CSWP NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. WINTER 1985 • VOL. XVI, NO. 4

# Additional Regulation of Profession Planned

*By Marsha Wineburgh, CSW*
*Legislative chair*

Assemblyman Mark Alan Siegel, a sponsor of our parity legislation, held a public hearing in October as chair of the Higher Education Committee to hear testimony on A.8293, a bill to regulate all mental health practitioners in New York State. In addition to the Society, witnesses included 9 other mental health, education and substance abuse organizations.

There are an estimated 30,000 mental health practitioners currently charging fees for "psychotherapy services" who are not certified as social workers or psychologists or licensed as nurses or physicians. Because regulation of the mental health field in New York State has been piecemeal, some areas of mental health practice have no legal regulation at all. Persons may call

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# Federation Establishes Goals at Fall Meeting

*Report by Jacinta L. Costello, Ph.D.*
*NYS President*

The Federation held its fall meeting in Los Angeles on October 23-25 with the following representatives from New York: Marsha Wineburgh, Federation past president; Crayton E. Rowe, Jr., chair, committee on psychoanalysis; Hillel Bodek, co-chair of the forensic committee; and Dr. Cindy Costello, New York State president.

A primary goal was to review the Federation's past efforts and direction and to arrive at a consensus regarding future priorities and objectives. To achieve this, one full morning was devoted to goal-setting workshops. The board broke up into small groups to discuss proposed goals; all groups then reconvened to review their work and achieve consensus. The following five goals were adopted:

1. To provide national level advocacy for clinical social work;
2. To promote the development of legal regulation (certification, licensure) and endorship in all states;
3. To establish a national Federation office;
4. To strengthen clinical social work education;
5. To promote marketing and public relations for the clinical social work profession.

The board again divided into groups to explore ways to implement the goals. These strategies were reviewed with the entire board, and specific committees and/or board members were appointed to pursue further planning and report back at the spring 1986 meeting in Washington. The experience demonstrated clearly that, in spite of regional differences, Federation board members are unified regarding their expectations for the future. Now the hard work of realizing the goals begins.

The remainder of the meeting was devoted to reviewing the work of standing and ad hoc committees; highlights of committee reports follow.

**Public Relations**—The new Federation brochure was presented to the board and initial plans for a national public relations campaign were reviewed.

**Membership**—Delaware achieved full member status, bringing the total to 28 states. Other states carry affiliate status and hope to upgrade to full status.

**Forensic**—The committee has contacted the American Academy of Forensic Sciences and the American Academy of Psychiatry and Law to initiate a relationship and ongoing communication. In addition, the committee invites NASW to work with it to develop standards and certifying criteria for forensic social work. A proposal was distributed which defines this specialty; this will be reviewed by all states and presented for a vote.

**Peer Review**—This committee had been assigned to investigate the possibility of

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# Special Meeting Explores State Needs

## Public Relations, Education Among Primary Needs

*By Bobba Jean Moody, CSW*
*Chair, Five Year Planning Committee*

The November board meeting, held in Manhattan, was devoted to a structured workshop to establish goals and priorities for the Society. This special meeting was an outgrowth of recommendations coming from the September meeting of the five year planning committee with committee chairs, chapter presidents and other chapter representatives. Chapters had been asked to send to the November meeting at least as many representatives as there are votes on the Board (Met, 3 votes; Nassau and Westchester, 2 votes; all others, 1 vote). Most of the representatives at the September meeting believed that their members desired more services for their money and would support changes to realize that end. A variety of suggestions came from the September meeting regarding sources of revenue, ideas for specific strategies and a consensus that, as a group, the Society should set goals before any specific strategies or changes could be adopted. Further, once priorities were established, the mandate of the planning committee could be more clearly defined.

Those present divided into five groups, each composed of a mix of the 30 members present from all chapters. The first task assigned was (a) to develop a concise statement of purpose for the Society in current operational terms; and (b) to list and rank the 5 most important objectives for the next 12 months and for the next 5 years. The groups came back together to report on their results. Once all the groups had reported and common objectives were pooled, it was

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# EXECUTIVE REPORT

## A Look Back. . .

It does not seem possible that my two years as president is coming to an end. The experience has been stimulating, at times taxing, and certainly rewarding. In reviewing the highlights of the last two years, the final passsage and now implementation of the parity bill clearly has been center stage. Under Marsha Wineburgh's leadership and the ongoing support and hard work of so many members, we finally did it. It has been a great honor to serve during this period of achievement and to participate in the slickest celebration party the Society has ever organized.

Now we have to redirect our efforts to ensure that outpatient mental health services are continued as part of existing medical insurance plans, and to foster the inclusion of clinical social workers as reimbursable vendors among self-insured employers.

The membership campaign which began under Peggy Isbell's tenure proved to be an extraordinary success. Since our original mailing in September 1984, over 240 new members have joined the Society. Furthermore, a great number of the new members are from outlying areas. Both the growth in numbers and representation from all over the State enable us to impact more effectively on clincial social work issues.

The expanded scope and breadth of our newsletter also demonstrates the increased need for a forum and vehicle to share relevant information. Barbara Pichler and Alyce Collier should be applauded for their efforts and success in adding the conference and book review sections, increasing our newsletter revenues through additional advertising, and stimulating David Phillips and Hillel Bodek to contribute regularly through their ethics and legal columns.

David and Hillel have also begun the process of reviewing our adjudication procedures and, after consultation with the Society's legal counsel, will be making recommendations to the board in December. A viable and sound adjudication process is crucial to the profession; otherwise we leave ourselves open to control and regulation from external sources.

One of the more significant achievements of the past two years is increased communication and collaboration with the State Board for Social Work. Since parity we have been actively involved in the development of regulations for the implementation of the social work vendorship bill and, although we were not able to realize all of our expectations, we were successful in some major compromises. We are also pleased that Patricia Landy, a long-standing active member and clinician, was appointed to the State Board this past spring.

Finally, the State Board appealed to us to arrange workshops with our members to draft clinical questions for the NYS certification examination. Three such workshops have been scheduled. Our continued participation in the development of the CSW exam will assure that adequate measurement of recent graduates' clinical knowledge and skills does occur.

One of the first issues I had to address when I took office was malpractice insurance. As you all remember, the policy we had procured from J.J. Negley left a lot to be desired. Though the experience was difficult, the board and I learned a lot about the field of liability insurance and ultimately were successful in finding a policy with the American Professional Association which provided comprehensive coverage, offered our members an alternative to the NASW policy (where membership in the latter was required) and, for the first time, gave the Society and Federation a chance to establish our own experience record.

The insurance dilemma, growth in membership and increased demands for State Board involvement in clinical issues such as peer review, education and legislative activities also necessitated that the board review our present goals and organizational structure. All board members, committee chairs and interested members met on November 9th to review and establish goals and strategies for the immediate future as well as for the next five years. Please refer to the related article in this newsletter for the results of that meeting.

While the above discussion does highlight some of the major activities we have pursued over the last two years, it in no way captures what that experience was like for me emotionally. Writing this report gave me a chance to step back from the operational details and reflect on the experience overall. If I had to identify one reward for all of the work, it would be the close personal relationships that have evolved since I took office. I am particularly honored to have worked with Mitzi Mirkin. She was always there when I needed her, provided ongoing emotional support, and pulled things together when it did not seem possible. Thank you Mitzi for everything. I would also like to thank Bobba Moody for her patience, support and friendship. In her quiet manner, she consistently provided balance, perspective and warmth. While Bobba will be stepping down as an officer, she has agreed to continue as chair of the five year planning committee.

Finally, I would like to thank the board members and committee chairs and their members for making it all work. You made my job a lot easier.

*Jacinta L. Costello, Ph.D.*
*President*


CSW

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**ADDITIONAL REGULATION** *(continued)*

themselves psychotherapist, psychoanalyst, marriage and family therapist or counselor independent of training, level of competence or experience. The proposed legislation would "enable the public to identify private practitioners with a greater assurance of minimally competent services."

Such legislation would apply to all persons providing mental health services to the public for a fee. It essentially establishes a generic mental health title of "mental health professional" and 3 specialty titles: "professional counselor," "marriage and family therapist," and "psychoanalyst." Certified social workers, psychologists and licensed physicians are exempt from qualifying as "mental health counselors," but all who wish to use the title "professional counselor," "marriage and family therapist," or "psychoanalyst" would have to meet the

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# CONFERENCE NOTES

## "Expanding Worlds of Family Therapy" Focus of AAMFT Conference

*Report by Ed Siegel, CSW*

The 43rd Annual/2nd International conference of the American Association for Marriage and Family Therapy took place in October in New York City, featuring presentations by renowned family therapists from this country and from 14 others. In addition to a variety of sessions and workshops, participants were invited to attend one of five live Master Consultations with families, as well as a networking luncheon.

Featured at the opening session was Dr. Mara Palozzoli-Selvini who spoke on "Towards a General Model of Psychotic Family Games," and who received the award for "Distinguished Contribution to Research in Family Therapy."

In "Systemic Interventions in the Treatment of Chronic Obesity and Alcoholism" Dusty Miller, Ed.D. and Jill Harkaway, Ed.D. (using taped excerpts from treatment sessions) introduced their framework for assessing and treating couples and families in which obesity and alcoholism have defied traditional treatment methods. Their focus centers on exploring the meaning of symptomatic behavior for the family system and on examining the patient's and family's belief system (as well as that of the helper) in terms of the "symptom" and how they view helping relationships. Both therapists discussed and demonstrated various traps or self-defeating sequences in which clinicians and patients may find themselves and offered suggestions for their prevention.

***The thrust of this presentation emphasized "empowering the patient" in an especially difficult treatment population.***

Harkaway and Miller attempt to take a neutral position with regard to a symptom: to ask, "when did you start to believe that this is a problem?" rather than "when did this become a problem?" Taped sessions illustrated strategic interventions for enacting their treatment plan; these clearly derived from a careful understanding of what was being defined as a problem and by whom. The thrust of this joint presentation emphasized empowering the patient—especially in these populations, often not empowered by helpers. Clearly, this approach is applicable to other patient populations.

In "Mourning Magic: A Marital Approach to a Developmental Crisis," Judith Siegel, Ph.D., assistant professor at Jane Addams College of Social Work, discussed marital problems related to the failure of one or both members of a couple to resolve the developmental tasks of early adulthood, particularly the difficulty in mourning the loss of adolescent grandiosity and omnipotence. She referred also to the difficulty in giving up the narcissistic identification derived from adolescent peer groups to enter into adulthood and a dyadic relationship with a marital partner, referring to the movie "Diner" as an example. Thoughout this presentation—refreshingly clear, good humored and perceptive—Dr. Siegel drew on cinematic and literary references that brought her points to life.

***Assigning "irrational" roles to spouse is often the result of ongoing adolescent needs.***

She detailed how the difficulty in negotiating this developmental phase often resulted in projection onto the spouse in various ways through the assignment of irrational roles, i.e., experiencing the other inaccurately according to one's own needs: as object substitute, ideal self, devalued self, etc. Such situations are especially evident in narcissistically vulnerable people.

Dr. Siegel's treatment approach involves redefining feelings of anger and grief as related to the life stage; stopping their projections immediately; stressing individual boundaries; and helping the patient to get in touch with these feelings of grief, anger and loss. She does this in the context of the couple and believes, once the therapist is able to tap into this pain of loss, that spousal projections begin to subside. The role of the spouse then changes to the more realistic one of valued friend and source of support.

Dr. Arnon Bentovim of the Hospital for Sick Children in London; England, worked with a couple in a live interview seen by a large audience via closed circuit TV. Prior to and after the consultation Dr. Bentovim—along with the couple's regular therapist and a respondent—discussed with the audience the dynamics of the family situation and what he had attempted to do. Since the entire family was not present, his intervention with the couple was clearly designed to "bring the family into the room." From the outset, he utilized circular questioning, i.e., asking the woman, "if your son or daughter were here with us, what would they say that they would like your husband to change?" This served the additional purpose of providing the couple with a somewhat less threatening way of talking about their own pain.

Dr. Bentovim also utilized quite sensitively the technique of reframing the family member's behavior in positive terms, such as relabeling the husband's "pessimism" as his way of being prepared. This was offered in an exceedingly genuine way, and Dr. Bentovim stressed that this sort of intervention should be utilized only when it can be offered genuinely.

*After receiving his MSW at Michigan State University School of Social Work, **Ed Siegel** returned to New York to work with Big Brother, Inc. He then worked with Jewish Family Service/Jewish Board of Family and Children's Services for more than 8 years, the last 3 serving as coordinator of counseling services for senior citizens and their families. He now maintains a private practice in family therapy and serves as chair of the legislative action committee, Brooklyn chapter.*

## Dues For 1986 Increased

To meet the needs of a growing Society, the executive board has voted to increase dues as follows:

Diplomates, Fellows and Members, from $100 to $125;

Students, from $50 to $60;

Sustaining Members, from $20 to $30.

In addition, a late fee of $10 remains for any member whose payment is postmarked after February 1, 1986, to defray the extra costs involved in backtracking procedures.

There has been no increase in dues for Diplomates and Fellows in more than 8 years, and it was 1981 when Students' and Members' fees were last raised. In an era of rising costs, we have done our very best to continue to provide high standards of service. As always, we anticipate your understanding and cooperation.

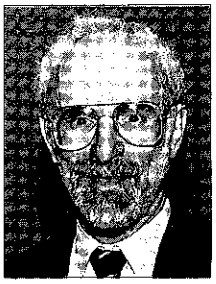
*Mitzi Mirkin*
*Executive Secretary*

## A QUESTION OF ETHICS

# Fee Splitting Takes Many Forms

## The Patient Always Loses

*By David G. Phillips, DSW*



In the increasingly complex and competitive world of psychotherapy practice, among the most common ethical and regulatory violations are those that involve fee splitting. Fee splitting is prohibited by the ethical codes of all major professional associations, and by the Rules Relating to Definitions of Professional Misconduct of the New York State Board of Regents, which defines it: ". . .directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services."

***Part of the client's fee is for a "service" of which the client is not aware.***

In the most blatant type of fee splitting, one professional will offer to refer a client to another in exchange for a set fee or for a percentage of the fees paid by the client. In this type of situation part of the client's fee is going to someone who is not providing a direct service to the client—for a "service" of which the client is not aware. It is to be expected that most professionals would recognize such an arrangement as clearly unethical, but many of us might have more difficulty in seeing the violations in the more complex arrangements that may exist between individuals and organizations. Of the latter arrangements, at least three types have been found to be in violation of prohibitions against fee splitting.*

In one kind of arrangement, found to be a fee-splitting violation by the Division of Professional Conduct in New York State, an institute or center would advertise evaluation and referral services and then refer clients to practitioners who were affiliated with the center and who paid a fee of some kind for that affiliation. A second type of arrangement, also constituting a violation, is that in which a practitioner rents space in a facility and the rental fee consists of a percentage of the income received by the practitioner. This is the type of operation that characterize the infamous "Medicaid Mills."

***Clinicians should monitor professional arrangements to prevent concealed violations.***

In a third, and more complex type of arrangement which might lead to fee-splitting violations, the client is originally seen in an institute where the provision of training is the major function. In such a setting, the major goal of the treatment program is the provision of clinical experience to the students in training. Treatment may be conducted either in the institute's facility or the therapist's office, and the therapist is supervised on the treatment of the client. "Fee-splitting violations tend to occur in this situation when the client is seen at the office of the student-therapist to whom the client pays the fee directly. The student-therapist then pays the institute for the supervisory services. In some cases, the supervisory services gradually phase out over a period of a year or two, but the student therapist is expected to pay a portion of his fee for as long as he continues to see that patient, ostensibly on the grounds that the patient was still a patient of the institute. This is clearly a fee-splitting violation."*

Only a few of the possible professional arrangements which might result in fee-splitting violations can be reviewed here. Specific arrangements between practitioners, their colleagues, and various treatment, training, and referral centers are complex, and possible violations are not always readily apparent. Clinical social workers should be familiar with regulations and ethical codes and must review professional arrangements to determine whether there may be concealed fee-splitting violations.

**Berger, Morton: "Ethics and the Therapeutic Relationship: Patient Rights and Therapist Responsibilities" in Rosenbaum, Max (ed)* Ethics and Values in Psychotherapy: A Guidebook, *The Free Press, 1982.*

***Editor's Note:*** *For the past 3½ years David G. Phillips, DSW, has addressed a variety of ethical issues—with discerning judgment, an able pen and an enlightened sense of integrity. This is the last issue in which the column will appear as a regular feature; other projects and interests make increasing demands on his time.*

*We are sorry to lose David's valuable contributions—and invite a "guest" column whenever possible.*

# Committee on Psychoanalysis Meets With APA

As part of its continuing effort to protect clinical social workers in their practice of psychotherapy and psychoanalysis, the Federation's committee on psychoanalysis met in October with Ernest Lawrence, Ph.D., past president of Division 39 (Psychoanalysis) of the American Psychological Association to discuss ways the two organizations could work together in advancing standards and practice.

Dr. Lawrence is also a member of the steering committee of the Group for the Advancement of Psychotherapy and Psychoanalysis in Psychology. This organization has brought antitrust litigation against The American Psychoanalytic Association to allow psychoanalytic training for psychologists. The suit is presently awaiting a ruling, and it was suggested that the National Federation could be helpful as a participant in the suit.

In addition to meeting and planning with national mental health organizations to protect the right of CSWs to practice the full spectrum of psychotherapy, the committee on psychoanalysis is currently focusing on how the Federation can lead the way in providing psychoanalytic education nationwide. For example, the board has accepted the committee's proposal for a revision of its bylaws to allow for voluntary contributions to individual committees for their use. Contributions will make it possible to keep pace with other mental health organizations that assess additional dues from members who wish to belong to a division or subspecialty within an organization.

*Crayton E. Rowe, Jr.*

# Ad Rates Increase (Modestly)

For the first time in 6 years, advertising rates will increase for the Society's *Newsletter*. The membership circulation base is now approximately 1,500—more than twice that of 1980, when current rates were fixed.

Beginning in 1986, advertising rates will be:

| | |
|---|---|
| ½ page | $250 |
| ¼ page | $125 |
| ½ column | $ 85 |

The classified rate minimum will be $30, or $1 a word, whichever is greater.

# BOOKS

**Mastering Resistance: A Practical Guide to Family Therapy**
***By Carol M. Anderson and Susan Stewart***
***The Guilford Press, 1983, 259 pages***

*Reviewed by*
*Elizabeth P. Marshall, MSW, ACSW*

Though *Mastering Resistance* is written primarily for family therapists, there is much to learn here of relevance to those clinicians of any theoretical base who are interested in a broader view of resistance and how family systems thinkers use it and respond to it in therapy. As the authors state, ". . . resistance is a major component in any form of therapy. In family therapy it is complicated by the number of people involved, by the variety of subtle forms it takes and the ease with which the therapist can perpetuate or even encourage a family's resistance to change." The authors have avoided any particular theoretical approach to family therapy and reflect the eclectic and often pragmatic way in which it is practiced. They explore first the development of the concept of resistance and the positions on it held by different types of therapies—which reflect how it is used in therapy.

A brief history of resistance and healing includes the Shamans (whose indoctrinal incantations and rituals depended on their patient's belief and expectations of cure for success), a review of Freud's thinking on the function of resistance in the service of the client's needs, and current psychoanalytic thought about the resistance of the therapist. Briefly but clearly outlined are the short-term therapies and the handling of resistance by various theorists such as Ferenczi, Rank and Sifneos, Mann and Davanloo. The authors also cover the behaviorist and cognitive approaches before summarizing the various approaches of family therapists, including their own views.

Anderson and Stewart point out that family therapists are on a continuum from psychodynamic and object relations theorists to the behaviorists of MRI (Mental Research Institute of Palo Alto), noting that both groups regard resistance as highly significant and take explicit and clear positions on handling it. The clear and concise manner in which the authors outline the basic working approaches of the various schools of family therapy is a valuable contribution. The meaning of symptoms and view of pathology are outlined according to the particular theorists or schools (such as the structural, strategic or behavioral). The reader unfamiliar with this territory will find much to explore. To the initiated the authors have done a real service in presenting, briefly, a clear comparison of what is current in a field in which therapists often feel out of date and overloaded by the many new approaches and techniques available.

The authors define resistance as "all of those behaviors in the therapeutic system which interact to prevent that system from achieving the family's goals for therapy." The therapeutic system includes the family, therapist, and the context in which therapy takes place, i.e., the agency or institution in which it occurs. The book then focuses on resistance in each part of the system and offers a wealth of "how to do its" for mastering resistances as they are unmasked and observed in a multitude of examples. Some of them are quite humorous and all are familiar. From the initial resistances experienced in first contacts between family and therapist, to what the authors call "contact related resistances" and "common resistances in ongoing treatment," the book gives excellent case examples; these can reduce anxiety in beginning therapists and illuminate both them and their more experienced peers. Chapter Six, titled "Resistances Produced by Helping Systems," includes an interesting overview of both therapists' resistance to clients and to the institutions where they practice, and institutions' resistance to therapists and the larger systems. There is excellent and often amusing advice on how to overcome these common stalemates.

In general the book will probably be most useful to the clinician newly engaged in family work or those interested in reviewing or expanding their knowledge of a family systems approach. To my mind it should be assigned reading for all students of family therapy. Experienced family therapists will find it well written and researched and a practical review of what they probably already know, but may have forgotten.

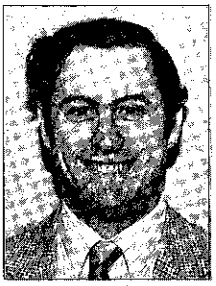
Because of the "how to do it" simplicity and clarity of the format at times, it might be easy for some to dismiss or miss the real contribution that the book makes to the family therapy literature. Ms. Anderson and Ms. Stewart are to be commended on making this the "piece de la résistance."

*Society Fellow* ***Elizabeth P. Marshall, MSW, ACSW,*** *was adjunct faculty member of Adelphi University School of Social Work, where she taught family therapy. Presently in private practice in Roslyn Heights, she is on the staff of the Flushing Hospital Mental Health Clinic in Queens and a clinical member of AAMFT.*

# IN BRIEF

## Evaluation of Mental Disability

*By Hillel Bodek, CSW*



Emotional disorders can have major impact on one's ability to function adequately at work on a regular basis. The determination as to whether a person is thus impaired and, if so, to what extent, is a clinical-legal question that arises in everyday mental health practice.

The criteria for the determination of mental disability differ based on the circumstances in which the issue arises. Such circumstances include eligibility for disability benefits (some define disability in terms of the person's usual work, others in terms of ability to engage in any gainful work for which a claimant is suited by training and age); workmen's compensation laws; employer benefit plans; Social Security Disability; SSI and public assistance. Criteria include whether the disability is partial or full, the expected period of disability and its causes.

***Criteria differ for determining mental disability.***

Most often, clinical social workers address the issue of mental disability as it relates to SSI and Social Security Disability (SSA) benefits. To be eligible for such benefits as a disabled person, the individual must be "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . .which can be expected to result in death or which . . .can be expected to last for a continuous period of not less than twelve months." (20 C.F.R. 404.1501.)

In determining whether a person is disabled for SSA/SSI benefits, the nature and extent of the disabling condition(s), the residual functional capacity of the person

despite the disorder, the age, training and work experience—as well as the kinds of work that exist in the national economy for an individual in the disabled person's situation—must be considered.

Assessment and reporting the clinical status requires a different format from the traditional examination and reporting process. The focus of the disability evaluation is to set forth how the patient's functioning is impaired and explain how symptoms are related to the impaired functioning.

The diagnosis of major mental illness (i.e., schizophrenia, bipolar disorder) does not justify a determination of disability. It is necessary to demonstrate how the disorder imposes limitations on the patient's ability to work as reflected by (1) daily social and occupational activities; (2) range of interest in his/her environment; (3) ability to take care of personal needs; and (4) ability to relate to others.

***Diagnosis of major mental illness does not justify a determination of disability.***

The disability report should outline:

1. the nature of the relationship of the examiner to the patient;
2. a brief review of the patient's educational, social, medical, psychiatric and occupational history;
3. a brief review of the history of the patient's present illness, with particular reference to the development of limitations in the patient's ability to work and otherwise engage in usual daily activities;
4. a mental status examination detailing the pathological symptoms and their impact on the patient's ability to function;
5. a description of the patient's current level of daily functioning, how it is impaired, specific examples of such impairment; and
6. a prognostic statement of the projected course of the patient's disabling condition and of the extent to which the patient may be able to resume participation in some substantial work activity in the future.

Too often, disabled persons obtain their disability benefits only after an appeal because the report that was relied upon to make the initial determination, though accurate and comprehensive, failed to described how their everyday functioning was impaired as a result of the diagnosed disorder. The key to a useful disability report is to describe how the patient's ability to work and function on a daily basis is impaired in functional rather than diagnostic terms. □

# Events Calendar

## Society Chapter Events

**BROOKLYN**

**January 12** ..... **Working with Families of Alcoholics**
Carol Becker, CSW

**February 9** ..... **Therapy With Children**—Jerome Pollack, M.D.

**April 13** ..... **Brief Psychotherapy**—Monica Pierrepointe, CSW

**May 18** ..... **Heterosexual Therapists Working With Homosexual Patients**—Edward Dunne, Ph.D.

*Information: Jerry Agate—718-941-4724*

**WESTCHESTER**

**March 1** ..... **New Directions in Working With Dreams**
Helene Fagin, Ph.D., CSW

**May 3** ..... **How to Establish and Maintain a Therapy Group in Private Practice**
Ruthe Feilbert-Willis, CSW; Phyllis Gordon, CSW; Adrienne Starkman-Resnick, CSW

*Information: Elaine Bieber—914-241-2790*
*Rhoda Green—914-946-4206*

**March 20-22** ..... **The Orton Dyslexia Society** 13th Annual Conference
*Penta Hotel, NYC—212-691-1930*

**January 31; February 28; March 14; April 18; May 16; June 13** ..... **The Women's Therapy Centre Institute**
Lecture Series—The Edible Complex: a feminist view of compulsive eating disorders.
*NY Academy of Sciences, 2 East 63 Street, NYC.*
*7-9 p.m. $20 each, $100 series.*

**January 31-February 1** ..... **Ackerman Institute for Family Therapy.**
The Many Roads to Change: Models of Therapy, Models of Supervision.
*Barbizon Plaza Hotel, NYC.*
*$125; $110 group; $90 alumni. 212-879-4900.*

**January 10; February 7; March 7; April 4; May 2** ..... **The New York Freudian Society, Inc.**
Schedule of Scientific Meetings.
*NY Academy of Medicine, 2 East 103rd Street, NYC.*
*212-348-1230.*

**January 17; March 21; April 18; May 17** ..... **Institute for Psychoanalytic Training and Research (IPTAR)**—Program of Scientific Meetings
*Academy of Medicine, 2 East 103 Street, NYC*
*8:30 p.m.—212-427-7070.*

**January 15; February 19; March 19; April 16** ..... **Association for the Advancement of Psychoanalysis**
Program of Scientific Meetings: Contributions of Psychoanalytic Theory and Practice.
*329 East 62 Street, NYC—212-752-5267—8:30 p.m.*

**May** ..... Annual Karen Horney Lecture

**January 17; February 7; February 28; March 14; April 11** ..... **The Associates of The Training Institute for Mental Health Practitioners**
Film Program, Discussions
*40 East 30 Street, NYC—7:30 p.m. 212-291-2961*
*$5 nonmembers; $2.50 senior citizens, students.*

**SPECIAL MEETING** *(continued)*

realized that the five groups had defined and agreed on exactly five objectives as those most important for the Society.

Then, again in small groups, each developed a strategy and action plan for two objectives. Completing this, and reassembling, each group again reported. The general consensus of those present emerged, noting pros and cons of strategies. Step five was general comment and discussion and an action plan for further refinement.

The results of the workshop showed remarkable consistency and consensus in developing a concise statement for the Society in operational terms and in delineation of the goals on which the Society should focus, both short- and long-range. The five goals arrived at (not yet assigned priority) were:

1. Public Relations – including improving our public image and developing liaison with other professional groups;
2. Promoting education across the state –

*continued on page 7*

## SPECIAL MEETING *(continued)*

both graduate and postgraduate;

3. Legislative Advocacy – including protection of the profession, maintaining legislative gains, licensure;

4. Increasing membership and number of chapters throughout the state, and increasing membership benefits;

5. Promoting a more efficient state administration – dissemination and coordination of information among chapters, avoidance of duplication, development of subspecialties, perhaps an executive director.

The integrated statement from the group was: "to advance the practice of clinical social work in New York State through improved graduate and postgraduate education, public relations and legislative advocacy."

The board requested that the planning committee proceed with further revision and analysis of the above goals and strategies and submit recommendations for implementation. Members are encouraged to share their reactions, to provide input to their board representatives and/or to the five year planning committee itself. □



## ADDITIONAL REGULATION *(continued)*

education and practice requirements outlined. A State Board for Mental Health Professionals would be appointed by the Board of Regents and would oversee certification, accreditation of academic and training programs and professional conduct.

The Society voted unanimously to support legislative efforts to ensure public access to quality mental health services, and to support the legislature's efforts to assure that persons providing mental health services are properly qualified to do so. This particular legislation presents several problems, as indicated in the Society's testimony.

While the bill exempts certified social workers, psychologists and physicians from registration to practice as mental health professionals and allows them to supervise the qualifying experience required for such registration, it does require these exempt professionals to register in order to use the titles "psychoanalyst," "marriage and family therapist" and "professional counselor." This would mean that social workers would be required to be certified by both the State Board for Mental Health Professions as well as the State Board for Social Work if they wished to identify themselves as "psychoanalysts," etc., and also to maintain *P* and/or *R* vendorship status.

The educational standards proposed in this legislation lack specificity and fail to guarantee a consistent high level of education and training for the persons proposed to be certified as mental health counselors. No specific level of education is required. With regard to specialty titles, although training in institutes chartered by the Board of Regents is recognized, there is no ongoing management to assure quality curricula nor are there currently any uniform standards for training.

Prior mental health legislation has recognized the need for extensive supervised clinical experience beyond entry level certification. Under existing state law, social workers must have 3 years of postmasters supervised psychotherapy experience to qualify for optional insurance reimbursement for the mental health services they provide. This is in addition to 2 years of supervised experience required to earn a master's degree in social work school. This proposed bill requires one year of training and does not specify when this internship experience should be obtained nor the number of hours which constitute one year of training.

For further information on A.8293, contact your chapter legislative chair. □

## FEDERATION *(continued)*

sponsoring a National Clinical Social Work Peer Review Board. Such a board would select, train and reimburse peer reviewers; in questionable cases, evaluate the appropriateness of claims; monitor and evaluate the quality and efficiency of peer reviewers' work. Several plans to pursue this proposal were presented and will be considered at the spring meeting, after board members have had a chance to review it with their respective state members.

**Psychoanalysis**—(See committee report, page 4.)

**Ethics and Bylaws**—Recommended changes for both ethical standards and bylaws were approved to simplify the content, and achieve content consistency.

**Licensure/Vendorship**—Presently 36 states have some type of regulation, and 16 states have vendorship for clinical social workers. The committee continues to serve as a resource for all states pursuing regulation and/or vendorship and has proposed a Federation position paper. Gary Unruh has requested that all states provide feedback by February, to be integrated into a final proposal offered to the Federation board for a vote in May '86

**Education**—This committee has represented us at the planning meetings for the international Conference on Clinical Social Work to be held in York, England, in August 1987. Further information will be forwarded as it becomes available.

**Capital Reserve Fund**—This committee's fundraising activities have developed a solid financial base from which Federation operating expenses can be drawn. To date it has accumulated more than $10,000; New York State has been the most generous contributor.

**National Advocacy**—Ken Adams, national advocate, reported on the progress of Mary Rose Oakar's (D-Ohio) proposed bill to reform the FEHBA, mandating vendorship for CSWs; so far this bill has not fared well. It so happens that the present FEHBA carriers have, effective December 1984, accumulated a $2 billion surplus which they would like to return to beneficiaries through a rebate. This cannot be done without amending the present FEHBA. Therein lies opportunity! Mary Rose Oakar has attached several reform proposals to the rebate amendment. One of these reforms mandates reimbursement for CSWs. And, although there are problems with the terms of reimbursement, the bill has passed the House—and there is good chance for passage in the Senate and signing by the President.

**Postscript**—A reprint from the *Social Science Review*, March 1985: "Psychotherapeutic Outcome and Professional Affiliations" reviews the research on the differential effectiveness of the 3 major mental health disciplines: social work, psychology and psychiatry. The review of 7 studies covering 1,200 patients suggested that essentially equivalent results are achieved by all.

**Finally**—This was my last Federation meeting as New York State president. It was a pleasure to serve as your representative and a delight to be with so many topnotch clinical social workers throughout the country. □

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