Illinois Society for Clinical Social Work Newsletter

Development through research, advocacy, education, affiliation and action.

Save the Date!

Fall Conference on Ethics & Cultural Competence

October 18, 2019

Jeanne A. Douglas, Ph.D.
The MIlitary Culture:
Enhancing our Clinical Competence

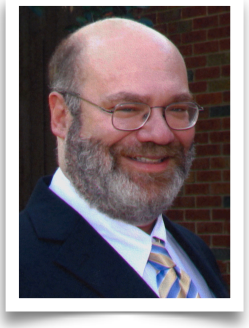
Joseph Monahan, MSW, ACSW, JD
Professional & Ethical Considerations for Social Workers and Counselors

Venue:
Hilton Garden Inn Chicago North Shore/Evanston
1818 Maple Avenue Evanston, IL 60201

Register: www.bit.ly/LinkTBD
see page 16

Outgoing President's Message

This is my last President's Message. By the time you read this, I will have left the position of President of the Board. Leading the Board for the last 7 years has been an incredible experience, and I would like to use this message to review some of the highlights of my term as president.



Eric Ornstein

I am particularly proud that leading national clinicians have presented at our conferences during the years I have served on the Board. These presenters have included Alan Shore and Louis Cozolino, who each shared their cutting-edge visions of how concepts from neuroscience can be integrated with the everyday practice of psychotherapy. Jon Allen shared his sophisticated integration of attachment theory and mentalizing interventions in the treatment of trauma, while Laura Brown raised our consciousness with her feminist perspective on cultural competence in working with trauma survivors. I was particularly impressed with Alan Levy's evocative and transparent discussion of case material and countertransference issues at our last major conference.

In addition to our major conferences, for the last six years ISCSW has organized and presented day-long bi-annual Ethics/Cultural Competency workshops that enabled our members and the larger social work community to obtain their ethics and cultural competency CEUs, in order to renew their LCSW licenses. Speakers for these work-

President's Message (continued)

shops have included Social Work Professors Carlton Munson, Henry Kronner, and myself, as well as social worker Kimberly Lux, and lawyers Jonathan Nye and Joseph Monahan. Over 100 people attended each of these events.

I also led the board in developing the Society's popular Networking Events, in which the board hosts members and participants from the larger social work community in an engaging experience of socializing and discussing clinically relevant topics while enjoying a delicious brunch provided by board members.

One of my proudest accomplishments during my tenure as president has been planning, organizing, coordinating and facilitating The Jane Roiter Sunday Morning Seminars over the past five years, with the assistance of a wonderful committee of members: Carol Crane, Jane Pinsoff, Mary Ann Jung, and Margaret Grau.

Over these years, the presenters at the Seminars have been among the most distinguished and talented clinicians in the Chicagoland area. In recent years, presenters have included Irwin Hoffman, Frank Summers, Froma Walsh, Katherine Tyson, Joseph Palombo, Jill Gardner, Hylene Dublin, Barbara Burger Mathew Selekman, Anna Lieblich and Laurie Kahn. The Seminars have provided participants wonderful opportunities to improve their clinical skills, gain cutting edge knowledge of contemporary practice theories, to socialize and network with friends and colleagues, and to accumulate CEUS for LCSW license renewal.

I am leaving the presidency of the Society in the extremely capable hands of Kristy Arditti, who has succeeded me as President. She is a social worker with years of experience working with traumatized children and their families. She has also been an administrator, a supervisor and consultant at several prominent social work agencies. In addition, she has a successful private practice serving children, families and adults. Recently, her impressive clinical expertise was amply demonstrated in a wonderful presentation she delivered (with her colleague Amy Chandler) on "Holding Families with Trauma", during the last round of our Jane Roiter Sunday Seminars. Her leadership and participation on the Board has been exemplary as she has ably served in two board positions, Board Secretary and as Chair of our New Professionals Committee. I know you will join me in welcoming her to her new position as our President and I hope you will have the opportunity to meet her in the near future when you attend our Society events.

Eric Ornstein
Outgoing President, ISCSW

Incoming President's Message

Kristy Arditti

It is with much gratitude, honor and excitement that I take on the role of President of ISCSW. I have been reflecting on how important ISCSW has been to my own professional development over the years. I have looked to this organization for relevant and thought-provoking seminars and trainings through the Sunday Morning Seminars and the Ethics and Cultural Competency Trainings, for stimulating original articles provided in the newsletters, and for wonderful networking opportunities and events. It is an organization where I have been able to hear the work of seasoned clinicians such as Jill Gardner, Irwin Hoffman and Frank Summers. I have had the opportunity to listen to gifted clinicians like Ruth Sterlin share their clinical work. I have also had the opportunity to present my own work at a Sunday Morning Seminar.

Given what a wonderful organization ISCSW is, I am aware that I have very large shoes to fill as President. Such skilled and dedicated long-serving presidents like Eric Ornstein and Ruth Sterlin have continually propelled our organization forward ensuring that it provides relevant, cutting edge, and needed support and information to clinicians. In my service to the board, I hope to provide consistency and continued structure in our programs and offerings to the clinical community along with some new opportunities and programs, so that ISCSW continues to be an important and relevant resource within the field of social work.

I would like to share a little bit about myself and invite you to contact me if you have ideas for the organization or would like to share the important work that you are doing! I consider myself to be a psychodynamic, relational therapist who specializes in the impact of trauma on children and adolescents. I received my Masters Degree in Clinical Social Work from the University of Chicago and completed a three year postgraduate course in trauma at Womencare Counseling Center. My professional experience has been varied, but has focused largely on working with individuals who have experienced cumulative forms of relational trauma. I am lucky to have had the opportunity to do long-term clinical work that includes stints working as a mitigation social worker for individuals on death row, investigator at the Office of the Inspector General, a child/ adolescent therapist at Rainbow House, a children's therapist at The YWCA- RISE Children's Center and now as a clinical supervisor and therapist at A New Direction Beverly Morgan Park. I also maintain a private practice in Evanston, IL where I see children, adolescents and adults. Through the years I have been continually reminded of how important it is to have resources and support in my work.

President's Message (continued)

I am already in the process of creating a database of clinicians who are willing to offer reduced fee clinical consultation and/or therapy to ISCSW members in need. The database will be available in the coming months to members of ISCSW through a login on our website. With this new resource, we hope to provide renewed and easier access to collaboration and support with each other. Please look for the information form linked in this newsletter (page 19) if you are interested in providing service to others or are in need of support yourself.

I look forward to the work ahead and invite you to collaborate with me in the coming months. A treasured mentor of mine, Laurie Kahn, said "No one should do this work alone" and I could not agree more. I look forward to seeing you all at our events and being in relationship with you.

Kristy Arditti

Kristy Arditti
Incoming President, ISCSW

Advertisement:

Open Board Positions

This is a time of exciting transition for ISCSW. If you would like to be a part of steering and shaping the organization through this new era of leadership and development, we are looking for new board members to fill the following vacant positions, spanning a variety of interests and skill sets:

Legislation and Policy

Membership

Public Relations

Cultural Competency

Student Liason
(to be filled by a social work student)

The board meets on the third Tuesday of every month in the Lakeview neighborhood of Chicago (convenient to Belmont Red/Brown/Purple lines) from 7:30 to 9 p.m., and our meetings are both fun and productive.

If you would like to be part of our board, please contact us at **iscswcontact@gmail.com**

Original Clinical Article

Acute Care and Long-Term Relationships

by William Kinnaird

Abstract

Hospital social work is regarded generally as short-term practice. However, Veterans Adminisration hospital social workers' experiences and VA readmission rates suggest that hospital-based social workers' practice may often evolve into long-term helping relationships where many patients come to rely on the hospital social worker as a helper to return to many times, and who may be regarded as much more than an acute care provider. This paper surveys VA hospital social workers' experiences in extended patient relationships at three Chicago Metropolitan VA hospitals (N=31). These are compared with hospital readmission rates over one and three-year time periods. How long-term relationships evolve from episodes of acute hospital care is discussed, and then implications for hospital social workers and healthcare are considered.

Introduction

This paper is about opportunities presented to acute care hospital social workers to establish long-term helping relationships when there is the probability of repeated contacts with many patients. This challenges the overly simple notion of hospital social work as necessarily short-term (Dhooper, 2012; Dzieglewski, 2004; Fort Cowles, 2003; Gehlert & Browne, 2012; Johnson & Grant, 2005). This paper sets the context for multiple helping contacts in an evolving healthcare system where healthcare access is opened by the Affordable Care Act (ACA) to a greater, more diverse population. VA hospital social workers are surveyed and VA readmission data are presented as evidence of opportunities for long-term helping relationships with patients. How long-term helping relationships evolve in the acute care setting is discussed. Finally, the implications of long-term helping relationships for hospital social workers' practice and training are considered.

Background

Advances over many years in medicine, technology, allied fields and the way medical care is organized and funded have pushed costs of healthcare ever higher in the United States. Healthcare expenditures account for almost one-fifth of GDP and are the highest per capita in the world. At the same time, it has been estimated that 40-50 million Americans do not have health insurance, and therefore struggle with insurmountable barriers to accessing needed health care. As costs of healthcare have climbed, having adequate healthcare insurance is essential to afford ever more expensive medical care.

Since the passage of the Medicare Act in 1965, followed by Medicaid, successive administrations enacted piecemeal solutions to extend health coverage somewhat, and to specific classes of people, but mostly opted to leave the administration of healthcare to the private sector of our national economy to allocate medical care resources. This was the path of least political risk. There were perennial concerns about soaring costs and suspicion about government interference (Lobosky, 2012; Richmond & Fein, 2005). Yet the problem of unequal access remained, and while great inequity persisted, the time had come when the access problem would be directly addressed. This was context for passage of the Affordable Care Act (ACA). While the President and Congress continue to wrangle over it, the ACA survives.

In the years leading up to the passage of the ACA, and to address concerns about expanded government intervention into healthcare, the Veterans Health Administration or VHA was held up by some as an example of a Government program that had demonstrated success (Gerencher, 2010; Ibrahim, 2007; Longman, 2005; Longman, 2010). VHA is tasked with caring for people who have served in our Armed Forces. Many VHA patients struggle with chronic medical, psychiatric and addiction conditions and co-occurring psycho-social problems (McGuire, Birkson & Blue-Howells, 2005). The VHA is the nation's largest healthcare system and employs more social workers than any other healthcare system. In the early 1990's, VHA was threatened with Congressional dismantlement following public revelations of poor care. In response, visionary leadership

Original Clinical Article (continued)

initiated far-reaching reforms resulting in dramatic improvements in cost of care, patient satisfaction and, most importantly, quality of care (Longman, 2010).

During its transforming time in the middle to late 1990's, the VHA measured its progress by comparing itself to market-driven private healthcare. A former deputy director for VHA succinctly stated the VHA had "to demonstrate that [it could provide] an equal or better value than the private sector, or frankly, [it] should not exist" (Longman, 2010). Consequently, VHA social workers were never insulated from the same challenges faced by healthcare social workers in the private sector. For hospital social workers this meant developing innovative approaches to improve care and contain or reduce the cost of that care. These challenges were magnified by the evolving profit-oriented, market-driven business of healthcare. Lest it lose its place or be replaced by nursing or other professions, hospital social work had to rethink and reinvent. Practically this meant focusing on discharge planning and mastering short-term interventions. Since hospital stays are one of the costliest elements in healthcare, if hospital social workers could help reduce the length of stay (LOS), they would continue to be a valuable asset on the hospital team.

Consequently, hospital social work is regarded as a short-term intervention practice. While for the most part this may accurately describe hospital social work practice, VHA medical center hospital social workers may have another side of this story to tell. Namely, there is a confluence of circumstances favoring long-term helping relationships developing between hospital social workers and many patients who depend on the VA for healthcare. Many of these patients have chronic health and psycho-social problems (McGuire, Birkson & Blue-Howells, 2005). Many are unemployed or underemployed, have low incomes, and without the VHA would otherwise face much higher barriers to accessing medical care and social services. Millions more previously uninsured people gained access to care with the Affordable Health Care Act. This paper draws from the VHA experience and VHA hospital social workers to show how hospital social work may become long-term social work. How patients become long-term hospital social work cases and suggestions for helping are considered in this paper.

Methods

Both qualitative and quantitative sources were gathered in order to assess possibilities of acute care hospital social workers developing long-term helping relationships with their acute care patients. While "long-term" could imply "open-ended," how long should a relationship be to be considered "long-term?" Writing about long-term psychotherapy relationships, Gabbard (2010) designated a duration of six months or longer as "long-term." While describing the process of case management, Kanter (2000) discussed long-term duration of many years. For the purposes of this study two time periods are considered: one year and three years. Readmission rates from three Chicago metro VA medical centers' medical and psychiatric wards were compiled (Table A). The readmission rates only suggest possibilities for social workers to have multiple contacts within the context of any patient's re-admissions. Next, at each of the three VA medical centers, a brief survey questionnaire was distributed via email to social workers (N=31) who were identified by the respective social work leadership as being currently assigned to acute care inpatient psychiatric, medical or surgical wards. The emailed survey consisted of ten questions: six questions to determine workers' general demographic, professional and employment background (Table B); three questions to estimate approximate numbers of patients with whom they had multiple formal and informal helping contacts with over the previous one-year and three-year periods; and, finally, a question about the worker's sense of having established many long-term helping relationships. Likert scales were used for recording estimates of contact frequencies over the one-year and three-year periods (Table C).

Acute care hospital social workers' roles in these VA medical centers generally include assessing patients, providing education about and referrals for concrete services, leading groups, evaluating families, coordinating with the multi-disciplinary team, and assisting with discharge plans. All potential participants were initially contacted by email with an encrypted letter, assuring that participation was voluntary, confidential, and would not affect employment status in any way. The general purpose of the survey was described. Many respondents (13) indicated they could not respond to the encrypted message but opted for either completing the survey by telephone interview or in paper format. Some of the respondents (9) were known by the author, most (22) were not. All of the respondents were

Table A

Readmissions for Sites A, B, and C for 1- and 3-year periods reported as totals and as percentage of the total admissions for the period.

Readmissions for 1 year: Site A

Total **A** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**3054** pts)	853 pts or 27.9%	114 pts or 3.7%
Psychiatry (**744** pts)	158 pts or 21.4%	22 pts or 3%
Surgery (**609** pts)	89 pts or 14.3%	8 pts or .2%

Readmissions for 1 year: Site B

Total **B** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**1385** pts)	278 pts or 20.2%	32 pts or 2.3%
Psychiatry (**566** pts)	48 pts or 8.5%	1 pts or .2%
Surgery (**231** pts)	18 pts or 7.8%	0

Readmissions for 1 year: Site C

Total **C** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**3200** pts)	884 pts or 28%	83 pts or 2.7%
Psychiatry (**735** pts)	142 pts or 19.3%	9 pts or 1.2%
Surgery (**1136** pts)	148 pts or 12.5%	2 pts or .2%

Readmissions for 3 years: Site A

Total **A** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**7045** pts)	571 pts or 23.6%	84 pts or 3.5%
Psychiatry (**1733** pts)	135 pts or 7.7%	16 pts or .9%
Surgery (**1847** pts)	89 pts or 14.3%	2 pts or .3%

Readmissions for 3 year: Site B

Total **B** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**3714** pts)	571 pts or 23.6%	84 pts or 3.5%
Psychiatry (**1743** pts)	135 pts or 7.7%	16 pts or .9%
Surgery (**705** pts)	86 pts or 12.2%	2 pts or .3%

Readmissions for 3 year: Site C

Total **C** Admissions	2 to 4 Readmissions	5 or More Readmissions
Medicine (**7276** pts)	2276 pts or 32%	560 pts or 7.6%
Psychiatry (**1774** pts)	461 pts or 26%	78 pts or 4.4%
Surgery (**3212** pts)	605 pts or 19.3%	17 pts or .5%

Table B

Demographics of the Social Worker Sample (N=32)

1. Gender	1 Male	30 Female
2. Age range	Mean: 35-44	Modal age range: 25-34 (14)
3. Years practicing post masters	Mean: 5.5-9 years	Modal: 5 years or less: 14
4. Years on current station	Mean: 2.5-6.45 years	Modal: 5 years or less: 25
5. Years in current assigned position or ward assignment	Mean: 3.06-5.51 years	Modal: 3 years or less: 9
6. Current ward assignment	22 participants are inpatient only	9 both inpatient & outpatient

Table C

Social workers' estimates of formal and informal helping contacts with patients for previous **1 year**

Worker estimates of #s of patients they've had **at least 5** contacts with during previous **1 year period**	**>5** patients	**6-10** patients	**11-20** patients	**21-30** patients	**Over 30** patients
Workers Reporting	**0**	**1**	**5**	**6**	**19**

Social workers' estimates of formal and informal helping contacts with patients for previous **3 years**

Worker estimates of #s of patients they've had **at least 5** contacts with during previous **3 year period**	**>10** patients	**10-20** patients	**21-30** patients	**31-50** patients	**Over 50** patients
Workers Reporting	**2**	**2**	**4**	**3**	**20**
Worker estimates of #s of patients they've had **at least 10** contacts with during previous **3 year period**	**>10** patients	**10-20** patients	**21-30** patients	**31-50** patients	**Over 50** patients
Workers Reporting	**6**	**4**	**5**	**1**	**15**

Social workers and their long-term helping relationships with patients

Workers' response to whether they consider themselves to have developed many **long-term** helping relationships with patients they have served.	**Yes,** many long-term helping relationships	**No,** not many
Workers Reporting	**22**	**9**

Original Clinical Article (continued)

masters-level social workers. The study protocol was approved by the Jesse Brown VA Medical Center IRB.

Results:

The author was able to achieve a response rate of 100% (31 of 31). While such a robust response to a survey is unusual, the response rate may be attributed to several factors: first, the professionalism and responsiveness of the social workers surveyed; second, the conveniently brief survey where participants were invited to take just three to five minutes to respond; third, the author followed up those who did not respond initially; and fourth, initial non-responders were offered an alternative to an email response. Initial non-responders were offered an option of either answering with a paper survey or by telephone interview. Thirteen participants opted to respond by telephone or in paper format. These accommodations facilitated the robust response.

Of all the acute care hospital social workers—psychiatry, medicine, and surgery—only one was a male, the rest (30) were female. While this gender ratio may not reflect the gender ratio of the social work profession in general, women at the three facilities sampled are apparently more strongly drawn to hospital-based social work. Other characteristics of the respondents - age, years of post- masters practice, years on station, and years in their current practice or ward assignment - all suggest hospital social workers in this sample are early career professionals. Specifically, almost half of the sample (14) had been practicing five years or less, with a sample average of 5.5 to nine years practicing (Table B).

Over two-thirds (22 out of 31) of those surveyed responded that they had established many long-term helping relationships with patients. When asked to quantify frequencies of contact, 19 respondents estimated having "at least" five contacts with over 30 individual patients over the previous year of service. While over the previous three years of service, 20 respondents estimated having "at least" five contacts with over 50 patients. Fifteen respondents, or one less than half of all respondents, estimated they had "at least" ten contacts with individual patients over the previous three-year period (Table C). Respondents were invited to comment about their relationships with patients. The following is a selection of comments offered:

It feels like the veterans truly rely on this hospital as a source of support. For some, the institution is another dependable family member.

Most of our patients feel safe here... [They] always have the same social worker...We build very long-term relationships [with] a lot of our patients.

I wouldn't say ongoing long term relationships, but usually we remember each other when they are readmitted. It is over time and we reconnect when they come in. This is sometimes helpful because we already have established trust/rapport.

We often get "repeat" patients. Also, I receive calls weekly from veterans who have been inpatients in my unit in the past. I try to encourage veterans to contact their outpatient social worker. However, I often end up triaging calls and assisting with services.

I have come to see several chronically ill veterans in these areas come and go throughout the years and have contact with them either as their current social worker or as a past worker who exchanges pleasantries in the hallways... Some of the veterans, even after no longer under my service line, still feel they can come and ask questions and get help as needed. I have found that the veterans like to be acknowledged as individuals with their own special needs/wants and not just lumped together as "just another patient... "

I am able to see the veterans from the moment of diagnosis through their cancer journey. I feel that I am a constant during their journey while other providers may change. I feel that having the same social worker on an inpatient/outpatient basis is very beneficial for these veterans because they always have someone they can turn to but, of course, also leads to me being pretty busy.

There are so many stories

Original Clinical Article (continued)

Additionally, the survey of hospital social workers readmission data for the three medical centers suggests there are opportunities for multiple social work contacts over one and three-year periods. In sum, many hundreds of patients are readmitted two to four times to medical wards at each medical center (sites A, B and C) over a one-year period with respectively 158, 48, and 142 patients readmitted two to four times to psychiatry wards in the one-year period. For the three-year period many hundreds were readmitted five times or more at two of the medical centers with many thousands readmitted two to four times (Table A). It must be noted that the differences in re-admissions between the three sites may be attributed to special characteristics of the one site's client population. Namely, the one site serves both civilian and military populations. Since military personnel are subject to discharge for medical or psychiatric reasons, many sicker patients are removed from the population served at this site.

Limitations

There are several limitations in this study methodology. First, having opportunities for serial social worker-client encounters suggested by the readmission data does not necessarily signify that a long-term helping relationship has developed. Readmission data only suggest that through repeated opportunities for contact, the stage may be set for a long-term helping relationship to occur. Second, workers being asked to estimate numbers of clients they have developed long-term helping relationships with is a very subjective indicator. Third, the term "long-term" is not well defined and left open to the respondents' interpretation in the context of estimating for one to three year periods. Fourth, there may be overlap among the sets of clients each respondent estimates they have long-term helping relationships with; and if that is so, then the absolute numbers of clients a given group of social workers have long-term relationships with would be a smaller absolute number of clients. Related to this is that some acute care social workers also have outpatient assignments. Since that would be another setting in which they may encounter some of the same clients they encounter for acute care, this study is not exclusively about acute care hospital providers, but some outpatient providers too. Fifth, some respondents had a collegial (but non-supervisory) relationship with the author, and this may have skewed some findings. Since this study was not funded, employing a trained external surveyor was not a viable option. Finally, the generalizability of this convenience sample to other health care settings and populations should be approached with caution. That is, veterans are a special population with a unique sense of identity as veterans and a special connection to other veterans (Junger, 2016). However, the settings in which the survey was conducted—several large vertically integrated care networks where many with chronic health conditions are treated—may come to resemble private sector health providers' clientele as access to health care increases for many more under the ACA. The notion that acute care hospital social workers end up developing long-term helping relationships with considerable numbers of clients should receive ongoing study in the context of the changing, more inclusive healthcare system and evolving roles of hospital-based acute care social workers.

Discussion

A patient may attach and decide to continue with an acute care hospital social worker or treatment team for many reasons: barriers to alternative care, convenience, idiosyncratic healthcare notions, good previous experiences, or personality and attachment issues (Karen, 1998; Wallin, 2007). While identifying and resolving these issues is often a social work aim, resolution may take time. Progress and trust come very slowly for some patients. Many patients do not readily fit into standard diagnostic categories, have hidden motives, and have struggles that are difficult to articulate. Further, people stressed by chronic illness— conditions requiring many re-admissions—may become impoverished, and poverty adds stress (Ansell, 2017) and can narrow one's range of healthcare and life options. With fewer healthcare options, some patients have to rely on specific providers, and that is often a hospital team or an acute care social worker.

Over the course of multiple re-admissions or crises, patients may become attached to an acute care social worker who helps them through crises. Patients often come to trust and feel known by inpatient social workers more than other healthcare providers. They may choose to return to an inpatient social worker or team they know with new problems or to do more work on something not yet finished. Patients often complain about frequent changes in healthcare providers or even occasional changes, especially when a patient feels he/she is losing a good relationship. Patients grow weary of confiding in serial healthcare providers. Some patients seek continuity of care on their own terms, and when they feel it isn't available in other healthcare settings, they may seek it from acute care providers who have been a more constant presence.

For patients with similar needs, some healthcare settings structure patients' care so that multiple contacts

Original Clinical Article (continued)

with an assigned social worker are more likely to occur. This may occur when a social worker is assigned to a specific program or when particular patients are assigned then reassigned to a specific social worker. Some acute care programs provide for the inpatient social worker to continue following cases as they progress to outpatient care. It has even been suggested for certain cases when re-admissions are anticipated that re-admissions be scheduled in advance much like outpatient appointments are scheduled (Merchant & Henfling, 1994).

Some patients' lives eventually may become centered on the healthcare providing hospital not only for care but for social enrichment. Health care administrators may facilitate this by accommodating patients with appropriate services and programs. While patients may rely on these, some may choose to volunteer or assist the healthcare center in other ways. These are some ways in which opportunities for formal and informal worker-patient contacts are likely to increase. These kinds of arrangements favor long-term relationships developing between an acute care hospital social worker and a patient. An encompassing healthcare setting culture may support these relationships or inhibit them from developing.

This perspective does not contradict efforts to reduce LOS or re-admissions, nor does it contradict measures to reduce unnecessary use of expensive inpatient medical care. It merely recognizes the simple fact that when systems fail to provide what patients feel they need, they will try to find ways to work with or around systems in order to get their needs met. Many people are not ready or able to use outpatient or residential modalities as they are configured locally. Some do not adhere to care plans providers recommend, but lurch from crisis to crisis, sometimes requiring re-admissions. An impoverished person who is preoccupied with day-to-day survival may not adhere to a daily healthcare regime or appointment schedule. Of course, for some kinds of chronic conditions re-admissions may be unavoidable. These would be patients with a range of chronic health and/or psychiatric conditions, patients inclined to somaticize, or those with drug and/or alcohol addictions.

For the impoverished and chronically ill, management often requires coordinating care across multiple agencies and programs. The hospital social worker may become an essential contributor or coordinator in a network of interacting systems sustaining the person. The social worker may become a coordinator in the course of multiple hospital re-admissions often typical for people with chronic conditions. Many patients come to think of an acute care social worker as their case coordinator.

While following through on certain interventions, a social worker may become so well versed in the case's complexity that handing it off just does not seem practical. Some patients know this and seek a trusted worker they think will be most knowledgeable about their case or their best resource (Kinnaird, 2007). Deftly managing a caseload may become more challenging when a worker gets to know many patients and helps them with their problems but begins to feel overwhelmed by such a large caseload. Sometimes a worker needs to find tactful, respectful ways to set limits without being off-putting.

Addressing concrete needs and discharge planning not only meet immediate basic needs but may be an entrée into a deepening relationship. Over multiple formal and informal contacts an acute care worker may come to be trusted and considered special. Much may be shared in conversations and during helping activities. When it is mutually comfortable, playfulness and banter may occur. What isn't spoken may be enacted, and after a while a worker may begin to grasp what cannot be said directly (Ganzer & Ornstein, 2008) and subsequently be able to help the patient to articulate it. An attentive worker will remember important things about patients, and patients often feel valued by a worker who remembers.

When a long-term worker-patient relationship develops through many contacts over a long time, a worker may come to serve many roles for a patient: discharge planner, case coordinator, case manager, and therapist. Contemporary psychodynamic theory provides a rich source of concepts to help understand the vicissitudes in these patient-worker relationships (Ornstein & Ganzer, 2005; Borden, 2000; Poland, 2000). As a person is helped, subtle changes and progress may be noted, personal information is disclosed, mutual influence is exerted, and a mutually co-created narrative may develop (Saari, 1991; Borden, 1992).

In the helping relationship, how the social worker manages her/his feelings is challenging. A variety of reactions are well known by acute care social workers: counter-transference attendant on pressures to reduce LOS; unrealistic expectations; and frustration with patient setbacks, non-linear progress or lack of any progress. Social workers may react to patients who seem overly dependent, demanding, unappreciative, deprecating, or just puzzling. Reducing LOS is a long-standing healthcare objective and may distract from weighing the long-term needs of the patient. Many patients are stressed by fear of abandonment and neglect. They may be lonely. Any patient is reassured when

Original Clinical Article (continued)

she/he senses that the worker's concern for the patient's welfare extends beyond the short-term treatment episode.

Does more fully participating in a relationship mean a social worker is enabling dependency or overuse of services intended as acute care? Scarcity of appropriate community resources such as outpatient mental health or residential care (Frank & Glied, 2006) may leave the hospital as many patients' default option. This poses an institutional care dilemma and a dilemma for the social worker: does it come down to discouraging or even turning patients away to discourage them from depending on acute care providers when it may be their tenuous or sole lifeline? With all of these looming factors, acute care providers, as all providers across the patient-care spectrum, must always search with the patient for roads to recovery and better health. But it is critical to remember that the course of each patient's struggle is different, and often non-linear, with some getting better, some not, and some remitting for periods of time.

Conclusion

This paper presents a different perspective on the tasks of the hospital social worker; acute care social work is much more than short-term intervention, but occasions long-term helping relationships. An expansion in healthcare coverage means many who have been excluded will now have access to healthcare, and this may change the kinds of patients who will present. More patients who have been denied access due to lack of adequate private health insurance or outright denial of health insurance will now have it with the ACA. Consequently, the patient profile in the private healthcare sector may come to mirror the public healthcare sector as represented by the Veterans Health Administration where many without health insurance, chronic health conditions, and struggling with a range of psycho-social problems seek care. These are people who have always been the clients of social workers. If profiles of patients accessing hospital care in the private sector come to mirror those seen in the Veterans Health Administration, then adjustment in thinking, clinical orientation, and practice preparation may be indicated to account for managing long-term relationships by social workers in the acute care setting.

References

Ansell, D. (2017). The Death Gap. Chicago, IL: University of Chicago Press. DOI:10.7208/chicago/9780226428291.001.0001

Beder, J. & Postiglione, P. (2013). Social work in the Veterans Health Administration (VA) System: rewards, challenges, roles and interventions. Social Work in Health Care, 52, 421-433. DOI 10.1080/00981389.2012.737906

Borden, W. (1992). Narrative perspectives in psychosocial intervention following adverse life events. Social Work, 37 (2), 135-141.

Borden, W. (2000). The relational paradigm in contemporary psychoanalysis: toward a psychodynamically informed social work perspective. Social Service Review, 74, 352-373.

Dhooper, S.S. (2012). Social work in health care: Its past and future (2nd ed.). Los Angeles, CA: Sage.

Dziegielewski, S. (2004) The changing face of health care social work (2nd ed.) New York, NY: Springer Publishing Co.

Fort Cowles, L. A. (2003). Social work in the health field (2nd ed.) Gaithersburg, MD: Aspen

Frank, R.G. & Glied, S.A. (2006). Better but not well. Baltimore, MD: John Hopkins University Press.

Gabbard, G. (2010), Long-term psychodynamic psychotherapy: A basic text (2nd ed.). Washington, DC & London, England: American Psychiatric Publishing, Inc.

Ganzer, C. & Ornstein, E. D. (2008). In and out of enactments: a relational perspective on the short- and long-term treatment of substance abuse. Clinical Social Work Journal, 36, 155-164. DOI 10.1007/s10615-007-0086-4

Gehlert, S. & Browne, T. (2012). Handbook of health social work (2nd ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Gerencher, K. (2010). For quality, it's hard to top veterans' health care. The Wall Street Journal. Retrieved June 9, 2010, from http://www.marketwatch.com/story/its-hard-to-top-veterans-health-care-2010-06-02

Ibrahim, S. (2007). The veterans' health administration: A domestic model for a national health

Original Clinical Article (continued)

care system? American Journal of Public Health, 97 (12), 2124-2125.

Johnson, J.L. & Grant, G. *(2005). Medical social work. Boston, New York, San Francisco: Pearson*

Junger, S. (2016). *Tribe: On homecoming and belonging.* New York, NY: Grand Central Publishing.

Judd, R., & Sheffield, S. (2010). Hospital social work: contemporary roles and professional activities. *Social Work in Health Care*. 49, 856-871. DOI: 10:1080/00981.2010.499825

Kanter, J. (2000). Beyond psychotherapy: therapeutic relationships in community care. *Smith College Studies in Social Work,* 70 (3), 397-426.

Karen, R. (1998). *Becoming Attached: Unfolding the Mystery of the Infant-Mother Bond and Its Impact on Later Life.* New York: Oxford University Press.

Kinnaird, W. (2007). A systematic approach for providing concrete services and discharge planning based on using information handouts. *Social work in health care*. 45 (4), 23-41.

Lobosky, J.M. (2012). *It's Enough to Make You Sick: The failure of American Health Care and a prescription for the cure*. Lanham, MD: Rowman & Littlefield Publishers, INC.

Longman, P. (2005). The Best Care Anywhere. *Washington Monthly*

Longman, P., (2010). *Best Care Anywhere: Why VA health care is better than yours (2nd ed.).* Sausalito, CA: PoliPoint Press, LLC.

Merchant, D.J. & Henfling, P.A. (1994). Scheduled brief admissions: patient "tuneups." *Journal of psychosocial nursing.* 32 (12), 7-10.

Ornstein, E.D. & Ganzer, C. (2005). *Families in society: the journal of contemporary social services*. 86 (4), 565-572.

Poland, W.S. (2000). The analyst's witnessing and otherness. *Journal of the American Psychoanalytic Association*, 48 (1), 17-34.

Richmond, J.B. & Fein, R. (2005). *The Health Care Mess: How we got into it and what it will take to get us out.* Cambridge, MA, and London, England: Harvard University Press.

McGuire,J., Birkson,K., & Blue-Howells, J. (2005). How many social workers are needed in primary care? A patient-based needs assessment example. *Health & Social Work,* 30 (4), 305-313.

Saari, C. (1991). *Creation of meaning in clinical social work.* New York: Guilford Press

Wallin, D.J. (2007). *Attachment in psychotherapy*. New York & London: Guilford Press.

Advertisement:
Calling All Writers!

The Illinois Society for Clinical Social Work Newsletter is looking for contributing writers! Regardless of your level of experience with writing— whether a lot or very little—we believe that if you are a clinician in the field, you have something worthy to say… and our Newsletter is an excellent place to say it!

If writing a full article is not your preference, we invite you to submit a review of a book or professional journal article, or to express your opinion on cultural competence issues. In addition to the satisfaction of sharing your knowledge and opinions, you will have the opportunity to work with seasoned editors to facilitate your writing process and see your work featured in our striking new Newsletter design.

Please get in touch at **iscswcontact@gmail.com** for more information about submitting your work.

Book Review

The Body Keeps Score

by Bessel Van Der Kolk, M.D. (2007)

(445 pages)

Reviewed by William Kinnaird

Recalling the previous ISCSW newsletter's *The Cutting Edge* review of David Wallin's Attachment in Psychotherapy, it may be remembered that to help people who struggle with preverbal issues the client's non-conscious or unconscious preverbal life must be experiencially engaged in therapy. But preverbal life often becomes accessable through other-than-verbal channels. Wallin identified three preverbal or non-verbal transference-countertransference communication modes: enactment, evocation and embodiment.

While enactments and evocations are familiar to this reviewer and, perhaps, to the reader, embodiment as a non-verbal transference-countertransference communication mode may be less so. Wallin cites analyst-psychiatrist Bessel Van Der Kolk's The Body Keeps Score as his source explaining the embodiment mode.

Bessel Van Der Kolk, M.D. is the founder and medical director at the Trauma Center in Brookline Massachusetts. He is also a professor of psychiatry at the Boston University School of Medicine and director of the Complex Trauma Treatment Network. He is a recognized world authority on trauma and author of the book in this review.

The Body Keeps Score has three basic parts. The first part is an autobiographical story of Van Der Kolk's career and interest in treating trauma. His story begins in July, 1978, on Van Der Kolk's first day as a staff psychiatrist at the Boston Veteran's Administration, where he encounters an aggitated man struggling with combat-related PTSD. Nothing in his training had prepared him to deal with any of the challenges of veterans with PTSD. Faced with VA Administrative resistance to acknowledge the existance of PTSD, Van Der Kolk resigned from the VA in 1982 and continued at the Massachusetts Mental Health Center, a Harvard teaching hospital. While recounting his 30-plus-year career and interest in trauma, Van Der Kolk also traces thinking and developments in the field of psychiatry and the public domain as they relate to trauma. His discussion covers the range of traumatic kinds of experience including childhood neglect, abuse, abandonment, disasters, accidents, wars, incest, rape, and terrorism.

The second part of the book embedded in the first is his discussion about the physical, neurological and psychological effects of traumatic experiences. Citing research with advanced technology such as MRI and CT studies, he summarizes advances in neuroscience, the study of how the brain supports mental processes; developmental psychology, the study of the impact of adverse experiences on the development of mind and brain; and interpersonal neurobiology, the study of how our behavior influences the emotions, biology, and mind-sets of those around us (page 2).

Book Review (continued)

The third part of the book is a survey of treatment approaches Van Der Kolk has used or investigated . These include: psychotherapy, medication, EMDR, CBT, mindfulness, yoga, internal family systems, neuro-feedback, psychomotor therapy, breathing techniques, writing, theater acting, gigang, and pet therapy. Using case examples from his work, he illustrates each of these. However, what works best for whom is not always so clear.

What does Van Der Kolk say about embodiment? Citing supporting neuoscience research he explores how traumatic experiences become etched into the central nervous system, lodged there as non-conscious or unconscious memories often not accessable to verbal expression. He cautions that traumatized people may quickly become overwhelmed, shut down or flee if approached too quickly with talking or other kinds of expressive therapy. He recommends a gradual approach helping people first feel safe, acknowledging and identifying body sensations and then emotional feelings. He may initially use breathing techniques or mindfulness. These first steps help a person develop enough emotional regulatory capacity to tolerate processing traumatic experience. He describes this as "calming the physiological chaos within" (page 266).

As non-conscious or unconscious presents in the mind traces of trauma may gain expression nonverbally through behavior. For example, emotional numbing, flashbacks, dissociative experiences, emotional shutting down, temper outbursts, drug/alcohol addiction, self-injurious behavior, avoidance, emotional blunting, alexithymia and somatic symptoms. Citing "innumerable studies on the subject" (page 382) he notes varieties of "somatic symptoms for which no clear physical basis can be found are ubiquitous in traumatized children and adults. They can include chronic back and neck pain, fibromyalgia, migraines, digestive problems, spastic colon/irritable bowel syndrome, chronic fatique, and some forms of asthma." (page 100).

Van Der Kolk describes how advances in neuroscience have enabled studies of measurable "changes in the structure and function of the brain" (page 358) of traumatized people and provided "us a better understanding of how trauma changes brain development, self-regulation, and the capacity to stay focused and in tune with others." (page 249). This is how the body keeps score and what is meant by embodiment.

Finally, Van Der Kolk concludes "trauma is now our most urgent public health issue, and we have the knowledge necessary to respond effectively." (page 358). While acknowledging the complexity of responding socio-culturally, he offers practical management and intervention suggestions for therapists, teachers and social workers.

The Body Keeps Score is a primary recent addition to literature on trauma and recommended for any therapist treating people struggling with psychological trauma.

Illinois Society for Clinical Social Work

Fall Conference on Ethics & Cultural Competence

Friday, October 18, 2019

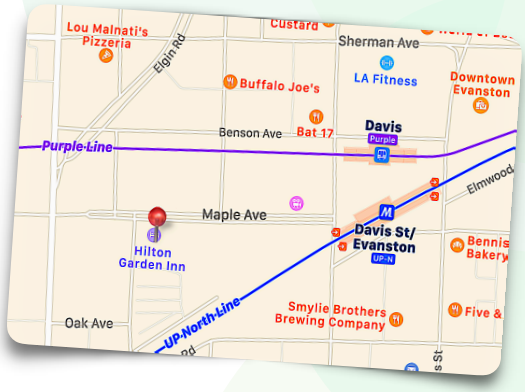
An all-day conference in two parts, providing CEUs to fulfill license renewal requirements for Social Workers and Counselors. Participants may attend the morning conference, afternoon conference, or both!

Register Here: www.bit.ly/iscsw-fall

email iscswcontact@gmail.com with any questions

Location:

Hilton Garden Inn Chicago North Shore/Evanston
1818 Maple Avenue
Evanston, IL 60201



Times:

Professional & Ethical Considerations	9:00AM – 12:00 PM
Cultural Competency	1:00PM – 4:00 PM

Registration starts at 8:30 AM. Continental breakfast provided; attendees are encouraged to make your own lunch arrangements.

CEUs: (Social Workers & Counselors)

3.0 for half-day attendence
6.0 for full-day attendence

See next page for more information >

Fall Conference on Ethics & Cultural Competence

(Information Continued)

Morning Conference

Professional and Ethical Considerations for Social Workers and Counselors

In this conference, clinicians will learn to:

- Address recent changes to the revised NASW Code of Ethics, especially regarding technology in social work practice, and some of the risks, benefits and special considerations when integrating technology into your practice.
- Address legal, licensing and regulatory issues related to when patients are on vacation or move from IL, as well as addressing when therapists go on vacation or leave IL for extended periods.
- Provide risk management strategies and best practices when dealing with divorce and visitation issues, juvenile court and child welfare cases. Identify common areas where social workers and counselors get into trouble and how to avoid these issues.
- Identify common risk issues when complying with the Mental Health and Developmental Disabilities Code, Mental Health and Developmental Disabilities Confidentiality Act and other state and federal confidentiality laws.
- Differentiate between and understand the various reporting requirements including child abuse and neglect, elder abuse and neglect, duty to warn, and FOID reporting.

Joseph Monahan, MSW, ACSW, JD

Joseph is the founder of the Monahan Law Group, LLC, which provides legal services to hospitals, agencies and social service providers. He teaches at Loyola University Chicago School of Law, and has served as President of the NASW malpractice insurance company for the past six years.

Afternoon Conference

The Military Culture: Enhancing our Clinical Competence

This presentation will address unique features of the military and how these features impact civilian life. While military personnel face challenges during combat deployments, there are also stressors on family members.

We will discuss the impact on family members and the readjustment process as the veteran returns to family and/or civilian life. Both exposure to combat and military sexual trauma are often precursors to Post Traumatic Stress Disorder and this diagnosis will be examined.

The presentation will also explore the factors that contribute to the high rate of suicide among veterans and the efforts the Department of Veterans Affairs has made to respond to this phenomenon.

Jeanne A Douglas, Ph.D.

Jeanne Douglas is a Clinical Psychologist and serves as the Director of the Forest Park Vet Center and the Acting Director of the Chicago Vet Center.

For over 35 years she has provided individual, marital and family therapy to eligible veterans and their families at the center. In addition, she provides leadership and oversight to all staff members at both Vet Centers.

She is on the steering committee of the Chicago Veterans Economic Council which coordinates the Standdowns that provide services to homeless veterans.

For the past 15 years, she has been an adjunct faculty member in Roosevelt University's graduate psychology program.

Register Here: www.bit.ly/iscsw-fall

Membership Corner

Mentorship, Supervision & Therapy at ISCSW

One of the benefits of ISCSW membership is the opportunity to network with clinicians with a wide range of experience and expertise, who share the basic core values of social work practice. We believe no one should do this work in isolation and through our trainings and networking events, we have seen that the ISCSW can support of each of us in our clinical growth and connection.

New clinicians have an especially important need to find good support and supervision as they begin their clinical careers. To address this need, we at ISCSW are creating a database of experienced professionals who are interested in providing mentorship, LCSW supervision and reduced-fee therapy to new professionals. Participation in the database also allows participants to promote their practice to other members, along with their specialization and experience.

Clinicians who are interested in working with new professionals should be Licensed Clinical Social Workers with a minimum of 5 years experience in the field of social work, and members in good standing with ISCSW. Their names, expertise, office locations and phone numbers would be listed on the database.

Please consider becoming a resource to our emerging social worker community and sign up today at the website below! Email **iscswcontact@gmail.com** with any questions or difficulties.

www.bit.ly/ISCSW-mentorship

Announcement!

We continue to work through the process of updating our contact information following last year's administrative transition.

If you have tried to get in touch in recent months and encountered difficulties, we sincerely apologize for any frustration or inconvenience.

As we build new and robust options for contacting ISCSW, please **disregard** previously published contact information (including phone, web forms, email, PO box, and fax lines) until further notice. Note: The return address on this newsletter is also temporary.

In the meantime, we are making available this temporary email address. It is staffed by a team with direct access to the highest levels of the ISCSW organization, who will make every effort to assist you:

iscswcontact@gmail.com

We appreciate your patience & understanding as you bear with us during this transitional period. For updates:

www.ilclinicalsw.com/contact/

Illinois Society for Clinical Social Work
%: Ruth Sterlin
2237 Strawberry Lane
Glenview, IL 60026-1345

Illinois Society for Clinical Social Work

Board Members

President
Kristy Arditti

Vice President
Ruth Sterlin

Treasurer
Jeff Pyritz

Legislation and Policy
Open for application

Secretary
Kristy Arditti

Education
Eric Ornstein

Membership
Open for application

Standards & Practices
William Kinnaird

Public Relations
Open for application

New Professionals
Kristy Arditti

Newsletter Editor
Ben Goldberger

Cultural Competency
Open for application

Student Liason
Open for application

Members-at-Large
Kristy Winters, Michelle Greene

Downstate President
Susan Keller

IT Administrator
Adam Ornstein

www.ilclinicalsw.com/contact