NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. SUMMER 1991 • VOL. XXII, NO.2

Surviving in Tough Times: The Economics of Practice in the 1990s

Marketing Experts, Workshops Provide Current Data at Annual Conference

Report by
Diana List Cullen, CSW, BCD

The annual membership meeting of the NYS Society began with a warm welcome to the almost 200 attendees by Carole Ring, PsyD, education committee co-chair. She spoke briefly about what makes for the current "tough times" — heightened competition, a poor economy and increasing intervention from purchasers of mental health services. The day-long conference, "Surviving in Tough Times," was structured to help clinical social workers confront and learn to survive — indeed, to flourish — in these times. Experts in all facets of marketing were on hand, as speakers and workshop leaders, to provide a concentration of expertise to Society clinicians. An institute and book fair ran throughout the day. Following is a report of the morning program. After lunch, workshops addressed a variety of practice issues in the context of the present "tough times."

President Philip Banner extended the society's welcome to all present. Among attendees, he recognized and acknowledged past president Adrienne Lampert, CSW, BCD, current president of the National Federation; David G. Phillips, DWS, president-elect; and Alyce J. Collier, Newsletter editor. Mitzi Mirkin, executive secretary of the Society, received special recognition and appreciation for her continued outstanding service to the Society.

Banner reported that liability insurance is now available through National Federation to all social work psychotherapists, not just Federation members. A health insurance package is currently being explored and, hopefully, it too will become available soon.

An update of other activities of Federation and the New York Society included

- the upcoming Federation 20th Anniversary Clinical Conference in Chicago, September 27-29
- the "retirement" as director of the national committee on psychoanalysis of founder Crayton E. Rowe Jr, to be succeeded by Rosemarie Gaeta
- the resignation in February of executive director John Odom and the search committee's active recruiting for a replacement
- attendance at the National Federation meeting in Washington and a meeting with NY's Congressman Charles B. Rangel (D).

Following President Banner's report,

continued on page 6

Practice Marketing: Issues and Strategies

By Dolores E. McCarthy, CSW

"Issues and Strategies of Practice Marketing" was presented at the NYS Society's Annual Conference on May 11. This is the first of a 2-part article.

The world of private practice is changing; CSWs have worked in agencies, taken advanced training and now we have to think in business as well as clinical terms. But, we're not alone. All the professions — law, medicine, architecture, and others — must accept this fact and address the issues of practice development or marketing.

Marketing 101

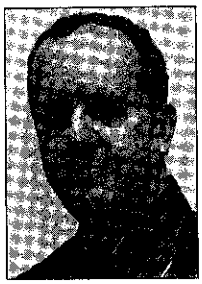
The formal definition of marketing is "Meeting consumers' wants and needs". This isn't far afield from a clinical perspective. What skills are necessary for good marketing? One could say, basic social work skills: assessment, communication and relationship skills.

In private practice, we have three "consumer" targets: the patients themselves, referral sources and third party payers such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations). Psychotherapy is often considered "surrogate" marketing, that is, marketing to someone other than the end-user consumer (the referral source or the HMO/PPO). To be successful, we must assess the wants and needs of these surrogate-consumers as well as the wants and needs of the patient-consumers. When we "market," we must determine which of these to select as primary targets.

continued on page 12

EXECUTIVE REPORT

Freedom, Competence and Entrepreneurship: The Struggle Continues



In early May this year, I attended the semi-annual board meeting of the National Federation in Washington, DC. President-elect David G. Phillips, DSW, accompanied me. During "time off" from board meetings Walter Alvarez graciously led Rosemarie Gaeta, Carol Tosone and myself to the Washington Monument at 11:15 pm. The view was reminiscent of Paris. On we marched, respectfully, to the Lincoln Memorial, at midnight. Lit up, it was awesome and stirring. The figure of Lincoln prompted associations of struggle and of freedom and emancipation. The next day Walter led the way to the Vietnam Memorial with its more than 58,000 names of Americans etched in marble. The emotional impact was indescribable. I tearfully watched relatives kneeling and paper-tracing the names of their lost loved ones. And I watched a group of children walking along the pathway, obviously unable to fathom the meaning and sanctity of their surroundings.

Remuneration should walk hand-in-hand with competence, recognition and respect.

With little talk and, I am sure, many private thoughts we continued on foot to the Tomb of the Unknown Soldier in Arlington, Virginia, arriving in time for the changing of the guard. Surveying the vast field of monuments, I considered the high price of freedom and liberty and the controversies around all wars. Certainly how returning Vietnam vets were ill-treated and how the Persian Gulf War, though over, continues to yield casualties.

Still Seeking Parity

Later that day I found myself thinking about those very special visits and pondering whether our world had had ample options to consider that might have prevented the wars that we have come to know so well. I began to reflect on the current meeting in Washington and our primary purpose for being here. And, while it surely paled in significance to the earlier events, there was a common path. I thought of clinical social workers and our desire to obtain just due for our profession. We necessarily wage our own "wars" to fight for what we need and deserve. We want licensing. And we want true parity. We don't want a professional attachment to another nonphysician mental health discipline for Medicare reimbursement. Remuneration should walk hand-in-hand with competence, recognition and respect. Additionally, social work should and can provide credible role models for the young and a desirable profession for a lifetime of service and reward. While our Code of Ethics is exemplary, our values as social workers may in part represent a double-edged dilemma. Schools of social work have trained us to be sensitive to the needs of other human beings and to develop a social conscience; they have not routinely provided the business savvy nor the encouragement to those who also wish to provide private services. Entering the private sector therefore demands a modification of the values that we were taught in social work school and perhaps also in our early lives.

Schools of social work spawn graduate social workers inadequately prepared for the increased demands of clinical practice.

By virtue of primary training, clinical social workers contribute a significant measure of specialness to their practice which, when translated into the helping process, provides an "extra dimension". No doubt we are also casualties of archaic views of what makes for a clinical social worker. Fortunately, however, we have identified the sources of our failings and have initiated programs to effect needed changes. While the National Federation, the American Board of Examiners in Clinical Social Work, the National Institute for Clinical Social Work Advancement, etc. provide leadership and direction on a national level, the state clinical social work societies must increase their efforts to influence legislators, the public and the schools of social work. With few exceptions the schools of social work dwell in yesteryear and seem not to be in touch with the needs and demands of their students and with the broader realities of current-day practice. They spawn graduate social workers inadequately prepared for the increased demands of clinical practice. It is our responsibility to influence those in academia to see the broader picture and to implement necessary changes in curricula that will enable graduates to be better prepared for all facets of practice.

Philip Banner, MSW, BCD
President

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Advertising for Fall 1991 issue due October 1.

All advertising must be camera ready.

Insurance Fraud: Clinicians Liable

Criminal, Civil, Disciplinary Charges are Possible

By Hillel Bodek, MSW, CSW, BCD

The inception of parity in vendorship for CSWs represented a significant step in the development of clinical social work as a profession and in the public's recognition of the value of our services. Regretfully, parity in vendorship has brought with it parity with those few members of other health care disciplines who engage in insurance fraud.

Section 176.05 of the New York State Penal Law defines the commission of a fraudulent insurance act as **"knowingly and with intent to defraud presents, or causes to be presented, or prepared with the knowledge or belief that it will be presented to or by an insurer or purported insurer, or any agent thereof, any written statement as part of, or in support of...a claim for payment or other benefit pursuant to an insurance policy...which he knows to: (i) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto."**

Committing insurance fraud can also lead to state criminal charges for larceny, federal criminal charges for mail fraud, civil suits and disciplinary charges for professional misconduct brought by the New York State Education Department. These can result in incarceration, fines, civil monetary penalties and loss of licensure.

The Many Facets of Fraud

Over the course of the past year, several types of insurance fraud have been committed by CSWs. The most common type is billing for services not rendered. This doesn't include merely billing for extra sessions in addition to those provided. It also includes billing the insurance company for missed sessions. Although a CSW may charge a patient for missed sessions, insurance companies reimburse charges only for services rendered. *When a patient misses a session, no service was rendered, and submitting the cost of such missed session to the insurance company for reimbursement is a fraudulent act.*

Another type of fraud occurs when an eligible provider signs an insurance claim for services rendered by a provider whose services are not eligible for reimbursement. *An insurance claim form should be signed only by the person who provided the services listed thereon.* If a provider who is not eligible for insurance reimbursement is being supervised by a provider who is eligible, the supervisor may write a cover letter, to be attached to the claim, indicating that the services rendered were provided under supervision and explicitly stating that she/he did not provide the services. A supervisor, in contrast to a consultant, is one who takes personal professional responsibility for the professional action or failure to act of the supervisee.

It is fraud when a provider bills for services that are not covered and disguises this fact by describing those services ambiguously.

A third type of fraud occurs when a provider bills for services ambiguously. For instance, most medical insurance policies limit coverage to clinically necessary treatment of mental disorders. Most do not cover marriage therapy. What some providers do is describe such service as "psychotherapy" and list a DSM-III-R diagnosis of depression or anxiety. This is misleading. The provider should describe the service accurately, "marriage therapy," and list, along with whatever diagnoses may be applicable, the diagnosis of "marital problem (V61.10)."

A variation of this problem occurs when a therapist who is treating a child sees the parents to discuss the child and bills the session as therapy for the child or a parent, neither of which is accurate. The therapist should bill such services as rendered for the child as the patient and describe such services accurately as a "conference with the child's parents" incidental to the therapist's treatment of the child. Still another variation occurs when a therapist is treating a family and bills the sessions as therapy for one member of the family, often until that person's coverage runs out, after which the family sessions are then billed as therapy for another family member. Such services should be billed as "family group therapy" and the fee for each session divided equally among the family members attending. Accurate diagnoses should be given for each family member. If the family therapy is primarily for treatment of a parent-child or other family problem, that should be listed as the primary diagnosis and the appropriate V code utilized from the DSM-III-R.

It is essential that the services for which a claim is made and the diagnoses for which the services are being rendered be fully, accurately and unambiguously described on the insurance claim form and that claims for services be attributed accurately to the patient to whom they relate. The insurance company can then knowingly process the claim and accept or reject it depending upon the terms of the insurance policy.

Another instance of insurance fraud, a corollary of the third, occurs when a provider describes a service as being for the treatment of a physical disorder rather than a mental one in order to get around an insurance policy's lower reimbursement rate for and annual limitation on mental health benefits. For instance, a provider bills half of the session as psychotherapy for treatment of anxiety and half as biofeedback/hypnosis for stress reduction. Or, a provider bills for a psychotherapy session and for a session of biofeedback/hypnosis on the same day when these were provided as part of a combined treatment of the patient's emotional disorder during the same session.

A clinical social work therapist is participating in a fraudulent act ("knowingly and with intent to defraud") when

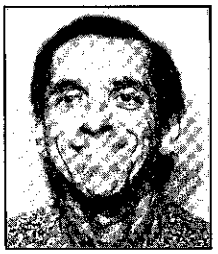
- **. . . billing for services not rendered**
- **. . . an eligible provider signs an insurance form in place of the ineligible provider who rendered the service**
- **. . . billing for services not covered and describing these services ambiguously**
- **. . . explaining a service as treatment of a physical disorder to obtain a higher rate**
- **. . . a provider increases the usual fee to take advantage of insurance payments**
- **. . . a practitioner fails to collect coinsurance and deductible from the patient**
- **. . . a provider bills one family member's insurance company while rendering "family group therapy"**

continued on page 11

DIPLOMATES

Society Diplomates

The highest level of membership, Diplomate status is awarded in recognition of a sustained commitment to the purpose and goals of the State Society. The contribution of the Diplomate to clinical social work is distinguished by the "unique and special manner" in which it is performed. Such contribution/effort warrant a higher credential and a further level of recognition. The following members have been awarded Diplomate status.



E. John Levinson, MSW, CSW, BCD
Nassau

1987-1991 – Nassau representative, legislative committee
1987-1988 – Vice president for social action
1983-1986 – Chapter treasurer

1991 Diplomates

Rosemarie Gaeta, CSW, BCD
Staten Island

1990 – Chair, National Committee on Psychoanalysis; co-director, Third National Clinical Conference
1987-1990 – Chair, NYS committee on psychoanalysis
1980-1984 – NYS education committee; helped initiate state conferences
1976 – Founding member of chapter; first treasurer

Catherine LaChappelle, CSW, BCD
Rockland

1990- – Chapter nominating committee; leadership committee
1985-1986 – President, chapter; State nominating committee
1983- – Consistent service on chapter level: 1st Vice President; membership, education, referral committees
– Lecturer, workshop leader; initiated chapter conferences; organized yearly calendar of educational seminars

Emery Gross, CSW, BCD
Metropolitan

1989-1991 – Treasurer, American Board of Examiners (ABE); chair, finance committee
1988-1989 – President, chapter
1989 – Chair, task force to create position of executive director
– Chair, State nominating committee for special election of State president
1987-1989 – Founding director, ABE

Carl Bagnini, CSW, BCD
Nassau

1989 – Certificate of Appreciation from chapter for dedication and service
1980s – Consistent contributor to consumer press; initiated panels addressing crucial issues on state level; co-founder, family practice committee
1977-1987 – Chapter board member
1975 – State ethics committee; helped draft Society's Ethics and Adjudication Procedures

Carolyn Bersak, CSW, DSW
Mid-Hudson

1990- – Co-chair, chapter membership committee.
Workshop leader; contributor to professional journals
1985-1990 – SUNY New Paltz and Albany. Coordinator, dual degree program. Particular position affords unique opportunity for recruitment.
1981-1982 – Founding chapter member; vice president; education chair

Selma E. Lane, CSW, BCD
Nassau

1981-1991 – Membership chair, chapter; membership has doubled in 10 years and has served to start new chapters. Initiated current quarterly county-wide membership brunches
1987- – Founder, director, coordinator, Centers for Treatment of Eating Disorders
1980s – Served on State parity and membership committees

1990 Diplomates

Shayne Lee Raze, CSW, BCD
Brooklyn

1991- Search committee for executive director

1989- – Recording secretary, Society "retreat" for long-term planning

– Recording secretary, State; consultants and supervisors panel

1985-1988 – State membership committee; vice president, chapter

Cecily S. Weintraub, PhD, CSW, BCD
Nassau

1991 – Presenter, 20th Anniversary National Federation Conference and

1990 – Third National Clinical Conference; committee on psychoanalysis

1989- – Editorial board, *Clinical Social Work Journal*

1982- – Lecturer, Smith College for Social Work; instructor at psychoanalytic institutes; contributor to journals

1971-1972 – Founding member, recording secretary, Nassau chapter

Maria P. Warrack, CSW, BCD
Nassau

1985-1986 – 2nd vice president, State; chair, chapter development

1981-1983 – Chapter president; member, 5-year planning committee

1980s – Ongoing and consistent service to chapter

Carole Ring, PsyD, RCSW, BCD
Brooklyn

1989-1990 – Chair, State education committee; developed supervisory panel; ongoing service on various State committees

1988-1989 – Organized Annual Membership Conference

1986-1988 – Chapter president

1980s – Editor, chapter newsletter; co-chair, membership, national committee on psychoanalysis

Monty Kary, CSW, BCD
Rockland

1984-1985 – 2nd vice president, State

1982-1984 – State treasurer (2 terms)

1979-1982 – Chapter president

1978 – Founding chapter member, initial vice president

Barbara Kuerer Gangi, CSW, BCD
Metropolitan

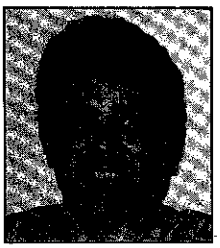
1990 – Book in press, Crown Publishers

1989 – State public relations committee; workshop leader; conference speaker; TV appearances

1988 – Book: *Making Therapy Work: Your Guide to Choosing, Using and Ending Therapy*, Harper & Row

1982-1983 – Vice president, chapter public relations

1980-1982 – Co-chair, chapter referral service



Joseph A. Ventimiglia, DSW
Queens

1990- – Chapter president

1981-1983 – Member-at-Large

1979- – Legislative committees, chapter and state; active in work for parity bill (1985); consistent service to chapter

1970s – Served 2 years on city health planning board (HSA) as Queens representative of Society

Consuelo V. Alsapiedi, CSW, BCD
Queens

1989- – Chapter secretary

1986-1988 – State education committee

1984-1986 – Chapter president

1978-1980 – Education committee representative to National Federation

1978 – Chair, chapter education committee

Patricia Morgan Landy, CSW, BCD
Metropolitan

1985- – New York State Board of Social Work (2nd 5-year term); chair, 1988; book review editor, State *Newsletter*

1980s – Publication in *Clinical Social Work Journal* (reviews)

1970s – Founding member, Queens chapter; vice president; chair, referral committee; State education committee

1991 Diplomates were announced and brought to the podium for this merited award (see page 4).

Marsha Wineburgh, chair of the legislative committee, reported on present activities. The committee's primay focus currently is licensing, which it considers imperative, both for CSWs as acknowledgment of professional credibility and for the protection of potential clients. She gave an overview of licensing issues, history, licensing legislation in other states and an outline of the multi-level plan being developed by the committee, as well as a review of other activities.

Marketing Issues/Managed Care

Maura deLisser, CSW, education committee member, introduced featured speaker Dolores McCarthy, who discussed "Issues and Strategies of Practice Marketing." Defining the four aspects of marketing — product, place, price, promotion — she identified skills CSWs already possessed that could easily be converted to general business marketing. (Story, page 1.)

Nancy Bernstein, BCD, CAC, a practicing psychotherapist and insurance company claims reviewer, discussed "Managed Care and the Clinician." 'Managed care' is a shorthand term for the intervention by purchasers of treatment (eg, insurance companies and PPOs [Preferred Provider Organizations]) to monitor therapy providers in order to control costs. In an effort to contain costs in the present escalation, managing mental health care requires focusing on prognosis and outcome. (Complete article in Fall issue.)

Mental health care practice in the future will be directed to "customer satisfaction."

Improving Reimbursement $

John A. Chiaramonte, CSW, BCD, NYS vendorship chair, introduced the keynote speaker and discussed the problems practitioners face in dealing with insurance companies/third party payers and managed health care reviewers. In the past year, he noted, more than 200 therapists had called concerning adverse reimbursement decisions from insurance carriers.

He shared examples of the problems these illustrated and how they were handled so that decisions were reversed. In pointing out the cost containment efforts of third party payers, Chiaramonte observed that it is not individual practitioner fees that have driven up health care costs but rather in-hospital costs and poor diagnosis in hospitals. He also reported on the committee's success in getting reimbursement for CSWs included in corporate insurance policies at IBM and United Parcel Service (UPS).

Haruko Brown (left) presents Diplomate award to Carole Ring. Membership co-chair Katherine M. Pelly and President Philip Banner stand by.

Keynote Speaker Predicts Goal of "Customer Satisfaction"

Keynote speaker Gary Unruh, CSW, BCD, is president of Provider Network, Inc., consultant to NICSWA, and a private practitioner in Colorado. He predicted that mental health care practice in the future will be directed to "customer satisfaction." And so, "everything will be managed." The old system, in which the provider said "it is best because I say so," referring both to fee and treatment, will no longer be operative.

Unruh identified and discussed three major driving components in a managed care system: price, access and quality. He pointed out four types of emerging delivery systems. The longest established system, prevalent for years but now rapidly decreasing, is fee-for-service — a direct and unsupervised interaction between customer and provider. This is the way most CSWs have practiced. Other — and currently more predominant — systems include a) managed fee-for-service, b) PPOs, c) health maintenance organizations (HMOs), and EAPs, which Unruh believes will soon stand on their own.

He noted the changing relationships among providers, clients and institutional payers, such as insurance carriers and self-insured businesses. These changes relate primarily to a shift in control and treatment emphasis.

Unruh observed an encouraging aspect in the drive to manage care rather than leaving it to the former "professional knows best" approach: companies are looking at indirect costs — absenteeism and productivity — and noting that these can be improved by timely and appropriate mental health care. Corporations are acknowledging that social issues are a real problem and affect employees' productivity. Thus, the market for mental health care may be increasing.

Companies are noting that productivity can be improved by timely and appropriate mental health care.

An important element in the present structure is the increase in costs connected with alcohol and drug problems and related mental health care. Corporations are beginning to publish information on the importance of effective care in situations involving chemical dependency. Executives can see the results in the workplace. Moreover, research is showing that outpatient care can be effective and costs far less than prolonged inpatient treatment.

Concerning future distribution of health care, Unruh noted that by 1992, 59% of the market share of health care will go to HMOs and PPOs. Further, the established fee-for-service delivery system will comprise only 12% of the market.

CSWs must develop methods to evaluate progress.

"Managing is here to stay." Unruh asserted that the real problem in managing health care relates to quality. There is a crucial need to be able to determine quality: outcome, standards and ways of developing standards that can be measured. For this reason, he stressed, it is urgent for CSWs and other practitioners to develop the methods to evaluate

continued on page 11

Child Abuse: Doubts Assail Clinicians

Reported Cases Often Result in Destruction of the Treatment Relationship

By Barbara Pichler, CSW

Along with increasing media coverage about child abuse, there is growing concern about professionals' mandated reporting of child abuse. How much is it affecting clinicians in private practice; how are they handling it and how are they feeling about it?

Robin Ashman (Met); full-time private practice in New York City; supervisor, New Hope Guild clinics.

I have not yet had a situation in which someone revealed abuse, but the whole question makes me nervous because the details of the law are not clear to me. I have not ever seen anything in print. I am also quite shocked that other professionals must take the 2-hour course on abuse and social workers — who certainly do an enormous amount of work with children and families — don't.

These are some of my concerns: The law is certainly correct in its intent, but is it effective for all parties involved? Mandated reporting puts a very great responsibility on the treating individual, especially the private practitioner. Must we report immediately, or do we have the luxury of listening for a little while? How sure do we have to be — should "beyond a reasonable doubt" as applied to criminal cases be the standard for our suspicions? It is certainly important to identify abuse, but what happens to the treatment relationship, what about the pledge of confidentiality? If we spell out the conditions up front, do we lose our chances to ever hear the material?

If we spell out the conditions up front, do we lose our chances to ever hear the material?

There is also the difficult issue of culture-bound values. People of certain cultures who have migrated here in large numbers use corporal punishment routinely. Further — do we report neglect in a middle class family of parents who work 60-hour weeks and who leave their child with what appears to be an uninvolved caretaker? These issues are not amenable to simple solutions.

Sharon Klayman Farber (West); full-time practice in Westchester treating adults, adolescents and children; specialty in eating disorders; has taught in several programs; enrolled in a doctoral program.

I took the course on abuse after seeing it advertised in a local newspaper. Unfortunately, this important material was presented in a deadly boring way.

I would not work with them while the abuse was ongoing.

I have had several cases to report and have learned a great deal from each. In the first, a couple came for treatment, and he was beating her. I worked with them for a few weeks but, by the third or fourth session, found out he was also abusing their son. With this, it was clear I had to report the father.

I called Child Protective Services (CPS), mistakenly believing they would honor my request not to intervene until after the following evening's session, when I could tell the couple first. At that session they were furious with me for reporting, although I believe the mother was secretly relieved. The agency had already been in touch with them. I was fearful of violence in the office, which did not occur. I later received numerous telephone taunts, however, and there was vandalism outside the house.

This was a particularly difficult case. My stance was that I would not work with them while the abuse was ongoing. We had already established a connection and they had confidence in me, but because of the way events unfolded, it was impossible to save the working relationship.

A few years ago, a teenager at risk for suicide was referred to me. She revealed that her mother had come at her with a knife several times. The family would then hold POW (Prisoner of War)-type interrogations, telling her she was wrong, was not to cry, and was not to bring shame to the family. When I reported this case, I had no control on the follow-up. The girl was furious at me for reporting. (I did not tell her first, and I don't remember why.) I did not see her again and I don't know what happened to that case because she appears to have continued in school.

The mother had attained enough clarity to act on her own and her child's behalf.

The third case involved suspicion of sexual abuse. The marriage was in big trouble. In the second session, the wife told of some peculiar things about the husband, and thought she "must be nuts" to think like this about his relationship to their 3-year-old girl. As she talked, it became clearer to her that she was right. She fully supported my reporting and also reported on her own. She took her daughter, moved out and started divorce proceedings; she and her daughter entered treatment. The State did not have sufficient evidence to prosecute, but the mother had attained enough clarity through her brief treatment to act on her own and her child's behalf. Even with the help of a highly reputed lawyer, however, the mother did not succeed in getting supervised visitation or other protections for her 3-year-old. □

Corrections . . .

In the Fall 1990 issue, the byline for the article entitled "Consultation Panel Formed to Serve Members" by Carole Ring, PsyD, should have included co-author Lynne L. Morris, CSW.

Photos of the Third Clinical Conference in the Spring 1991 issue were taken by Rosemarie Gaeta, CSW, BCD.

WORKSHOP

Practice Development: Fact and Fiction

Self-Sabotage Presents Crucial Dilemma

Report by
David Grand, CSW, BCD

This is the first of a 2-part article. It is excerpted from the workshops presented under the auspices of the education committee of the NYS Society for the past 3 years and includes that presented at the annual meeting in May.

Any discussion of private practice development is woefully inadequate if it does not explore how and why we tend to undermine our attempts to expand our practices. What is the use of obtaining valuable practice development information if we can't sufficiently mobilize ourselves to implement the ideas? To illuminate these issues, the workshops present the concept of private practice resistance or, in short, practice resistance.

The definition of practice resistance (which parallels all other forms of resistance) is the unconscious, and occasionally conscious forces, residing within the therapist which sabotage the clinician's attempts at private practice development. It is notable that this phenomenon has gone almost entirely unexplored in the clinical literature. This suggests that powerful taboos are operative in our field; these are associated with the monetary aspects of practice. Where do our inhibitions emanate from concerning being "business people," as well as clinicians? A self-selection process draws us to the field of clinical social work. The psychodynamic factors that attract us to being healers, however, are the identical determinants that generate the self-sabotage in our attempts to further develop our practices.

Observations of many therapists have illustrated that three primary factors contribute to practice resistance: the childhood role played in the family of origin, the clinician's fear of success, and the therapist's aversive experience of intense pain resulting from treating the emotionally wounded.

Reconstruction, Repetition, Restitution — and Fear

Many of us have emerged from dysfunctional or addictive families with a concomitant need to cure our own parents. All of us have suffered and, accordingly, possess an exquisite attunement to the suffering of others. We have gravitated to the healing fields in a repetition compulsion in which we both reconstruct and repeat past family experiences in addition to attempting our own restitution.

Fear of success also contributes to practice resistance. In 1916, Freud analyzed this condition in his monograph, "Those Wrecked by Success." Success phobia is a ubiquitous phenomenon particularly afflicting the clinical community, especially social workers. It is not coincidental that a field labeled as a "woman's profession" would be particularly plagued with people hampered by fear of success. My own observations of female and male independent social workers are that they both possess high levels of practice resistance. It appears that many male social workers have gravitated to a "female profession" as a result of a strong identification with the caretaking object. However, it is often surprising to social workers that so many psychologists and psychiatrists also grapple with the strong pull of the fear of success and practice resistance.

Success phobia is a ubiquitous phenomenon particularly afflicting the clinical community, especially social workers.

Private practice resistance also results from the existential pain we experience in treating the emotionally distressed. An intense discomfort lurks unconsciously, silently discouraging us from pursuing larger caseloads. We feel the responsibility for our patients' emotional health weighing on us as we face their transferences, aggression, depression, sexuality, regression, merging, splitting and projective identifications. The pain of treating can be so anxiety provoking that at times we harbor the unconscious wish to treat fewer patients or even none at all! Although we are highly dedicated, it is understandable that at times we would rather flee the threat to our own emotional stability than actively work for practice expansion.

The following are often encountered as examples of practice resistance:

- believing that being a good therapist is reason enough to gain a steady supply of referrals
- meeting once with a potential referral source and then not following up — putting off calling or writing a possible source of patients
- not providing EAP counselors with regular, helpful feedback on shared cases

Practice Assistance

Practice resistance can best be counteracted with methods we can call "practice assistance." Unless a return to therapy or analysis is clearly in order, the use of a peer group of therapists is the optimal method of countering practice resistance. This can be provided in either an informal network, a structured peer supervision group, a self-help group for clinicians or an ongoing group with a leader who has expertise in practice resistance. Peer support and sharing experiences engender a sense of connectedness and so reduce the therapist's sense of isolation. This provides an excellent format to identify, examine and control the effects of practice resistance.

Part 2 will appear in the Fall issue and will examine a variety of business and marketing strategies that address the practical issues of pursuing practice development. □

NATIONAL FEDERATION

20th Anniversary Clinical Conference

The 20th Anniversary Clinical Conference will take place at the Palmer House in Chicago, September 27-29. Some 40 workshops and special institutes will cover topics from psychopharmacology to family therapy, and everything in between, including a panel on AIDS. A workshop on Post-Traumatic Stress and the War will feature a chief social worker from the military.

Featured speakers include nationally known clinical social workers: Florence Lieberman (NY Society), Jean Sanville, Elaine Pinderhughes, Joseph Palombo. Managed health care will be discussed by Michael Freeman, MD, president of Behavioral Health Care. Politics and mental health will be addressed by nationally known editor of *The New Republic* and frequent guest on television, Morton Kondracke. Further presentations include papers from the national committee on psychoanalysis.

In addition, special exhibits, parties and an all-'round gala celebration will assure a special social event — in addition to a topnotch learning experience.

Letters . . .

Managed Care/HMOs

To the Editor:

It was discouraging to read John Chiaramonte's article in the Spring 1991 issue of the *Newsletter,* in particular because he seems to have confused the words "managed care" and "HMO". In using these words interchangeably, an impression is given that they are synonymous. While an HMO is one form of managed care, many managed care plans are not HMOs.

In the paragraph entitled "Indemnity Plans vs Managed Care," Mr. Chiaramonte describes a fee schedule pertaining to an HMO model of reimbursement. Other managed care plans operate with what is known as "preferred provider organizations" where fees, although preset, are more reflective of the usual and customary fee of the region and do not decline per number of sessions. Additionally, although a limit for the number of sessions is suggested, I have talked with some very knowledgeable folks including CSWs who, based on the practitioner's assessment of patient need and a demonstrated knowledge of clinical data, have not put pressure to end therapy precipitously.

The Society and the vendorship committee have done admirably in the past by obtaining third party reimbursement. Let us realize, however, that we must be equally skillful and probably more vigilant in understanding the complexities of today's health care delivery system within the context of "cost-containment".

Helen Altman, MSW, BCD

Mandated Reporting Proves Complex Issue

To the Editor:

The following is in response to Hillel Bodek's article, "Mandated Reporting of Suspected Child Abuse and Neglect"(Fall 1990 *Newsletter*).

In his article on this topic Mr. Bodek provided accurate information about legal requirements for reporting of suspected child abuse and neglect, but he ignored the implications of the Rand Corporation study which found that mental health professionals do not comply consistently with state laws mandating such reporting. And he gave false assurance that calls made to New York State's "800" number for reporting such cases are "assured of receiving the careful attention and rapid response they deserve."

According to Mr. Bodek, the Rand study found that practitioners believed that reporting was likely to disrupt treatment and that they could provide better services. Those mental health clinicians who used discretion in deciding when to comply with mandatory reporting statutes tended to consider the poor quality of child protective services (CPS) as a key factor in reporting or not reporting.

Clinicians are concerned about the quality of CPS services.

Rather than reiterating rules, which most clinicians know quite well by now, we should be considering why clinicians are still choosing to ignore the law and what should be done about it. In my experience those clinicians who are concerned about the poor quality of CPS — who feel they may be able to provide better service to the abusing family and who fear that reporting may disrupt treatment — have good grounds for their concerns, even if they are unjustified in ignoring the law. I offer my own experience as evidence.

- A paranoid father came with his infant girl to an intake interview at a preventive service program and, apropos of nothing that had been said, began threatening to kill her if anyone tried to take her away from him. CPS was called and I spent more than an hour trying to calm him while he kept repeating that if anyone tried to take her he would give them a corpse. A CPS worker finally arrived, grumbling that he would be late for his moonlighting job as a disk jockey. He then sent the father and infant back to an unheated apartment lit only by an extension cord from a hall light. The next day it was the police who had to talk the father down before they dared to get close enough to take the child.

- A mother of very limited mental resources told me that, against medical advice, she had taken her daughter (who suffered from a life-threatening heart condition) out of a treatment center where she was getting good medical care. The mother had only an unheated apartment and no beds, so the child was sleeping on the cold floor. The mother realized she had made a mistake and believed that her daughter's life was being endangered. However, she could now not find a place that would take her daughter. I advised CPS of this situation, suggesting that the girl should be in foster care until she could be placed in a medical center. I spoke to the mother 6 weeks later and learned that no one had even come to the home to investigate — and the girl's life was still in jeopardy.

- A school-aged boy whom I was seeing in therapy, and with whose mother I had a good working relationship, reported to me that his mother had choked him; on further questioning, he maintained this story. I had my doubts as to the validity of this claim but had to report it. The CPS worker came, and the boy retracted his story; CPS found no grounds for further investigation. The mother was incensed that a report had been made and withdrew her son from treatment.

Legal questions aside, should these cases have been reported? In one case definitely yes, since a child's life was in danger. Given the gross incompetence of the CPS worker in the first case, however, I now believe that the police should have been called first. In the second case, CPS was my best bet for quickly getting the child into a secure setting, but my call did not get the "careful attention and rapid response" which Mr. Bodek alleges. What about the third?

What can be done about the concerns that I and other clinicians have about mandated reporting? It is time now to consider that some modification of the law is desirable rather than simply repeating that we are mandated to report. I recommend that we lobby for an amendment to the law so that qualified mental health workers may be treated differently from other mandated reporters. We should be able to call specially qualified workers at protective services and consult with them about cases of suspected or actual abuse/maltreatment that do not appear to pose an imminent threat to a child's safety. Such calls should not automatically result in a direct investigation by a CPS. Instead, the CPS worker should decide, in discussion with the clinician, whether an investigation is in the child's best interests.

The CPS worker should be able to monitor the case through the report of the clinician while advising the clinician of information to be obtained or conditions to be met before the case can be closed. Such modification of the law would help not only to preserve the treatment relationship and protect the child from potential negative impact of an investigation, but to lessen the growing burden of investigations for overworked protective service offices.

Richard Trachtman, PhD, CSW, BCD

continued on page 10

Author's Reply

To the Editor:

I read with interest Dr. Trachtman's response to my article. I share his frustration in dealing with Child Protective Services (CPS) and note that my columns are intended to be brief general discussions of legal issues that impact on clinical practice rather than comprehensive discussions of these topics.

The goals of this particular article were: 1) to remind CSWs that, despite their appropriate misgivings, they are mandated reporters of suspected child abuse/maltreatment, and 2) to inform them that, in response to criticisms by mandated reporters that their reports were often ignored, not taken seriously and not investigated thoroughly, New York State established a special phone number for mandated reporters. Use of this statewide number assures only that the mandated report will be taken seriously and investigated promptly because it comes from a mandated reporter. It does not guarantee the quality of CPS services.

The cases cited by Dr. Trachtman provide an important opportunity to correct several misconceptions about the CPS process. In the first case, I agree that it would have been more appropriate to call the police first when faced with a paranoid father who was threatening to kill his infant daughter. Unlike CPS, the police would have been able to safeguard the child immediately. CPS could then have made an emergency placement. The law requires reporting to CPS. *It does not preclude a CSW from taking other appropriate steps in such an emergency situation.* The inappropriate, potentially criminal* conduct of the particular CPS worker involved might have been dealt with effectively by contacting his supervisor or (after business hours) the supervisor at CPS emergency services.

The second case cited arose because a mother was unable to obtain needed medical care for her child. Dr. Trachtman's misuse of CPS as "the best bet" to get the child back into the hospital was improper; this case did not involve child maltreatment or abuse. Rather than inappropriately referring this case to CPS and then waiting 6 weeks before speaking with the mother again, it would have been more useful and appropriate for Dr. Trachtman to have accompanied the mother and child to the hospital to facilitate her obtaining treatment for her child. He could have advocated with the hospital or with hospital regulatory authorities to arrange for the needed care. Additionally, supportive follow-up should have been provided to the mother on an ongoing basis to assist her in planning and obtaining needed services for her child.

In the third case cited, Dr. Trachtman should have been aware that, as noted in a prior column on this topic that appeared in the Fall 1985 edition of the *Newsletter,* pursuant to section 413 of the Social Services Law, reporting is only mandated in a case where there is "reasonable cause" to believe that a child is abused or maltreated. Dr. Trachtman notes that he doubted the validity of the claim by the child, with whom he was familiar. Further, he claims to have had a good working relationship with the mother, and it appears that he did not have reasonable cause to suspect that the child was abused or maltreated. He was not required therefore to report this case. Assuming that he was required to report this case, as Dr. Trachtman states, the CPS worker investigated the case and agreed with him that it was unfounded. The fact that "the mother was incensed that a report had been made and withdrew her son from treatment" cannot be blamed on CPS.

Constant attention to the therapist-patient relationship is crucial.

The constant attention to the therapist-patient relationship that is crucial to effective social work was apparently absent here. In this regard, Dr. Trachtman should have a) explained to the mother why he had to make a report and b) shared the report with her. He should have expressed to the mother (and in his report) his doubts as to the validity of the claim. He should also have offered to be with the mother when she met with the CPS worker. This situation is not much different from one in which a CSW must arrange to hospitalize a patient psychiatrically against the patient's will. Provided that the CSW remains focused on maintaining the therapeutic relationship, such situations need not destroy that relationship. Indeed, they may serve to enhance it.

Dr. Trachtman's suggestion that the law be changed misses the point. He would have mental health professionals call "specially qualified [CPS] workers" and consult with them in cases that present no apparent imminent threat to a child's safety, without such calls resulting in an investigation by CPS; further, he would have CPS allow these clinicians to handle such cases while CPS monitors them through contacts with the clinician.

This plan fails to recognize that investigation of alleged child maltreatment/abuse and protection of such children is a governmental obligation and cannot be abdicated and given over to private citizens. It overlooks the sad fact that many mental health professionals are not adequately trained and equipped to investigate and monitor such cases. Most important, it sidesteps the need for all CPS workers to be "specially qualified" to handle these cases, which are among the most complex and challenging for social workers.

As the recent column pointed out, "the quality of child protective services is often poor." The solution is not, as suggested, to use others to perform CPS's task. It is to teach health and mental professionals and others about the CPS process, and to improve the quality of CPS services.

With regard to teaching health and mental health professionals, under New York law, commencing in 1990, all health care professionals other than certified social workers — who, regretfully, were exempted — must complete an approved seminar regarding child abuse/maltreatment as a condition precedent of re-registration of their licenses.

With regard to improving the quality of CPS services, our profession — which has for the most part stood by idly while the provision of CPS and child welfare services has been taken over by non-MSW "social workers" — is largely responsible for the deterioration in the quality of these services over the past quarter century. What is needed is a sustained and concerted effort by properly trained, experienced and qualified MSWs to replace ill-trained and overworked nonprofessionals in adequate numbers to assure the welfare of society's most important resource — its children.

Hillel Bodek, MSW, CSW, BCD

*Official misconduct in violation of P.L. section 195.00. Emphasis added by author.

The Public Image of Clinical Social Work: An Open Conversation

By Richard M. Alperin, DSW

When social work psychotherapists meet informally, oftentimes the conversation turns to dissatisfaction with their profession's public image. Although a frequent topic of conversation, this dissatisfaction is rarely addressed at our public forums. Like individuals, professions often utilize certain defense mechanisms; regarding this issue, our profession's major defense is denial. This was not so, however, at the Third National Conference of the Committee on Psychoanalysis in the conversation hour on "The Public Image of Clinical Social Work."

Of utmost concern to those participating in this discussion was the negative perception of social workers. Those present unanimously believed that they were not perceived as expert or competent as psychologists and psychiatrists providing mental health services. This belief was not idiosyncratic to those engaged in this discussion, for research indicates this perception does exist. In a study we conducted in 1985 *(Psychological Reports,* October 1985) comparing the perceptions college students have of social workers to those they have of psychologists and psychiatrists, social workers were viewed as warm and easy to relate to but not particularly intelligent. Psychiatrists were viewed antithetically as bright, but cold and reserved. With these stereotypes, it is not surprising that the subjects indicated they would most likely consult psychologists for help with their problems. (Psychologists appear to fall between the two: smarter than social workers and warmer than psychiatrists.) Other research confirms these findings.

Although the significance of this problem has been largely ignored, its consequences are harmful to us and our clients. For example, how can this public image not affect our clients' transference to us and thereby become a treatment issue? Further, numerous empirical studies in counseling and psychotherapy have demonstrated that differences in clients' perceptions in the expertise of a helping professional produce differential compliance with the professional's suggestions, and are strongly related to posttreatment outcomes. This public image also has a major impact upon clients' choices of mental health professionals and what they are willing to pay these professionals for treatment. Our public image, therefore, has an impact upon our potential helpfulness to clients and on our incomes.

Of equal importance to those who attended this conversation hour was our profession's poor self-image. One major symptom of this was thought to be the tremendous amount of infighting, especially between psychodynamically oriented clinicians and those more generically (environmentally) oriented. This inability to tolerate ideological differences would seem to be a direct manifestation of social work's shaky identity and poor sense of self. All of us know that when an individual does not feel secure within himself, he or she is more sensitive and vulnerable to the behavior of others and easily feels angry and narcissistically injured. Turning our aggression inward and attacking each other is self-defeating and self-destructive. We should utilize our aggressive energies to enhance our profession and to compete with those disciplines considered to be more prestigious such as psychology and psychiatry.

In conclusion, the feedback that came from those attending this conversation hour was that they found it helpful sharing these concerns with colleagues and having them addressed at a professional meeting. We left, however, with the same nagging question: "When are we, as a profession, going to do something about these problems?"

Richard M. Alperin, DSW, is in full-time private practice of individual and group psychoanalysis in New York City and Teaneck, NJ. He is also adjunct associate professor at Fordham University and NYU School of Social Work and is a faculty member at Rockland Institute for Psychoanalysis & Psychotherapy.

INSURANCE FRAUD *(continued)*

A fifth incidence of fraud involves a provider's increasing the fee for services in order to take advantage of a patient's insurance. For instance, a patient has a policy that provides for 50% reimbursement of the provider's "reasonable and customary fee," and does not impose an annual maximum. A CSW recently informed me that he billed $150 a session, thereby having the insurance company pay 50% of that, the $75 that was his usual and customary fee. In his defense he noted that, "everybody does it. My therapist did it with me so I could afford therapy twice a week."

A corollary of this occurs when a provider consistently fails to collect the coinsurance and deductible amounts from a patient. In such instances, the fee the provider lists on the insurance claim is not the actual fee for the service, since the provider is accepting the insurance company's payment, which is only a percentage of the fee noted on the claim as payment in full for the service. There are rare situations in which a provider who doesn't have a general policy of waiving collection of the coinsurance and deductible amounts might appropriately accept the insurance company's payment as payment in full. These would include a situation where the cost of billing for coinsurance would exceed the amount of the coinsurance or a very unique situation where a provider charges the insurance company the usual, standard and customary fee, and waives collection of the coinsurance from a patient because of the particular patient's indigency, not merely financial hardship. In several states and under the Medicare program, consistent failure to collect coinsurance and deductible amounts may result in criminal prosecution.

Interestingly, the CSWs with whom I spoke who engaged in insurance fraud

continued on page 12

ANNUAL CONFERENCE *(continued)*

progress. This would serve both managed care and provider autonomy needs.

Therapists need to do a lot more work in developing outcome standards in conjunction with the purchaser so that clinicians can indeed "own" the managing. "We can either accept their standards of outcome, or bitch and moan, or work in partnership to determine and define outcome."

Finally, Unruh posed a challenge to the assembly: "There is $3.5 million in this room." Most businesses spend 1 to 3% on marketing. "If this group spent only 1% on marketing," it would be in a strong position to have an impact on what happens for its members in the arena of managed care.

Diana List Cullen, CSW, maintains a private psychotherapy practice in Manhattan with individuals and couples. Current emphasis is on parents in difficult relationships with their adult children. She is membership chair of the Met chapter.

MARKETING: THE FOUR "Ps"

Before we actually "market" our practice, we should use our assessment and planning skills to evaluate the design for our strategy. This involves the four Ps: Product, Price, Place, Promotion.

Most people think of marketing in terms of the last "P": Promotion. This step really can't be accomplished adequately, however, until the other "Ps" are addressed.

Product

This is the most difficult concept. In a course on "Marketing for Services and Non-Profit Groups" our group developed a paper on "Psychotherapy: The Ultimate Intangible". From the objective perspective of professional marketing, what is our "product"? What is psychotherapy? And how is this "product" perceived by potential consumers? What are consumer "wants and needs" for our "product"?

For example, do consumers want techniques for improving relationships? Handling panic attacks? Having more self-esteem? Only a certain group of potential patients are actively seeking long-term, insight-oriented work and, of course, our profession must satisfy this group. But what about all the potential (and growing) groups of consumers who want only brief, crisis-oriented treatment? While the overall market for therapy in general is increasing every year (as more and more consumers are amenable to the idea of therapy), many of these clients are interested in more limited goals. Further, many patients seek "bits" of therapy — a little bit at a time — and then return a few months or a few years later for a bit more. For many potential patients, this may be preferable to no therapy at all, and can be a good source of referrals, even though the period of work with them at any given time may be brief.

A specialty is very important in the current therapy marketplace. Some of us have an interest in a particular problem: substance abuse, eating disorders, anxiety disorders, etc; others, in a population: children, adolescents, women, gays. Other attributes of therapy include differentiation by modality (individual, group, couple, family); length (short-term, long-term, crisis intervention); philosophy/methodology (psychodynamic, cognitive-behavioral, hypnosis). The more we define the focus, the easier it is for consumers to locate us.

Price

Setting high fees may price us out of the market. Setting fees that are too low may not cover the expenses of maintaining a private practice. If we join an HMO or PPO, they may control the fees we can charge. Flexibility with fees and accepting insurance assignment directly may improve our ability to attract clients, but this may add to increased bookkeeping. What is the "competition," both among social work colleagues and among all mental health professionals?

Place

The location of your practice is important to practice development. The farther one gets from Manhattan, the less competition, and the easier it is to expand your practice. Is your area saturated with other therapists? How convenient, and how physically attractive is your office for patients? Some practitioners may have more than one office, or develop relationships with referral sources from another town. Also, group practices may increase options for referrals.

Promotion

Communication about your practice takes place formally and informally. Joining a PPO and waiting for referrals may not be the best way to develop your practice. A successful practice requires conscious attention to communication.

Formal promotion includes brochures, advertising, writing articles, teaching, public presentations. Within a PPO, it means completing and updating the correct forms, supplying appropriate documentation and communicating specialty areas in your practice. Take a course or use consultation to improve formal presentation, speaking and writing skills. The more visible and accessible we are, the greater possibility for referrals.

Informal communication is equally important. These include all the basic social work "relationship skills". Contact with colleagues as well as formal referral sources is part of the "communication" or relationship aspect of practice. When a colleague refers a patient, it is important to acknowledge this courtesy promptly. A referral from an EAP counselor reflects a valuable business connection and requires prompt communication and, sometimes, sharing information. Not only is it common courtesy, acknowledging referrals is good business practice; without such recognition and acknowledgment, practice development is slow or nonexistent. Referrals are a *systemic* issue. Referents are part of the referral. Don't forget them, their needs and preferences.

Part 2 will discuss the "marketing mix" and how to target your marketing message. Look for it in the Fall issue.

were all able to rationalize it as acceptable for a variety of reasons. These rationalizations include "everybody does it," "CSWs won't be able to compete with psychiatrists and psychologists if we don't do it," "it helps the patient by increasing the number of sessions they can afford," "making the patient pay for a missed session is part of the therapy, so it should be covered," "it doesn't hurt anyone," and "nobody will know."

Rationalizations include "everybody does it," "it helps the patient," "it doesn't hurt anyone."

Aside from the fact that engaging in insurance fraud is illegal, unethical and may lead to criminal, civil and administrative sanctions against the practitioner involved, there are other reasons to avoid scrupulously such conduct. First, such behavior detracts from the respect others have for our profession and impacts negatively on our struggle for professional recognition. Second, insurance fraud, just as any other so-called "white collar crime," is not a victimless crime. It results in increased insurance rates and decreases in insurance benefits. Third, and most important, by engaging in insurance fraud together with a patient, the therapist harms the patient. Such therapists involve patients as partners in a criminal act that can result in patients' incurring criminal and civil penalties. And, such therapists indicate to their patients that it is all right to engage in antisocial behavior and dishonesty. It is easy to rationalize such conduct as being acceptable because it benefits patients by allowing them to obtain therapy they might otherwise not be able

Insurance fraud increases therapists' incomes while undermining their therapeutic efforts.

to afford or which they could afford only with hardship. However, this noble end can be accomplished honestly by therapists' adopting a sliding fee scale or referring such patients to other providers. What insurance fraud really accomplishes is increasing therapists' incomes while undermining their therapeutic efforts to facilitate patients' development of healthy ego functioning. □

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