Illinois Society for Clinical Social Work

President's Message

Eric Ornstein

At a recent Jane Roiter Sunday Morning Seminar, our speaker Anna Lieblich gave an outstanding, thought provoking presentation on the topic of "Bad Therapy." She reviewed the empirical evidence that calls into question the effectiveness of recovered memory therapy, EMDR (Eye Movement Desensitization and Reprocessing) and facilitated communication.

I experienced the presentation as both provocative and challenging. It provoked me to reconsider my understanding of false memory syndrome and to reexamine my assumptions about working with survivors of sexual abuse. Similarly, I was challenged to review my tacit acceptance of the efficacy of EMDR. At the very least, this experience encouraged me to revisit some of the literature in these areas to update my knowledge and re-immerse myself in the controversies surrounding these approaches, in order to make my own decision about whether reconsideration of some of my long held beliefs is necessary and called for. This presentation was a good antidote to my clinical inertia and complacency. Personally, this wake-up call is especially important because of my current role in teaching B.S.W. and M.S.W. students in two different programs in Chicago.

The presentation also rekindled my awareness of my deep seated ambivalence about the tension between the sensibilities of empirically supported approaches to practice that focus on measuring outcomes, and more narrative post-modern kinds of therapy, that emphasize context and personal meaning. I recall that many years ago – January 29, 1991 to be exact – I attended a Psychiatry Grand Rounds at the University of Illinois at Chicago at which Ken Howard, a renowned psychotherapy researcher from Northwestern University, presented his research on "A Phase Theory of Psychotherapy." He used his research to support dividing the psychotherapy process into three phases - remoralization, remediation and rehabilitation. Furthermore, he suggested that his research showed that most psychotherapy patients would go through these stages in the order that he described.

What made this Grand Rounds a remarkable, unforgettable experience for me was the discussion of the paper by an equally renowned psychoanalyst, Irwin Hoffman. I recall his voice was shaking with emotion and passion as he challenged the core assumptions of Howard's research, strenuously questioning whether there ever could be "average" patients who go through invariant stages in psychotherapy. His deeper message was a penetrating social constructivist critique, and a deconstruction of the notion that empirical psychotherapy research should be a more highly regarded, sacrosanct source of guidance for any given therapist-patient dyad than individual case studies and or the subjective opinions and experiences of both participants.

Hoffman's erudite arguments had a powerful impact on me and have affected my teaching and clinical practice to this day. For the interested reader, a more recent discussion of Hoffman's perspective on these issues can be found in his article, "Doublethinking our Way to 'Scientific Legitimacy': The Desiccation of Human Experience" found in the 2009 issue of *Journal of the American Psychoanalytic Association*. This article was presented two years earlier in 2007 as the plenary address to the American Psychoanalytic Association. Furthermore, Hoffman presented his latest thinking about his views on the integration of social consciousness and psychotherapy at our own Jane Roiter Sunday Morning Seminar in 2015!

Speaking of the Sunday Seminars, we will complete this year's series of seminars with the last one being a presentation by Barbara Berger on April 3rd entitled, "An Unexpected War of Ages; Clinical Issues: Conflicts between Young and Middle Adult Development". The Seminars have been incredibly successful this year in terms of both attendance and the high quality of clinically relevant presentations. In addition to Anna Lieblich's wonderful presentation discussed above, Carla Leone gave a fascinating presentation on "Couples Therapy from the Perspective of Self Psychology", and Denise Davis gave a well-received presentation on "Embracing Our Clients' Healthy Strivings: A View from Self Psychology".

I sincerely hope that you will join us in this clinically rewarding and nourishing experience by attending our next round of Seminars which will start in the fall of this year.

Reference

Hoffman, I.Z. (2009). Doublethinking our way to "scientific legitimacy": The desiccation of human experience. *Journal of the American Psychoanalytic Association*, 57, 1043-1069.

Important Position Now Available!

Alas, it's time to pass the baton. **We are looking for a new Newsletter Editor.** As the current Editor, I'd like to express how gratifying it has been to be in charge of our tri-mesterly newsletter for the past eight years. Although it is time consuming for short periods, there are many wonderful advantages that I've experienced being the Editor:

- Editing original clinical articles, published for the first time in our News-letter. This often involves a gratifying mentoring of newer writers.
- Having a strong voice in what gets published, and how it will look when formatted.
- When you have collected all of the copy, it gets sent to Diana Hodge, our Administrator who is responsible for the formatting. The Editor doesn't have to do any formatting.
- Lots of contact with other social workers while working with them on their submissions.
- *An automatic position on the ISCSW Board, which meets every third Tues-day of the month from 7:30-9 p.m. at 1300 W. Belmont in Chicago.*

Our new Editor would be dedicated to good writing skills and know how to recog-nize when wording needs to be changed. (The former Editor will be happy to help with this.) In addition, the new Editor will need to be tactful when rewriting some-thing others have submitted. He or she can always get lots of help with grammar and spelling from a laptop.

If you are interested in this position, vital to the ongoing mission of ISCSW, I would be happy to meet with you. You can reach me at 630) 951-1976, or at *rasterlin@comcast.net* .   Looking forward to hearing from you!

Ruth Sterlin, L.C.S.W.
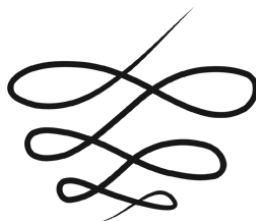
ORIGINAL CLINICAL ARTICLE

The Potency of Narratives:
Observations from Work in Intensive Psychiatric Services

David Javier Thompson

Introduction

My longstanding personal interest in the narratives of patients, families, and clinicians about *care* and the interaction among the participants in the process of receiving *care* are the initial impetuses for this article. Through my current direct clinical work in what several senior colleagues have affectionately called the *Intensive Psychiatry Services*, I have seen time and again the potency of these various narratives: defining, derailing, and mending whatever type of *care* is being provided to patients and families. The following pages will use a combination of theory, observation, and clinical work to establish an understanding of how this single intangible element – narratives – manages to shape the actions, preconceptions, and interactions that drive patient *care*. But first, let me define Intensive Psychiatric Services through the sharing of specific contexts that continuously inform an understanding of the ideas presented in this essay.

All of the observations within this essay are based on current clinical work in a major metropolitan area children's hospital, in particular within its Intensive Psychiatric Services' Partial Hospitalization Program (PHP) and Emergency Department (ED) Consult Service. Additionally, all identities are disguised in order to protect the privacy of those involved.

The services that are often included within mental health care's Intensive Psychiatric Services are psychiatric inpatient units, partial hospitalization/day programs, intensive outpatient programs, and psychiatric consult-liaison services. While there are notable differences between these mental health services, they often have the following elements in common: 1) a defined length of admission (days to weeks); 2) a high level of acuity in patients' presenting concerns (*e.g.*, suicidal ideation, substance use, aggression, psychosis, depression, anxiety, etc.); 3) multidisciplinary staffing (*e.g.,* psychiatrists, nurses, social workers, psychologists, milieu therapists, recreational therapists, etc.); and 4) staff with expertise in crisis/risk assessment and stabilization.

Definitions of "Care" and "Narrative"

In analyzing narratives of care, including caregiving, caretaking, etc., having a general sense of how *care* and *narrative* are defined serves as a useful starting point. Dictionary definitions for "care" include, "effort made to do something correctly; things that are done to keep someone healthy, safe, etc.; things that are done to keep something in good condition; painstaking or watchful attention (Merriam-Webster's *Online Dictionary*, n.d.)". Thus, "providing care" can be defined as an effortful attempt to keep someone healthy and/or safe by keeping him or her in working condition through the aid of watchful attention. Nonetheless, when translating these definitions and concepts into standards for patient clinical care, one should ask, what do "watchful attention", "good condition", "health", "safe" and other components of these definitions look like in the world? Additionally, what do their antitheses look like?

Moving on to "narrative", its dictionary definitions include, "a story that is told or written; the representation [in art] of an event or story; and an example of such a representation (Merriam-Webster's *Online Dictionary*, n.d.)". The stories are comprised of details about specific actions (*e.g.*, interacting with a physician) or broad tasks (*e.g.,* parenting, mental health treatment). Some key types of details include the setting, relevant background information, the people who are involved, their actions, and the consequences of

those actions. Some overarching narratives that are often at play within patient care include those about being a clinician, patient, or family member. These narratives' individual components might include clinicians' training in assessment and treatment, patients' feelings about treatment, caregivers' existing knowledge about health care, and the setting in which the treatment is occurring. In addition, these narratives can form the basis for any expectations and interactions between peoples.

People define what it means to receive care and how to provide it in numerous ways, and narratives can play crucial roles in processes of defining and establishing standards of practice. For instance, whatever narratives the individuals, groups, and institutions providing care to others carry within themselves about being a patient, provider, and family member will eventually come into contact with each other, creating the potential for conflict. As one example, a narrative of providing care that sees clinicians as *imparting information* to patients and another narrative that sees clinicians as *collaborating with* patients may set notably different precedents for who and what is involved in a patient's treatment.

Narrative: A Grounding in Theory and Clinical Practice

With narratives having the potential to markedly influence how care is defined, as well as what it means to provide and receive it, a working knowledge of theories behind what narratives are and how they are created will help us understand their power.

To paraphrase a principle from post-modernist thought: peoples' experiences of and interactions with the world are constantly moulded by a combination of stories told by others, elements that individuals carry within themselves, and new stories they then create. While some absolute truths or realities may indeed exist, people's experiences of these elements, themselves, and their surroundings are also influenced by the ways in which they and others view the world. Accordingly, Narrative Therapy employs a combination of post-modernist notions of reality, views on language, and theories of human development that highlight the importance of the reciprocal exchange between persons and their environments. For instance, narrative(s) provide one manner through which the subjective experiences and resulting beliefs described in post-modernist thought can exercise influence over

others. These stories can provide templates for behaviour grounded in beliefs about specific persons, places, and things. As one example, a narrative about parenting might suggest that caregivers are meant to nurture, protect, and sacrifice in order to secure better futures for their children. Additionally, the same narrative may stress that information about events, beliefs, and practices is only shared among immediate family members. During moments when caregivers are unable to meet the expectations set forth by this narrative, potentially because they are afraid of their children, feel rage toward their children, or do not know how to best provide for them, caregivers may feel shame or guilt due to this perceived shortcoming. Also, when families who narratives stress keeping the details of their affairs to themselves interact with clinicians whose professional narratives of providing care include gathering details from patients, one can see where potential clashes may arise.

Narratives that are often present within the broad realm of *caregiving* include those about being a parent, patient, clinician, and trainee. Each narrative houses views, beliefs, customs, experiences, and other elements that come together to create what at times may read like guidelines or blueprints for behaviour. For instance, a clinician interacts with patients in one particular manner, patients provide information to clinicians in a different way, trainees interact with their patients and supervisors in yet different ways, and so forth. Culture, sex, gender, socio-economic status, ethnicity, family make-up, education, profession, spiritual beliefs, and other facets of an individual then add additional details to these narratives. For instance, the narratives around being a mental health clinician are expanded through one's faith traditions, ethno-racial heritage, gender identity, and so forth. Lastly, all narratives exist within specific contexts, which then contribute additional details. Some examples of contexts include a rural mental health practice, and an urban paediatric hospital's emergency room.

Two important questions that narrative theory raises are, 1) where do these influential stories originate, and 2) how do they come to be carried/internalized by others?

Beginning with the first question (Where do these influential stories originate?), clinicians and researchers alike theorise that people develop, learn, and establish a sense of self in part through the interactions between their internal (*e.g.,* biological, intra-psychic) and

external (*e.g.,* family, neighbourhood, school, etc.) environments. For instance, some influential concepts that incorporate this view on human development include attachment theory and its role in development across the lifespan (Bretherton 1992); behaviourism's learning history and the role it plays in guiding current behaviour (Ramnerö & Törneke 2008), and allostasis' (McEwen 1998; Sapolsky 2004) view of the body's biological rhythms responding to and at times resetting their overall functioning due to the influence of perceived and actual challenges (both intra-psychic and environmental).

It could be said of narratives that the ways they shape the exchanges between one's internal and external environments originate through a two-fold process: their interactions with the various narratives around them, and the creation of new narratives.

To illustrate this, one series of narratives that play a prominent role within the specific niches of mental health in which I work are those around *parenting*. These narratives often describe who traditionally holds the authority during interactions between family members, when and how limits are set with children, expectations for parents and their children, and so forth. Through work and research with families, researchers and clinicians have come to use terms such as *authoritative*, *permissive*, *authoritarian*, and *neglectful* (Smetana 1995) to describe the manners in which parents interact with and parent their children. As a result, various therapeutic interventions such as Parent Child Interaction Therapy (Funderburk & Eyberg 2011), Parent Management Training (Kazdin 2008) and the Collaborative and Proactive Solutions model (Greene 2014) were designed in part to introduce additional narratives about parent-child interactions and caregiving into families' existing relationship repertoires.

The psychiatric Partial Hospitalization Program in which I worked continues utilizing Greene's Collaborative and Proactive Solutions model (CPS) (2014) to inform patients' and families' care. This model delineates three separate yet complimentary parenting approaches, plans A, B, and C. Unfortunately, when used improperly, Plan A can resemble a combination of authoritarian and neglectful parenting styles (*e.g.,* no other choice but the parents' way), and Plan C can resemble a combination of neglectful and permissive parenting styles (*e.g.,* parents never setting limits and letting everyone figure things out on their own). Plan B, or

the model's approach to building problem solving and communication skills within the family, reflects an authoritative parenting style that promotes growth in all members (*e.g., working to elicit everyone's concerns and then problem solve together to address them*). However, with practice, and when used properly, Plans A and C can serve as important tools for reducing the power struggles that exacerbate crises and setting clear limits that help maintain safety. When successful, parenting narratives in which caregivers only provide instructions and children obey them are then expanded through CPS to include moments in which family members learn with and from each other.

In sum, one goal of therapeutic parenting interventions is to expand and modify the existing narratives of what it means and how to be a caregiver through the introduction of new behaviours (*e.g.,* problem solving with one's child) and views (*e.g.,* children and parents can learn from and with each other). The hope of the clinicians introducing these interventions is that when these children become caregivers, they will remember their helpful consequences when creating their own narratives of what it means to be a caregiver and to provide care to their own children.

To expand further on where the narratives originate that are targeted by therapeutic interventions, let us look to key elements of family systems theory. In family systems theory, even a lone person atop a mountain is part of a larger system. Being part of any system, no matter how far removed one may be from its other components, involves all individual components being both influenced by as well as influencing each other (Nichols 2014; Kaslow, Bhaju & Celano 2011). It could be said that the interactions among individuals, groups, and their environments help form patterns, beliefs, practices, and policies that shape not only the social and physical landscapes but also the views on how best to navigate them. For instance, the narratives of "care" and "providing care" espoused by social work stress the equal inclusion of all parties in defining and providing care, respecting and integrating all parties' knowledge, acknowledgement of power dynamics, and having professionals directly address this divide by meeting clients at whatever point in their lives they may be. Through interactions with clients, other social workers, conferences, marketing, portrayals through media outlets, the profession's research and code of ethics, and other elements, the social work narrative around "care" is maintained and passed to future gen-

erations of professionals.

Concerning the second question (How do these stories come to be internalized?), I would like to refer to my personal experience in the Emergency Department where I work. Narratives often include suggestions or lessons on how to best navigate the world, and the various expectations and beliefs within it. Several parent caregivers with whom I work in the Emergency Department have expressed disappointment about not being able to keep their children and their families safe without help from others (*e.g.,* SASS workers, EMS paramedics, the police department, Hospital Emergency Department staff, etc.). They have also mentioned, with understandable reservation, not wanting to be afraid of their child. When reflecting on these statements in supervision, my colleagues have repeatedly noted that, "bringing your child to an Emergency Department for a psychiatric evaluation and potential hospitalization can be a major shock", in part, because doing so was neither expected nor desired.

I had similar experiences with families in the psychiatry Partial Hospitalization Program in which I worked. Coming to the Emergency Department or another intensive psychiatric program often includes involving "strangers" in a family's intimate moment of crisis. Clients' emotional states make it exceedingly difficult to moderate their emotions and actions, or put a socially desirable foot forward due to the level of stress at play. As one senior colleague put it, "family members are in an altered state when they are in the ED."

By this she means that family members are carrying certain narratives about parenting, mental health, and intensive psychiatric services that play a powerful role in their reactions. Michael P. Nichols, a seminal Narrative Therapy clinician, describes one function of life stories and narratives as providing "filters that screen out experiences that don't fit the plot line or, if they can't be screened out, distort events until they somehow fit" (Nichols 2014, p. 90). Following this line of thought, when parents bring their children to intensive psychiatric services, they may feel consistent confusion, anxiety, sadness, shame, anger, and other notable reactions. The narratives they carry about what it means to be successful caregivers, as well as the larger societal narratives on caregiving may not jibe with having to bring their child in for emergency crisis care. Additionally, when these families hear the narratives of the professional staff about how they can provide

effective care (*e.g.,* making internal referrals for services, providing referrals to other organizations, recommending an inpatient hospitalization, etc.), many of these families' core, internalized narratives about care, mental health, intensive psychiatric services, and so forth are being directly challenged and strained.

Applying Concepts: Part I
Set-up and Case Example

As suggested by my experiences while working in intensive psychiatry services, providing "care" to others can be a particularly complex and difficult task. This is in part due to the fact that being brought to the emergency department, given a vaccine, asked multiple questions, or having to adjust behaviours, etc. can directly compromise individuals' and families' personal boundaries: patients may insist on things like, "I don't need medications to calm down", "Why do we have to tell you about our family's psychiatric history?" "Our child doesn't want to stay in the ER any longer, can't we all just go home?" or "What do you mean your program lasts for two weeks? Can it be any shorter?" Additionally, the potential for each person's internalized narratives to come into contact with those of others is also high. This can result in an ongoing series of negotiations to (re)define what the care being provided will look like, who and what will be involved, and so forth. With the case example below in mind, the remaining pages will illustrate the ways in which this family's narratives were at play in the "care" they received.

Late one Sunday afternoon, Mrs K. brought her son, Jack, to the emergency department (ED) searching for recommendations on how best to help him and her family. She was a registered nurse with twenty years of service, and he was an 11-year-old cisgendered Caucasian male. While speaking with the medical resident assigned to the case, Mrs. K. noted that Jack's developmental paediatrician had recommended that he be brought to the ED for a neurology consult to see if an as-needed medication could be prescribed to help him calm when he became physically aggressive (*e.g.,* hitting, kicking, pulling others' hair, throwing objects). At this time, the ED was currently full to capacity with a waiting list long enough to fill it a second time. All were waiting for triage and admission.

Over the past few months, Jack had become increasingly irritable and easily upset at home, which over the past few weeks meant that he was pacing around the

house, shrieking, and hitting family members on a daily basis. The family was also experiencing several stressors due to his parents' recent divorce, causing Jack and his two sisters to move in with their mother, and instability in Mrs K.'s employment and housing.

I learned a little more about Jack's history by reviewing his medical chart, talking with his mother and siblings, and talking with the ED resident and nurse assigned to the case. He had been diagnosed with Autism Spectrum Disorder, Sensory Integration Disorder, and Attention-Deficit Hyperactivity Disorder when he was a toddler, and also had longstanding anxiety. His ability to communicate verbally included a few syllables and utterances, and he was currently attending a therapeutic day-school. Between the ages of four and six, Jack's developmental paediatrician had started him on a stimulant medication trial to aid with Jack's impulsivity, as well as others for aggression. Jack's mother chose to stop all medications due to the lack of improvement in his behaviours and her concerns about their side effects. Since then, he had been on no other psychiatric medications. Over the past two years, Jack had been psychiatrically hospitalized twice for aggression toward family members. During each inpatient admission, intake appointments with local specialty outpatient therapists and programs were secured for the family. On the day that I met with the family in the ED they had no current mental health providers or services.

Applying Concepts: Part II
Case Reflections

Jack's mother had several concerns about what the ED and psychiatry could do to help her son and her family. She stressed that Jack's previous inpatient hospitalizations had only briefly helped him, and that what the family needed at this point was something to help Jack calm down when he was markedly agitated. Additionally, Mrs. K. noted that his needs were more developmental or medical than psychiatric, and that as a result he would benefit little from any mental health intervention. She had come to the ED because it served to help her get quick access to medical care, specifically medication, and to get some more answers that she could then take to Jack's developmental paediatrician for use in his current care.

A portion of Mrs. K.'s narrative around patient "care" within an ED included the prescribing of medications to families for use during instances of marked aggression or other forms of emotional and behavioural dysregulation. Another portion of that narrative also saw medically trained personnel (*e.g.,* physicians, nurses, etc.) as being the ones who would provide care for the concerns she was describing. Yet another portion of her narrative saw treatment in the ED for behavioural concerns as happening within a relatively short timeframe.

The narrative of "care" followed by the hospital's ED and the psychiatry department was and is notably different than the one Mrs. K. had internalized. For instance, prescribing new medications for mental health concerns was not done due to the notable risks from not being able to monitor a patient's potential reactions and medication adherence, making adjustments if needed, and not being able to coordinate or secure outpatient medication management.

The issue of Mrs. K.'s wish for treatment to occur within a short timeframe brings up differences between the mother's, the ED's, and psychiatry department's narratives around providing patient "care". The ED's narrative highlights the efficient assessment of presenting concerns, provision of interventions, securing resources and follow-up care in disposition planning, as well as the discharge of patients in order to continue serving those in need throughout the day and night. At the time of this case, the department was operating well past its capacity, trying to provide services to an ever-increasing number of patients in the waiting area, and working to adhere to its own narrative of "care".

With the combination of tangible and intangible symptoms, contributing factors, and resources involved in mental health care, the psychiatry department's narrative of "care" within the ED involves the following elements: First is gathering enough information to thoroughly evaluate the current risk level for the patient and family members, stressing any imminent threats to their safety. Second is gathering information about the patient's and family's ability to adequately address imminent threats to safety and additional risks. Third is sharing this information with other colleagues in the department in order to get additional insights and assistance in creating suggestions for next steps. Fourth is presenting these next steps to parents, addressing potential questions and concerns, and moving forward with the proposed disposition plan or making adjustments if the family is not in agreement. Fifth, and final, is the consistent coordination with ED staff on all of these elements, as well as

the practical and logistical elements involved in the disposition plan. In sum, maintaining a balance between *efficient* and *thorough* "care" in mental health can involve a timeline that creates a dissonance between the expectations of the ED and those of the patients.

In looking at the challenging exchanges between the hospital staff, including myself, and this family during their time in the ED, the differences between each party's narratives around "care" may have played a significant role. That of the psychiatry and ED did not conform to the parent's expectations of what her family needed and what they were going to receive. Due to her son's past psychiatric inpatient hospitalizations and their impact on his presentation, Mrs. K. was certain that Jack would not benefit from additional consultations with psychiatry department providers such as myself. Additionally, the need for information about multiple elements of patients' and families' lives within my narrative of providing "care" as a member of the psychiatry department clashed with both Mrs. K.'s and the ED's timeframes around being a patient there. Lastly, it seemed likely that some overarching narrative about what it meant to be a "good parent" was being directly challenged by Mrs. K.'s having to bring Jack to another emergency department and having additional strangers involved in her family's care. A number of times she said to me, "I just need help. I can't figure out what Jack needs and how to keep everyone safe." Here again, the elements of intervening in families' personal lives and witnessing their vulnerability involved in the narrative of "care" within an intensive service like the emergency department, may place additional stress on families and providers alike.

Conclusion

Narratives are a constant presence in daily life, shaping the expectations around which many actions and reactions are based, and helping suggest how to effectively navigate the world within or outside of those expectations.

In emotionally charged and vulnerable circumstances, such as when loved ones are experiencing a psychiatric crisis, narratives around key aspects such as providing and receiving "care", being a parent/caregiver, health, mental health, and healthcare can be directly challenged and strained.

Working as a provider in settings such as the Intensive Psychiatric Services involves interacting with individuals and families who, by choice or by force, are actively renegotiating their relationship with long-held narratives about numerous aspects of their being and their relationships to the larger social context. Additionally, the multidisciplinary nature of the Intensive Psychiatric Services often requires providers to renegotiate their own narratives around "care", being a person who provides it to others, and the ways in which the differences and similarities influence work with colleagues and patients.

In sum, providing thorough, effective, efficient, and empathetic care involves working to keep this ongoing (re)negotiation in mind. When guiding narratives are strained, one can often feel that their thoughts, behaviours, and feelings are not meeting the expectations of these influential stories. The stress and vulnerability of being a patient, family member, or provider in these intense situations have the potential to drive people to look for perfection, a magic cure-all, or a missing link that will explain everything. Unfortunately, this search for perfection has a tendency to disappoint those involved, despite everyone's brave efforts.

To help combat the resulting cycle of desperation and disappointment, providers and caregivers alike need to work on incorporating forgiveness and concepts such as the English aphorism, "perfect is the enemy of the good," and Donald Winnicott's "good-enough mother" into our narratives of "care" and "caregiving". Doing so highlights a necessary component of all narratives: fluidity. People have the ability to rewrite and personalize the most influential stories that define their expectations and the manners in which they interact with the world. Accordingly, this potential for change is a core belief upon which Narrative Therapy interventions and their iterations are built. While doing so may feel overwhelming, it also provides a level of dynamism and influence that can help buoy patients, families, and providers during crises, as well after these crises have passed.

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About the Author

David Javier Thompson is a psychiatric social worker at a major metropolitan area children's hospital and a former Illinois Society for Clinical Social Work board member. He received his A.M. in Social Service Administration and his Graduate Certificate in Health Administration and Policy from the University of Chicago in 2015. Before moving to Chicago he completed graduate studies on refugees' resilience in the United Kingdom via a Fulbright Research Grant, undergraduate studies on the psychophysiology of stress at the University of Louisville; and work on the stories of displacement and resilience at the University of Michigan. His clinical interests include narratives of care, building resilience via acceptance, caregiver-youth communication, parenting/behaviour management, intensive brief treatment models, and crisis stabilization.

ISCSW Welcomes
William Kinnaird to Our Board

William "Bill" Kinnaird, L.C.S.W., has joined the ISCSW Board as the Standards and Practices Chair. He graduated from Michigan State University in 1970 with a B.A. in psychology. He also served as a medic in the U.S. Army from 1971 to 1974 where he began working in addictions treatment. After leaving the service, he was a case manager at a New York City methadone clinic but then returned to the Chicago area, from where he originates, in late 1974 to work as an aide and counselor in a residential alcoholism program. In 1978, he completed his M.S.W. at Jane Addams College of Social Work pursuing the mental health concentration. He was employed as an inpatient social worker at Chicago Read Mental Health Center, and then by the Veterans Administration Lakeside Medical Center, working as a social worker on the inpatient psychiatry unit. Later he transferred to the VA Jesse Brown Medical Center where he took a clinical social work position in the Outpatient Psychiatry Clinic.

Bill also completed a two-year post-masters Advanced Clinical Social Work Certificate program in 1984, then offered by the Loyola School of Social Work. While continuing his full-time psychiatric social work at the VA, Bill began part-time evening employment in 1984 at the Scholarship and Guidance Association, Chicago, treating both adolescents and young adults. He continued part-time work at S&GA until 1999, also carrying a few individual cases in private practice from 1990 to 2001.

In September, 1992, Bill transferred from Outpatient Psychiatry to continue as a clinical social worker in the VA Jesse Brown Inpatient Psychiatry Unit. He has since remained in this position. Additionally, since 2008 he has coordinated the VA JB Social Work Service's graduate field placement program and has been a field instructor for students from many area social work graduate schools. His special interest is how to optimize relationships with indigent adult patients in the context of acute hospital care. In 2007, he published an article, *A Systematic Approach for Providing Concrete Services Based on Using Information Handouts,* which explores efficient ways to employ *relationship* in the hectic, acute-care inpatient setting. He hopes to publish another article soon, *Acute Care and Long-term Relationships*.

Bill and his wife Cheryl were delighted with the birth of twins, John and Marnie, in May 1992. In addition to enjoying the unfolding lives of their now adult children, Bill and Cheryl share many diverse interests and hobbies. Currently, Bill is working on his French language skills at the Alliance Francais de Chicago.

The Cutting Edge...

Literature Reviews for Clinical Practice…

Robert Wallerstein. (1989). The psychotherapy research project of the Menninger foundation: An overview. *Journal of Consulting and Clinical Psychology,* **57: 195-205.**

I have chosen to review what I consider to be a classic article by Robert Wallerstein, M.D. The article has significant implications for clinical social work practice and is tremendously affirming of the value and effectiveness of our work.

To give the reader some context, Robert Wallerstein, who died at 93 in 2014, was one of the true giants of psychoanalysis. Foremost among his prodigious accomplishments (20 clinical books and 400 professional publications) was his role as principle investigator of the Psychotherapy Research Project of the Menninger Foundation. This research study represents the most intensive, systematic and long-term research into the process and outcome of psychotherapy and psychoanalysis. The study, which began in 1954, followed the treatment experiences of 42 patients over a 30-year span. Half of the study participants were in psychoanalysis, and half were in expressive and/or supportive psychotherapy. (The full, definitive report of the study can be found in Wallerstein's [1986] book, *Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy.)*

On a personal note, I was present when Wallerstein presented the findings of this study at a conference on Adult Development in the early 1980's at Michael Reese Hospital, and I remember feeling "blown away by his findings", at the time. By the way, Wallerstein's wife, Judith Wallerstein, a social worker and psychologist who died in 2012, did the definitive longitudinal 25-year study of the psychological impact of divorce on children.

The Psychotherapy Research Project was designed to answer two seemingly simple questions: 1) What changes take place in psychotherapy? and 2) How do these changes come about? The Project had several distinguishing characteristics that set it apart from all other psychotherapy research. First of all, it was a naturalistic study, because neither the therapists nor the patients knew they were part of the study until the termination stage of the therapy. Therefore, the therapies being studied occurred naturally, unaltered by the research or by the patient's and therapist's knowledge that the therapy would be the subject of later research scrutiny. This aspect of the study can never be repeated because of changes in research ethics and the advent of concepts of informed consent. The other unique feature was that, according to Wallerstein, the study obtained 100% of its follow-up information during the period of the formal study (Wallerstein 1989). For these reasons, and others having to do with the unique structure, resources and prestige of Menninger Clinic, it is reasonable to assume that no one will ever to be able to do a study like this one again.

I would like to focus my review mainly on the surprising and unpredicted results of the study, rather than on the research methodology – which the interested reader can ascertain by reading the original article or the previously cited book. Suffice it to say that the subjects in the two groups were comprehensively assessed through intensive psychiatric case studies, comprehensive psychological test batteries, and in-depth social histories (probably done by a social worker). A similarly rigorous termination study was done, which included reviews of all the clinical records of the cases and in depth interviews of the patients, the therapists and the significant others in the patients' lives. Finally, the formal research included a follow-up study conducted between two and three years post treatment, which included the same in-person psychiatric assessment interviews of the patients, psychological tests, and social histories as in the previous studies. In addition, less extensive follow up information was obtained for 17 patients in 1981-1982, approximately thirty years after the start of the study (Wallerstein 1989).

As for the complex multi-year long process of data analysis and control methods, for this review I only wish to state that the data from each of the 42 patients was coalesced into a 50-page case study for each patient, and that elaborate methods of statistical analysis and control mechanisms were developed and utilized (Wallerstein 1989).

Proceeding to the results of the research, I will summarize the results in a very condensed format. Almost all of the results challenged the accepted wisdom, assumptions and conceptual formulations about the differences between

psychoanalysis, expressive psychotherapy and supportive psychotherapy. Similarly, conventional understanding of the predominant change mechanisms in each of these types of therapy – as well as the nature of the operation involved – was literally turned on its ear.

The study found that both psychoanalysis and expressive psychotherapy were systematically modified in the direction of introducing supportive interventions, with a substantially greater amount of change than expected accomplished through non-interpretive, supportive interventions (Wallerstein 1989). Both supportive and expressive psychotherapies accomplished more change than was expected or predicted with most of the change being achieved on the basis of supportive interventions (Wallerstein 1989).

The treatment results of psychoanalysis, expressive psychotherapy and supportive psychotherapy tended to converge in their outcomes in that all carried more supportive elements then originally expected or intended; and these supportive elements accounted for substantially more of the changes achieved then had originally been anticipated (Wallerstein 1989).

The structural changes in personality brought about by interpretation, insight and conflict resolution (the change mechanisms thought to be central to psychoanalysis), were indistinguishable in terms of durability and effectiveness, from the changes brought about by supportive interventions (Wallerstein 1989).

Psychoanalysis, expressive psychotherapy and supportive psychotherapy hardly exist in ideal or pure forms in the real world of actual practice. Real treatments in actual practice are an intermingled blend of expressive, interpretive and supportive-stabilizing elements. In addition, all treatments (including "pure psychoanalysis") carry more supportive elements then they were originally thought or expected to involve (Wallerstein 1989).

Therefore, in the words of Wallerstein, "…a more circumscribed narrow role for psychoanalysis and an expanded scope for expressive-supportive psychotherapy and an enhanced therapeutic heuristic and conceptual dignity should be accorded to supportive psychotherapeutic activities. Specifically, sicker patients should be treated more often with supportive psychotherapy rather than psychoanalysis and supportive interventions need to be given more attention in practice and research and deserve to be treated more respectfully" (Wallerstein 1989).

It is important to reiterate that none of these results were expected by Wallerstein and his research team, because they did not conform with the broadly accepted psychoanalytic clinical theories and assumptions of the time; especially regarding the expectations of clear boundaries between psychoanalysis, expressive psychotherapy and supportive psychotherapy, and the relative roles that interpretive mechanisms versus supportive interventions were expected to play in each of these therapeutic modalities.

From my perspective, the results of this research represent a ringing endorsement of the flexible, responsive psychosocial interventions that have always been at the core of clinical social work practice. The best clinical social work interventions have always been a sophisticated and exquisitely sensitive mixture of both insight-oriented, interpretive interventions and more supportive mechanisms and techniques. In fact, my point of view is that the most effective and impactful interventions are those that explicitly place support and interpretation in close juxtaposition to each other to achieve a profound synergistic impact on our clients.

I find it to be extremely encouraging that one of the most sophisticated and comprehensive research studies on the process and outcome of psychotherapy that has ever been done, so clearly supports the kind of clinical social work practice we have all been doing for a long time. It is also very reassuring that the quality and the enduring nature of change brought about by the typical social work mixture of expressive and supportive techniques, or by supportive interventions alone, is equivalent to the results of strictly insight-oriented interventions. Thank you, Robert Wallerstein!

Eric Ornstein

References

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy,* New York: The Guilford. Press.

Wallerstein R. S. (1989). The psychotherapy research project of the Menninger foundation: An overview. *The Journal of Consulting and Clinical Psychology*, 57: 195 -205.
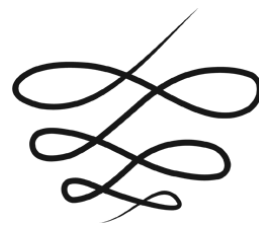
Policy and Legislation

Given that we are in the midst of the 2016 presidential primaries, this issue's Policy and Legislation section will focus on federal political issues. Below are two important resources: 1) *National Association of Social Work's* political action arm PACE, and 2) *National Alliance on Mental Illness's* stance on Mental Health Parity.

From NASW:

PACE: Building Political Power for Social Workers

Political Action for Candidate Election (PACE) is the political action arm of the National Association of Social Workers. As a political action committee, PACE endorses and financially contributes to candidates from any party who support NASW's policy agenda. The national PACE Board of Trustees endorses and contributes to federal candidates running for U.S. House and Senate seats; the state chapter PACE units decide on local and state races.

PACE

- Mobilizes thousands of social workers to vote by informing NASW members about which candidates NASW-PACE has endorsed.
- Compiles valuable facts such as voting records of U.S. Senators and Representatives and information on more than 150 social workers elected to federal, state, and local office.

Why Social Workers Should Get Involved

From NASW: https://www.socialworkers.org/pace/why_involved.asp

It is easier to spend a few months and some money electing the right people than to spend years and a lot of money trying to get the wrong people to do the right things.

—Senator Debbie Stabenow, MSW

Political Change Starts with the Social Worker in Campaigns and Elections

Social workers give time, money, and their valuable perspective to campaigns that elect public officials who support NASW policy goals.

Elected officials committed to social work values write, co-sponsor, and vote for legislation that becomes public policy.

Sound public policies enable social workers to meet human needs, be fairly compensated, and promote social justice.

From NAMI:

Parity for Mental Health Coverage

(Taken from *https://www.nami.org/Learn-More/Public-Policy/Parity-for-Mental-Health-Coverage)*

Parity is legally recognizing mental health conditions and substance use as equal to physical illnesses. Without parity mental health treatment is often covered at far lower levels in health insurance policies than physical illness, which means people do not get the care they need to experience recovery.

Health Plans Subject to Federal Parity

About one-half of all covered Americans are enrolled in large self-insured health insurance plans that are subject to federal parity. The federal parity law doesn't require plans to offer coverage for mental health or substance use, but if they are covered, then the law requires that coverage is equal with coverage for other health conditions.
The federal parity law also applies to all plans available through state and federal health insurance marketplaces. State-regulated group health plans must continue to follow state requirements to provide coverage of specific (or all) mental health and/or substance use disorders.

Health Plans Subject to State Parity

Federal parity replaces state law only in cases where the state law "prevents the application" of federal parity requirements. For example, if a state law requires only some coverage for mental health disorders, then the federal requirement of equal coverage will replace the "weaker" state law. However, if a state's parity law is stronger than the federal parity law, then health insurance plans regulated in that state must follow state laws. For example, if state law requires plans to cover mental health conditions, then they must do so, even though federal parity makes covering mental health benefits optional.

Where Does NAMI Stand?

⇒ The adoption of parity laws in states that cover all mental illness with a broad array of treatment and supports and requires inclusion of mental health care in all insurance plans sold in the state.

- Assertive enforcement of parity by the U.S. Departments of Labor and Health and Human Services and state insurance commissioners.
- Enforcement of the federal parity requirement for all health plans sold through state, federal or partnership Health Insurance Marketplaces.

⇒ See more at *https://www.nami.org/Learn-More/Public-Policy/Parity-for-Mental-Health-Coverage#sthash.TG9xJKs1.dpuf*

Submitted by Christina James

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Brunch will be served, followed by a discussion:

"Cyber Social Work?
Social Media and its Effects on Social Work"

Please plan to attend from 11 a.m. to 1 p.m., free of charge,
at 1314 W. Winnemac Ave., Unit 2,
in Chicago's Andersonville neighborhood. For more information or to RSVP
email *iscsw@ilclinicalsw.com* or visit our website.

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