."

In discussing Dr. Shechter's presentation, Dr. Goldstein addressed the paradox for clinicians, that "in order to be hopeful and to instill hope, one must be able to be hopeless and have an emotional tolerance for both the client's and our own discomfort, pain and despair." She also added that, "remaining hopeful in today's practice environment requires professional supports from our schools of social work, professional organizations, and professional peer groups. Conferences like this one are one way of bringing people together not only to increase their knowledge and skill but to validate their work and provide opportunities for refueling."

Eda G. Goldstein, DSW

It was evident that Dr. Goldstein had inspired and evoked a responsive chord in the audience as she said, "The times also should move us to constructive anger. We need to join with other mental health professionals and say, 'We are mad as hell and we're not going to take it any more!' It is crucial for us to empower ourselves and collaborate with others in order to protect and foster clients' rights to a range of services and to advocate for the role of clinical social workers in providing such services. The alliance of mental health practitioners that has been fighting for managed care reforms and the patients' bill of rights is one avenue for this protest."

As she concluded her remarks, Dr. Goldstein discussed the important historical role of clinical social workers. From our profession's inception, it has been those engaged in direct practice who always have put themselves on the front lines in working with troubled clients. It is clinical social workers who allow them-

selves to get close to human suffering and who try to ease clients' burdens. The work is difficult and there are not always sufficient monetary rewards, recognition, or appreciation but our identity as clinical social workers is one in which we can take pride. We are part of a profession that has devoted itself through good times and bad to ameliorating human suffering and improving the quality of life. And we shall continue to do so.■

The Psychodynamics of Hope

CONTINUED FROM PAGE 1

pands as we listen to our client, incorporate a mental picture of the client's tragic life experience into self, and associate it to similar experiences of our own. Affect intensity, not content, may be the greatest similarity between client and self." However, the courage to identify with someone brings its own set of risks. "Disabling therapist-transference suggests a personal experience that may be too painful or too intimate for the clinician to relate to." The practitioner, in an understandable effort to protect the self, "blocks" the true meaning of the material and thus "defeats" the therapeutic process. It is difficult, if not impossible, to ask our clients to deal with thoughts and feelings which we ourselves are unable to bear.

Roberta Ann Schechter, DSW

The respondents' capacity to examine the role of hope and hopelessness in the therapeutic situation, even if after the fact, was encouraging. Acknowledging limitations, exploring internal resistances to understanding our clients, and struggling with our own conflicts ultimately makes us better clinicians. Linda's patient left treatment abruptly, but to her credit, Linda was able to examine why this occurred and what role she played in this outcome. Sarah, in spite of the Board of Education's disregard or misunderstanding of clinical social work, worked to bring about "small changes" in the lives of her clients and maintained hope in the face of insurmountable odds. It was this investment and commitment to clients that Dr. Shechter so eloquently conveyed to her audience. She stimulated the thinking of her audience but, most importantly, Dr. Shechter presented us with the best of who we are and validated our efforts on behalf of those with whom we work.

If an individual therapist begins to lose hope or questions the work we do, forums such as this one provide a place of containment and an opportunity for mutual support and revitalization.■

Maryellen Noonan, Ph.D., is assistant professor in the New York University Shirley M. Ehrenkranz School of Social Work. She is co-author with Dr. Eda Goldstein of ***Short-term Treatment and Social Work Practice: An Integrative Perspective.***

Keynote Speaker

Jeffrey Seinfeld: A Master Teacher and Masterful Clinician

By Donna Jacobs, MSW

Jeff Seinfeld's paper "The Dialectic Between Social and Personal Factors in Schizoid Self States: Alienation, Isolation, and Despair," offered a perspective that provides hope in working with clients who suffer from the pain of emptiness and an inability to make meaningful connections in life.

Through a distillation of ideas from German sociology, existentialism, English literature and British object relations theory, Dr. Seinfeld laid a theoretical foundation for understanding the dynamics of the schizoid state, and the social, cultural and philosophical factors involved. He described the profound impact that schizoid states have had on the quality of his clients' life experience and their impact on the treatment process. As he discussed the feelings of confusion and futility that he experienced in his efforts to reach these clients, Dr. Seinfeld revealed his deep caring for people and a passion for achieving a meaningful therapeutic encounter.

Donna Jacobs, MSW, is on the faculty of the Object Relations Institute and President of the Postgraduate Psychoanalytic Society. She is also founder and director of Women's Health, which provides health workshops.

Conference Committee: (l. to r.) Patricia Landy, MSW, Rosemarie Perez-Foster, PhD, Eda G. Goldstein, DSW, Co-chair, George Frank, DSW, Prof. Emer., NYU S. M. Ehrenkranz School of Social Work, Carol Tosone, PhD, Dianne Heller Kaminsky, MSW, Co-chair, and Helen Hinckley Krackow, CSW, BCD, Society Past President

Dr. Seinfeld's use of the term schizoid is in keeping with the view in Great Britain where schizoid refers to a category of patients characterized by a tendency to cut

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Study Shows Members Use Informal Practice Evaluation Methods

RESEARCH COMMITTEE REPORT

By Jacinta Marschke, Ph.D., Chair

The Research Committee recently presented the results of the member survey on practice evaluation at the National Conference of the Society of Social Work and Research in Austin, Texas, January 23-25. The results emanated from a survey of Society members during the summer of 1997. In a stratified randomly selected sample, 222 society members responded to demographic questions, a needs assessment and a survey of their practice evaluation involvement. The demographic profile and needs assessment were reported in earlier issues of *The Clinician*.

The practice evaluation results affirm that our members are evaluating their work and are open to learning new user-friendly and relevant practice evaluation methods. However, members do not use the practice evaluation methods that they were taught in graduate school or that the literature asserts is empirical. Rather, members prefer the less formal methods of intuition, observation and consultation and avoid the more formal methods of single subject design, standardized tests and Goal Attainment Scaling (GAS). These study results, which are consistent with other practice evaluation studies, raise questions about the validity and relevance of what the literature asserts constitutes empirical practice evaluation and what social work schools are teaching students to prepare for them to review their work.

A more detailed description of the study has just been submitted to a journal for review and publication, has been accepted for presentation at the Council on Social Work Education Conference to be held in San Francisco in March and has been accepted for a poster presentation at the Federation Conference in Washington in May.

Other Research Committee initiatives include a study of the development of multi-cultural sensitivity among MSW students. Having access to previously-collected baseline data on students' perceptions of their multi-cultural awareness, knowledge and skills upon entry to an MSW program, the Committee will resurvey the same subjects as they graduate from MSW programs. The subsequent analysis will explore whether there are any changes in subjects' perceptions about their multi-cultural awareness, skills and knowledge, and whether there are any significant factors associated with subjects' perceptions of their multi-cultural sensitivity.

We hope that additional members will join us in this and other research activities by contacting us. Under the leadership of Ira Frankel, the Committee will also begin to develop and, upon request, conduct practice research workshops for chapters throughout the state. These workshops will introduce clinicians to practice evaluation methods that are user-friendly, easily implemented and clinically relevant. The goal for the first year is to develop the program and to pilot it with at least one or two chapters. Please contact Ira Frankel directly to arrange for workshops at 718-544-8821.

Finally, the Research and Mentorship committees will meet to consider doing a study to explore the experience and impact of the Mentorship Committee activities to date. The Mentorship Committee hopes the study will generate information to help them tweak and expand their efforts.

Our hope is that we have piqued your interest and that you will consider joining us on the research committee. Just call me at 914-255-5466 for more details, Cindy Marschke, Chairperson.■

PRE-CONFERENCE WORKSHOP:

How to Conduct a Workshop

A workshop is different from a formal lecture in that it presents theoretical content within an interactive format. To make this experience successful for both the presenter and participants, this pre-conference workshop will help clinicians who are planning to lead workshops at the Annual Conference. Those hoping to do so in the future will also learn how to organize their material and time, as well as actively engage workshop participants. Emphasis will be placed on the tasks, boundaries, goals, and expectations inherent in a workshop experience.

DATE: Saturday, April 17, 1999
PLACE: 125 East 87th Street, Suite 17C
TO REGISTER: Call Phyllis Mervis at (212)369-8879
DEADLINE: April 9, 1999 (Limited Registration)

How to Treat Managed Care Anxiety

THE PRACTICAL PRACTITIONER

By Sheila Peck, LCSW, Chair

An earlier version of this article was published in 1994. Since then, we've received numerous requests for it. We present an update here.

I. The Disorder

Here's an excerpt from DSM-IV: "this category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific Anxiety Disorder [it includes] clinically significant phobic symptoms..." This is the description of "300.00, Anxiety Disorder NOS." Relative to this, a new syndrome seems to have arisen, one which affects psychotherapists in general and clinical social workers in particular. This article is about the disorder and its "treatment."

I call it "Managed Care Anxiety (MCA) and suggest it be assigned a DSM code of "300 Uh!-Oh!," which is the way many clinicians are reacting to managed care. MCA is characterized by resistance, feelings of helplessness, teeth-gnashing, outrage and, often, an intense longing to return to the "good old days" of indemnity health insurance before there was managed care.

There's also another important clinical symptom in this syndrome: amnesia. This is specifically connected to those so-called "good old days." Many sufferers of MCA seem to have forgotten something important. Fifteen or so years ago, most clinical social workers received no payment from insurers, whether indemnity or managed care. Those of us who practiced back then, before so-called parity, received no money in the mail. Some of our clients could have chosen therapy with psychologists or psychiatrists, all of whom were eligible for vendorship 15 years ago. But our clients elected us. We survived. All of us who started out then and are still in practice now survived. And so, we're sure, did our clients.

In fact, if you go some years further back, much health insurance didn't cover in-office doctor visits, much less mental health management. No psychologists. No psychiatrists. Not even family physicians. The patients paid for it. (Of course professionals kept their fees lower, too, so care was more affordable.)

As a result of these MCA symptoms, many clinicians are suffering. How can we help them? Is there a "therapy" for this emerging syndrome?

II. The Treatment

Treatment for MCA is multi-pronged. First, let's remember that we still have options which some of us have forgotten.

Especially in an improving economic situation, many people have access to discretionary income. Some of them are spending these funds on health care. They hire chiropractors, acupuncturists, podiatrists, massage therapists, homeopaths and other such practitioners, most of whose services require repeat visits (as does psychotherapy).

Insurance, managed care or otherwise, rarely covers such modalities. Yet people who want and need these services find the money to pay for them. So clinicians should keep in mind that our skills are necessary, too.

Another part of treatment for MCA is to decide that we can live with or without managed care, particularly with the new fees (reduced) announced by Magellan and ValueOptions. It's a choice.

Some clinicians ask anxiously, "But how will I get referrals if I'm shut out of panels?" The development of marketing skills is an excellent tranquilizer. Although I used to be on a lot of panels, I got most of my referrals from other sources — and those that come from managed care often arise because I'm one of only two practitioners in my zip code. With all the latest developments, it's been a lot of fun resigning from panels.

Most of us get our referrals from old clients, personal contacts and from letting the general public know about us. That's marketing — which they don't teach us in social work school or in a doctoral program.

If an already-existing client gets switched in mid-therapy to a panel of which you are not a member, there are many creative arrangements you can make to keep working with that client, if you both want to continue. We are not aware of many therapists who have stopped seeing clients for this reason. Enjoy the challenge of arranging an elegant financial solution for new clients, too. And think of all the paper work you'll save!

Don't let yourself be owned by managed care. Look at all the opportunity these fee cuts offer for creative practice development — WITHOUT MANAGED CARE.

If you love your work — and most of us do — keep in mind that marketing is part of that work. AND IT ALWAYS WAS, even in those "good old days."

Learn how to do it as a part of "taking responsibility for yourself", that wonderful phrase we're always telling our clients they need to act upon.

Ask yourself if the burdens outweigh the rewards of the work (and not just financial ones). If your answer is truly "yes," then it may be time to think about changing careers. If not, keep on rewarding yourself. Remember, "Managed Care Anxiety (300. Oh!-Oh!)" is a perfect candidate for brief therapy treatment.■

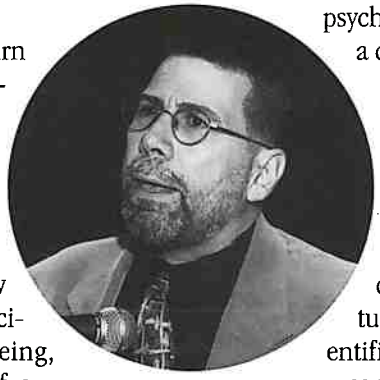
Jeffrey Seinfeld: A Master Teacher and Masterful Clinician

By Donna Jacobs, MSW

CONTINUED FROM PAGE 5

themselves off in ways that may not be apparent to the observer. This view differs from the American view of the schizoid personality disorder that is evidenced by social withdrawal and a preoccupation with eccentric ideas. The broader application of the term schizoid increases the usefulness of the concept in that it can be applied to understanding a particular state of mind, which all individuals sometimes suffer.

In the tradition of Winnicott, Fairbairn and Bion, Dr. Seinfeld drew from an existentialist view of ontological insecurity to broaden the psychoanalytic concept of the fragile sense of self, and to include societal as well as psychological factors that contribute to the loss of the sense of genuine being. He noted how western metaphysical tradition has dissociated or neglected the importance of being, and our culture is, in many ways, of a schizoid nature.



Jeffrey Seinfeld, Ph.D.

Psychoanalysis has contributed to our understanding of schizoid phenomenon through object relations theory, which is, in Dr. Seinfeld's view, a theory of schizoid states. Schizoid states are understood as states of psychic fragmentation and splitting which form the basis for our mode of living, and our states of being authentically, or in-authentically. Dr. Seinfeld discussed the nuances of this complex theory that begins with etiological factors organized around the developmental stage of separation. Briefly summarized, when the subjectivity of the caregiver is experienced as a threat to the subjectivity of the infant, the infant internalizes the fantasied threatening object in an effort to omnipotently control it and transform it into a good object. Yet, the internal object begins to possess the infant, as it becomes an integral and dynamic structure in the personality. Closeness to others stirs needs than cannot be fulfilled, and incurs rage. Pushing away is ironically a way of staying in contact. The schizoid person becomes the role that he has assumed in order to meet environmental demands and to protect himself from environmental impingement. A more thorough explication of Dr. Seinfeld's views on schizoid states can be found in his book, *Containing Rage, Terror, and Despair: An Object Relations Approach to Psychotherapy* (1996, Jason Aronson).

Seinfeld drew from an existentialist view of ontological insecurity to broaden the psychoanalytic concept of the fragile sense of self, and to include societal as well as psychological factors that contribute to the loss of the sense of genuine being.

In an interview following the conference, Dr. Seinfeld responded to some questions about his views on psychoanalytic theory, and his experience as a clinician.

How do you reconcile the fact that object relations theory relies so heavily on the hypothetical narrative of the infant?

It's intriguing actually. The hypothetical narrative of the infant rests on a cultural view which is more literary than scientific. It presents the notion of a true self corrupted by the industrial age. It's useful, I think, for patients to first understand themselves in non-threatening ways, and slowly get in touch with their internal destructiveness. I like fiction and literature a lot. I think that whatever we understand is a construction, and our theory is as good as any other construction that helps us understand. I try to look at theory critically. What are its basic assumptions, philosophically and theoretically. I take a philosophy of science approach to analytic theory.

Don't you think our theories perpetuate an attitude of "blaming" the infant's caregiver for failing to provide optimally for the infant's developmental needs?

Sure. Sometimes the infant narrative does that. Melanie Klein's theory gives more of the mother's point of view in handling the devouring, destructive infant who envies her goodness. Fairbairn gives the counter-narrative. I think the truth is somewhere in between. Remember, the child has internalized the mother's point of view. I like Bion's distillation of Klein. Bion brought in environment in a big way. He brought in environment, mysticism, the psychotic part of the personality...

What ideas do you see influencing the evolution of psychoanalytic thinking/theorizing now?

We're turning more toward philosophy and intersubjectivity, which originated in the German hermeneutic

Public Relations

COMMITTEE REPORT

By Sheila Peck, LCSW, Chair

Did you know that the State Society now has a presence on the web? As a part of the Clinical Social Work Federation's site, we have our own page. Those of you who are on-line can access it at: http://www.cswf.org. Right now there's not much on it — but that's going to change. Soon we're going to post an article by Al DuMont about the guild, some information from our membership brochure and material about our state conference (in May).

If any of you has any ideas for more items for inclusion on the site, please call me at (516) 889-2688 or send me an e-mail at Sheila2688@aol.com.

There's also more publicity in the offing. We're going to be ordering some social work mugs and pens with Society name and number, to be sold or handed out at conferences and workshops. We'll let you know when these items are available.

Since the last issue of *The Clinician*, we've also written a number of letters to the editor in response to articles printed in *The New York Times, Washingtonian, Consumer Reports* and several other publications which omitted mention of the Society or which didn't quite have the right information about clinical social work.

Workshop in Membership-Building

Last year we offered a workshop open to two representatives of each chapter for the purpose of learning skills in membership-building, getting members to work and enhancing the professional image of clinical social work. Unfortunately, it was inadvertently scheduled on a holiday weekend.

Now we're going to do it again right! We plan to present a similar workshop again in the fall, just prior to the first fall board meeting after the summer break. This will make it easier for all chapters to have a representative attending, since they may also be planning to attend the board meeting. As soon as we know the exact date, we'll send out a mailing to your chapter president. We'll also print a follow-up in the next issue of The Clinician. Anyone who is interested in knowing more can call me at the number in the first paragraph above. The workshop will include useful printed material which you can take back to your membership.

Please send information on any presentations or programs your chapter will be offering to me at 1010 California Place South, Island Park, NY 11558, so that we can get together a spring calendar and send it out to all chapters.■

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and existential schools. Our theories are also being influenced by post-modernism and social constructivism, and the eastern philosophies and mysticism.

How do you think psychoanalysis will be impacted by neuroscience and genetics in the years ahead?

I don't think we're knowledgeable enough. Grotstein has written on the idea that internal objects are based on neurochemistry. This is very exciting stuff. Psychoanalysts tend to get intimidated by neuroscience. I think we have to be open to this and other fields if psychoanalysis is going to survive.

On a more personal note, what would you say it is that you 'do' as an analyst. Has it been you intention to make a particular contribution to the field?

I started out working with inner city kids in the Bronx, and tried to apply object relations theory in working with them. I wanted to be helpful to socially disadvantaged inner city kids — to come up with some clinical skills to help these clients. In future, one goal I have is to expand object relations theory to incorporate Eastern thought.

What makes you write?

That's a good question. Problems, I think. Writing about a problem helps me understand and get some distance from it. It also makes me feel less inadequate if I write about it. Maybe I can help other practitioners with some of the things I've discovered in the writing. *(Laughing)* If there weren't problems to solve, why would anyone write about all this?

Let's see, you've written three, four books.

Interpreting and Holding (1993), *Containing Rage, Anger, and Despair* (1996), *The Empty Core* (1991), and *The Bad Object* (1990).

Anything forthcoming?

I'm working on a primer on negative therapeutic reaction, and a book on object relations theory, Eastern thought and addictions.

Thanks for the interview. We'll be looking forward to your next publication.

It's been a real pleasure talking with you.■

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