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- 10 Essentials Social Workers Need To Know About Hope
- The Criminalization of Addiction in Pregnancy: Is This What Justice Looks Like?
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Publisher’s Thoughts

Dear Reader,

Happy New Year! The year 2016 was an eventful one, marked by a contentious election, a record number of reported hate crimes and/or bias-related incidents, and a lot of uncertainty. At the same time, as social workers, we can be proud of our accomplishments and for being part of a profession that not only encourages, but mandates, us to act to preserve human rights and attend to human needs. As we enter the new year, I have been thinking about our core values. “Respecting the worth and dignity of all people” is my motto, and if we keep this in mind as our guiding principle—in our daily lives, in our work, in our advocacy for and with others—I think that’s a good place to start. Together we’ll stand for our ideals and for our clients.

In 2016, our top five articles were on the topics of child protection social work, mindfulness, human sexuality, trauma-informed care, and the impostor syndrome. Articles on ethics, self-care, and social work job search continued to be popular, as well.

In 2017, let’s also turn our focus to hope and its role in our profession (see Elizabeth Clark’s article on page 10). In this issue, we are finishing our series on achieving racial equity through social work (page 28) by Mary Pender Greene, Sandra Bernabei, and Lisa Blitz. I want to say “thank you” to these three dedicated social workers for sharing their expertise on this topic and their commitment to fighting racial injustice and inequity. This is an important series, and if you haven’t read it yet, I invite you to check it out on our website. As our nation and the rest of the world continue to struggle with issues surrounding race and racism, we will continue to explore such issues and social workers’ role in efforts to achieve equal opportunity and justice, one of social work’s Grand Challenges.

I hope you enjoy the articles in this issue of The New Social Worker, covering topics from the ethics of documentation to criminalization of addiction in pregnancy to social work on wheels and in sports. We will be right here with you throughout the new year of 2017, so let me know what you would like to read about and what you would like to write about.

To subscribe to THE NEW SOCIAL WORKER’s Social Work E-News and notifications of new issues of the magazine, go to the “Subscribe” link on our website at http://www.socialworker.com. (It’s free!)

Until next time—happy reading!

The publisher/editor

Write for The New Social Worker

We are looking for articles from social work practitioners, students, and educators. Some areas of particular interest are: social work ethics; student field placement; practice specialties; social work careers/job search; technology; “what every new social worker needs to know;” and news of unusual, creative, or nontraditional social work.

Feature articles run 1,250-1,500 words in length. News articles are typically 100-150 words. Our style is conversational, practical, and educational. Write as if you are having a conversation with students or colleagues. What do you want them to know about the topic? What would you want to know? Use examples.

The best articles have a specific focus. If you are writing an ethics article, focus on a particular aspect of ethics. For example, analyze a specific portion of the NASW Code of Ethics (including examples), or talk about ethical issues unique to a particular practice setting. When possible, include one or two resources at the end of your article—books, additional reading materials, and/or websites.

We also want photos of social workers and social work students “in action” for our cover, and photos to accompany your news articles!

Send submissions to lindagrobman@socialworker.com. See http://www.socialworker.com/Guidelines_for_Writers/ for additional information.

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Tanisha Bowman is a reluctant leader, but an acknowledged one. “I hear a lot about being a leader, and it’s not 100 percent comfortable,” says Bowman, who graduated from the University of Pittsburgh School of Social Work with her MSW on December 17 and begins the Jewish Healthcare Foundation and Health Career Futures 2017 Fellowship on Death and Dying: “The Elephant in the Room” on January 23.

Bowman is the Southwest Division Representative on the NASW-Pennsylvania board of directors and is “the only student member who’s a full board member.” (She began in this position while still a student.) “They’re great about listening to my ideas,” such as about increasing the organization’s presence on social media, she adds.

She is also an NASW-PA delegate and a member of the NASW-PA Ethics Committee and the NASW-PA Child Welfare Task Force, which she co-chairs. Previously, Bowman was a BSW Board Representative for NASW’s Virginia chapter.

“This is where I belong,” she says of both her choice of social work and her NASW involvement.

Certainly, Bowman makes her mark in her work, as well. She is a Children’s Program Professional at Jeremiah’s Place, a relief nursery for children from birth to age six whose parents/guardians need respite care or are in crisis.

“One of my co-workers told me after a staff meeting that she was glad I was on board,” she says. “But I said that I was just doing what I’m doing—not setting out to be in charge.”

Still, Bowman admits, she can’t help being drawn to what others consider leadership in her volunteer capacity. “Every meeting, my hand goes up, and I’m put on another committee,” she says with a laugh.

One thing that drives her is advocacy, which she keeps pushing. “NASW is not reaching certain people,” she says. “We need to be a strong voice for them.”

But she adds: “We have to get back to activism, not just advocacy, because people don’t feel heard. Maybe that’s why I’m here [in NASW].”

Professor James Philip Huguley, assistant professor at the Pitt School of Social Work and Center on Race and Social Problems, who taught Bowman last semester, found her “one of the best [students] ever. She was very engaged with the material. It was almost like having a teaching assistant.”

Huguley also describes another aspect of Bowman’s leadership. “She was very active in class discussion, respectful of the range of opinions but also challenged things she thought needed to be challenged.”

Interviewing Tanisha, even by phone, is like interacting with a whirlwind. The 34-year-old exudes energy, passion, and compassion.

Although she calls herself an introvert—a quality she says her husband of a few months appreciates—Bowman also admits to being very talkative when passionate.

How engaging she can be is evident in Bowman’s personal as well as professional and academic life.

The background of Bryan, her husband, is very different from her own. “Yet, when we met through online dating, we matched 96 percent,” she says.

One interest they share is that they’re both musicians. “I’m also an odd duck, a black Irish dancer,” Bowman says. She also does belly dancing and has modeled.

Confidence is something Bowman didn’t come by easily. Hers was “not a happy childhood.” Her father was abusive, and her mother worked a lot. Later, they split.

Bowman also began to notice the institutionalized racism around her, which for a while she overlooked. “These things are not okay anymore,” she says.

But Bowman also found solace in school. She obtained her BSW in May 2015 from George Mason University, as well as an associate’s degree in social science and deaf studies from Northern Virginia Community College.

Even now, she takes CEU courses “I don’t need” [for licensure] and has participated in research studies on topics as diverse as food insecurity in Fairfax County, VA, and “interracial couples, race, and social media.”

Aside from NASW, she is a member of the National Association for Grieving Children and the National Organization of Forensic Social Workers.

The multitalented Bowman has tried many occupations. She was a...
To Record or Not To Record: The Ethics of Documentation
by Allan Barsky, J.D., MSW, Ph.D.

Social work documentation. Now, how exciting is that?! Yes, documentation is not exactly the most thrilling aspect of social work practice. In fact, sometimes the documentation process can be downright tedious. Still, if you want excitement in your professional life, try documenting in an incompetent, disrespectful, dishonest, incomplete, or disorganized manner. Nothing says “malpractice lawsuit” faster than situations in which social workers provide direct evidence of substandard practice in their client records. Conversely, good old boring records are vital to risk management, reducing the risk of malpractice lawsuits, professional disciplinary hearings, and agency discipline.

Standard 3.04 of the National Association of Social Workers (NASW) Code of Ethics (2008) provides social workers with guidance about documentation and record keeping. Part (a) states that social workers should ensure their documentation is “accurate and reflects the services provided.” That makes sense. Be honest. End of sentence.

Part (b) instructs social workers to include sufficient information to “facilitate delivery of services and to ensure continuity of services provided to clients.” Once again, this standard seems obvious. Records are supposed to support the provision of services. Social workers, supervisors, and colleagues need to know about the client’s concerns, the client’s goals, and the plans for reaching those goals. Good records can keep the helping professionals and clients on track, and ensure that services are provided in a competent and effective manner. For these purposes, comprehensive, and perhaps expansive record keeping might be suggested. Isn’t it better to have more than enough information, rather than not enough?

Part (c), however, suggests that “social workers’ documentation should protect clients’ privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.” Ah, there’s the rub. More is not always better. Given that clients have a right to privacy, documentation should be limited to what is relevant to service delivery. Even though most client records are “confidential,” there are many people within the agency and beyond who could have access to all or parts of the records:

- Supervisors and co-workers
- Researchers and program evaluators
- Government auditors or other officials responsible for monitoring and accountability
- Insurance providers
- Other agencies or people as authorized by client consent

In addition, client records may be used in courts under various circumstances—for instance, in child protection cases, in family law cases, in malpractice lawsuits, and in mental health hearings. To protect client privacy, social workers should consider limiting what they document, so as not to embarrass clients or share information that clients may want to remain private.

“So,” you may be asking, “how do I balance the need to provide full and accurate information in client records with the interest of protecting client confidentiality?” I’m glad you’ve asked. To address this balancing act, consider the following factors: laws, agency policies, client wishes, and social worker needs.

First, various statutes and regulations may govern your practice, including what information needs to be recorded, how records should be maintained, client rights to access records, and under what circumstances confidential records may be shared with others. At a federal level, consider the Health Insurance Portability and Accountability Act (for health settings) and Federal Education Rights and Privacy Act (for educational settings). At a state level, there are specific laws regulating child protection, criminal justice, mental health, and other practice settings. At a minimum, records should meet these standards. For instance, when requesting reimbursement for services provided under Medicaid, consult the laws governing Medicaid.

In addition to laws, agency policies also govern what type of information needs to be gathered—for instance, date of contact, purpose of meeting, client concerns, and information related to safety (child or elder abuse and neglect, suicidal or homicidal ideation, drug use, or intimate partner abuse). Note that when laws and agency policies conflict, laws generally take precedence. For example, an agency policy may require gathering client Social Security numbers, while a state law may prohibit this. Follow the law—and change agency policy to comply. Agencies often provide specific forms (digitally or on paper) requiring social workers to gather and document particular information as part of their intake, assessment, intervention, and evaluation processes. Although it is important to follow the law and agency policies, these are far from the only considerations.

Standard 1.02 of the NASW Code reminds us that clients have a right to self-determination. Ideally, this right includes the ability to provide input into what types of information are gathered and documented by the social worker. Consider a client who is having extramarital relations, but does not want this information documented. Alternatively, consider a client from another country who does not want you to document that she is working without a proper visa. Does the law require you to document this information? Does agency
policy require such documentation? Is this information relevant to the services you are providing? Is there a way that you and the client reach agreement about how to handle these sensitive issues in an ethical manner, meeting both client wishes and your professional obligations?

As a social worker, consider what needs to be documented for you to provide safe and effective services. If you have many clients, records help you keep track of the work you are doing with each. They also allow colleagues and supervisors to follow up with a client if you take ill or are not available for other reasons. In some instances, clients may return to services after many months or years. Records allow you to refresh your memory and ensure that new services take prior assessments and experience into account.

I have worked with agencies that have no documentation for clients. I have worked with agencies that have kept complete videos of all social work-client interactions, to maintain a full record of all communications and interactions. Each of these situations had reasonable ethical justifications for its approach. Some agencies that provide outreach to survivors of state torture, for instance, do not maintain documentation about the individual clients they serve. These clients have been traumatized and may not engage with any helpers who collect and record personal information. To build trust, outreach workers forgo consent forms, progress notes, and formal assessments. They may document the number of clients served and the types of services offered, but they do not maintain any identifying information. In contrast, some forensic social workers use video to ensure that they have a complete record of the information they are gathering, as well as the process used to collect the information. If their forensic evaluations are questioned in court, they are able to produce the videos. Most agencies fall somewhere between these extremes. In these situations, social workers need to make choices about what is legally required to be documented, what is important to document, how to respect client wishes, and how to respect client privacy.

When in doubt about what to document, consult your supervisor or another trusted professional. As a general guide, do not put anything in your case records that you would not want a client to see. In most practice settings, clients have a right to see their records, as well as to request changes. And finally, find ways to document what is important in an honest and efficient manner. Social workers and their agencies can take the tedium out of record-keeping by streamlining the process, using mobile technology (where appropriate), and avoiding documentation of information that does not advance the helping process.

Dr. Allan Barsky is Professor of Social Work at Florida Atlantic University and former Chair of the National Ethics Committee of the National Association of Social Workers. He is the author of Ethics and Values in Social Work (Oxford University Press), Conflict Resolution for the Helping Professions (Oxford University Press), and Clinicians in Court (Guilford Press). The views expressed in this article do not necessarily reflect the views of any of the organizations with which Dr. Barsky is affiliated.
Hello, social work students! No matter where you are conducting your field placement, you are meeting clients facing an array of issues. A working relationship is forming, and as it forms, many questions, feelings, emotions, and concerns are surfacing. One of the recurring issues that have been brought to my attention by students just like you is the hardship they face when they realize that the rate of client change is slow. In the box on this page are some reflections of former interns depicting their feelings associated with the slow rate of client change. I am certain that you will be able to relate!

Reflections of a Former MSW Intern—Alexandra Sapera, MSW Graduate, 2015

As a student when you start your field placement, you have the idea that you are coming into this new place with a fresh perspective and you are going to make a difference and see change. Then you start meeting with patients and realize that change is slow. As a student being in a placement for as short a time as eight months, I worked with patients who have been in programs for years and have gone through a number of workers. Part of the biggest learning experience for me was to change the way I measure success. I would take it personally when a patient would relapse, but part of educating the population included educating myself and realizing that for any step forward, there may be two steps backwards, and that is okay. I felt overwhelmed when I started working with substance abuse, but through supervision and continued education, I found it so rewarding that it is now the population I work with. This really is how I feel. I was so nervous starting my field placement and if you had told me two years ago this was the population I would have chosen to work with out of school, I would have said no way! Meanwhile, I love my job!

Reflections of a Former MSW Intern—Jonathan Belolo, MSW Graduate, 2014

To best explain my experience with the population of addiction, I have to bring in a client that I worked with for the majority of my experience at my field placement. The client was a mid-20s, Caucasian male who was struggling with a severe opioid and cocaine use disorder. He comes from an affluent family, and as a result of his substance use has been alienated from his family and accustomed lifestyle.

My supervisor noticed that a rapport was being built between the client and me, and she assigned him as a “case” that I would work on. Excited to work on my “first case” (as I called it back then), I looked forward to meeting him for individual sessions and helping him maintain sobriety, as he was to have a new therapist whom he thought could understand his perspective. After two successful sessions, I began to notice that the client was returning to old behaviors, both with his substance use and self-defeating beliefs. As this was happening, I became more frustrated and disappointed at my ability to “promote the positive change” that I was so desperately seeking. These thoughts only worsened when listening to other clients discuss the hopelessness and helplessness they felt related to the disease of addiction.

I spoke to my supervisor about my struggle with my ability to facilitate change in others and started blaming myself for the client’s failures. She immediately (almost instinctually) responded with the concept of “meeting the clients where they are,” explaining to me that not everyone is ready to change and that I have to first recognize what the clients’ current goals are. I’ve learned that when you do that, you can start seeing the small successes in the client’s progress rather than focusing on the overall objective. As I continued to process these feelings through supervision (and still do today), I realized that sometimes I, too, strive for immediate gratification like the client. The reality that I have come to accept is that by treating the client, we—as social workers—are having an impact in their recovery, no matter how small or how large and whether the change happens immediately or years later.

The Stages of Change: A Model for Social Work Students in Field Placement

by Maria E. Zuluaga, LCSW-R

Stages of Change Framework

Prochaska and DiClementes’ (1982) Stages of Change is a trans-theoretical framework that allows clinicians to meet clients where they are in relation to their readiness to change. The authors caution that change should not be looked at as a linear process, but rather as a process that happens along a cyclical continuum. This is a valuable framework for social work students and recent graduates to learn, because it can be used in any social work setting and can be applied to all clients no matter where they are in the process of change. This user-friendly clinical tool...
can be learned by students at all levels. It will allow you to identify where your client is in relation to readiness for change. Identifying the stage of change your client is in is invaluable, as it will allow you and your client to select interventions that are compatible with that particular stage of change. Another instrumental aspect of this model is that you can teach it to your clients, so they can become empowered in their own treatment! Once you become familiar with this model, you will use it during your entire field placement experience and throughout your professional career.

This framework will allow you to meet clients where they are, thus empowering them. It will also encourage you to work from a strengths perspective. In addition, it will permit you to honor the clients' autonomy by allowing clients to move toward positive change at their own pace. Finally, it will deter you from feeling responsible for your clients' failures and successes.

**Overview of the Stages of Change Model**

- During the *Pre-Contemplation* stage of change, individuals have no intention to change, because they are not aware that they have a problem.
- During the *Contemplation* stage of change, individuals are aware of their problem and are thinking about ceasing the behaviors that have caused the problem, but they are not yet fully dedicated to taking action. Individuals can dwell in the contemplation stage of change for long periods of time.
- The *Preparation* stage of change marks the beginning of “small” changes that indicate the individual’s desire to change behaviors that have led to identified problems.
- The *Action* stage of change is defined by behavior, experiential, and environmental modification. The individual is ready to change those aspect(s) of life that are contributing to the undesired situation or problem.
- In the *Maintenance* stage of change, individuals carry out adaptive behaviors that can help strengthen their resolve. An individual can stay in this stage an entire lifetime if dedicated to maintaining change.
- During *Relapse*, individuals revert to earlier stages. It is imperative to let individuals know that “relapse” is part of recovery and that it is a simple bump in the road that can be overcome with hard work (Prochaska & DiClemente, 1982).

Students! It is vital to understand that a “relapse” episode is not a reflection of your skills or of something you did or didn’t do. Relapse is a normal part of the change process. When a relapse or setback occurs during treatment, encourage your clients to get back up and “dust themselves off” and try again and again and again!
Why Should You Learn This Model?

When interns begin a new field placement, they are eager to serve, to learn, and to make a change in the world. After all, you are supposed to be “change agents,” right? The harsh reality begins to set in when faced with clients who are not quite ready to make changes. I am certain you are nodding your head right about now!

In my decade of providing field supervision in the addictions field of social work, students have brought an array of issues to my attention. No issue has been as recurring as the anxiety, array of issues to my attention. No issue has been as recurring as the anxiety, as the anxiety, struggle, and controversies. Students completing their field placements in addictions, as well as many other fields of social work, come face-to-face with patients in different stages of change. When a patient in the “action” stage is assigned to you, it is usually smooth sailing. Am I right? However, when you are assigned a client in the “pre-contemplation” stage and the “contemplation” stage, it is a different story. Agree? You begin to question your abilities and even question whether you have made the right career choice. These are normal feelings and questions, but hang in there—you will get through! The best case scenario is to address these uncertainties, fears, and concerns as soon as possible when writing your process recordings and during supervision.

Changes in behavior do not occur instantaneously. For example, students working in substance use fields need to understand that the disease of addiction compromises the ability for a person to make automatic behavioral changes. These changes are difficult, even for people facing the risk of losing their homes, employment, family, or children. As a student, you might find it almost incomprehensible that a person would risk these losses. The fact is that the disease of addiction is so overpowering that even if a doctor tells someone “you will die if you do not stop using alcohol,” the person will continue to consume alcohol if not ready to stop. This notion can be applied to clients struggling with all sorts of issues, such as gambling, tobacco use, and eating disorders.

This reality is difficult for the most seasoned social worker to grasp. So I can imagine what you, as a student, must go through when you come face-to-face with this fact. It is overwhelming, to say the least. The array of biopsychosocial issues your clients struggle with, coupled with the slow rate of client change, can increase your level of anxiety immensely. This becomes even more difficult to cope with when you know that you have to meet the field placement and school’s expectations.

Conceptualizing Change Differently

Conceptualizing change as a stage process can be helpful in many ways. First, you can begin to see change happening along a continuum. Second, becoming familiar with the Stages of Change Model will provide you with the opportunity to integrate evidence-based interventions that are compatible with each stage of change. Also, understanding your clients’ readiness and ability to change will allow them to move at their own pace—thus, honoring their autonomy. In addition, this model will provide you with a concrete and logical framework that can be used with any client, no matter what Stage of Change they are in. Finally, it will provide you with a way to track your client’s progress.

Keep in Mind

It is important to keep in mind that the stages of change are cyclical. In other words, clients can suffer setbacks. A client can take two steps backwards before being able to move forward again. Also, movement from stage to stage is not time-specific. Some clients can move from stage to stage much faster than others. Other clients can be stuck in the same stage of change for a long time. Do not become discouraged when this occurs. Instead, take this time to explore the discrepancies that are preventing your client from moving to the next stage of change. Also, use this time to explore with your client the pros and cons of making changes. Finally, this time can be used to educate your clients about the possible consequences that can come from not making changes in their lives. Exploring discrepancies, discussing the pros and cons of change, and educating your clients about the consequences associated with current behaviors will help your clients begin to move toward change.

It is imperative to understand that clients can be in different stages of change relative to different life areas. For example, a client can be in the Pre-Contemplation Stage of Change in relation to alcohol use and in the Contemplation stage in relation to establishing mental health services. It is important to carry out a comprehensive assessment of your clients’ needs in order to be able to determine their readiness and willingness to make changes in different areas of life.

Having a clear understanding of the Stages of Change model will help you explore appropriate interventions, identify possible barriers to change, and provide you with the opportunity to team up with your client to find ways to remove those barriers. Finally, and most importantly, recognizing your clients’ level of readiness to change will discourage you from personalizing their failures or triumphs. Instead, it will help you become your clients’ ally, cheering them on until they achieve CHANGE!

Good luck in your field placements. Thank you so much for all the difference you are making.

References


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Few would dispute that social work is the profession of hope. It is, after all, the profession that works with marginalized, disadvantaged, and even devalued populations—what President Lyndon Johnson in his War on Poverty called people who live in “the outskirts of hope.” Many factors contribute to the decision to become a social worker. Certainly, most of us want to make a difference in the world. Some see social work more as a calling than a career choice. Regardless of the reason for entering the field, social workers come to the profession with an essential hopefulness. Without hope, without a belief that positive change is possible, the profession would cease to exist.

In 2012, the National Association of Social Workers (NASW) held an annual conference with the theme of “Restoring Hope: The Power of Social Work.” After the conference, 58 social work experts wrote essays that described examples of hope in their practices. Called Hope Matters, this collection of case studies spans the continuum of hope from the individual to society. It is a testimony to the importance of hope for our clients, our communities, and our nation (Clark & Hoffler, 2014). Equally important is that social workers combine hope with human rights, social justice, and advocacy. It is this activism that sets social work apart from other helping professionals.

While we recognize the power of hope in a general way, perhaps we have not paid enough attention to hope as a concept in our field. We rarely define it, assess it, measure it, research it, or use it as a clinical tool. We learn and discuss the importance of empowerment, resiliency, the strengths set in our classrooms. Yet, as indicated above, it provides the framework that underlies most of our interventions.

Surprisingly, we have no entry for “hope” in the Encyclopedia of Social Work (Franklin, 2016) or the Social Work Dictionary (Barker, 2014). Several other major and important works, such as the Oxford Textbook of Palliative Care Social Work (Altilio & Otis-Green, 2011) and the Handbook of Oncology Social Work (Christ, Messner, & Behar, 2015), each have fewer than half a dozen references to “hope” in their almost 800-page volumes.

Not to be discounted, though, is the groundbreaking work of individual social workers who have been using hope clinically in their practices. Almost 30 years ago, oncology social worker David Callan (1989) described the value of hope in the counseling process. He developed a practical framework for assessing and enhancing a patient’s hope with special attention to identifying sources of hope, distinguishing hope from denial, and using hope to change maladaptive behaviors.

Similarly, a decade ago, Koenig & Spano (2006) looked at the use of hope in gerontological social work. They challenged the assumption that social workers use hope effectively when working with older adults and encouraged incorporating hope-inducing models into clinical practice. They also emphasized that we need to examine the role hope plays in our educational programs, as well as the agencies in which social workers practice. Other helping professions, especially psychology and nursing (Herth, 2001; Lopez & Snyder, 2009), have higher levels of training in using hope clinically. They also have developed formal assessment measures, such as the Nowotny Hope Scale in nursing (Nowotny, 1991) and hope measurement scales in psychology (Snyder, 2002). These instruments identify critical components of hope and provide direction for clinical interventions and future research.

One difficulty with hope is defining it. On a personal level, we each have our own definition of hope, but we may not fully understand the concept as it applies to others. To the untrained eye, hope may appear fairly uniform, and people believe that everyone hopes like they hope. In actuality, hope differs from person to person and from family to family.

While hope is unique and individualistic, hope is embedded in a social context. The way a person hopes develops within a particular family culture and with a set of life experiences. How one’s family views hope—and the values, beliefs, and strategies they use to maintain it—have an impact on how and for what an individual hopes. These patterns are called “family hope constellations” (Murphy, 1991), and they can cause conflict within families and with therapeutic goals. When this happens, it is the responsibility of the clinician to help the parties find an acceptable compromise.

What Social Workers Need To Know About Hope

Regardless of focus, level of intervention, or practice area, there are important points about hope that every social worker should know. The following 10 items comprise an essential starting point.

1. We need to recognize that we live in a hope-challenged world, and, as social workers, we have an obligation to be hope providers.
2. Hope is complex and multi-dimensional. Hope theory states that hope involves goals, emotions,
and perceived pathways to achieve those goals (Snyder, 2002). It is a psychological asset and a coping strategy. It is considered a prerequisite for action and a guard against despair. In short, hope is a way of thinking, feeling, and acting (Scioli & Biller, 2010; Clark, 2008).

3. **Hope is not denial or optimism or wishing.** Hope is always based in reality. It works because it expands perspective and increases persistence (Lopez, 2013). Hoping is an active behavior, while wishing is passive in nature. Wishing, therefore, has no force or drive. Likewise, optimism has no plans for action and is focused only on a positive outcome. It simply puts the best face on any situation.

4. **There are high-hope individuals and low-hope individuals.** Individuals can also become “hope-lost.” It is almost impossible to overstate the impact of hopelessness. A hopeless person becomes helpless and powerless.

5. **It is easier to prevent someone from becoming hopeless than it is to help a hopeless person regain hope.** Hopelessness suggests the loss of all hope and an acceptance that what is feared or dreaded will occur. It threatens quality of life and precludes perseverance and resiliency.

6. **Hope is dynamic and has a consideration of the future.** Its focus, its degree, and its intensity change as situations change. When this happens, clients and their families may need help reframing or refocusing their hopes. From a clinical perspective, this requires a mutuality of hope, as well as a mutuality of goals between the client, the family, and the clinician.

7. **No matter how difficult a problem or situation, there is always something to hope for, and everyone has the right to be hopeful (Clark, 2008).**

8. **Professionals have a tendency to think in terms of therapeutic hope—hope that is based on the outcome of therapy.** For our clients, hope is broader than that. It may be a generalized hope (such as hope for a better quality of life) or a hope that is personalized (hope for something specific). There is also transcendent hope, variously defined as hope that transcends reality, or has a spiritual component, or is a search for meaning. The important thing is that the client determines what to hope for; the clinician is there to support clients in their hope.

9. **Sometimes, professionals worry that they may, inadvertently, give a client “false hope,” but that is not possible.** There can be false reassurances, but not false hope. Just as truth cannot be false, hope, by definition, cannot be false. Hope does not require certainty or assurance of success. It can be maintained and refocused, even in the face of bad news, if that news is accompanied with honesty, compassion, and support.

10. **Professional hope is an antidote to burnout.** When we frequently witness setbacks, disappointments, suffering, and loss, we sometimes feel our own hope slipping. This can undermine our effectiveness and even our capacity to keep. Keep in mind that professional self-care is an essential component of social work practice, and it reflects both a choice and a commitment to be the best social worker you can be (Clark, 2011; Katz & Johnson, 2006).

## Ensuring Your Best Practice in Hope

As your career progresses, become not only a student of hope, but become an expert about it. Begin by understanding your own hoping style. How did you learn to hope? How do your family members and friends hope? What do you hope for? How do you cope when you have a setback?

Listen to stories of hope and resilience. Read about hope, both professional articles and novels. Watch movies about hope. Look for hope in everyday life. Learn to distinguish between various types of hope so you can become a more hope-knowledgeable clinician.

Discuss the concept of hope with colleagues. Include hope in your client assessments. Learn how to honor the stories, respect the suffering, and support the hopes of your clients. Make sure your intervention strategies are hope-inspiring. When clients are low on hope, hold their hope for them until they can regain it, or let them borrow some of yours. No matter what the situation, never take hope away. Instead, help individuals learn, expand, and refine their hopes. By doing so, you will expand and refine your own.

Perhaps most importantly, recognize both the potential you have to create hope and the professional responsibility you have to maintain hope for your clients, for yourself, and for the profession (Hoffler, 2014). Never forget that your hope, and the hope you instill in others, can become a major source of motivation for positive change. Isn’t that why you joined the profession of hope in the first place?

## References


Clark, E. J. (2008). *You have the right to be hopeful*. Silver Spring, MD: National Coalition for Cancer Survivorship.


*Hope—continued on page 35*
Have you thought about how to market yourself during your social work job search? You are competing with social workers with the same or similar degrees, credentials, licensure, and experience as you. How do you make yourself stand out from the crowd of qualified applicants to land that social work job?

All degreed social workers have accumulated a collection of experiences from various jobs and internship placements and have developed a variety of marketable skills. It is the thoughtful presentation of your career accomplishments that can provide professional opportunities and advancement. When applying for a position, it is essential to market your specialized social work package, so an employer can easily assess your candidacy based on how you are qualified and how you are better fit than the competition.

Important note: There is a difference between marketing yourself and selling yourself during your job search. “Selling” yourself can often turn into trying too hard to fit into something that might not be right for you or the organization. Marketing yourself as a professional social worker is about knowing your value and understanding that there is no one out there exactly like you. Being able to articulate your value is key.

Your Personal Marketing Plan

First things first—create a Personal Marketing Plan for your job search. This isn’t a new job search strategy but one that social workers don’t often use. Applying for anything and every job posting is not strategic and can actually hinder your job search instead of help. To increase your chances of being successful at your job search, you should treat it as a full-time job. Check out the article 5 Tips to Help You Stay Strong During Your Social Work Job Search for more on job search planning: http://www.socialworker.com/feature-articles/career-jobs/5-tips-to-help-you-stay-strong-during-your-social-work-job-search/

Let’s start by getting comfortable with Marketing 101. Every job seeker should become familiar with the 4 P’s of Marketing: Product, Promotion, Place, and Price. Let’s apply this to your social work job search.

Product

You are the product. To effectively market yourself as the product, you need to examine what characteristics and skills make you unique and help you stand out among competing job seekers. You need to be able to articulate what kind of social worker you are, what populations you serve, and what skills you have as a professional social worker. This can include professional, volunteer, and leadership experience; professional memberships (such as NASW); partnerships and alliances; education; and credentials.

What is your Unique Selling Point, or what is the one thing that makes you different from any other job seeker applying for the same social work job? What are your accomplishments, not just duties or job titles? Again, this is not about making yourself fit into a position that is not right for you, but highlighting how spectacular you already are and how your skills will benefit the organization.

How can you stand out from the crowd of dozens of other social workers who just graduated with the same degree and similar internship experience? Do you have a professional brand that will help set you apart from others? To help you explore your professional brand, I highly recommend The New Social Worker magazine’s Your Social Work Brand series: http://www.socialworker.com/feature-articles/your-social-work-brand/

From a business marketing perspective, people buy well-known brands they trust and feel good about. Employers want to feel confident about the employees they are investing in. Help them feel warm and fuzzy that you are the right fit for their open position by touting your unique social work acumen.

Promotion

How are you promoting your product? What are you doing to ensure that potential employers know who you are and why you are valuable? The strength of your professional promotional tools may be the most vital piece of your social work career marketing. These tools include résumés, cover letters, your elevator speech, and interviewing skills—anything you can use to get a job interview and ultimately get a job offer. How much time have you spent developing these promotional tools? Do you have a solid résumé and a striking cover letter that you tailor for each position? Do you have what it takes to articulate your skills to the employer during the interview? If you haven’t already, please take the time to read the following articles that will help you prepare your promotional tools:
• 5 Ways to Ace Your Social Work Job Interview: http://www.socialworker.com/feature-articles/career-jobs/5-ways-to-ace-your-social-work-job-interview/

No matter how great your social work experience and how strong your Unique Selling Point, if you cannot effectively communicate these skills to employers, you will not land the job.

Place

Okay, now you have solid promotional tools. Where should you be promoting your product? Where will you distribute this valuable information about yourself? As I mentioned, marketing is more than just applying for a job opening online. It is about building a campaign for your professional career.

Online: The first “place” you need to consider when you are promoting your product is a single website where you can send people that contains the above promotional information about you. This can be a blog or a website like your LinkedIn profile. This is content you can control and are proud to show your network and potential employers. It is imperative that this content and presentation is professional and well-managed.

Your network and networking: Networking, without a doubt, is the most crucial marketing tool for your job search. Your network consists of people who will help you distribute your product (you) to the employer. You need to access your network to let them know you are on the hunt and remind them of your professional skills, so they are willing to spread the word to their connections. Get out of the house to attend meetings, conferences, and events and to expand your network. You never know who you are going to meet who will connect you with your next job.

Target your search: Create a list of target organizations you want to work for that match with your area of practice interest, so you can focus your efforts. Researching information about what the organization does, what client populations it serves, and what will be expected of you will show the potential employer that you have the knowledge and motivation to be a successful employee.

Job postings: Yes, online job banks are a great place to see who is hiring, but also to get an idea of what organizations are in your area if you have recently relocated.

Cold calling: There is nothing wrong with picking up the phone to learn more about what an organization does or whether they are hiring. I had a member call me recently to let me know that she called an organization after their job posting deadline ended to see if they were still interviewing. They were so impressed with her professionalism and knowledge of their organization, they scheduled an interview with her for the next day. This uninvited job-hunting is a proven method of finding employment, but do your homework about the organization and know what questions to ask before you pick up the phone.

University career centers/Alumni offices: Keep in touch with your social work programs, because they value their alumni and want to keep you engaged. Most have job boards and newsletters with upcoming networking events and agency highlights.

Recruiters/Employment agencies/Job fairs: I have attended and been an exhibitor at my fair share of job fairs. Your local colleges and universities, NASW chapter, or community organization collectives may organize opportunities for job seekers to meet with hiring organizations. Take these opportunities seriously if they are available in your area. Even if the organizations who attend might not be hiring at that moment, this is a good way to get your name out there and use your promotional tools.

Price

What is the value of your product? What is the fair market value for your level of skills, experience, and the position you are seeking? For job seekers, price refers to the entire compensation package you can expect from potential employers based on the value you will bring to the organization.

You should also consider the strategies you need to get the price you want and that the employer feels you deserve. Check out the following articles on compensation research and negotiation:

• The Social Work Job Offer: Decline or Accept: http://www.socialworker.com/feature-articles/career-jobs/the-social-work-job-offer-decline-or-accept/

Remember, you don’t need to be someone else to get the job. Be yourself, but make sure you effectively communicate why you are a social work rock star and an asset to an organization.

Valerie Arendt, MSW, MPP, is the Associate Executive Director for the National Association of Social Workers, North Carolina Chapter (NASW-NC). She received her dual degree in social work and public policy from the University of Minnesota and currently provides membership support, including résumé review, to the members of NASW-NC.
Ann’s story is the harsh reality for many pregnant women with addiction to prescription drugs. Pregnant women battling opiate use disorders face multiple barriers when seeking treatment. Barriers include punitive measures, potential incarceration, lack of access to specialized services, conflicting treatment approaches for opioid dependency, and stigma regarding their ability to mother. Social work practitioners must be prepared to handle these barriers and advocate for interventions that preserve dignity and increase options for pregnant women.

According to the Centers for Disease Control and Prevention (CDC), opioid use is a rising problem for women of reproductive age, with seven out of 10 drug-related overdose deaths including some form of prescription painkiller (CDC, 2013). Females are more likely to receive opioid prescriptions for issues such as chronic pain, and they tend to develop drug dependency faster than their male counterparts (Salter, Ridley, & Cumings, 2015). Prescribing disparities also exist among women living in poverty. On average, 39 percent of women on Medicaid fill an opioid prescription at a pharmacy, compared to 28 percent of women with private insurance (CDC, 2015). Overdose deaths among women resulting from the use of prescription opioids has increased since 2007, and has surpassed deaths from motor vehicle-related accidents—with a “5-fold increase between 1999 and 2010, totaling 47,935 during that period” (CDC, 2013, SAMHSA, 2016).

Neonatal Abstinence Syndrome

Although prescription opioids are often less stigmatized than street drugs like heroin, they are plagued with the same consequences. In addition to the individual, social, and familial devastation that substance use brings, there are unique risks for pregnant opioid users. Opioid abuse in pregnancy includes the use of heroin and/or the misuse of prescription opioid medications (American Congress of Obstetricians and Gynecologists, 2012). The primary concern is that a baby will be “addicted.” However, this term is misleading and deeply stigmatizing. Addiction has been described as a set of compulsive behaviors that continue despite negative consequences, whereas the withdrawal symptoms in newborns are associated with evidence of only physiological consequences, whereas the withdrawal behaviors that continue despite negative consequences, whereas the withdrawal symptoms in newborns are associated with evidence of only physiological dependence (Newman, 2013). The term for withdrawal in newborns is neonatal abstinence syndrome, or NAS.

NAS is a result of fetal exposure to certain drugs, primarily opioids, and manifests as clinical symptoms in newborns with withdrawal. Symptoms may include uncoordinated sucking reflexes leading to poor feeding, neurological excitability, gastrointestinal dysfunction, and a high-pitched cry (ASTHO, 2014). Although this outcome is not ideal, it may pose less harm to a pregnant mother and her baby than detoxification or the behaviors associated with high-risk drug use, such as frequent physical withdrawal or exposure to infectious disease, tainted street drugs, criminal activity, or violence. NAS is treatable and anticipated in pregnant women using opioids, including those being treated on methadone (Terplan,
On average, between 50 and 60 percent of opioid-exposed infants will experience NAS and require some form of pharmacological intervention (Salter Ridley, Cumings, 2015; ASTHO, 2014). Because of the unclear outcomes of opioid detoxification during pregnancy, the current standard of care remains the use of medication-assisted therapy (MAT) during pregnancy (American Congress of Obstetricians and Gynecologists, 2012). However, current research is being done (Bell et al., 2016) to include detoxification as an option for women. Unfortunately, practitioners across disciplines don’t always agree on best treatment practices, and such ideological disagreement creates conflicts among providers and community resources. This leads to improper or incomplete care for mothers and babies, including pregnant women being treated with non-therapeutic levels of medication to limit exposure to the fetus (Jones, et al., 2008).

### Treatment Options

Methadone has been used for decades to treat opioid dependency, and research shows it to be a safe option during pregnancy. However, one risk includes NAS (Substance Abuse and Mental Health Services Administration, 2008). Another treatment option for women is buprenorphine, which acts on the same receptors as morphine and heroin. This option may provide fewer drug interactions, fewer overdose risks, less severe NAS, and more flexibility in dosing and treatment schedules (ACOG, 2012). Buprenorphine is prescribed by approved and specially-trained physicians in an office setting, and often leads to increased patient compliance and reduced stigma (ACOG, 2012; SAMSHA 2008). In a 2010 study, infants exposed to buprenorphine, as compared to methadone, required an average of 89% less morphine to treat NAS symptoms, a 43% shorter hospital stay, and a 58% shorter duration of medical treatment. These results may support buprenorphine as best practice medication for pregnant opioid-dependent women. However, treatment should be individualized (AGOG, 2012). Ceasing opioid use during pregnancy may result in pre-term labor, risks to the fetus, and loss of pregnancy. Pregnant women who stop using opioids and relapse also have increased risk of overdose (SAMHSA, 2016). Therefore, MAT (Medication Assisted Therapy) is currently considered best practice (ACOG, 2012) but should include both medication and behavioral therapies.

### Policy Considerations

The rise in prescription drug abuse directly correlates with a rise in rates of the NAS epidemic, and this trend is a public health crisis. Further, despite the scientific evidence that addiction is a chronic relapsing condition, fears have prompted legislators in many states to focus their efforts on criminalizing pregnant substance abusers instead of expanding treatment options and increasing training on opioid use and medication-assisted therapies (Salter, Ridley, & Cumings, 2015). Although these laws are made with the intent to protect babies, they can discourage women from seeking appropriate treatment, including prenatal care, and in many instances they fail to rehabilitate the mother by forcing her into a treatment system that is plagued with inadequate resources.

Additionally, these policies neglect to preserve the dignity and worth of the relationship between mother and baby. Bonding should be promoted by keeping mother and baby together, encouraging breast feeding when possible, and providing space for mothers to “room in” with their babies, providing skin-to-skin contact in a calm environment. In a 2010 study, infants with NAS required less pharmacological therapy and shorter hospital stays when roomed with their mothers on a postnatal unit than when admitted to a traditional neonatal care unit (Saiki, Lee, Hannam, & Greenough, 2010).

The American Congress of Obstetricians and Gynecologists (2011) states, “Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing.” A more effective treatment approach requires coordinated community intervention focused not only on the newborn’s health, but the dignity and worth of the pregnant woman. This can be achieved through interagency collaboration with social service providers, women’s health providers, and pediatric care providers.

### Recommendations

We recommend the following to improve individual and community practice.

- Expand and fully fund current policies supporting family-centered residential treatment for pregnant opioid users and access to mental health and substance abuse services.
- Promote comprehensive medication-assisted therapy (MAT), which includes prenatal care, individual and group therapy, resource allocation, psychosocial support, parenting skills training, family education, and standardized scoring for NAS among treatment providers.
- Expand training on screening (SBIRT) for substance use and addiction in pregnancy, as well as reproductive justice among social service providers, medical students, OB-GYNs, and pediatric nurses and physicians.
- Educate elected officials and policy makers on treatment options, and advocate for fair policies that preserve the relationship between mothers and babies by promoting bonding and attachment and discouraging separation.
- Expand Medicaid coverage for one year post-delivery to ensure completion of treatment plan, cover the costs associated with MAT, and continue vigorous opposition to fetal assault laws.
Resources for Working With Pregnant Women

American Congress of Obstetricians and Gynecologists: http://www.a cog.org


MAT/SAMHSA: http://www.samhsa.gov/medication-assisted-treatment

National Advocates for Pregnant Women: http://www.advocatesforpregnantwomen.org

Screening, Brief Intervention, and Referral to Treatment: http://www.integration.samhsa.gov/clinical-practice/SBIRT

References


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child advocacy specialist intern, resource unit/foster care intern, community development intern, and a houseparent in a crisis nursery.

Yet she remains to some degree a reluctant leader. “One of the things about leadership that almost always comes to mind is the responsibility to the people following behind me that it implies. I think that is why I have such a hard time being considered a leader,” Bowman says. “I dread people following my lead so much that I hesitate to even recommend a movie to people—what if they hate it and I have steered them wrong?”

But then there is the acknowledged ability. “I know people consider me a leader,” Bowman continues. “I hear it in my classes, at my job, on the board... and perhaps it is just a bad case of imposter syndrome, but I just do not want to disappoint anyone or make them regret listening to me. Having said that, I do feel a confidence in myself that I have never felt in the past. Social work was waiting for me, and I am so glad I found it. What I need to get used to is that I may have found myself to be a leader, as well.”

Bowman will further display her leadership qualities when Advocacy Day takes place on campus in the spring. She will invite all the social work students to come in groups to speak with legislators.

One quality Bowman embraces is authenticity. “I’m very big on honesty,” she says. “The person I put out is the real one.”

She speaks candidly about her interracial marriage and about being diagnosed right before community college—the first time in her life she was struggling in school—with ADHD. She isn’t worried about the “stigma” of the diagnosis or of the medications she was prescribed. At the same time, Bowman laughs as she admits, “I feel more normal when a lot is going on in my life.”

Wherever she chooses to go or whatever she decides to focus on in her career, Huguley says, “She’ll be outstanding. She’s a very impressive person.”

Freelance writer Barbara Trainin Blank, formerly of Harrisburg, PA, lives in the greater Washington, DC, area. She writes regularly for The New Social Worker.
The A-to-Z Self-Care Handbook for Social Workers and Other Helping Professionals

Erlene Grise-Owens, Justin “Jay” Miller, and Mindy Eaves, Co-Editors
Foreword by Linda May Grobman, MSW, ACSW, LSW

Make a Commitment to Self-Care—For Yourself, For Your Agency

Self-care is an imperative for the ethical practice of social work and other helping professions. Using an A-to-Z framework, the editors and contributors outline strategies to help you build a self-care plan with specific goals and ways to reach them realistically. Questions for reflection and additional resource lists help you to dig deeper in your self-care journey. Just as the ABCs are essential building blocks for a young child’s learning, you can use the ABCs in The A-to-Z Self-Care Handbook for Social Workers and Other Helping Professionals to build your way to a happy, healthy, ethical life as a helping professional. Great for social work courses at all levels, in-agency training, and individual use.

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It’s 7:00 p.m., and my partner and I are in one of the high-crime areas of Brooklyn standing in the middle of a New York City Housing Project apartment. We are waiting for NYPD and EMS to arrive to involuntarily transport a patient to the nearest psychiatric emergency department. I ask the patient if she has eaten anything today, and she points to a stale bread roll. I look over and notice that the cockroaches that have taken up residence in her apartment have gotten to that parcel of food before she has. She is sitting on the floor, next to the makeshift bed where she says she sleeps, even though she tells us it has been two days since has rested. I observe her to be responding to internal stimuli, and her mood goes from irritability to inappropriate laughter. She has no electricity, because the electric company turned her lights off for unpaid bills. Luckily, I have my flashlight tonight.

In between answering questions, she mumbles. She was just in the hospital several weeks ago, admitted to the inpatient psychiatric floor. She is unsure why she was there for two weeks, but it is clear she is currently showing signs of psychosis and not taking her psychotropic medications. Her insight into her illness is poor. As I move closer to her and step on the crushed cigarette butts, empty beer cans, and debris that litter the floor, she grows increasingly suspicious. Her eyes are wide and darting, and she shows an increase in psychomotor activity and agitation. I ask her when was the last time she used cocaine; she denies using it. I ask her when was the last time she used dart across the street, NYPD pulls up. She stops. The officer knows our patient well. EMS arrives and transports her to the hospital, where she is admitted.

My partner and I jump into our mobile crisis unit and drive across the borough to a more affluent part of town. We have very little information regarding our next patient—only that she is a 67-year-old female who has been behaving “bizarrely.” She is not leaving home, expresses the wish to die, and appears paranoid and anxious. The patient is said to have past psychiatric diagnoses of obsessive compulsive disorder, anxiety, and depression. We arrive and are let in by the doorman.

We knock on the apartment door and are greeted by the patient, a disheveled woman wearing a nightgown and slippers. We tell her that her friend sent us to talk with her and make sure she is doing well. After several questions, she reluctantly lets us inside her home. The apartment has no furniture or belongings except for a desk and a small twin bed in the living room. The room is covered in dust and gives the sense that it hasn’t been cleaned in more than a year. On the desk and kitchen counter, there are stacks of paper and other odds and ends that are all neatly organized in perfect piles and rows. On one area of the counter lie four spoons, organized by length from smallest to largest.

The patient reports that she has not left her apartment in more than a week. She is anxious and has bouts of screaming spells to which the neighbors keep calling the police. She states that her neighbors often think she is getting attacked in her apartment because she will stay up all night screaming and sometimes banging her head against the wall. She has scratches on her arms and face. When I ask her if these are self-inflicted, she answers “yes.” She also states that she has bed bugs and they bite her in the middle of the night. My partner and I stand back from the bed where the patient is sitting. The patient reports that she has no social supports and is not receiving treatment. She states that between her anxiety, OCD, and isolation, she no longer wants to live. We talk with the patient for an hour, before determining it is best for her to be taken to the hospital for further evaluation and observation.

Our next call is a 45-year-old woman who has been referred by a co-worker who has concerns about the way her friend is living. The referrer reports her friend has been exhibiting depression for the past six months, after a leg injury a year ago that kept her home and unable to work. She says the patient is living in unsanitary conditions and has voiced vague suicidal statements.

We arrive at the apartment and knock on the door. Nobody answers, but we can hear shuffling around from the other side. The patient’s friend has warned us that it is unlikely for the patient to open the door. We arrange for the friend to meet us at the residence. She arrives 20 minutes later. We instruct her to knock on the door, but she is concerned that the patient will be upset with her if she finds out that she called us. We assure her that we won’t notify her friend of the source of the referral. That seems to suffice, and her friend knocks on the door.

My partner and I are in the stairwell. The friend calls the patient through the door: “Open the door. I am concerned about you.” After 10

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Mobile Crisis Unit: Psychiatric Social Work on Wheels
by Johnny Dutcher, MSW, LMSW

The mobile crisis unit.
minutes, we hear the door open. From where we are near the stairs, we can already smell an odor that instinctively forces my head to bury into my coat sleeve. We can hear the patient’s friend talking to her.

We decide to walk up the stairs and approach the patient. “Hello, my name is John. I am a social worker with the Mobile Crisis Unit. Someone called because they wanted to check in with you and make sure you are doing okay and to see if you’re safe.” Even though the smell is strong enough to choke a maggot, the patient denies anything is going on with her, and says she is unsure why someone would be concerned.

It is very typical for many of our patients to deny crisis, for a multitude of reasons (poor insight, defenses, paranoia, not wanting help, normalized behaviors, and so forth). We ask if we can come in and talk with her, saying that maybe she will find that we can be of assistance. We introduce ourselves, as if it’s the first time, to her co-worker who is standing near the door. Her friend is anxious. “Nice to meet you,” I say. “Is this a friend or neighbor of yours?” Her friend awkwardly says, “Yes.” The patient anxiously invites us inside the home.

I brace myself for what is on the other side of the door, as I can smell a combination of animal urine, feces, and rotting food. As I step inside the home, I observe about 15-20 cats. Feces are all over the living room floor and there are yellowing spots on the walls. In the center of what appears to be the living room is a king-size bed, on which there are yellowing spots on the walls. In the other side of the door, as I can smell an odor that instinctively forces my head to bury into my coat sleeve. We can hear the patient’s friend talking to her.

The patient is disheveled in appearance, and her affect is flat. She walks with a slight limp. She looks fearful, and her mood is depressed. I ask why her living environment is the way it is. She tells us she had an injury a year ago that prevented her from going to work or leaving the house. She states that she worked for the school board prior to her injury. Her insight is poor, and she tells us that the mess is no big deal—she will clean it up today. We check the kitchen and find there is nothing in the home to eat. On the kitchen counter sit two cat litter boxes. The cupboards are bare.

The patient finally states that she has not been doing well. She is depressed and anhedonic. She has no energy and feels hopeless. She tells us she has thoughts of dying. Her only sources of support and motivation to live are her co-worker, who checks in with her from time to time, and her cats. We ask her if she is interested in receiving help; she is ambivalent. After more talking, we encourage her to go to the hospital. She is afraid that her cats will not be taken care of, so we speak to her friend, who reassures her they will be safe and that she will stop by and care for them as long as needed.

It’s getting late, and we finally arrive at our last stop of our shift and seventh stop of the day. A 12-year-old girl has been referred by her mother. The girl’s mother reports that her daughter has been experiencing intense anxiety attacks for the past two weeks, and that they have grown worse as each day passes. These attacks are interfering with the girl’s ability to attend school, sleep, eat, and socialize.

When we arrive, we observe a very intelligent girl of 12 who looks much older than her chronological age. As we assess the patient, we determine that the girl’s panic attacks started several months ago when she was bullied at school and in the community. The girl is fearful and anxious as she recounts the numerous incidents of bullying, from being called names to getting objects thrown at her to being harassed through social media sites. She is in honors class, has blue hair, and presents to us as a bit socially awkward. She states that she is “different” and that is why, perhaps, she is bullied. I tell her that she has been a victim of bullying and that we will work on helping her become a survivor, so she can feel better and return to school feeling safe.

We refer her to a community counseling center and later call the school to notify the principal about the numerous bullying incidents that have gone unnoticed. Later, we learn that the school has set up a meeting with parents and students. The children who bullied her have been suspended. We advise the patient’s mother to contact the school or the police if her daughter’s safety is of concern.

The Mobile Crisis Team

My partner and I work on a mobile crisis team that covers roughly 80% of the borough of Brooklyn. We respond to calls from the community that are routed through Lifenet, the city’s confidential crisis hotline for New York City residents. I am a psychiatric social worker, employed by a major hospital in Brooklyn to work in the Mobile Crisis Unit, which is part of the hospital’s Comprehensive Psychiatric Emergency Program (CPEP).

My days are never dull, and I have plenty of opportunities to sharpen my clinical and therapeutic skills. We respond to a wide range of psychiatric complaints experienced by a diverse community—everything from an individual who is experiencing acute psychosis, feelings of suicide, and self harm, to those who are chronically depressed, living with anxiety attacks, personality disorders, drug and alcohol abuse, bipolar disorder, and neurological or cognitive impairments.

I have held many titles in my career thus far, including working as an inpatient social worker, outpatient psychotherapist, and mental health consultant. By far, my role as a psychiatric social worker practicing on a Mobile Crisis Team has been exceptionally rewarding, challenging, and educational.

A typical day encourages me to use my assessment and diagnostic skills and expertise and my ability to meet the patient where he or she currently is. My tools include advocating for my patients and deciding the best mode of treatment. This may include linkage to outpatient mental health services, hospitalization, or admittance to a drug and alcohol program. My role is to help stabilize the patient and help return him or her to a normal level of functioning, while making sure they are safe in the community. I approach this work with a clinically eclectic toolbox that includes assessment and diagnosis, crisis intervention techniques (the Seven-Stage Crisis Intervention model), Motivational Interviewing, Cognitive-Behavioral techniques, Problem-Solving Therapy, and case management. I view my patients’ obstacles and difficulties from a biopsychosocial lens to ensure I incorporate all parts of the individual.

Mobile crisis unit—continued on page 21
Social work students have been using simulation to practice skills for many years now. Role-plays and standardized clients are examples. Students have also been using a basic form of virtual reality (VR) to practice skills, as well. For an example of this, think of computer simulations, on a screen, similar to Second Life or any other avatar-based game that allows a student to play a social worker or otherwise interact with environments that a social worker might see in the field. But recent developments have taken this kind of simulation to a deeper level. With this year’s release of commercial VR head-mounted displays (HMDs), role-plays and simulations are now many times more immersive.

The BSW program at the University of Montevallo in Alabama is testing out a VR group dynamics simulator. The simulator, once it is developed further, will immerse one student at a time within a virtual setting. When the student puts the headset on, the student’s field of vision is completely encompassed by an environment that looks like a classroom with four seated virtual clients in front of the student. The student can walk around within this environment and use small, wireless controllers to point and select clients or other options. When a client is selected, he or she starts a pre-recorded dialogue, full of rich descriptions of issues the client is having that day. Amateur voice actors within the university’s theater program have lent their talents to record the dialogues. The presence of these virtual group members is incredibly immersive, and the sentiment of most people who enter the simulation is that they feel as if they are really there.

This VR experience is being developed for a Social Work with Small Groups class, so the decisions the students make within the simulation relate to group leadership assessment and practicing action skills. For example, they can call on clients and, after receiving a bit of dialogue, can ask the clients to “tell me more,” “interrupt and move on,” or suggest other steps for the group to take to achieve the group’s goals. These activities, coupled with the immersive environment that only a VR HMD can provide, make for a unique learning experience.

This particular simulation, paid for in part by the Montevallo Research for Creative Projects grant, is still months away from being fully functional. Eventually, the simulation will be able to guide the student through the group therapy session, challenging the student to make decisions regarding group leadership and giving students a grade at the end based on the choices they make. It will be replayable many times over if the student wants to practice these skills further. Elements to be added in this version of the simulation include a client “blow-up,” in which the avatar yells at the group leader, and a
scenario in which the student must read a client’s nonverbal communication to best assess the situation. This last feature will be developed using a motion capture rig called the Perception Neuron Suit and will require someone to act out the body language of an avatar.

Whether or not VR will be a natural fit within the social work classroom or just a novelty still remains to be seen. The research on VR HMDs in this capacity is still in its infancy, but because of our field’s dedication to experiential learning, these kinds of new developments might fit perfectly into the social work curriculum.

Regardless of ultimate results of the research in the coming decades, these new VR devices are coming into our personal lives, our classrooms, and perhaps even our work spaces soon.

Brendan Beal, MSW, Ph.D., is an assistant professor of social work at the University of Montevallo in Montevallo, AL. He teaches BSW classes, and his research is on technology applications for social work students.

Mobile crisis unit—continued from page 19

Mobile Crisis Teams operate under community agencies and hospitals. Each team covers a designated area. These teams respond to psychological crises experienced by individuals of all ages, races, genders, sexual orientations, and socioeconomic backgrounds. The team will be dispatched to homes, shelters, schools, or other locations in the community. A psychiatric crisis may include suicidal ideation, depression, post-traumatic stress/acute stress, panic/anxiety, aggressive behavior, self-injurious behavior, or any other symptoms that alter an individual’s mental status and equilibrium. Mobile Crisis Teams are activated by treatment providers, family members, neighbors, co-workers, school staff, or any other concerned party.

For more information on mobile crisis work or to refer a patient to a Mobile Crisis Team, check with your local or county mental health system. Most major cities and counties operate mobile crisis teams.

Johnny Dutcher, MSW, LMSW, is a licensed social worker in New York state and practices in New York City. He is a graduate of the University of Southern California, where he earned his Master of Social Work with a concentration in mental health. He has postgraduate training in psychodynamic psychotherapy, as well as emergency psychiatric social work and advanced assessment and diagnosis. He currently works in emergency psychiatry at a large city hospital in Brooklyn. In addition, Mr. Dutcher has experience as a mental health consultant with the City of New York, as a staff psychotherapist in a busy outpatient mental health clinic and provides supervision to a crisis intervention agency.

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On Campus

William Woods University BSW Students Adopt Three Families for Holidays

Senior BSW students at William Woods University in Fulton, MO, shopped for Christmas gifts for three adopted families. The students from this small university raised $500 from faculty, staff, and students to purchase gifts for children in foster care in Callaway, Gasconade, and Audrain Counties in mid-Missouri. BSW students in the photo include: Anthony Bedford, Kalen Posey, Darianne Maclin, Nikki Harris, Hope Gastler, Hannah Henke, Ryan Stocker, and Reiana Barton.

Rake Up Boise

The Organization of Student Social Workers from Boise State University partnered with Even Stevens for the Rake Up Boise event. The team is shown raking leaves for a community member who asked for a helping hand this year. This photo was taken during Rake Up Boise on November 12, 2016.

Phi Alpha Honor Society for Social Work

The Phi Alpha Poster Board Presentation was held in conjunction with CSWE-APM in Atlanta. The chapters listed below were awarded $1,000.00 travel funds and received a monetary award for presenting.

Boise State University:
Kathie Leschinski & Nallely Ramiriz

Loma Linda University:
Melissa Weipert & Gabriela Navarro

Texas A&M–Central Texas:
Lisa Landen

Please visit the Phi Alpha website to apply for chapter community service awards and individual scholarships at PhiAlpha.org.

Kind regards,
Tammy Hamilton, Coordinator
PhiAlphaInfo@etsu.edu

PHI


Share this issue of THE NEW SOCIAL WORKER with your friends, colleagues, and classmates!
With a focus on mass incarceration and the War on Drugs, Salisbury University Department of Social Work BASW and MSW students and faculty visited Eastern State Penitentiary in Philadelphia, PA, the first prison built in the U.S. The adventures continued with an engaging poverty tour of the Kensington neighborhood by the Poor People’s Economic Human Rights Campaign, where students learned first-hand about the devastating effect of the War on Drugs and the loss of industry. Photo Credit: Jennifer R. Jewell.

University of Portland Social Work Students stand up for racial, economic, and gender justice at the Oregon Health Equity Alliance (OHEA)/Fair Shot for All Coalition launch of their 2017 legislative agenda, which includes bills to fund health insurance for all Oregon’s children, end racial profiling by Oregon law enforcement, and address issues for renters that will increase housing stability and prevent homelessness. In addition to supporting the broader goals of these coalitions, UP students are involved in policy research and advocacy to secure paid family and medical leave as part of the CSWE/Policy Practice in Field Education Initiative sponsored by the Fund for Social Policy Education and Practice. Photo credit: Alice Gates.

Tianca Crocker, a doctoral student at the University of Texas at Austin whose research focuses on digital inclusion for economic opportunity, is serving as a NTEN/Google Fiber Digital Inclusion Fellow to supplement her research with practice. In this photo, she is shown teaching a group of AARP clients at her host organization, Austin Free-Net, about computers and the Internet to help them use these newly-acquired skills to transition in the workforce.

Ramapo College students staffed a table for World AIDS Day, December 1, 2016. They sold t-shirts and contributed to the NJ AIDS Services. The students were raising awareness of AIDS/HIV on the Ramapo campus in Mahwah, NJ.
University of Alabama School of Social Work students participate in an innovative collaboration with the Tuscaloosa Fire and Rescue Service EMS Prevention Program to reduce the city’s number of non-emergency calls. Photo Credit: Crimson White/Jake Arthur.

Stockton University’s Social Work Club hosted its third annual Osprey-THON last spring. Osprey-THON is a 12-hour dance marathon that raises money for the Children’s Hospital of Philadelphia. Stockton’s Social Work Club set out and hoped to reach a fundraising goal of $8,000. The event finished with a total amount raised of $8,627.49. Top from left to right: Savannah Gregory, Stephanie Willems, Sydney Zori, Becka De Valve, April Westergaard, Jeannine Welsh, Lauren Baghsarian, Ashley Cameron, Robert Carolla. Bottom from left to right: Jazmin Torres, Jeremy Moscat, GiGi Bennett, Cherie Sloan.

BSW students at the University of Georgia support the Amnesty International Write for Rights campaign. Photo credit: Jane McPherson.

(From left to right) Debbie King, Leo Gavin Koivisto, Gina Rae Garibaldi, Tyler Atkinson, and Beth Diehl (dressed as the Disney character Elsa) from Northern Arizona University with the mural they helped paint for the Flagstaff Family Food Center during a Thanksgiving party they threw for the children and families there in Flagstaff, Arizona, on November 12, 2016.
I see a lot of movies. I just wrote a book about movies (check out Adoption at the Movies on Amazon!), and I also write this column and maintain the website Adoption at the Movies. In general, this is a good thing. I see films that I might not have watched were it not for writing about them. Some of them turn out to be disappointing, and others are as good as I had hoped. Some are surprisingly touching, heartwarming, or powerful. This past year, I’ve covered a few excellent films in this column—two that especially stand out to me as worth seeing are Zootopia and Kung Fu Panda 3. To close my column for 2016 and open 2017, I want to share three more of the films that surprised me with how good they were. Along with Zootopia and Kung Fu Panda 3, here are Addison Cooper’s Must-See Movies for Social Workers from the films I’ve reviewed over the past year.

Queen of Katwe

Queen of Katwe (PG, 124 minutes). In a particularly low-SES region of Uganda, Nakku Harriet’s children must sell corn to earn enough money to pay rent and buy food. Nakku’s young children, including her daughter Phiona, are welcomed into a local chess ministry run by Robert Katende. Phiona and her siblings are shown how to play chess, given food, and shown love. Phiona finds that she has a strong aptitude for chess; she quickly becomes the champion of the youth center, which allows her to travel to national and international competitions.

The film captures a caring adult in action, and it also shows that, given opportunity, kids from difficult places can thrive. Robert is a mentor and an advocate for the children who come to his chess ministry. He captures the heart of social work. Robert’s family sacrifices financially for him to do this work. His wife supports him, saying that his work with children is the shared work of his whole family. As you watch Queen of Katwe, be inspired by the hope that your clients can thrive, and also take joy in seeing your heart and your work reflected in Robert.

Father Unknown

Father Unknown (NR, 75 minutes). The earliest memories of Urban Quint are set in an orphanage in Switzerland. His mother eventually sent from America for him. He grew up in America, became a teacher, had a family, and retired. His mother refused to tell him who his father was. After his mother passed, Urban and his son, filmmaker David Quint, travelled to Switzerland to try to uncover some answers about Urban’s history. Captured mostly with David’s camera phone, Father Unknown takes us to the orphanage where Urban lived as a child, and we are with him when he finds someone who might have some clues to Urban’s history. Father Unknown is a remarkable testament to the deep need many adoptees feel for their own histories. It also shows the power of knowledge, relationships, and family.

One of the things I love best about being a social worker is learning the stories of others. Father Unknown powerfully shares the story and the feelings of the filmmaker’s father. Watch it with the eyes of a social worker, and let it touch your heart.

Inner Workings

Inner Workings (NR, Short). Paul works at a small desk in the large, soulless building of Boring, Boring, and Glum. He wakes up, walks to work, sits at his desk, eats at his desk, and leaves. There doesn’t seem to be much going on in Paul’s life—but Inner Workings gives the inside story. His heart yearns to seek adventure, to find love, and to be joyful, but his mind continually warns him to be cautious. Flirting could lead to rejection. Joy could lead to danger. Adventure could lead to death. In an effort to preserve his life, Paul has created a safe but joyless life. Eventually, his mind reflects on the inevitability of death—and this new perspective encourages Paul to make the most of the life he has. This nearly-wordless short, packaged with the also-worth-seeing film Moana, is a powerful invitation to find the soul in our lives.

As social workers, our jobs don’t feel as meaningless as Paul’s button pushing, but the stresses inherent in our work—both the clinical and perhaps even more so, the administrative side—can sap our joy. Inner Workings is a gentle but poignant, wordless nudge. Let it invite you to re-embrace your work and your life outside of work. Let it invite you to refuel and renew yourself.

What films have been meaningful to you in the past year? I’d love to hear from you at http://www.facebook.com/AdoptionAtTheMovies.

Addison Cooper, LCSW, is a clinical supervisor at a foster care and adoption agency, and is the creator of the website Adoption at the Movies (http://www.adoptionsatthemovies.com). His first book, also called Adoption at the Movies, is due out on January 19, 2017, from Jessica Kingsley Publishers and is available on Amazon.com and BarnesandNoble.com.
Working as a clinical social worker in the Washington, DC, area with patients diagnosed with life-limiting illnesses such as Huntington’s disease, Parkinson’s, multiple sclerosis, and Lou Gehrig’s disease (ALS) has taught me to be consistently dedicated to a person-centered approach to therapy with patients and their families. Person-centered care is a trend that has been building in the social work community over the last few years, and I had considered the idea of person-centered care as a decent and noble practice.

I now wholeheartedly trust patients as the most salient guides in developing their own treatment. My most valuable work with patients is to listen and learn from each one and let them determine their goals.

The person in person-centered care is more of an expert in what is best for them than I am. As shocking as this fact was to me, it has been liberating to let go of having to know everything about a patient I just met. As a result of my experience with my therapy patients, person-centered care has now become the foundation of my practice.

Over time, I observed that patients diagnosed with a prolonged terminal illness have a unique response to this medical situation based on many factors, such as their support system, belief system, the popularity of the illness in society, present mental health, resources, and many more influences. The patients all have different resources that affect the way they can adjust to the logistics of being ill, whether that means being immobile or determining issues like care in the home or choosing a long-term care facility. It is my role to take these influences into consideration, and walk with patients through their journey of illness and to help navigate the difficult places.

Many of the patients I have worked with in clinical and community settings tell me that the onset of their illness experience begins when the patient and/or their loved ones notice that something is different physically about the patient. They eventually visit with medical professionals and receive diagnostic tests to determine the reason for changes in their bodies. The moment the physicians give the difficult news that, yes, the test results and symptoms reveal that these patients have a life-limiting illness, their lives change forever.

Often, patients have shared with me that the fear of the possibility of illness has lingered as a dark cloud over them well before they get the official news. Many emotions settle in as they allow the news to work its way into their consciousness. Disclosing this personal information to loved ones can be one of the most difficult tasks after a diagnosis.

When told devastating news, others are bound to highlight the landscape of emotions that are already bubbling to the surface for these patients. These conversations with the loved ones often make the illness concept even more real, and leave the entire family with more questions than answers. I have explored how to express this kind of news with patients who have mounting anxiety around these conversations.

The question of “what's going to happen next” often consumes the patient and family unit. Not knowing how to sort through these unanswered questions can lead individuals down a complex and winding road. Weighing through the murky waters of what if the worst happens, and “how long do I have,” likely requires a multi-disciplinary team approach to attend to the questions and ongoing patient care. From a mental health perspective, the clinician on the team must consider that patients may experience feelings of avoidance, anger, despair, anxiety, and numbness—or they may be ready to take on their illness and their physical symptoms with a new-found determination to beat the odds.

I have found that all of the emotions mentioned are normal and to be expected. However, high rates of anxiety, depression, and suicidal ideation are associated with prolonged terminal illnesses. Mood changes can be a result of these patients dealing with the uncertainty of their illnesses, or may be another symptom of the illness itself. Mental health support can play a vital role in assisting patients when their emotions become overwhelming and detract away from their functioning as they try to adjust to their new roles as patients. For example, several of my patients have needed help with
Patients in various settings as a part of their illness. Others have needed support in planning for life when they become immobile and the emotional distress that comes with this reality.

Social workers who provide case management can also be pivotal team members for patients during this difficult time. Patients often have no idea where to start as they parse out the necessary services required for care. They may need such services as medical specialists, legal supports, transportation, nutritional guides, and many other services. Dedicated social workers and case managers in many settings work with patients to sort out all these services and get patients linked to care. However, many busy social workers do not have the time built into their schedules to help patients sort through the crippling emotions during a life-limiting illness, particularly not long-term. In addition, in the past, family members and caregivers have sometimes been left out of the process altogether, as therapeutic services may be limited to the patient alone.

Providing wrap-around services that include more long-term mental health supports to the patient and the family unit has become a more person-centered approach in many mental health agencies. Research supports the theory that patients who are a part of a family system have better functioning when the entire family can be educated and attended to during the illness. My program, like many others, is now providing comprehensive long-term mental health services to patients and their families. I can track the service needs of patients and their families while providing emotional support. We have found that providing some case management triaging along with counseling is a more holistic approach.

Working with patients from “where they are” in a person-centered context takes on a whole new meaning when working with patients with a variety of illnesses. Their treatment needs may differ widely based on the stage of their illness experience. Treatment for a newly diagnosed, moderately ill patient may be very different from the treatment of an end stage, seriously ill patient. In addition, working with patients in various settings as a part of a multi-disciplinary team requires an added consideration of the approach to the staff in the setting. Each patient care setting has a culture of its own and requires that a clinician be mindful of how to work with the staff, as well as the patient, in that particular environment.

Assessing patients requires looking beyond the psychosocial factors that may be affecting their functioning. For instance, with Huntington’s disease, psychiatric issues can be directly related to the illness. Working closely with these patients’ psychiatrists is an essential aspect of assessment and treatment of Huntington’s patients. Moreover, monitoring these patients’ adherence to their medical treatment is often a priority, as well. With the complex clinical aspects of their care to consider, it is vital to focus on learning directly from them and tailoring treatment with this information in mind. These factors provide me with more proof that focusing on these patients’ specific treatment needs must be developed within an effective therapeutic relationship in which they and their family units feel as if they are driving the process.

Early on in my career, a part of my journey as a clinician was about figuring out what I needed to know as a professional in each job. Somewhere along the line, it became clear that my journey is not so much about knowing as about always learning. If you have a limited number of treatment approaches that you’ve mastered, it can be professionally intimidating to focus on the patient as your teacher. It can be even more frightening to take the extended time to allow patients to open up and share their thoughts and feelings over a long period of time.

Significant value is put on conducting brief therapy work in a short period of time in the context of our managed care system. Many clinicians don’t have the luxury of taking extended periods of time with patients. I’m fortunate that my program’s grant funding allows me the opportunity to build my therapeutic relationship with my patients. Rapport building with my patient has become an important priority in my practice.

I continue to use therapy techniques such as Cognitive Behavioral Therapy (CBT), Mindfulness, Conflict Resolution, Motivational Enhancement, and Systems Theory as the foundation for the tools that I use to assist patients. These tools are helpful in framing my practice into interventions that are evidenced based and effective. However, I’ve found that allowing patients and their families to be the guide for the treatment plan gives them much needed control over their lives, as an uncertainty and lack of control have become the norm for them. It also keeps me honestly engaged in intentional and active listening. I am always looking to my patients for cues on ways to join them on their journey.

Treating my patients from a person-centered perspective cures my need to solve everything for them. Many have the solutions and we are partners in discovering the road to those solutions. Even when they may be full of despair and feeling low, they continually express that they are more than a diagnosis. They are individuals who have many influences that may greatly affect their illness experiences. As their therapist, my role is to respect their desires and goals, and help them maintain optimal functioning in this context.

Kimberly Washington, licensed clinical social worker, has long held a deep interest in the connection between mental health and physical health. As the lead clinical social worker for the St. Jude’s Project, Kimberly is combining her interest in physical and mental health issues while spearheading an effort to build a broad network of clinical community support for patients with life-limiting illnesses.

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Since our introduction in the Fall 2014 issue, we have explored undoing structural racism. Work this complex requires a multidimensional explanation of racism that points a way toward individual action and structural change. To this end, each column has focused on principles outlined by the People’s Institute for Survival and Beyond: undoing racism (Winter 2015), learning from history (Spring 2015), sharing culture (Summer 2015), developing leadership (Fall 2015), maintaining accountability (also Fall 2015), networking (Winter 2016), analyzing power (Spring 2016), gatekeeping (Summer 2016), identifying and analyzing manifestations of racism (also Summer 2016), and undoing internalized oppression (Fall 2016).

Although we have discussed each principle separately, they are neither independent nor linear. Sharing culture can promote learning from history; recognizing both internalized racial superiority and inferiority can strengthen accountability; identifying and analyzing manifestations of racism can promote diverse leadership; and so forth. PISAB’s principles (http://www.pisab.org/our-principles) work as an interdependent matrix that guides three aspects of structural change: education (for a common language and understanding of the concerns and goals), organizing (for coherent collective action), and activism (to garner interest from those who do not recognize the problem).

For our final regular column, we return to action steps from our article, Think Creatively and Act Decisively (Blitz, Pender Greene, Bernabei, & Shah, 2014), which summarized our work with the Antiracist Alliance (http://www.antiracistalliance.com/). These action steps are informed by our experience with antiracist organizational development, described in Strategies for Deconstructing Racism (Carten, Siskind, & Pender Greene, 2016) and Racism and Racial Identity (Blitz & Pender Greene, 2006), and are discussed here in the context of the PISAB principles.

Envision Something Awesome. Articulate your personal vision—one that inspires, conveys a sense of hope for a better future, and is easily communicated to others. Clarify your target for change (who and what) and how the people and organization will benefit. State your vision in the positive: “The racial and cultural climate of our agency will respond to and value all of our staff and consumers, who will know we advocate for racial justice and equity for all people” is more inspiring than “We will end institutional racism in our agency.”

You Have a Role. Your vision is big; making it a reality requires that you...
scale your action to something you can begin now. Clarify your role and the steps you can take, using the principles of learning from history, developing leadership (including your own), and maintaining accountability as guides. Is the first step educating others so that you have a shared language to communicate as you move forward? If you have that foundation, is your role to organize a group to take the next steps? Does your organization not recognize the concern? If so, your role may be to engage in productive activism to draw attention to the issue. Note that activism does not need to be confrontational, and certainly not hostile. You are working for an awesome vision, not against people or institutions.

You Can’t Do It Alone. Identify partners, allies, and people whose support you need to achieve the vision. Figure out how you will access these people and what you will need to do to gain their trust and partnership. The principles of networking and gatekeeping are helpful here. Some of those you meet in this process will already be active in their own endeavors. Make sure your actions support and enhance, not detract from or compete with, theirs.

There Is Different Work for Different People in Your Group. Analyzing power and sharing culture are important as your group comes together to understand social and organizational culture and manifestations of racism. As the members of the group build trust, their different histories and culture emerge and they will clarify how their work will be different. It is not unusual for internalized racial oppression, both superiority and inferiority, to become central here, and it is important to identify challenges in working together and plan for what can be done to address concerns.

Develop and Nurture Systems of Accountability. Networking will broaden your base, and it will likely bring you closer to leaders who can make change in the organization. Meaningful change, however, requires accountability to communities of color and open communication with them to continually assess the strength and viability of your partnerships. Since diverse groups of people of color are often not represented among agency leaders, accountability structures must be developed inside and outside the organization’s hierarchy.

You Don’t Need Critical Mass; You Need Gatekeepers Who Can Open Up a System. Effective organizing requires that you analyze the power structure and identify gatekeepers for the systems you are working to benefit, and that you use your own gatekeeping power productively. Develop allies outside of your organization who can guide and support you. Use allies’ help to figure out how you can access people in power and bring those in power closer to the group to whom you are accountable so decisions about change can be made collaboratively.

Thank you to those who have thoughtfully read our columns, those who “liked” us (and those who didn’t!), and especially to those who are using our experience to move your antiracist work forward.

In solidarity,
Mary, Sandy, and Lisa

References


Mary Pender Greene, LCSW-R, CGP, is an organizational consultant, psychotherapist in private practice, career/executive coach, professional speaker, and co-founder of the AntiRacist Alliance.

Sandra Bernabei, LCSW, is President of the National Association of Social Workers—New York City Chapter. She is a founding member of the AntiRacist Alliance.

Lisa V. Blitz, Ph.D., LCSW-R, is a social worker, researcher, and educator with 25 years of experience in mental health and social justice centering on culturally responsive trauma-informed practice and organizational development.
Is the Social Work Licensing Board for Me or Against Me?
by Brian Carnahan and Tracey Hosom

The interests of the public take precedence over those of the individual. Keeping in mind that licensees are not the “clients” of the board—rather, they are “customers”—can help when confronted with an issue. Although the board staff is here to help applicants or licensees achieve the best outcome for their individual situations, they cannot act as advocates for any applicant or licensee. The board must consider the public interest first and foremost.

The board is not an advocate for a profession, a set of values associated with that profession, or any political position—and the board is cognizant of these limitations. Advocating is the role of professional associations such as the National Association of Social Workers, the American Counseling Association, or the American Association of Marriage and Family Therapists. These organizations and their state affiliates advocate for the professional licensees, encourage their development, and promote the professions that they represent. Nonetheless, board staff recognize that the services provided by the board facilitate the licensee’s or applicant’s ability to pursue a career and earn a living.

As a licensee, what can you expect from your board? First, you should expect good, respectful customer service, including information on how to navigate the licensure process. In essence, you should be treated as a customer—one who has options. You should have prompt and courteous responses to your questions. Recognize, though, that not all questions may be answerable by board staff. The board may suggest someone else who can answer practice-related questions, or may refer you to seek legal counsel.

You can expect the laws, rules, and scope of practice for your profession to be protected by the board. These issues could arise in the legislature, from another board, or through a stakeholder. What this means is that the board should be watchful for any law or rule changes that make it more difficult for you to practice, erode your authority as a licensee, or negatively affect public protection.

Transparency and access to the board should be available to you as a licensee or applicant. You should be able to understand how the board operates and comment on proposed rules and changes. A related concept is consistency and equity in decision-making. While we wish to be treated as individuals, often individual circumstances cannot be a factor in making a licensure or disciplinary decision. This is when the difference between the values of the professions and the board may become very apparent. Therapists must treat clients as individuals, tailoring their treatment to the needs of the individual. A licensing board cannot do so and maintain its public protection role, ensuring everyone who comes before the board is treated fairly and equitably.

As a licensee, you can expect to have your board provide resources regarding applicable laws and rules, continuing education, and other information that helps you stay current with your obligations as a licensee. The board may also issue newsletters and use social media to communicate.

It can be challenging to work with entities such as licensing boards, as they have a role to play in a professional’s life, but are not directly involved in the profession. Keeping the purpose of the board in mind will help to maintain a good perspective on any interactions with the board, as well as help you understand what the board does and does not do.

Brian Carnahan is Executive Director of the State of Ohio Counselor, Social Worker, & Marriage and Family Therapist Board. Brian can be reached via email at brian.carnahan@cswb.ohio.gov. Tracey Hosom is an investigator with the State of Ohio Counselor, Social Worker, & Marriage and Family Therapist Board. Tracey can be reached by email at tracey.hosom@cswb.ohio.gov.
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Social Work Gets in the Game

by Adam G. Grobman

Mental health and other issues are especially relevant among those close to the National Football League. In 2007, the NFL Player Care Foundation was formed. In 2014, Nate Recknagel, MSW, was hired as a mental health specialist with the organization. “The organization initially started as a financial resource for athletes,” Recknagel says, “but our needs and mission have evolved to address mental health and cognitive issues.” Recknagel works primarily with “the older population of football players, at least five to ten years out of the league.”

Recknagel, a former minor league baseball player, states that although it is not necessary to be a former athlete to do his job, he “comes in with a different learning curve and rapport being able to say that I’m a former athlete” when meeting his clients. Many of the issues that his clients face are different from what the general public and media might expect. “There’s a lot of generic cases of depression and anxiety, and they’re not always attributed to what the media proposes,” he says. “A lot of what I do has to do with transition, maintaining employment past playing in the league, even living with ongoing physical conditions that may be injuries resulting from playing in football, chronic pain. We’re learning that a good portion of former players have diagnosed or undiagnosed sleep apnea.”

Dr. Moore describes many of the issues that sports social workers address: “Mental health aspects, depression and anxiety, substance abuse, eating disorders, helping individuals struggling with the stigma of mental health [disorders].” It can be a struggle for outsiders and the general public to feel sympathy for athletes the way they would for others, in general. “Most of us are fans of sports so we watch for the entertainment value and don’t think about the pressures that are put on,” Moore adds.

Although there is overlap with their professional counterparts, amateur athletics present their own set of issues. As with any target group, Dr. Moore stresses the importance of getting involved early and often, hoping to make an impact on at-risk individuals at a young age. “We want to establish patterns while individuals are in college. If you set the standard at that fundamental stage, then hopefully as a professional athlete… those trends will continue to be a part of their lives, as well,” he points out.

Sports social workers interacting with athletes have a unique challenge in that the majority of their clients’ athletic careers end at the amateur level. Dr. Moore continues, “We get and understand competition, but at the end of the day, we’re aware that the individuals competing are most likely going to go on to do things other than sports. We have to prepare them for life after college and consider other aspects of life.”

The sports social work field is quickly growing and evolving. Recknagel, a University of Michigan graduate, has seen that growth firsthand. "From my standpoint, I see that there’s more people joining the school of social work at Michigan that have an interest in sports, more people from the field of public health that have an interest, and understanding where the differences are between this and psychology and how does social work differentiate from other similar professions. I think that’s where it’s evolving now. It was merely a conversation when I started."

Indeed, the field has evolved beyond conversation and is present in many areas across the country. Recknagel’s alma mater is home to its own Social Work and Sports Association. The University also held a mini-conference in 2016 on Social Work and Sports. NASWIS has compiled a comprehensive listing of articles and research papers and maintains a blog commenting on current events. The Alliance’s online job center is another resource, demonstrating the need for social work professionals throughout the sports community.

Adam G. Grobman, a graduate of Penn State University, writes from Harrisburg, PA.
Reviews


Anger becomes a problem if it is too intense, if it occurs frequently, if it lasts a long time, or if it is hard for you to let go of. Bernard Golden, a practicing psychologist for 40 years, has written Overcoming Destructive Anger to help people manage their anger better through reflection, mindfulness, and self-compassion. This book integrates contemporary insights from neuroscience and Buddhist psychology to help readers “recognize and control triggers that lead to anger.”

The author believes that anger is a cry for help when uncomfortable feelings have been aroused. Part I of the book helps readers to understand where anger comes from and why it can seem uncontrollable. The author explains how mindfulness decreases the need to act on anger, and self-compassion helps reveal the roots of our anger. Part II shows readers how to analyze their anger from basic needs through unrealistic expectations and triggering events, and underlying hurt feelings, which in turn lead to faulty appraisals of situations and aggressive actions. Part III shows readers how to move beyond anger to compassion for self and others, which leads to healing.

Overcoming Destructive Anger is written for many kinds of clients social workers might see. It is easy to read and practical in its approach. Each chapter includes practical exercises and reflection questions. Golden includes a journal format for thoroughly debriefing each incident of disruptive anger. Social workers will find the mindfulness exercises helpful to use with clients. These exercises include mindful breathing, progressive muscle relaxation, acceptance of feelings, focusing, and compassion enhancement.

Whereas many books have been written on “anger management,” Overcoming Destructive Anger includes unique elements such as “wisdom perspective,” compassion, and understanding basic needs and motivations that lead to excessive anger.

Golden does not include socio-political analysis of male control over women, which some social workers feel is essential to ending interpersonal violence. Nor does this book address the extensive trauma that occurs in chronically abusive relationships. Instead, Golden approaches destructive anger as a disruption of our own inner peace that can be healed through scientifically sound and spiritually grounded practices.

Overcoming Destructive Anger naturally follows on contemporary positive psychology books such as Rick Hanson’s Buddha’s Brain. This makes Golden’s book very approachable, compassionate, and helpful for social work clients who continually experience intense, or destructive, anger.

Reviewed by Samuel W. Gioia, MSW, LCSW, Assistant Professor of Social Work Practice, Portland State University.


To help readers acquire the foundations of assessment, this fourth edition of Jordan and Franklin’s text is organized into four parts and ten well organized chapters. Both of these accomplished authors teach at the University of Texas at Arlington and possess years of practical experience and expertise in clinical assessment and intervention. They conceptualize clinical assessment as both an art and a science, and a lovely aspect across all four editions of this book is that the content equally covers and appreciates the beauty of both quantitative and qualitative methods in social work practice.

Thankfully, this edition continues to include a vast array of useful standardized assessment tools to help students, practitioners, and educators be flexible and masterful in their research and practice efforts. An indispensable cornucopia of measures, surveys, scales, and tests listed on pages ix and x makes this book “a keeper” for readers who’ve been assigned the book for coursework purposes. Upon graduation, or even in fieldwork, readers will enjoy having at their fingertips tables, figures, and box-es that are clearly laid out, replete with source reference information. Many of the tools found in this book are readily available in the public domain.

Across the pages, each chapter ends with a summary and succinct set of study questions that aid critical thinking and application. The book’s content allows readers to ascertain how multiple assessment instruments may be used with children, adolescents, and families. Table 8.4 aids in the assessment of caregiver stress, and Table 9.1 lists measures for four ethnic groups, as well as cross-cultural measures for ethnic minority children and families. Classic tools such as the Geriatric Depression Scale (Box 6.2 on page 224) and questions for use in solution-focused assessments (on page 28, Box 1.3) are useful.

This fourth edition examines the clear differences between assessment and diagnosis and boldly critiques the strengths and weaknesses of the Diagnostic and Statistical Manual (DSM-5). Chapter 8, entitled “Families Who Are Multi-Stressed,” goes to the heart of assessing families who find themselves in oppressive situations experiencing environmental stress. Sub-headings and topics that are particularly noteworthy in Chapter 8 are (1) gay and lesbian families, and (2) child maltreatment in families.

The final section, Part IV (Assessing Outcome), does a nice job of addressing the importance of monitoring and evaluating outcomes of interventions being delivered to clients. An emphasis on EBP (evidence-based practice) is included herein, and additional information about how to use measures in research designs to ascertain whether clients are improving or not are unveiled. Chapter 10 gives readers several great resources for identifying interventions that are grounded in research evidence.

Once again, Jordan and Franklin have edited a book of substance—no fluff—in the company of fine chapter contributors who have done their homework. This book is worth the investment. Read, employ, and enjoy!

Reviewed by Lisa E. Cox, Ph.D., LCSW, MSW, Professor of Social Work and Gerontology, Stockton University.

The Assertiveness Guide for Women, by Julie de Azevedo Hanks, Oakland, CA: New Har-
It’s not a surprise to many clinicians that many women struggle with being assertive. In a world that teaches and often perpetuates mixed messages about what is appropriate feminine behavior, this book asserts that women in fact can be assertive in their lives and still remain feminine. In her new book, Dr. Julie de Azevedo Hanks shows readers that a woman can fulfill her need to make meaningful connections while simultaneously communicating what she needs, wants, and desires.

Readers are taught how to understand their own attachment style and how it may be impeding their ability to assert themselves in their lives. This particular book is different from others on assertiveness in part because not only is it written by a woman for women, but also because it takes a more systems approach in focusing on both the individual and the individual’s communication with others. The reader is given practical examples throughout the book, with both professional and personal anecdotes from the author.

The book is clearly laid out for readers in a logical progression—from defining assertiveness, the connection with attachment, and the importance of recognizing factors that influence one’s assertive nature to self-awareness, self-expression, and self-expansion. Throughout the book, the reader is introduced to a balanced mix of research, theory, and practical application of the concepts described. In addition, the latter chapters provide examples of self-awareness activities, case examples, communication techniques, and reflection questions to ponder as one masters the material. Overall, the reader is given an outline of how one can learn and know when to be assertive in ways that they might have otherwise ignored in the past.

Based on both clinical wisdom from working with women and from her own experiences, Dr. de Azevedo Hanks invites women to embark on a journey to create a stronger sense of clarity, confidence, connection, and compassion by increasing their assertiveness in the areas of their lives that matter most. This book is useful to any woman who desires to increase her assertiveness and is a good tool for clinicians to use when addressing issues of connection, gender, attachment, and assertiveness. This wonderful guide is highly recommended for anyone who wants to be more assertive.

Reviewed by Beth Russell, Ph.D., LCSW, Clinical Associate Professor of Social Work, The College at Brockport.


This collection of essays evidences an impressive body of feminist thought and discourse. Collectively, the editors and contributors serve to bring attention to the domination of “American” perspectives on gender violence, including its etiology and widely-accepted interventions and methods of prevention. The book exposes the pervasive ideologies of misogyny and patriarchy evident in legal discourse on gender violence, including the frequent unwillingness or inability of legal systems worldwide to adequately address the issues.

Beyond exposing flaws in legal mechanisms, the book serves to identify structural root causes of, and contributions to, gender-based violence. The editors also engage in discussion regarding tools and techniques to “work around” the omnipresent barrier of legal resistance and blindness, which is aided by deeply-ingrained cultural norms and traditional views of gender roles. The authors urge engagement with societal structures and formal and informal institutions through open discourse, advocacy, and education.

While it is likely excessively advanced for baccalaureate-level students, this volume should be a core component of graduate-level social work education. It opens a dialogue on subjects often neglected in the field and in the classroom. The editors offer a well-reasoned critique of the ethnocentrism of “American” intervention and how it is “exported” into global contexts, and question the efficacy of those models in the amelioration of the issue of gender-based violence. Additionally, they utilize a strengths-based view of cross-cultural work to eradicate this class of violence, focusing on effective models of intervention and how they may be “imported” into the United States.

From a practical standpoint, our increasingly diverse communities bring with them a need for social workers with more awareness of global perspectives and knowledge of varying cultural contexts within which social problems may exist. This text would be a valuable resource for practicing social workers, particularly those with a multicultural client base or those who work with the ever-increasing refugee populations. In the classroom, it would provoke crucial discussion on feminist theory and application to practice, international social work and cultural humility, and policy practice. This volume provides a rich array of perspectives on a global social problem and presents them in a way that is relatable to students and professionals in the field alike.

Reviewed by Jennifer L. Wood, Ph.D., LMSW, MSSW, Program Director, Assistant Professor of Social Work, West Texas A&M University.


Lesbian, gay, bisexual, transgender, and queer/questioning LGBTQ youth face many psychosocial issues in a world that does not always embrace them. It is for many of these reasons that LGBTQ youth end up homeless and on the streets. According to the Williams Institute at the University of California at Los Angeles School of Law, nearly half of the homeless youth served in agencies may identify as LGBTQ.

Ryan Berg worked in one of those agencies serving LGBTQ youth in New York City. In his memoir, No House to Call My Home, Berg discusses the joys and challenges of serving LGBTQ youth, highlighting the stories of...
youth who navigate a world of racism, homophobia, transphobia, and other risk factors. Berg came to the world of LGBTQ youth a bit by chance. Although Berg is LGBTQ-identified himself, he came to the work at the Keap Street group home in Brooklyn at a time in his life when he was feeling aimless and unsure. Through much personal reflection and use of clinical supervision, Berg came to better understand himself and the role that he could serve in the lives of the LGBTQ youth in the group home.

No House to Call My Home illustrates the stories of several youths, combined with Berg’s own reflections about how he managed the day-to-day struggles of helping the youths toward a brighter future. Many youths struggled as they transitioned to adulthood, unable to overcome addiction to drugs, sex work, and other elements of street life. Some youths were successful and went on to college, graduate school, and other endeavors. Through each of his experiences at Keap Street, Berg learned about the importance of telling the stories of these LGBTQ youth and advocating for the foster care system to better serve them.

Students and new social workers will identify with Berg’s uncertainties and challenges in reaching the youth of Keap Street. Students and new social workers are often managing changes in their own lives. Berg’s abilities to self-reflect and to fully engage in supervision can be a model for many of these students and social workers. And while students and new social workers, like Berg, may struggle in working with youth and others because they do not always see the positive results of their work, they will learn through No House to Call My Home the importance of listening to the stories of LGBTQ youth, despite the youth’s readiness for change. In all, students and new social workers will find Berg’s work helpful in understanding how we both succeed and fail at meeting the needs of LGBTQ youth.

Reviewed by Trevor G. Gates, Ph.D., LCSW, Assistant Professor, Social Work, Greater Rochester Collaborative MSW Program, College at Brockport, State University of New York.


I love the way Photo Explorations encourages girls to use photography, writing, and art to explore themselves and the world around them. Cathy Lander-Goldberg is a licensed clinical social worker and photographer who conducts workshops to help women and girls learn more about themselves through these artistic methods.

This activity book/journal reminds me a bit of the Anti-Coloring Book series. Through a series of prompts, Lander-Goldberg asks readers to take or find existing photographs of themselves; their families; their friends; and their homes, neighborhoods, and communities. She then asks questions that encourage the readers to write about the photos and what they mean.

For each section and each prompt, there is plenty of space on the page for the users to paste in photographs, make their own drawings, and write their responses.

Lander-Goldberg encourages readers not to worry about making the photos “perfect” or to judge how their hair or smile looks. She instead asks them to use photos that represent what is real for them.

There are also sections on strengths and accomplishments, worries and challenges, life balance, meaning in one’s life, and the “real me.” The book concludes with a list of resources for girls, as well as one for parents.

Photo Explorations can be used by girls on their own or in conversation with a parent. It can also be used as a workbook in schools or with a therapist to help girls explore themselves and their feelings on a deeper level.

Social workers who work with children will find this a useful resource, as the ideas for using photography, writing, and art can be helpful for people who have a hard time opening up in traditional “talk therapy.” Finally, although the book is for girls, I think many of the exercises can be meaningful for clients regardless of gender and can be adapted for use with adults.

Reviewed by Linda May Grobman, MSW, ACSW, LSW, publisher/editor of The New Social Worker.

Hope—continued from page 11


Dr. Betsy Clark is President of the Start Smart Career Center, which helps women navigate their careers, and she co-authors the Smart Women book series. Previously, she served 12 years as the CEO of NASW. Her clinical background is in oncology, and she has written extensively on survivorship and hope. She holds a doctorate in medical sociology and master’s degrees in social work and public health.
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Real World Clinical Social Work
Find Your Voice and Find Your Way
by Dr. Danna R. Bodenheimer, LCSW

Social work graduate school is only the beginning of your preparation for professional life in the real world as a clinical social worker. Dr. Danna Bodenheimer serves as a mentor or a supportive supervisor as she shares practice wisdom on topics such as thinking clinically, developing a theoretical orientation, considering practice settings, and coping with money issues. She addresses the importance of supervision and how to use it wisely. A frank discussion on the important and rarely-talked-about issue of loving one’s client is followed by a practical look at next steps—post-graduate options and finding your life’s work in clinical social work. Altogether, Real World Clinical Social Work will serve to empower you as you find your own voice, your own way, and your own professional identity.

What People Are Saying

Danna Bodenheimer's book is the clinical supervisor you always wanted to have: brilliant yet approachable, professional yet personal, grounded and practical, yet steeped in theory, and challenging you to dig deeper.

Jonathan B. Singer, Ph.D., LCSW, Associate Professor of Social Work, Loyola University Chicago, Founder and Host, The Social Work Podcast

[From the Foreword] Using powerful case examples and a series of carefully crafted questions, this book challenges readers to think broadly and deeply about their own social work practice and identity. It is an invaluable companion for beginning social workers and educators alike.

Lina Hartocollis, Ph.D., LCSW, Dean of Students, Director, Doctorate in Clinical Social Work Program, University of Pennsylvania School of Social Policy & Practice

Reading Danna Bodenheimer’s Real World Clinical Social Work: Find Your Voice and Find Your Way is like spending a weekend in a wonderful candid conversation with many of our favorite theorists! While sharing her own perspectives and experiences, Bodenheimer invites us to reflect on topics as far-ranging as the essential components of the different modalities we can use in assessing and addressing client needs and the sustenance of our personal lives. In language that is accessible, oftentimes metaphoric, and yet not at all simplistic, this book also introduces us to some of the clinical experiences of clients and therapists through an interweaving of their stories and theories. …spending time with Real World Clinical Social Work is a real gift to yourself and everyone you serve.

Darlyne Bailey, Ph.D., ACSW, LISW, Dean, Professor, and MSS Program Director, Graduate School of Social Work and Social Research, Bryn Mawr College

It is nearly impossible to begin a career as a budding clinical social worker without the accompaniment of a variably loud inner voice that says, “You have no idea what you are doing.” Dr. Bodenheimer befriends the beginning clinician with this incredibly personable and accessible book and says, “Sure, you do.” Dr. Bodenheimer uses herself as a vehicle for connection with the reader, and she speaks directly to that inner voice with compassion, understanding, and guidance.

Cara Segal, Ph.D., Smith College School for Social Work, faculty, Private Practitioner, Northampton, MA

ABOUT THE AUTHOR
Dr. Danna Bodenheimer, LCSW, lives and works in Philadelphia, PA. She graduated from Smith College, earning her bachelor’s degree in Women’s Studies, and received a post-baccalaureate degree in psychology from Columbia University. Danna began her social work career at the Tuttleman Counseling Center at Temple University. After receiving her DSW from the University of Pennsylvania, Danna began a teaching career and her own private practice. She currently teaches at Bryn Mawr’s Graduate School of Social Work and Social Research and is director of the Walnut Psychotherapy Center, a trauma-informed outpatient setting that she founded, specializing in the treatment of the LGBTQ population.

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Beginnings, Middles, & Ends
Sideways Stories on the Art & Soul of Social Work
Ogden W. Rogers, Ph.D., LCSW, ACSW

A sideways story is some moment in life when you thought you were doing one thing, but you ended up learning another. A sideways story can also be a poem, or prose, that, because of the way it is written, may not be all that direct in its meaning. What’s nice about both clouds, and art, is that you can look at them and just resonate. That can be good for both the heart and the mind.

Many of the moments of this book have grown from experiences the author has had or stories he used in his lectures with students or told in his office with clients. Some of them have grown from essays written for others, for personal or professional reasons. They are moments on a path through the discovery of social work, a journey of beginnings, middles, and ends.

With just the right blend of humor and candor, each of these stories contains nuggets of wisdom that you will not find in a traditional textbook. They capture the essence and the art and soul of social work. In a world rushed with the illusion of technique and rank empiricism, it is the author’s hope that some of the things here might make some moment in your thinking or feeling grow as a social worker. If they provoke a smile, or a tear, or a critical question, it’s worth it. Everyone makes a different journey in a life of social work. These stories are one social worker’s travelogue along the way.

PRAISE FOR THE BOOK

“As someone near the end of a long career in social work and social work education, I found the stories of Ogden Rogers in his collection, Beginnings. Middles, and Ends, to reflect so much of my own experience that I literally moved back and forth between tears of soulful recognition and laugh-out-loud moments of wonderful remembrances. There is something truthful and powerful about the artist who is willing to put a masterpiece together and leave the telltale signs of failed attempts. Too many who reflect on their past do so to minimize imperfection, setting standards unreachable by others. Ogden Rogers has charted a course of professionalism that encourages creativity, allowing for errors, and guided by honest reflection and dedication to those whom he would serve. This read is a gift to all, whether they are starting or ending their journey of service to others.”

Terry L. Singer, Ph.D., Dean, Kent School of Social Work, University of Louisville

“I found the stories humorous, sometimes painful, and incredibly honest and real. There is really nothing else out in our literature that is quite like this. It reminds me of when we teach the art and science of social work practice—this is the art.”

Jennifer Clements, Ph.D., LCSW, Associate Professor, Shippensburg University

“...a profound piece of creative literature that will reinstall idealism within senior social workers who are on the threshold of being cynical about their work.”

Stephen M. Marson, Ph.D., Professor, University of North Carolina Pembroke

“Recommended reading for new social workers, experienced social workers, friends and families of social workers, and future social workers because of the variety of anecdotal case presentations and personal perceptions. Truly open and honest portrayals of social work and the helping professions with touching, easy-to-read entries fit within the beginning, middle, and ending framework. This book is suggested for both public and academic libraries to support the career services and/or professional development collections.”

Rebecca S. Traub, M.L.S., Library Specialist, Temple University Harrisburg

For the complete Table of Contents of Ogden Rogers’ Beginnings, Middles, & Ends and other information about this book, see:

beginningsmiddlesandends.com

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ABOUT THE AUTHOR

Ogden W. Rogers, Ph.D., LCSW, ACSW, is Professor and Chair of the Department of Social Work at The University of Wisconsin-River Falls. He has been a clinician, consultant, educator, and storyteller.