NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. FALL 1991 • VOL. XXII, NO.3

Marketing Strategies: The Mix

Manipulating the Four Ps for Success

By Dolores E. McCarthy, CSW

The first part of this article (Summer 1991 Newsletter) discussed the "Four Ps" of marketing: product (service), price (fee), place (location) and promotion (advertising and communication). The challenge for a marketer is how to "mix" these ingredients.

In the current practice environment, there is no "right" way to market a practice. Although there is much speculation as to certain practice trends such as increased short-term therapy, and more managed therapy, no one knows exactly how this turbulent marketplace will develop. Many marketing decisions for practitioners depend on personal interest, skill and training, as well as objective issues such as location, fees, and marketplace needs. As always, one should "know yourself" (including resistance to practice development), to create an effective marketing plan. For example: is it better to concentrate on developing and communicating directly with potential clients, with referral resources, or with networks such as HMOs and PPOs — or with a combination of each? What's the best way to apportion time? Which of these targets is likely to yield the largest number of referrals, and which target will feel more comfortable? Each of these markets requires different techniques.

It may seem easier to apply to a PPO panel and wait for referrals; however, this depends on "place". In Manhattan, for example, many panels are already full, or are so large that one may never actually receive a referral. In suburban areas, however, a PPO panel may yield more referrals and this may be the best way to go. Perhaps therapists in Manhattan may need to open two offices, develop a very specific specialty, or target potential patients directly, rather than using a PPO. These decisions reflect the art of marketing.

As in all business decisions, there is always risk. The greater the risk, the more likelihood for both success and failure. For clinicians who are not comfortable taking larger risks, it may be more appropriate to limit expectations as to the number of new patients one can reasonably expect in a year, and work within this reality. For those who are comfortable with greater risks there is much more work involved, and there is always the possibility of

continued on page 8

Substance Abuse Among Professionals: New York State's Special Program

As we all know, having a professional license is no protection against chemical dependency. Alcoholism and other drug abuse is rampant in our culture and poses the number one personal health problem each of us is likely to face. Current estimates show that at least 10% of the adult population abuses alcohol or other drugs.

Most of us know someone who has a problem with alcohol or drugs. Addiction is now recognized as a chronic and progressive disease. Those professional friends and colleagues who are struggling with this illness often have to struggle alone. Lack of treatment in the early stages of addiction can mean physical deterioration, increasing dependency, negative impact on family, friends and work. Our efforts can help prevent this; friends, family and colleagues

continued on page 8

Should There Be a Fifth Mental Health Profession?

The Dilemma of Licensing in New York

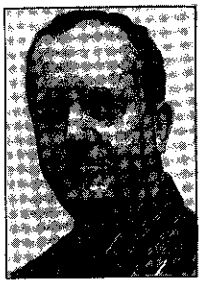
By Marsha Wineburgh, CSW, BCD
Legislative Chair

The New York State Board of Regents and the State Education Department have initiated a review of the area of professional regulation which pertains to licensing mental health professionals. The provision of mental health services, other than the medical and psychiatric treatment of mental disease, is unregulated in New York State. Only practitioners in medicine, nursing, social work and psychology are licensed to deliver mental health services and are therefore regulated. However, many other unlicensed practitioners from

continued on page 5

EXECUTIVE REPORT

Autumn and Rebirth: Designing A Structure for the Years Ahead



Time has passed swiftly and I am in the final "September" of my 2-year term as your president. I have enjoyed the experience of representing the Society and believe that I coped reasonably well with a number of rather difficult situations. I have felt your support and the support of your elected board. I cherish the esprit de corps that exists within our voluntary structure. This voluntary effort is crucial to our strength and will hopefully never fade into the shadows despite the presence of salaried staff. As our bylaws state, I will serve on the board for 2 years more — a year on the Executive Committee and the second year on the Executive Board.

Since January President-Elect Dr. David G. Phillips and I have worked closely together. David is no newcomer to the Society. He is very knowledgeable and ready to take the reins. In September we attended the semiannual board meeting of the National Federation in Chicago which also encompassed the national clinical conference and the 20th anniversary celebration of the Federation. It was a memorable occasion and New York was well represented.

Like many of you I watched with fascination the special Senate hearings concerning the allegations brought against Supreme Court nominee Judge Clarence Thomas. Several times members of the Senate panel as well as those testifying were heard to say something like "now, I'm not a psychiatrist or psychologist . . ." Of course, the words "clinical social worker" were never uttered. And that, to a large degree, is one of our most significant problems. John and Mary Public are not aware of clinical social work. Just how we can modify how we are seen is a complex matter that appears to go beyond our current national public relations effort. While managed health care has become increasingly aware of, and interested in, clinical social work, the general public has not. We have pondered this problem at Federation meetings and have considered that a restructuring may be required so that it might constitute a more powerful national presence and have greater clout. Accordingly, a task force will study the problem and recommend appropriate changes — at the least, a complex and time-consuming process.

Philip Banner, MSW, BCD
President

Task Force Established to Study Managed Care

Report by
Mark Dworkin, CSW, BCD

It should be clear to anyone who reads *The New York Times* or indeed any national newspaper that there is a crisis in health care in this country. Those with mental health needs, whether outpatient or inpatient psychotherapy or any "alternate level of care" in between, have reason to worry. Much misinformation has been disseminated about "skyrocketing behavioral health" costs. (Behavioral health is the phrase the business community now uses to describe mental health.) While the need for cost containment in all sectors of health care is evident, how this is done will be subject to the exploding changes in policies and practices of health care companies.

Various Methods of Economy

Enter "managed behavioral health care" — in many shapes and sizes, including HMOs, PPOs, full-service specialty vendors. Each has different benefit designs depending on the contract between an employer (purchaser) and insurance company (payor). Each has different rules about reimbursement to providers: how much to pay, how to discount fees, claims reimbursement times tables, etc. Each has a different way of containing costs: capitation, differing levels of benefits to patients. Each has a different method of reviewing work to determine the "medical necessity" and appropriateness of care rendered by CSWs. Moreover, new evidence suggests that this growing industry is now designing "provider profiles" to assess preferred providers, which could lead to the elimination of some CSWs from such provider lists.

Open Minds, "The behavioral health industry analyst" newsletter, estimates over 300 specialty vendors are in operation competing for market share, not including the proliferation of HMOs and PPOs. While there will always remain a "private pay" market for psychotherapy, this will be an ever-decreasing portion. Some form of managed care is here to stay.

Those CSWs who have not kept current with this growing situation will face an uphill struggle to maintain private practices. Those who have joined provider panels face greater scrutiny and regulation.

continued on page 4

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Practice Development: Fact and Fiction

Finding Niche(s) is Key Element for Marketing Services

Report by
David Grand, CSW, BCD

This second in a 2-part article is excerpted from workshops presented by the education committee of the NYS Society for the past 3 years and includes the workshop presented at the annual meeting in May. Part 1 appeared in the Summer 1991 issue.

The first section addressed how to identify and overcome practice resistance. This part will review some "nuts and bolts" ideas on expanding one's practice. The "Formula for Successful Practice" is *D/T=S:* D=knowing what to do and *doing* what you know; T=*time* or the law of the cumulative; S=*successful* practice.

In market terminology, the therapist (and the treatment provided) are the product or service. The best sources currently for referrals are Employment Assistance Program (EAP) counselors and the growing managed care network (eg, American PsychManagement, Human Affairs International, etc.). Additional referral sources are school psychologists, physicians (pediatricians, gynecologists, internists), attorneys specializing in divorce and family issues, clergy, institute faculty and professional interest groups.

Two Cornerstones for Practice Expansion

The two most important factors in practice development are personal contacts and specialization. Much truth lies in the cliche that "it's not what you know but who you know." How many clients referred to you or those you refer involve clinicians with whom you have a personal relationship?

The two most important factors in practice development are personal contacts and specialization.

Many therapists, especially CSWs, consider themselves generalists. However, people who make referrals often seek out specialists. Moreover, if they are impressed by your work, they will also send you clients out of your designated specialty. In advertising, the concept and practice of specialization is increasingly developed as "niche" marketing.

Before marketing begins, the clinician should evaluate the existing practice. This step can be called R&D, or research and development. For a psychotherapist, R&D refers to one's personal treatment, supervision, postgraduate training, additional coursework seminars, and the incorporation of specialization(s). Our product should be developed and refined until it is of high quality and we feel confident to market it effectively.

It is a generally held misconception that therapists set their own fees. Assess supply and demand. These, in our marketplace, are defined as the number of competing practitioners balanced against the size of the pool of potential clients. The astute clinician/businessperson knows that in reality the marketplace sets the fee.

Long-Term Planning/Broad Knowledge Base

A successful business, as Japan has demonstrated, plans long-term. It is shortsighted and self-defeating to focus primarily on how to obtain referrals for the short term. Therapists should conceptualize and write down their goals, along with the plan for their accomplishment. These projections should stretch 6 months, 1, 2, 5 and even 10 years hence.

Therapists should conceptualize and write down their goals.

Practitioners often say, "I prefer not to work with addictive clients," "I don't like working with children, particularly adolescents and their parents," or "I only work with individuals, not couples or families." Certainly therapists have the right to treat whomever they want, yet one could estimate that the combined categories of addicts, co-dependents, children of alcoholics, couples, families, adolescents and their parents comprise upward of 75% of the potential pool of therapy and counseling patients available. No business would survive if it eliminated 75% of its potential market.

Gaining knowledge in the area of addiction is also a necessity for marketing a psychotherapy practice to EAP counselors. EAPs have their historic roots in the early alcoholism movement. To this day, virtually all EAP staff members embrace the disease/self-help model as the prime mode of treatment for the addicted population. A multitude of addiction cases have been mishandled by therapists who did not address the addiction first. If an EAP counselor determines that a therapist is deficient in the knowledge base around addiction, that therapist is not likely to be called as a referral resource. Ironically, presenting sophistication in the diagnosis and treatment of the addicted patient may bring a majority of referrals from the nonaddicted population. Obtaining a referral from an EAP counselor, the therapist has an opportunity to demonstrate both clinical skills and sensitivity to the counselor's needs (such as prompt availability). Success on both counts will likely result in additional referrals.

Gaining knowledge in the area of addiction is a necessity for marketing to EAP counselors.

In summary, it is crucial to reiterate the main premise that effective practice expansion is based not only on "knowing what to do," but also on "doing what you know." Thus, we must educate ourselves as well as recognize, face and overcome the powerful inhibiting effect of practice resistance. Then we are ready and able to enhance and maximize future practice development. □

David Grand, CSW, lecturer and consultant on practice development/management, presented a workshop at the Third National Clinical Conference, 1990. He is a clinical affiliate for the Cigna EAP. His certificate in psychoanalytic psychotherapy was earned at SPSR. President of Nassau chapter, he has a full-time private practice in Bellmore.

The National Committee on Psychoanalysis of the NYS Society continues to sponsor peer study groups for *all* members. Those interested may call Richard Alperin, DSW, Chair (212) 884-5574.

Psychodiagnostic Testing: Legal and Ethical Pitfalls

Computer Reports Should Not Be Used as Shortcuts

By Hillel Bodek, MSW, CSW, BCD

A recent advertisement in the *NASW News* encourages social workers to purchase the *Hand Test,* "a simple projective technique widely used to measure action tendencies — particularly acting out and aggressive behavior. Non-threatening and easily administered in just 10 minutes, it's an ideal starting point in any personality evaluation."

The advertisement goes on: "The test also provides six summary scores, including an index of overall pathology and an acting out ratio, which is often used to predict aggressive behavior... [T]he *Hand Test* effectively measures reactions that are close to the surface and likely to be expressed in overt behavior. It differentiates various clinical groups and successfully predicts acting out, aggression, and other kinds of problem behavior."

Similar advertisements in several publications market other psychodiagnostic tests to social workers, particularly computer-scored personality inventories such as the *MMPI-II,* where the examiner submits the patient's answer sheet for computerized scoring and obtains a report about the patient's personality functioning and possible diagnoses. Such advertisements can inadvertently provide an invitation to engage in unethical conduct, malpractice and behavior that violates State regulations.

Administration of Tests

Although the Education Law and the regulations promulgated pursuant thereto limit the use of the terms "psychologist," "psychological" and "psychology" to persons licensed as psychologists, they do not restrict the use of tests commonly employed by psychologists solely to members of that profession.

A January 3, 1991 opinion from the New York State Education Department's State Board for Social Work indicated that, "[b]y virtue of their professional education and training, certified social workers and psychologists who specialize in clinical practice are qualified to provide various services common to both professions, including but not limited to mental status examinations, diagnostic tests, and psychotherapy."

Nevertheless, education regulations which define unprofessional conduct by licensed professionals provide that unprofessional conduct includes "accepting or performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform . . ." 8 NYCRR 21.9(b)(9).

Competence to administer and interpret psychodiagnostic tests requires that the examiner 1) understand the standardized nature of the administration and scoring of such tests; 2) have a sufficient appreciation and understanding of the uses, norms, characteristics, reliability, validity, technical merits and limitations of such tests, so that the examiner will be able to choose appropriately which tests to administer for a given purpose and to interpret properly the results; 3) understand and be sensitive to the many variables and conditions that can affect test performance; 4) know and understand the development, nature, normal variables and pathology related to the characteristics (ie, personality, intelligence, neuropsychological and cognitive functioning) that the tests are designed to measure; 5) know how to integrate properly and effectively information obtained from psychodiagnostic tests into the overall assessment of a patient.

When properly administered and interpreted, psychodiagnostic tests can be very useful as part of the overall clinical assessment of patients.

Parameters of Tests

When properly administered and interpreted, psychodiagnostic tests can be very useful as part of the overall clinical assessment of patients. Psychodiagnostic testing is an adjunct to, not a replacement for, clinical evaluation of a patient by taking a proper history and performing a mental status examination.

Computer generated scoring and interpretation of psychodiagnostic tests is helpful to avoid scoring errors that can occur when tests are scored manually and to provide some standard guidelines for the interpretation of response patterns. However, a computer-generated report is never an adequate substitute for the review and interpretation of psychodiagnostic test results by an experienced, knowledgeable and sensitive clinician.

Clinical social workers have an ethical and legal responsibility to provide services within the limits of their competence. Although most clinical social workers do not administer and interpret psychodiagnostic tests, many integrate into their evaluation and treatment the findings of psychodiagnostic tests administered by others. To rely properly on such test data, a clinical social worker must have a basic understanding of the limits of psychodiagnostic testing in general as well as of the particular tests involved.

To help clinical social workers gain a basic understanding of psychodiagnostic testing and how to integrate such test data the Society's forensic committee is offering a 4-hour workshop entitled "Introduction to Psychodiagnostic Testing" on January 18, March 14, and May 16, 1992. The $60 fee for this workshop helps support other educational efforts of the Society. Members who are interested in this workshop can call Hillel Bodek at 718-596-7980 after 9:30 PM. □

TASK FORCE *(continued)*

A task force for the State Society will study the problems of managed behavioral health care and recommend solutions and directions. For this to be a viable effort, the task force solicits members' help. Please send written statements documenting any problems encountered with an HMO, PPO, specialty vendor or insurance company. We need to collect data, and quickly! Mail to Mark Dworkin, CSW, BCD, 251 Mercury Street, East Meadow, NY 11554. Fax: 516-579-0171. Those who wish to take an active role are urged to join the task force. The next meeting is Friday, January 10. Call 516-731-7611 for details.

a wide variety of education preparations and backgrounds are providing mental health services within the current law. The New York State Society has been invited to assist in a review of this area of public policy which may include the creationof a fifth profession, professional counselors.

An Occupation or a Profession?

The Society strongly supports the efforts of the State Board of Regents to protect and improve the standard of mental health care available. For many years, this Society has been supportive of an integrated network of qualified providers to serve the needs of consumers in New York. What has been of special concern is the lack of clear rationale for selecting which groups of providers are to be licensed. Recently, many special interest groups representing modalities of practice or areas of specialization, such as marriage/family therapists and sexual abuse counselors, have asked the legislature for recognition. Historically, the Society has endorsed the principle that only those occupational groups that can demonstrate that they are a profession should be licensed. Occupational groups as well as organizations tend to evolve along developmental paths. There is a growing body of literature that can help to determine when an occupational group has become a profession.

Only practitioners in medicine, nursing, social work and psychology are licensed to deliver mental health services and are regulated.

The reactions of the mental health community to the idea of a fifth profession are, as is the issue, quite complex. On one hand, the NYS Psychological Association believes that the practice of psychotherapy should be restricted to the four core mental health professions. It has opposed the creation of new mental health titles. The Joint Council for Mental Health Services, on the other hand, is strongly in favor of a fifth profession and requests that nontraditional credentials be considered as standards for professional certification.

Standards for Professional Competence

NYSSCSWP recognizes that there will be more occupational groups that qualify as mental health professions beyond the four disciplines currently recognized. However, it is imperative that the minimum standards for academic training and experience of new professions do not undermine the current standards for competence which have been established for each of the existing mental health groups. Because standards for training and experience differ widely among counselors and many, even with national accrediting bodies, are in fact modalities of practice rather than separate professions, there is the danger that this fifth profession may create a weakly credentialed back door into mental health services. We already have a problem with alcohol counselors, now certified, whose training is so narrow and specific that they have virtually no background in assessing underlying biopsychosocial problems, character disorders and psychoses once the chemical addiction problem is worked through.

There is a growing body of literature that can help to determine when an occupational group has become a profession.

1991 Update

Workman's Compensation legislation is in its final form thanks to Hillel Bodek (NYS Society) who researched and drafted the current version. When passed, this legislation will include qualified social workers as providers under Workman's Compensation law.

Our **Forensic Examiner** bill, which would authorize qualified CSWs to conduct certain psychiatric examinations, is reported out of the Assembly Codes Committee. However, efforts by public defenders in Upstate New York successfully held the bill in the Assembly Rules Committee.

The third and final draft of the **Licensed Clinical Social Work** legislation was completed in June, thanks to the initiative of the legislative committee. Special thanks to Joseph Ventimiglia and Hillel Bodek. □

Forensic Fellowship Program Commences for CSWs

Report by
Hillel Bodek, MSW, CSW, BCD

The Society's fellowship training program in forensic clinical social work began in September. The program, conducted with the cooperation of the Bellevue Hospital Center Department of Social Work, is designed to prepare experienced clinical social workers to provide forensic mental health evaluations.

Currently, 23 forensic psychiatry fellowship training programs are ongoing in the United States. Those programs provide psychiatrists with an intensive 1-year postresidency program of didactic education and supervised clinical experience in performing forensic mental health evaluations. The Society's program is the first of its kind for clinical social workers.

The 7 forensic fellows — Betty Gewirtz, Helen Hinckley Krackow, Brian McDonald, Vitilcia Nunez, Mark Sichel and Marsha Wineburgh — were chosen from a group of almost 40 CSWs who applied to participate in this program. Together with Frances Gautieri, Director of Social Work at Bellevue and Irene Freedberg, Assistant Director of Social Work in Psychiatry at Bellevue, the weekly meetings are under the direction of Hillel Bodek, chair of the Society's committee on forensic clinical social work.

The 40-week program includes lectures by judges and leading attorneys in specialized legal disciplines. The course will cover expert testimony, forensic evaluation, juvenile and criminal justice, child custody visitation, judicial decision-making, civil commitment, rights of the disabled, institutional litigation, civil competency, risk management, psychiatric malpractice, child abuse/maltreatment, licensing, professional discipline, working with crime victims, and peer review.

In addition to conducting forensic evaluations, participants will have the opportunity to spend a day with one of the participating judges and observe a criminal trial.

This program represents a significant step forward for clinical social work education and for the advancement of clinical social work practice in the legal system.□

Letters . . .

To the Editor:

I would like to raise a lone voice of protest against the main message of the keynote speakers at the May 11th conference of the Society in New York City. The message was loud and clear: "Surviving Tough Times" means, basically, that we must dance to the tune of the insurance companies.

That this interferes drastically with the very structure of the therapist-client relationship was not even mentioned. We were given very helpful advice in how to *deal* with these companies — and I do not mean to impugn the expertise or good intentions of the speakers — but no one asked *whether* we should get caught up in this "1984" Orwellian stuff in the first place.

My objections are three-fold: 1) that such a system disrupts the confidentiality essential to the therapeutic relationship, and it is ironically to the point that the company is termed the *"third* party"; 2) that it interferes with the fee-setting process between therapist and client, which is . . . of course an important part of the relationship; and 3) that it distorts the diagnostic process, forcing the therapist to come up with a label which the insurance company will pay for.

There is thus inserted a totally antitherapeutic wedge into the therapeutic relationship. This is what comes from using the medical model in a profession which has only the slightest connection, if any, with the practice of medicine.

Some of us may choose to deal with this system, and I will not cast the first stone. But there *are* options: Are we brave enough — or . . . *solvent* enough — to deal only with the client in the matter of the fee and keep the third party out of it? Is the client invested enough — or solvent enough — in the treatment to *pay* for it? Isn't *that* a part of the therapy?

My own preference is to decide the fee apart from the insurance, and then let the client deal with the company. But may God bless those clients who, although they may have coverage, decide not to use it because *they* want to preserve the privacy of their treatment!

I am aware that many therapists consider [that they are] underpaid . . . But at the very least, we should not enter this regularizing process without an awareness of what's at stake here, or without some sort of protest.

The regularizing process of technology is . . . taking over . . . even where it actually works *against* the very thing it is attempting to make more efficient. But *efficiency* must not be confused with *effectiveness,* and there are clearly areas . . . whose essence is neutralized or even destroyed by technology.

Norman Friedman, MSW, CSW

Interpreting the Mission of Schools of Social Work

To the Editor:

I am writing on behalf of the Deans of the ten schools of social work in New York State to take issue with the intemperate and inaccurate remarks of Philip Banner in the [Summer 1991] issue of your newsletter. Mr. Banner speaks of the need to "wage War" for policy changes. . . .He then proceeds to make war against social work education by suggesting that the graduates of social work schools are "inadequately prepared for the increased demands of clinical practice." We can expect to hear repetition of [this] at every meeting with New York State officials in which we participate in order to advance the status and jurisdiction of the social work profession. He has indeed given aid and comfort to the enemies of social work.

We looked for the evidence. . .of the inadequate preparation he decries. . .[and] found these charges: a) Graduate social work school does not provide "business savvy." b) Graduate social work schools do not encourage. . .graduates to enter the "private sector." . . .Education for social work practice — both clinical and non-clinical — entails the development of many competencies. Curriculum time and space are at a premium. To take away time in which students can learn about normal and abnormal patterns of human personality development. . .[and acquire understanding of the myriad complex problems that arise in clinical practice], and trade it in for modern office management and bill collection practices amount[s] to a criminal debasing of our professional function . . . .Short-term business education [can secure] such knowledge. . . .

Graduate social work schools prepare students for entry into [the] advanced professional practice of social work. Students. . .choose [the] field of. . .social work practice they wish to enter. . . . Schools of social work are not vocational training institutes for any one field of professional practice, nor will universities or the accrediting bodies permit them to become such distorted entities.

Mr. Banner. . .confus[es] clinical social work with the private practice of psychotherapy by social workers. This narrow constriction of function is. . .an insult to those thousands of clinical social workers who help individual[s], families and groups with problems. . .involving serious emotional distress. Whether they do so under agency auspices or in private practice is not an issue. . .they all deserve and need our help and attention. . .as graduate students and interns.

[The] mission [of schools of social work] is to prepare students for careers in . . .social work which will last until well into. . .the 21st century. We need all the . . .support we can generate. . .to accomplish this difficult mission. Mr. Banner['s comments]. . .serve to impede recognition of the broad based mission and competence of the social work profession to deliver on its mission.

We do not believe that Mr. Banner is speaking for the majority of members of the Clinical Society in asserting that entry into the private practice of social work requires modification of the values taught in social work school, many of whose faculty members are members of the society. To the extent that he speaks. . .for himself or for a narrow group, it may be necessary for him to correct the distortions in his own values in order to reidentify with the profession of social work.

If the leadership of the Clinical Society wants to affect the curriculum of social work education, they can. . .

1. Encourage their members to enter programs of doctoral education in social work so that they can apply for positions as full-time faculty members.
2. Help generate scholarship funds for social work students interested in clinical social work.
3. Examine school catalogs, and make suggestions for course offerings which they can help to evolve as field instructors and faculty members.

We remain interested in honest dialogue and constructive communication. . . .

William Pollard, PhD
Dean, School of Social Work
Syracuse University and
President, NYS Association
of Deans of Social Work Schools

BOOKS

Clinical Social Work with Maltreated Children and Their Families: An Introduction to Practice

Edited by Shirley M. Ehrenkranz, Eda Goldstein, Lawrence Goodman, Jeffrey Seinfeld; New York University Press, 1989, 211 pages

Reviewed by
Judith Adelson, CSW

This book is a reality-oriented guide to practice for the social worker who works with abusing families. The authors, on the staff at New York University School of Social Work, are clearly seasoned practitioners who know full well about the struggle to engage the involuntary, resistant client or what it's like to be a newly employed social worker with a large caseload of families in crisis. Child abuse is a frequent part of the terrain, and these clinicians are called upon to participate in life and death decisions, sometimes in an agency that fails to provide sufficient professional support and training. Here the authors have made sense of their hard-won clinical experience in the hope that each new social worker does not have to reinvent the wheel.

Fundamental Social Work Approach

The authors understand that national priorities are not focused on mitigating the current upsurge in the maltreatment of children. But this book is purposely clinical and not polemical. What is offered is a fundamental social work approach in work with abusive families that serves to make some clinical sense out of troubling and overwhelming case material. The worker does a broad-based assessment of "the client, the client's total milieu, and the service delivery network in relation to the needs of the client." What salvages this perspective from the yellowed pages of old notebooks from social work school is the authors' focus on worker empathy with the abusing client. "The ability to engage these parents requires the worker's empathy with their despair, which often may appear as apathy, hostility, distrust, and provocative behavior."

The lesson we all learned in Practice 101 — and perhaps tend to forget in the throes of actual agency work — is that the results of the assessment dictate appropriate interventive strategies. The authors, too, having traveled through the era of Reaganomics, seem to realize that the whole range of interventive strategies may not be available to each client. Still, it is of value to know which kinds of treatment have been most ameliorative to the abusive family. The chapters on individual, family and group work are peppered with clinical wisdom. An example is Judith M. Mishne's perspective that for the most resistive as well as for the most severely abusive families, individual treatment is the preferred approach.

Working with family violence puts the worker under special pressures. Equal support to the child and the parent is difficult, if not impossible, in family sessions. Each member of the system needs empathy and support in order to make something more than an unwilling and tenuous connection. Group therapy for some clients causes more acute disturbance, resulting in acting-out behavior.

The lesson we all learned in Practice 101 is that the results of the assessment dictate appropriate interventive strategies.

Sometimes clients who feel ashamed, humiliated, and guilty cannot tolerate public self-exposure and can be open and revealing only in the privacy of a one-to-one confidential contact.

Appropriate Interventions

The work offers useful clinical perspectives on a variety of subjects. The chapter on "Family Treatment" suggests that this modality is "suitable for mild cases of child maltreatment and is especially useful when specific familial interactions clearly lead to abusive behavior." The section on "Group Treatment" provides lucid guidelines in forming self-help groups for abusive parents and activity group therapy with maltreated children. The chapter on "Out-of-Home Care" acknowledges that placement outside the home is a radical intervention, but shows how the worker can be most supportive to parents and children through this traumatic upheaval. "Intervention with Maltreating Parents Who Are Drug and Alcohol Abusers" points out the high correlation between substance abuse and child maltreatment and offers subtle interviewing skills that may help the worker in piercing the abuser's denial.

Although a cornerstone of the book is the notion that, for the worker to intervene successfully with maltreating parents, s/he must develop empathy for their deprived and abusive pasts, it is also true that abusive parents can be extremely resistive.

Social workers need to use the authority of the agency and of the court . . . to motivate parents to change their behavior.

Thus, another thread that runs through the book is the need to use the authority of the agency and of the court firmly and sensitively to motivate parents to change their behavior. Similarly, in the "Group Treatment" section, there is a realistic discussion of how the worker can deal with the inevitable testing of limits that occurs within a group of neglected and abused children who are seeking to learn whether the worker will repeat parental patterns.

I found that the very low-key tone and the specificity of clinical purpose almost underplayed a subject which is usually so highly charged. The authors rightfully refuse to be polemical, but even they can't help mentioning certain programmatic changes — for instance, more coordination between agencies that treat substance abuse and agencies that treat child abuse. Also, excellent strategies offer the possibility of ameliorating social worker burnout. In general, however, the quietness of the book's tone allows the larger social questions to emerge in the reader's mind. Can't we do more than treat emergent, abusive family disasters? Isn't there a way to work on this enormous social problem more systematically? If and when national priorities are reordered, wouldn't it be wonderful for social work thinkers to be in the vanguard? This book, then, is as it is intended to be, a beginning.

Judith Adelson, CSW, is a school social worker at the Bronx High School of Science. She has a part-time private practice in Manhattan.

SUBSTANCE ABUSE *(continued)*

can provide needed encouragement. Many licensed professionals have recovered from addiction following their coming to grips with it and getting help to combat the problem.

Special Program for Professionals

Here's where we, as colleagues, come in. New York State has a special program for licensed professionals who abuse alcohol or other drugs but have not harmed a patient or client. The Professsional Assistance Program, protected by federal and state laws, assures confidentiality. Where the addiction has become grave, the program provides an opportunity for the licensed social worker to protect his/her license by applying for voluntary temporary surrender of the professional license while undergoing treatment.

Acceptance into the program is decided by members of the Committee for Professional Assistance who advise the Board of Regents and the State Education Department. The committee's members are professionals from several disciplines, the majority of whom have expertise in treating addictions.

The Professional Assistance Program provides an alternative to possible disciplinary action.

Seeking help from the Professional Assistance Program is an alternative to disciplinary action and the possibility of losing one's license. Those who enter the program agree: 1) to participate in a treatment program that is acceptable to the committee; 2) to be monitored for a minimum of 2 years; 3) to resume active practice of social work as soon as warranted.

The monitoring is designed to assist the individual with recovery while protecting the public, ie, the clients of the professional. As soon as the practitioner and the directors in the treatment program believe the participant is able to resume active practice, the professional may petition the committee to have the license reinstated. That reinstatement will be accomplished as quickly as possible. Now is the time to help oneself or a colleague. For further information, please feel free to call [the author] at 212-879-4736 or telephone or write to the Office of Professional Practice, Cultural Education Center, Albany, New York 12230 (518-473-6809). All inquiries will be confidential.

Patricia Morgan Landy, CSW, BCD
Board Member - New York State Board for Social Work

Executive Director Appointed

An executive director for the NYS Society has been appointed. Sue Heller began her tenure October 21. Her background includes administration and management in both the private and not-for-profit sectors as well as extensive marketing experience.

Ms. Heller is the successful candidate following a 6-month search process by a select committee and the Society's board.

A profile article will appear in the Spring issue. Welcome, Sue Heller!

MARKETING *(continued)*

failure; however, more of the control and decision-making is with the therapist.

Where to Start

1. Start with an audit of current practice. Where do current referrals come from? Has there been a change over the years? How are you perceived by referral sources? What kinds of cases do they refer?

Stay aware of the changing practice environment. Are there developing trends in services that clients desire?

2. What is the target number of new referrals? How many are needed to break even? to expand?

3. Develop a personal "marketing mix," and continue this strategy for at least a year. Don't give up!

4. Stay aware of the changing practice environment. Is managed care limiting the number of patients who are free to choose their own practitioners? Are there developing trends in services that clients desire? How does the social work profession respond to competition, both from other mental health professions, and within its own groups?

5. Examine internal resistances: fear of failure, fear of success, inhibition about promoting one's self, fear of competition, dependency/passivity conflicts, risk-taking styles, etc.

6. Consider that private practice in this current changing environment may not be best or may be workable only on a limited part-time basis. Perhaps you would prefer an agency job after all, or to change career direction — or even to change careers. Private practice is running a business, and not everyone enjoys the headaches and risks of a business environment. Even though it is certainly possible to develop marketing skills, perhaps you really would prefer not to.

It is certainly possible to develop marketing skills; perhaps you really would prefer not to.

7. Marketing is an ongoing necessity. About 20% of time should be devoted to marketing/practice development activities and that part of the fee ("profit") should be allotted to ongoing practice development.

8. Count reading this article as the first step!

Dolores E. McCarthy, CSW, is a psychotherapist in private practice in Manhattan and an EAP consultant. She is on the faculty at Fordham University School of Social Work. Her Advanced Professional Certificate in marketing is from New York University Business School.

Slate of Officers

Following is the slate of officers for 1992-1993 proposed by the nominating committee headed by Neil I. Teicher, CSW. A secret ballot, along with a summary of credentials of each candidate, will be mailed to members not later than November 17. All will serve 2-year terms beginning January 1, 1992. At this date a slot remains for member-at-large.

Office	Candidate
First Vice President	Marsha Wineburgh, CSW (Met)
Recording Secretary	Shayne L. Raze, CSW (Bklyn)
Treasurer	Allen A. Du Mont, CSW (Queens)
Members-at-Large	Jacinta (Cindy) Marschke, PhD (Mid-Hudson)
	Rhoda Green, CSW (West)

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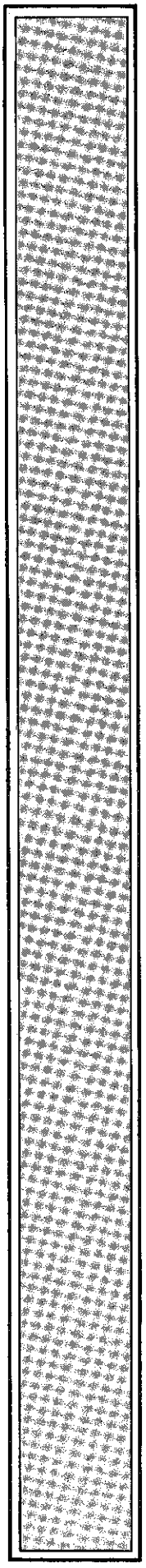

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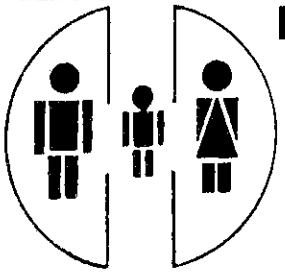

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