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Together We Thrive: How Social Workers and Communities Rebuild After Pandemic

While in the thick of the Covid-19 pandemic, social workers as essential workers navigated the public health crisis to achieve positive health and mental health outcomes for persons who were vulnerable, marginalized and underserved within their communities. These social workers faced unprecedented situations helping others to cope with multiple challenges ranging from health disparities to food insecurities brought on by the virus.

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Beyond the Pandemic: Sustaining Telehealth Practices for Tomorrow's Social Workers
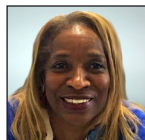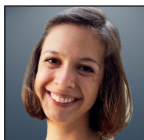
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Telehealth, the "remote provision of healthcare services using technology to exchange information for the diagnosis, treatment, and prevention of disease" (Weigel et al., 2020, para. 2), has emerged as an appropriate way to engage marginalized and underserved populations in clinical interventions (Camhi et al., 2020). Increasing access to care has long been a hallmark of social work practice, along with "meeting people where they are." This phrase acquired greater significance during the COVID-19 pandemic, as telehealth adoption and acceptance accelerated across the field to become a primary form of service delivery. The following discussion explores ways in which telehealth can help social work practitioners and the profession rebuild beyond the pandemic.

Telehealth is Well Positioned to Decrease Barriers

Telehealth epitomizes the ideal of person-centered care with its "delivery reversal": providers go toward clients rather than vice versa. It arguably evokes the home visits of the Charity Organization Society Movement by reimaging the person-centric approach of clinicians "traveling" to clients' homes. Recently, the National Association of Social Worker's publication of the *Code of Ethics* Standards for the Digital Age signaled a shift in the field and a recognition of telehealth's growing centrality to service delivery (Reamer, 2017). Telehealth is well positioned to decrease barriers associated with transportation, limited regional providers, and concerns for privacy and stigma. It has consistently demonstrated efficacy equivalent to in-person appointments when supporting diverse populations and people living with a range of mental health disorders, including PTSD, depression, anxiety, ADHD, and eating disorders (Trombello et al., 2020; Waller et al., 2020). Traditional assessments and interventions, even tactile-heavy treatments like EMDR, have been conducted virtually with outcomes comparable to in-person services (Winkler et al., 2021).

Adjusting to Telehealth Technology

However, the embrace of telehealth is not without concerns for ethical practice, provider burnout, perpetuated inequity, and plans for sustainable insurance reimbursement. Perron et al. (2010) analyze the advantages of technological formats as well as their pitfalls and challenges within medical social work. Following the emergence of the COVID-19 pandemic, which thrust practitioners into the world of telehealth, these queries became even more pressing. When COVID-19 hit, integrated health organizations made abrupt changes to adopt telehealth as their primary default modality. Social workers and students also adjusted to telehealth technology. Demand for mental health services, especially among children and adolescents, outpaced the system's capacity to respond (de Figueiredo et al., 2021). Many practitioners had not received formal classroom training for telehealth service delivery, as practicum settings had trained students to provide in-person direct practice with supervised training. Therefore, graduate students reported feeling underprepared and under-resourced to suddenly use telehealth in their practice.

The private sector started responding to the demand for telehealth services nearly a decade ago via online portals like BetterHelp and TalkSpace, which offer both messaging and video sessions. Although some digital platforms accept insurance coverage, many others offer limited or no coverage, requiring clients to pay out of pocket. Quality telehealth services, especially for marginalized communities, must remain accessible regardless of insurance type. Social workers and other providers must now spearhead efforts to maintain the sustainability of telehealth, with particular attention to developing novel and universal graduate-level curricula and training programs.

Less Appropriate For Certain Settings

Despite telehealth's well-documented effectiveness, it may be less appropriate—even dangerous—for certain settings and clinical needs. During a crisis call, virtual care can pose a challenge should the client's location be unknown, geographically distanced, or not easily accessible by medics. If a client endorses active suicidal or homicidal ideation, clinicians may find themselves unable to adequately intervene. For clients experiencing intimate partner violence, telehealth may weaken the quality of therapeutic contact or may destabilize client safety through inappropriate questions or actions (Jack et al., 2020). These scenarios are less likely for clients with an ongoing therapeutic relationship and known risk level. Regardless, the client's location and present company should be confirmed at the start of each visit. Maintaining boundaries and confidentiality becomes harder when family members and pets dash across screens. When working from home, practitioners also remain glued to their monitors throughout the day, raising concerns about the limits of focus and concentration. Without the built-in breaks of walking to waiting rooms or conversations with coworkers, providers may experience increased isolation and monotony, which may lead to compassion fatigue and burnout. Voice-only

platforms pose a unique risk of distraction for providers, combined with the frustration emerging from poor line connection and background noise—all of which may compromise therapeutic quality. Interventions by telephone also affect a provider's ability to assess congruency between verbal and nonverbal communications. New practice questions should consider how to hold space for silence and reflection without visual cues and through choppy internet and telephonic connections.

Losing Telehealth

The COVID-19 public health emergency acts temporarily expanded access to telehealth coverage for large segments of the American population, especially for Medicare and Medicaid beneficiaries. Unfortunately, Congress has not yet passed legislation to permanently protect these changes (ATA Action, 2022). Formally removing geographic and site restrictions would allow providers to reach more rural communities with marginalized care indefinitely. Other pending bills would eliminate high copayments for telehealth services and permit e-prescription for medication-assisted therapy—all critical steps to ensure equitable access to behavioral health (ATA Action, 2022). Without such planning, however, millions of Americans will lose telehealth access once the public health emergency acts expire.

Telehealth Reform

Unto itself, telehealth and reimbursement-focused initiatives are not a panacea to systemically inaccessible behavioral health services. Telehealth has traditionally favored more privileged and "connected" communities. Zhao et al. (2019) found that clinics serving mostly Black patients and patients living with substance use disorders were less likely to adopt telehealth services. Mehrotra et al. (2020) even suggested that without equity-focused planning, more affluent patients and White patients may increase personal rates of utilization without similar advances across social groups. Data since 2020 irrefutably demonstrate the

value of telehealth. Equity-focused planning would ensure telehealth remains available to all clients regardless of financial security and provider proximity. Social workers must work at the forefront to demand telehealth reform and to develop a graduate school curriculum that centers on inclusive, antiracist practices and challenges students to interrogate longstanding barriers to care. In other words, solely digitizing care does not fix discriminatory practices embedded in healthcare, but if effectively molded, it may become a critical means to expand access to care.

Implications for Practice

For social work educators, supervisors of licensees, and agencies, our first step is to engage in curriculum review—decide where within the curriculum to integrate telehealth knowledge, skills, and values. This will vary across states, institutions, and program outlines. Start by understanding your state's unique legislation regarding telehealth services within and across state lines. Supervisors of state licensure boards should advocate for reciprocity for telehealth. Curriculum review should also explore the nuances of confidentiality in the home setting and include skills training on the differing perception of responses between phone or video. We need to develop learning opportunities for students to observe when a client is reflecting, disengaging, or having technical issues on their end. Graduate program directors may want to introduce Telemedicine Health Certification for practitioners who want a hybrid or remote position. Social work continuing education programming may want to offer workshops that focus on telehealth ethics. Practitioners should regularly ensure their technology and internet systems are updated and working satisfactorily, and they should have a backup plan when audio and video falter. Finally, self-care practices are endless, to start, practitioners can integrate longer breaks between sessions to document, stretch, and adjust their technology.

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References

ATA Action (2022, January 25). *Avoiding the telehealth cliff ATA action federal policy priorities in 2022*. www.americantelemed.org/wp-content/uploads/2022/01/ATA-Actions-2022-Legislative-Priorities.pdf

Camhi, S.S., Herweck, A., & Perone, H. (2020). Telehealth training is essential to care for underserved populations: A medical student perspective. *Medical Science Educator, 30*(3), 1287–1290. https://doi.org/10.1007/s40670-020-01008-w

de Figueiredo, C.S., Sandre, P.C., Portugal, L., Mázala-de-Oliveira, T., da Silva Chagas, L., Raony, Í., Ferreira, E.S., Giestal-de-Araujo, E., Dos Santos, A.A., & Bomfim, P.O. (2021). COVID-19 pandemic impact on children and adolescents' mental health: Biological, environmental, and social factors. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 106*, 110171. https://doi.org/10.1016/j.pnpbp.2020.110171

Jack, S.M., Muncro-Kramer, M.L., Williams, J.R., Schminkey, D., Tomlinson, E., Mayo-Wilson, L.J., Bradbury-Jones, C., & Campbell, J.C. (2020). Recognising and responding to intimate partner violence using telehealth: Practical guidance for nurses and midwives. *Journal of Clinical Nursing, 30*(3–4), 588–602. https://doi.org/10.1111/jocn.15554

Mehrotra, A., Wang, B., & Snyder, G. (2020, August 5). *Telemedicine: What should the post-pandemic regulatory and payment landscape look like?* The Commonwealth Fund. www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation

Perron, B.E., Taylor, H.O., Glass, J.E., & Margerum-Leys, J. (2010). Information and communication technologies in social work. *Advances in Social Work, 11*(2), 67–81. https://doi.org/10.18060/241

Reamer, F.G. (2017, August). *Eyes on ethics: New NASW Code of Ethics standards for the digital age.* Social Work Today. www.socialworktoday.com/archive/081617.shtml

Trombello, J.M., South, C., Sánchez, A., Kahalnik, F., Kennard, B.D., & Trivedi, M.H. (2020). Two trajectories of depressive symptom reduction throughout behavioral activation teletherapy among underserved, ethnically diverse, primary care patients: A vitalsign report. *Behavior Therapy, 51*(6), 958–971. https://doi.org/10.1016/j.beth.2020.01.002

Waller G., Pugh, M., Mulkens, S., Moore, E., Mountford, V.A., Carter, J., Wicksteed, A., Maharaj, A., Wade, T.D., Wisniewski, L., Farrell, N.R., Raykos, B., Jorgensen, S., Evans, J., Thomas, J.J., Osenk, I., Paddock, C., Bohrer, B., Anderson, K., … Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: Clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *The International Journal of Eating Disorders, 53*(7), 1132–1141. https://doi.org/10.1002/eat.23289

Weigel, G., Ramaswamy, A., Sobel, L., Salganicoff, A., Cubanski, J., & Freed, M. (2020, May 11). *Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond. Kaiser Family Foundation.* www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/

Winkler, O., Dhaliwal, R., Greenshaw, A., O'Shea, K., Abba-Aji, A., Chima, C., Purdon, S.E., & Burback, L. (2021). Web-based eye movement desensitization and reprocessing for adults with suicidal ideation: Protocol for a randomized controlled trial. *JMIR Research Protocols, 10*(11), e30711. https://doi.org/10.2196/30711

Zhao, X., Innes, K.E., Bhattacharjee, S., Dwibedi, N., LeMasters, T.M., & Sambamoorthi, U. (2019). Facility and state-level factors associated with telemental health (TMH) adoption among mental health facilities in the United States. *Journal of Telemedicine and Telecare.* https://doi.org/10.1177/1357633X19868902

Melancholia in a Pandemic: The Burden of Failed Mourning
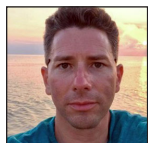
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"New Day's Lyric" Even if we never get back to normal, Someday we can venture beyond it, To leave the known and take the first steps. So let us not return to what was normal, But reach toward what is next. —Amanda Gorman (Baldwin, 2022)

Those of us engaged in psychotherapy private practice are necessarily isolated in our work. Each of us tends to this reality, of course—joining consultation groups, supervising, teaching, taking classes, or volunteering on committees in the profession or with community initiatives. Even with these adjuncts, we are mostly on our own compared with those who work in offices or in laboratories, in health clinics and service organizations, or in academies of learning. Day in and day out, our coworkers are our patients.

But our delicate balance of mitigating isolation with planned human contact has been upended. In March 2020, during the initial surge of the pandemic, most of us moved our practices online. We retreated from our "coworkers," and our contact with colleagues either evaporated outright or these individuals likewise joined the legion of faces on a screen or became fully disembodied voices on a phone.

We cloistered at home. Some of us were fortunate to be materially and psychically safe, and some of us were gratefully sequestered with cohabitants. In-person health care, grocery, and other "essential workers" continued to labor in person, though their usual way of being at work was lost to them too. And for all of us, what happened to our other activities of life? Our avocations, our socializing, our partying, our vacationing, our exercising, our holidays, our dining out, our joining together for the rites of passage of marriage, birth, graduation, various anniversaries, and death? For many of us, they were derailed entirely. At the very least, we lost them as we believed they should have been. All of us are in a protracted period of

deep and repeated loss. And, as we look around—in the mirror, in our practices, and in the world at large—not all of us are psychically faring well enough. All of us are feeling sluggish, and some of us are crushed by the weight of reality.

When Rebellion is Seductive and Toxic

Our mental health during this exceptional moment is multi determined, no doubt. I, however, have become interested in a thread that I see as common among the psychological tapestries of those around me.

If it has been a minute since you've read Sigmond Freud's Mourning and Melancholia (1917), or if it is completely new to you, it is worthwhile to (re)visit with its ideas now. In a paper born in the wake of the First World War, Freud observed two distinct versions of psychic process related to loss, as they played out in a traumatized populous. In one version of loss, the sufferer eventually healed, and the vigor of life returned; in the other, the reality of loss set off suffering that was evergreen and unending (Freud, 1917). Although living through

the COVID-19 pandemic and surviving warfare aren't equitable experiences, enough analogs exist between them to make Freud's framework helpful to us in understanding some of the grief in our present moment.

Freud (1917) framed mourning as a largely externally informed process of loss. Mostly taking place in the conscious mind, it affords the thinker sadness as well as reality-based reveries on experiences of loss and a sense of connection with those who have suffered similar traumas and/or catastrophic disruptions to the predicted unfolding of life. Mourning is a process with a beginning and end, and once complete, mourners possess a felt sense of an ending and an acceptance of the modified world in which they now find themselves.

To an outside observer, melancholia looks like mourning (Freud, 1917). It is an entirely different psychic animal though. Rather than being a process of the conscious mind seeking to integrate the knowledge and experience of loss—crafting a new internal and external world informed by reality—the melancholic person turns away from external reality and focuses inwardly instead.

Largely an unconscious process, melancholia is a rebellion against the reality of loss. It is a valiant and desperate attempt to retain what has already gone, died, been ruined, or was never to be (Freud, 1917). Melancholic thought content might very well be related to what has been lost or ruined, but the ideation will always center on what should have been—instead of on what is. When melancholia is challenged, sufferers will retreat into narcissistic fantasies, either spinning how the loss could have been prevented or averted or devaluing what has been lost in an attempt to decouple themselves from its import (Freud, 1917). Even when deeply negative and upsetting, both processes unconsciously serve to keep thinkers trapped in their internal preoccupations such that they can conjure a feeling of being in proximity to what is already gone. Desperate unending sadness, an undercurrent of profound negative self-regard, rage, self-preoccupied ruminations, empty-fatigue, and intractable shame are the domain of the melancholic person (Freud, 1917). Melancholia is also a lonely place and leaves no harbor for the bittersweet comfort that community and shared painful experience brings. Without intervention, sufferers of melancholia feel utterly alone in their experience. (Freud, 1917).

Some attributes of melancholia are familiar to us as universal elements of grief and mourning. Indeed, Kübler-Ross and Kessler (2005) described some of them in their posthumously published expositions on grief. What differentiates melancholia from mourning, though, is the lack of acceptance endemic to normative grieving. It also lacks the sense that the tragedy of loss is part of the human condition and binds us to it, rather than separating us from it. (Freud, 1917).

There is No Return to Normal

No one ever knows the future, of course, but in life before the COVID-19 pandemic, much of the time, all of us walked around with the unconscious notion that we could. We made plans. We rehearsed them in our minds. And often those plans unfolded in good enough fashion that our soothsaying remained unconscious—and a relatively efficacious defense against the awareness of the helplessness and vulnerability in which we all live, all the time.

During the pandemic, our attempts to plan, to forecast—and to hope that we once again could do so—have been continuously frustrated. Indeed, as the virus mutated, lingered, and surged repeatedly, we have been tasked with both having to live in the pandemic—navigating everything that goes along with it—and withstanding the awareness that we are perennially living in liminal space. Who would not rebel against that reality, at least in fits and starts if not entirely? At best, we have often persisted in clinging to "I will do this until we return to normal" instead of "I will do this because this is our reality." The former notion is an exhausting position. It is a powerful and solipsistic wish to return to a time that is, forever, ended.

Our development—individual and collective—has necessarily been shaped by the reality that the pandemic has placed us in, and we are forever psychically changed because of it. When someone longs to return to the "normal" times that have been lost, one need only look to contemporary work on child development to know that something is tragically amiss with that effort. Children today, who have spent critical years of their development in various states of relative isolation, already show alterations in their expected living circumstances and developmental trajectories and exhibit psychological suffering on a huge scale (Golightley & Holloway, 2020; Phelps & Sperry, 2020; Shah et al., 2020; Watson et al., 2022). Describing how the pandemic shaped character development and mental health for the worse, and for the better, will be the work of social workers for decades to come. The only certain thing is that there is no return to normal—that is, as if the pandemic never happened—for anyone.

For those clients stuck in the rebellion of melancholia, we private practitioners bear witness to their defenses fraying—with everything from denial to rationalization, to compartmentalization, to reaction formation and acting out being deployed in the service of preserving the hope of "getting back to normal." The fatigue that so many of us, clinician, and patient alike, are feeling can be understood as the result of our efforts to meet the psychic task at hand, whether through mourning, melancholia, or a wavering back and forth between the two.

Empathy is a Casualty of Melancholia

In my observation, when in rebellion and preoccupied with internal thoughts, wishes, and feelings, our capacity to attach to other people, and to care about them and their experience, is deeply hobbled or eliminated.

When we're in melancholia, we don't want to deal with other people, their human foibles, or the reality to which they are subject. Minor slights, incapacities, or inabilities feel more seminal than they are (and then they might have seemed at other times). In these moments of confrontation, we are forced to turn our attention outward, and our wish that other people perform as they did before the pandemic spills out. We are quicker to anger and umbrage. Our minds are hastier with harsh thoughts, and perhaps our tongues follow suit. People and situations might feel as if they are fatally disappointing and without redemption. We may be tempted to unreasonably complain. We may retreat into our various psychic and societal privileges without a second thought. And we might cling to expectations of others that are unreasonable, unyielding, and uncurious. When in this mode, we will always be subject to an undergirding of put-upon fatigue. We are so very tired—and so very tired of navigating this psychic ground of being forced to acknowledge the reality outside of our minds.

For therapists in the consulting room, patients who at other times were challenging to treat, like, or manage become burdens, and their saving graces become difficult to sense or to root out. Doing the work of therapy,

of being in service to the benefit of another, may feel harder in a way that is unfamiliar. We private practitioners might mistake our time off for vacations instead of recognizing their true nature being respite and recovery.

Our Task at Hand

Psychoanalysis, and the theory base that informs it, is not every clinician's treasure. I hope that regardless of how clinicians understand their patients' sufferings, and the orientations with which they attempt to help, the idea of melancholia might aid in deepening the work of some therapies and provide a basis to understand why some patients appear stuck in their grief.

I contend that there is a treatment objective common to all psychotherapies at present. We private practitioners are as midwives, helping to deliver a new world to ourselves and the patients and communities we serve. We are here to facilitate mourning—to help ourselves and our patients let go of what we have lost and will not return, and to tolerate and integrate external reality. We do this through doing our thing: building a treatment alliance and gently puncturing the bubble of melancholia such that that the light of reality might show through. How this work is done is highly idiosyncratic to the client involved; how long it takes is informed by many determinants that are well beyond the scope of this paper.

The reason for this work is simple if not dastardly hard: If we can let go of what we have lost, we get to have, and to feel, the fullness of what is available to us now—and feel a little less tired too.

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References

Baldwin, E., (2022, January 3). New Day's Lyric by Amanda Gorman. *Poem Analysis*. https://poemanalysis.com/amanda-gorman/new-days-lyric/

Freud, S. (1917). Mourning and melancholia. *Standard Edition, 14*(239), 1957–61.

Golightley, M., & Holloway, M. (2020). Editorial: Unprecedented times? Social work and society post-COVID-19. *The British Journal of Social Work, 50*(5), 1297–1303. https://doi.org/10.1093/bjsw/bcaa110

Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York, Scribner.

Phelps, C., & Sperry, L. L. (2020). Children and the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S73–S75. https://doi.org/10.1037/tra0000861

Shah, K., Mann, S., Singh, R., Bangar, R., & Kulkarni, R. (2020). Impact of COVID-19 on the mental health of children and adolescents. *Cureus, 12*(8), e10051. https://doi.org/10.7759/cureus.10051

Watson, K.R., Capp, G., Astor, R.A., Kelly, M.S., & Benbenishty, R. (2022). "We need to address the trauma": School social workers' views about student and staff mental health during COVID-19. *School Mental Health*. https://doi.org/10.1007/s12310-022-09512-7

As the *Washington Post* reported:

> Social workers have been finding shelter for homeless covid patients, providing treatment for people with addiction disorders made more challenging by pandemic-related social isolation, and comforting bereaved family members who have lost loved ones ... (Lerner, J. & Pollack, H. 2022).

Also, during the Covid-19 peak period, many practitioners were forced to re-evaluate how they provided services to their clients opting for online engagement. Most found this option to be an adequate solution to still interact with their clients, but some found those they helped were uncomfortable with the transition from face-to-face therapy to virtual sessions. So, these practitioners searched out different communicating tools, set boundaries and shared tele-health guidelines that would help their clients accept being treated digitally.

Thankfully, according to the World Health Organization, the end of the Covid-19 pandemic is at least in sight (Smith-Schoenwalder, C. 2022). Of course this is contingent upon what we as Americans, and we as global citizens do collectively to continue to combat the epidemic. Unfortunately, the end of Covid-19 will start the beginning of its aftermath. For example, how many people will have post-traumatic stress disorder related to living in a Covid-19 world so long? This InterSections in Practice, annual bulletin will look at how social workers are planning to prepare for the aftermath of the pandemic. It is true, with Covid-19 society has indeed made great strides, still we have a long way to go, and social workers are committed to going the distance healing and helping those in need as long as it takes to do so.

Lerner, J. & Pollock, H. (2022). Social Workers are the Unsung Heroes of the Pandemic. *Washington Post*. www.washingtonpost.com/outlook/2022/02/23/social-workers-burnout-pandemic-unappreciated/

Smith-Schoenwalder, C. (2022). *WHO: The End to the COVID-19 Pandemic Is in Sight*. www.usnews.com/news/health-news/articles/2022-09-14/who-the-end-to-the-covid-19-pandemic-is-in-sight

www.washingtonpost.com/outlook/2022/02/23/social-workers-burnout-pandemic-unappreciated/

Resisting Resilience & Making Room for Rest

Tiffany Walker, LCSW

COVID-19 has made the entire world aware of the impact of trauma. As a nation, we've endured back-to-back crises with no real time or space for recovery. Americans have seen the impact of constant death, financial hardships, fear, political upheaval, and our education system turned upside down in unprecedented ways. It's left many of us feeling fatigued, anxious, and at times hopeless.

Although research implies that the long-term impact of COVID-19 will continue and be considerable, we, as social workers, don't need data to validate what we are already seeing and supporting clients through. Our profession has and will always be on the frontlines with the most vulnerable communities and individuals—and many of us identify with those communities. Social workers are challenged with caring for others while also needing care.

The trauma imposed by COVID-19 has been a collective and communal experience; thus, rebuilding and healing must also be the same. Now more than ever, we need radical advocacy, compassionate care, and equitable, ethical policy changes (Ginwright, 2018). This movement will require more energy, tenacity, and fervor than we've seen in the last 50 years. It will also require more from those who experienced fewer impacts from the pandemic and have benefited from White supremacy and systemic oppression.

When traumatic or life-altering things happen, we must acknowledge that people process and navigate through challenges differently and on different timelines. Some feel an urgency to recognize and build a post-pandemic world; however, many of us are still in the thick of the pandemic. Loss is still taking place, the economy is still changing, family dynamics are still transitioning, our education system is plagued with teacher fatigue and shortages, and toxic workplaces are still toxic. Social workers have a responsibility to bring awareness to these truths and consider interventions and strategies with that truth in mind. The pandemic isn't truly over; there are just some communities and individuals who are ready to move on—regardless of the cost.

So, when asked, "How can social workers and communities rebuild after the pandemic?" my response is this: By radically making room for rest. We need to be prepared for the upheaval that awaits us.

As practitioners, we often lean on the power of resilience and give it praise without acknowledging that it is a response to and a result of trauma. Resilience is when individuals and communities "bounce back" from hardship (Smith et al., 2008). It is what keeps people going, but it also minimizes the perceived need for care, rest, and moments of ease.

Trauma-sensitive ideologies indicate that when communities build resilience, they can resist the effects of traumatic experiences and restore themselves. Additionally, trauma-impacted communities can develop innate responses (coping mechanisms) and strategies to manage future traumas.

Resilience is important but is it enough? We, as social workers, need to remember that Black, Brown, LGBTQIA individuals and communities, women (Black women in particular), and people in poverty often have a higher level of resilience because of their higher exposure to trauma. We must be mindful not to rely solely on resilience within these communities. Resilience always has been and always will be an integral part of these communities—but these individuals and communities need and deserve rest too.

Rest should be central to the urgency of restoring communities post-pandemic. The salience of the mind–body connection is showing up now more than ever. We need to radically accept that although our profession,

clients, and communities have urgent needs, our minds, bodies, and spirits need rest. After all, there is no recovery without a period of rest.

Everyone needs rest. As social workers, we can encourage rest in practical and creative ways—for practitioners and clients alike. Examples for practitioners include using paid time off and setting firm boundaries for communication expectations. For our clients, we can make room for rest by holding space for them and validating decision fatigue; we can honor that uncertainty is alright. We should encourage a moment of deep pause instead of hasty critical thinking, processing, and decision making.

When individuals don't rest, they risk overexertion and additional injury—emotional, financial, spiritual, mental, and psychological. Any decisions or interventions made in haste risk the lack of perpetuity and minimal long-term impact. Social workers who practice when experiencing burnout risk value misalignment, feelings of emptiness and lack of belonging, and compassion fatigue. Shame in the profession creeps up when we don't autonomously and collectively decide that rest is important and admit that burnout decreases effective and ethical work.

I urge us all to take a moment and resist the need to immediately depend on resilience and rest. We will all be better for it when it's time to rebuild.

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References

Ginwright, S. (2018). The future of healing: Shifting from trauma informed care to healing-centered engagement. *Occasional Paper, 25*, 25–32.

Smith, B.W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*, 194–200. https://doi.org/10.1080/10705500802222972

Social Workers Can Help Address Pandemic Drinking Especially Among Women

Diana Ling, **MA** • Leslie Sirrianni, **LCSW**

Risky drinking and alcohol-related harms have increased significantly since the start of the COVID-19 pandemic, especially among women. Data show a 41 percent increase in heavy drinking days among women since the pandemic began, compared to a 7 percent increase among men (Pollard et al., 2020). In addition, alcohol-related emergency department visits for suicide attempts increased 51 percent for young women during the pandemic compared to 4 percent for young men (Yard et al., 2021).

Risky drinking and alcohol-related harms have increased significantly since the start of the COVID-19 pandemic, especially among women. Data show a 41 percent increase in heavy drinking days among women since the pandemic began, compared to a 7 percent increase among men (Pollard et al., 2020). In addition, alcohol-related emergency department visits for suicide attempts increased 51 percent for young women during the pandemic compared to 4 percent for young men (Yard et al., 2021).

Pandemic-related stressors such as caregiving responsibilities, job loss and health issues may be increasing risky alcohol use among women, and research has shown women are more likely than men to drink to cope with stress (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2021). One study found that nearly 30 percent of mothers reported drinking more because of stress, and were more likely than fathers to say their mental health has worsened since the pandemic began (American Psychological Association, 2021).

These findings exacerbate an already worrisome uptick in women's drinking over the past two decades (Grucza et al., 2018; Substance Abuse and Mental Health Services Administration, 2022). Women experience problems related to drinking sooner and at lower levels of drinking than men do, due to biological differences such as less water in women's bodies, leading to higher blood alcohol concentration in women who drink the same amount as men of the same weight (NIAAA, 2021). These problems include faster progression to alcohol use disorder, and greater risk for blackouts, liver inflammation, and certain cancers, especially breast cancer (NIAAA, 2021). Those who are capable of becoming pregnant also risk prenatal alcohol exposure, the most common preventable cause of intellectual and developmental delay and disabilities in the United States, and fetal alcohol spectrum disorders (FASDs) may affect up to 1 in 20 US school children (Centers for Disease Control and Prevention [CDC], 2022).

As the nation's largest providers of mental and behavioral health services, social workers can play a key role in addressing this leading women's health issue. To help support this effort, NASW, the NASW Foundation and the Health Behavior Research and Training Institute at The University of Texas at Austin's Steve Hicks School of Social Work have teamed with leading medical organizations and the Centers for Disease Control and Prevention in a national initiative to train and educate health professionals in screening women for risky alcohol use.

Alcohol screening and brief intervention (SBI) has been proven to reduce risky alcohol use, including alcohol use during pregnancy (CDC, 2022). In fact, the U.S. Preventive Services Task Force (USPSTF) recommends alcohol screening and brief intervention for all adults, and found that pregnant women who received counseling interventions were more than twice as likely to abstain from drinking as those who didn't receive counseling (O'Connor et al., 2018). Electronic screening and brief intervention can also be used as an effective strategy for preventing excessive drinking (Community Preventive Services Task Force, 2022).

Social workers can incorporate alcohol screening and brief intervention into routine practice in three steps:

Step One: Screening
The first step of alcohol SBI is to administer a validated screening instrument to identify clients who have, or are at risk for, alcohol-related problems. Risky drinking for women means having more than three drinks in a day or more than seven drinks per week. The screening process should occur in the context of a routine session, and recommended screening instruments typically take only a few minutes to administer. For adults 18 or older, including pregnant women, the USPSTF recommends the use of brief prescreening instruments with 1 to 3 items, such as the Single Alcohol Screening Question, recommended by the National Institute on Alcohol Abuse and Alcoholism. If a woman is identified

to be at risk for alcohol misuse or an alcohol-exposed pregnancy, a more comprehensive instrument should be used. For instance, the 10-item AUDIT is validated for use with people who are or might be pregnant (Hammock et al., 2020).

Step Two: Brief Intervention

Brief interventions are short, targeted conversations with a client following screening results indicating risky alcohol use. The goal of a brief intervention is to help clients at risk of alcohol-related harms, including alcohol-exposed pregnancy, by explaining how alcohol use may put them at risk and helping them explore reasons for change (Hammock et al., 2020).

Brief interventions for alcohol use are often based on motivational interviewing (MI), a collaborative conversation style that focuses on strengthening a person's own motivation and commitment to change (Miller & Rollnick, 2013). In alignment with the social work ethics of self-determination and autonomy, MI emphasizes the client's power for change (Wahab, 2005). By working collaboratively, the social worker helps guide the client to consider how a change might fit with their own values and desires.

An evidence-based prevention and intervention program developed for use with women is CHOICES, which is based on the principles of MI and designed to provide people who may become pregnant with information to help them avoid an alcohol-exposed pregnancy. The CHOICES protocol has been widely disseminated across practice settings, including primary care facilities, jails and sexually transmitted disease clinics (Floyd et al., 2007; Velasquez et al., 2010).

Step Three: Referral

If a client wants to stop or cut back on drinking, but can't do it on her own, she can be referred for additional services. Social workers can provide information on local programs or go to the Substance Abuse and Mental Health Services Administration treatment locator (FindTreatment.gov). Being aware of local treatment options will also help facilitate "warm handoffs"—referrals in the presence of a client that encourage communication between the patient and treatment team—as needed. If a client refuses treatment, respect her decision while also making a short-term follow-up appointment and assuring her she will be welcomed back into your office.

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References

American Psychological Association. (2021, March 11). *Stress in America: One Year Later, A New Wave of Pandemic Health Concerns*. American Psychological Association. www.apa.org/news/press/releases/stress/2021/sia-pandemic-report.pdf

Centers for Disease Control and Prevention. (2022, April 1). *Fetal Alcohol Spectrum Disorders*. Centers for Disease Control and Prevention. www.cdc.gov/ncbddd/fasd/index.html

Community Preventive Services Task Force. (2022, March). *The Community Guide "What Works" Fact Sheet: Excessive Alcohol Consumption*. The Community Guide. www.thecommunityguide.org/sites/default/files/assets/what-works-fact-sheet-alcohol-p.pdf

Floyd, L., Sobell, M., Velasquez, M.M., Nettleman, M., Sobell, L., Dolan Mullen, P., von Sternberg, K., Skarpness, B & Nagaranja, J., and the Project Choices Efficacy Study Group (2007). Preventing Alcohol Exposed Pregnancies: A randomized controlled trial. *American Journal of Preventive Medicine, 32*(1), 1-10.

Grucza, R.A., Sher, K.J., Kerr, W.C., Krauss, M.J., Lui, C.K., McDowell, Y.E., ... & Bierut, L.J. (2018). Trends in adult alcohol use and binge drinking in the early 21st century United States: a meta analysis of 6 National Survey Series. *Alcoholism: clinical and experimental research, 42*(10), 1939-1950.

Hammock, K., Velasquez, M.M., Alwan, H., & von Sternberg, K. (2020). Alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Girls and Women. *Alcohol Research: Current Reviews*.

Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change.* (3rd ed.) Guilford Press.

National Institute on Alcohol Abuse and Alcoholism. (2021, September 9). *As Male and Female Drinking Patterns Become More Similar, Adverse Alcohol Risks for Women Become More Apparent*. National Institute on Alcohol Abuse and Alcoholism. https://niaaa.scienceblog.com/378/as-male-and-female-drinking-patterns-become-more-similar-adverse-alcohol-risks-for-women-become-more-apparent/

O'Connor, E.A., Perdue, L.A., Senger, C.A., Rushkin, M., Patnode, C.D., Bean, S.I., & Jonas, D.E. (2018). Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: updated evidence report and systematic review for the US Preventive Services Task Force. *Jama, 320*(18), 1910-1928.

Pollard, M.S., Tucker, J.S., & Green, H.D. (2020). Changes in adult alcohol use and consequences during the COVID-19 pandemic in the US. *JAMA network open, 3*(9), e2022942-e2022942.

Velasquez, M.M., Ingersoll, K.S., Sobell, M.B., Floyd, R.L., Sobell, L.D., & von Sternberg, K. (2010). A dual-focus motivational intervention to reduce the risk of alcohol-exposed pregnancy. *Cognitive and Behavioral Practice 17*(2), 203-212.

Wahab, S. (2005). Motivational interviewing and social work practice. *Journal of Social Work, 5*(1), 45-60.

Yard, E., Radhakrishnan, L., Ballesteros, M.F., Sheppard, M., Gates, A., Stein, Z., ... & Stone, D.M. (2021). Emergency department visits for suspected suicide attempts among persons aged 12–25 years before and during the COVID-19 pandemic—United States, January 2019–May 2021. *Morbidity and Mortality Weekly Report, 70*(24), 888.

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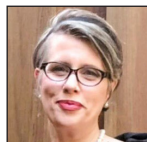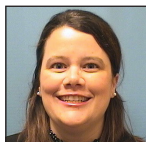
Lindsey Parrish, MSSW, LCSW • Gretchen Agans

Advance care planning (ACP) is a patient-centered process that begins when a cognitively able adult is ready to consider and discuss their values within the context of current and future medical care. Healthcare systems are required to address ACP concerns under the Patient Self-Determination Act of 1991. Block and colleagues (2020) recommend three steps to successful ACP within the clinical setting.

First, the patient selects a healthcare agent (HCA). This should be another adult that the individual believes would be willing and able to make medical decisions on their behalf if they are unable to speak for themselves. Second, the patient should talk through their goals of care and personal preferences about the use of cardiopulmonary resuscitation, mechanical ventilation, feeding tubes, and artificial hydration with their HCA. It is during this potentially sensitive and emotionally charged phase, particularly for those who are new to ACP, that the specialized counseling skills of licensed clinical social workers (LCSWs) are critical. Third, the patient's choices of HCA and treatment preferences must be recorded in an advance directive (AD) to be legally authorized. Without these documented conversations, the complexities of a sudden healthcare event or managing a long-term chronic illness can leave the patient, their HCA, their families, and their medical team unprepared—and primed for moral distress.

The Wellstar Health System serves greater metropolitan Atlanta and northwest Georgia with 11 hospitals and more than 200 physician offices. Wellstar created a department dedicated to ACP in early 2016; by November 2019, this department began to embed ACP facilitators in the primary care division to develop and implement a system to standardize the outpatient referral process. The department recruited LCSWs with experience in ACP,

palliative care, and hospice. Members of Wellstar's ACP team were trained in the Respecting Choices ACP method (Briggs & Hammes, 2011) and placed in primary care offices with varying socioeconomic demographics. Although anyone over age 18 should engage in ACP, historically, most consultations took place with patients over age 65. It has been a founding principle to encourage patients who have engaged in ACP not only to complete their AD but also to have a copy uploaded into their electronic medical record, so it is immediately accessible in an emergency.

With the rapid spread of COVID-19 came restrictions on visitors in healthcare settings, and hospitals across the country were forced to admit patients without their healthcare agent or family members by their side. Consequently, those patients who had only verbal conversations with no written AD may not have received goal-concordant care. If the patient became incapacitated, their healthcare wishes were often unknown, unclear, or disputed among loved ones. This lack of clarity added to the moral distress of already overburdened medical teams (Block et al., 2020). To address these concerns, Wellstar leadership championed further expansion of its ACP department by doubling the staff and adding an intern. Preliminary results show a 4 percent increase over the previous fiscal year in the number of patients completing a facilitated ACP conversation—despite the pandemic.

As infection rates rose, Wellstar saw increased hesitation from patients to return to a physician's office specifically for an ACP conversation. So, Wellstar pivoted to partnering with physicians to increase the

number of same-day ACP discussions during already scheduled annual wellness visits (AWVs). Targeting AWVs has the additional incentive of saving money for Medicare patients, because copays are waived when the ACP service is provided on the same day as the AWV. In certain circumstances, Wellstar also offered patients the option of virtual visits to handle ACP and AD matters.

Identifying appropriate on-site witnesses for finalizing a written AD was another significant challenge: State law limits who may serve as a witness, and visitor restrictions were in place at Wellstar outpatient clinics. In the early part of the pandemic, Georgia's governor issued an executive order allowing the use of virtual witnessing. Regrettably, these allowances were not permanent, and they expired when the governor declared an end to the official state of emergency—even though restrictions on visitors in healthcare settings continued. Obtaining witnesses at the time of consultation has reemerged as a significant challenge to the full completion of AD documents, and Wellstar is actively pursuing solutions. In the meantime, patients are encouraged to seek appropriate witnesses in the community and return their documents to the ACP facilitator upon completion.

The COVID-19 pandemic eliminated opportunities to organize public events focused on ACP education. As such, Wellstar turned its attention to what it could do. With support from hospital leadership, and adhering to strict infection control protocol, the health system hosted its first large-scale event in 10 Wellstar hospitals on April 16, 2022, in observance of National Healthcare Decisions Day.

By setting up information tables near each hospital's cafeteria, organizers were able to encourage hundreds of employees and visitors to engage in their own ACP. Organizers were able to speak briefly and provide written materials about ACP as well as advertise upcoming virtual ACP education sessions. They also learned that many staff members had not seriously considered completing their own AD; however, after what they had witnessed in direct patient care over the course of the pandemic, they felt motivated to get their own affairs in order. The event also served as a comforting debriefing presence, as staff shared stories of bedside care during the pandemic. Many expressed plans to complete their AD soon or participate in upcoming webinars.

With such renewed social awareness about why ACPs and ADs are important, members of Wellstar's ACP team feel energized about and more committed to expanding community outreach. Team members are working with Wellstar leadership to improve utilization of virtual/telehealth tools for ACP visits. Because understanding that technology is not always easy for some older patients, the ACP team will also be adding in-person educational events, as allowed by COVID-19 safety precautions. Future goals for the acute care setting include increasing the presence of ACP facilitators and strengthening collaborations with both chaplains and clinical ethicists. Finally, each LCSW on the ACP team will sit for the 2022 Advanced Palliative Hospice Social Worker Certification (APHSW-C) exam to demonstrate evidence-based expertise in this field.

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References

Block, B.L., Smith, A.K., & Sudore, R.L. (2020, July). During COVID-19, outpatient advance care planning is imperative: We need all hands-on deck. *Journal of the American Geriatrics Society, 68*(7), 1395–1397. https://doi.org/10.1111/jgs.16532

Briggs, L., & Hammes, B. (2011). *Respecting choices: Building a systems approach to advance care planning.* Gundersen Lutheran Medical Foundation.

Rebuilding Stronger in School Settings: Lessons in Resilience from the Pandemic

Amanda Snyder, LCSW, HSV, PCSSW

It has been quite a ride these past couple of years in schools. I do not know anyone who could have predicted the rise and fall of this pandemic. As a school social worker, I found myself smack-dab in the mix of trying to make sense of this new reality. At first, I had time to catch up on continuing education and figure out how to use Zoom. I reached out to families on my caseload that I knew needed extra support now that their kids were home full-time, and I tried my best to access resources that were still available to support them. I started attempting to lead my social skills groups on Zoom, which was quite the learning experience. All the while, my son with autism was unmuting himself and saying all sorts of unexpected things on school Zoom calls—or otherwise falling asleep during class. My high-schooler stopped submitting assignments. At that time, I had to live within the moment. I did not predict the way the stress of the pandemic would impact the mental health of our students.

According to a study by the United Kingdom's Department of Education, "the COVID-19 pandemic led to increased adolescent depressive symptoms and decreased life satisfaction" (U.K. Department of Education, 2022, p. 3). This is clearly reflected in my experience professionally and personally. In my work with students, anxiety has multiplied—making simply attending school very challenging for those students already experiencing trauma. Truancy intervention and risk assessments have absorbed much of my time and energy.

To rebuild, we, as a society, must make sure students can access mental health and basic needs in schools. Currently, there are too many barriers and not enough staff to provide what students need to recover from the effects of the pandemic. Legislators must fund what is needed and get more mental health workers in schools so we can recover from the pandemic. Mental health workers need a living wage and time in their schedules to meet and process the trauma they witness. Entering the mental health field needs to be feasible for students from all backgrounds. The U.K. study found that "moving forward, given the potential long-term nature of impacts, it is important to prioritise mental health support for school-aged children and young people" (U.K. Department of Education, 2022, p. 9).

It seems that more families are willing to use mental health services when their children's behavior reaches a breaking point. Elopement was a frequent problem this year. Students who were not used to discussing feelings appeared to go in fight-or-flight modes and take off from their schools and homes.

Police and mobile crisis involvement increased; without a plausible solution everyone could agree on, it truly was a bleak year. People like me, who are on the ground in the schools, need to be consulted on how to address these problems holistically, not piecemeal. Too many times, especially over the pandemic, administrators and legislators have instructed school staff on what to do, never asking for input.

One positive step in the effort to build back after the pandemic is to create a task force in each school. Students, mental health staff, teachers, custodians, cafeteria workers—everyone—should be considered for the team. Once the team meets and comes up with a plan, it can be presented to administrators. It's important that administrators be left off initially so staff will openly communicate about concerns without feeling intimidated. I recently attended a meeting about advocating for mental health workers in schools, and I was surprised to discover a custodian participating in the meeting. But students reach out to him. This encounter was one of many this year that opened my eyes to an overlooked way to rebuild after the pandemic: We need all hands on

deck. We must value every school staff member. What would we do without bus drivers, custodians, lunch aides, secretaries, and classroom assistants? The truth is, of course, we would flounder.

When asked by friends what to do when their teenager refuses therapy, I suggest they get therapy for themselves. I usually get a surprised look when I share this piece of advice. Modeling the behavior we wish to see is the best teaching tool, and we can use it to help dig ourselves out of the pandemic fallout. We need to show kindness to everyone so that we can teach kindness to young people. We need to provide the scaffolding to help both employees and students reach their goals. We need to provide a living wage to all school employees so their daily stress is reduced and they can be fully present—so they not only can do their jobs but also be that person who connects with a hard-to-reach student.

Most of all, we need to look at how we can rebuild after the repeated trauma of mass shootings after mass shootings in schools. We have made fortresses of our schools and practiced all kinds of drills, yet the shootings continue. Building schools

back after the pandemic needs to include gun buybacks and mandatory gun training. We also need to stop filling the jails with drug convicts in light of recent events related to cannabis usage. We must fund effective counseling programs to prevent violence before it starts. There are too many waiting lists for mental health services, and it is too easy to purchase a gun. The combination is deadly. Let's work together to open our minds and change what is not working. This does not mean administrators and school board members get together and decide; we need all hands-on deck to rebuild.

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References

U.K. Department of Education. (2022). *The impact of the COVID-19 pandemic on adolescent mental health.* Retrieved June 16, 2022, from www.gov.uk/government/publications/the-impact-of-the-covid-19-pandemic-on-adolescent-mental-health

Being There: Developing Social Worker Resiliency and Professional Longevity Through Direct Supervision
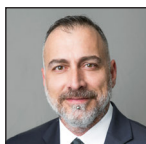
David Estringel, LCSW-S, BCD

The field of social work is, for many, one that is replete with purpose and beneficence. Its devotees have careers marked by endless opportunities to serve individuals, groups, and communities that most need intervention. As social workers, we are uniquely tasked to navigate this world of varied systems and complexities, while negotiating the intricacies of human lives and relationships, to facilitating equanimity, social justice, and healing.

Despite the benefits offered to providers and consumers alike, through challenging work and tireless commitment, we cannot escape the inevitable realization that social work is hard. This is not a career path for the meek. Providing social services requires not only specialized knowledge and training to meet the unique needs of clients, but also the ability to tread the turbulent waters of the internal and external environments that many of them often occupy. It takes years of experience for social workers to build the resiliency and learn the lessons they need to navigate these waters. Social workers who are at the beginning of their careers or who are still finding their ways through field placements via their academic programs are notably less equipped to manage such stressors. These disparities in experience and resiliency within the field emphasize the importance of proper supervision, which is needed to ensure both the efficacious delivery of social work services and the longevity of providers within the profession.

One of the greatest challenges social workers face today is the effective management of prolonged, daily exposure to emotional and relational stressors that can lead to burnout. The negative impact of burnout on helping professionals can manifest in myriad ways, including "exhaustion, cynicism, and inefficiency" and a "lack of compassion or empathy toward others" (Mack, 2020, p. 596). An increased likelihood of "fatigue, mental health symptoms, and job dissatisfaction" (p. 597) have also been reported among social workers who demonstrate symptoms of untreated work-related stress. Such factors have adversely affected social workers and the profession to the extent that in 2020 "over one-third of social workers employed in the profession considered resigning from employment due to work-related stress," and "31% of social workers had left the field and another 13% were likely to leave their jobs" (p. 597). These outcomes have not only duly increased focus on the role of provider self-care in the development of resilience within the social work field, but they also highlighted the need for high-quality supervision of novice social workers and student interns.

Commitment from supervisors and their institutions is paramount in ensuring the current and future successes and longevities of today's new social workers. This "commitment" can manifest in varied ways, but perhaps nothing is more important than time. Mentorship and direct supervision do not happen by osmosis; they are important administrative and clinical tools defined by space and interpersonal relationships that facilitate growth, learning, and resilience. Although the day-to-day operations of any given agency are likely to pull managers and supervisors every which way, social work leaders are charged, ethically, to dedicate portions of their time and

themselves (ideally regularly and consistently) to experienced and new staff alike. They need to provide the support necessary to not only keep their staff's practices effective and efficient, but also to attend to their burgeoning self-care (i.e., emotional) needs.

According to Sturt and Rothwell (2019), to recognize the restorative effects of supervision is to understand "that the expression of affect is what helps us function best. Inhibition of practitioners' opportunities to safely process the impacts on them of danger, distress, anger, loss, grief, and confusion of families takes its toll" (p. 119). Most social workers, in fact, have "identified supervisors and regular supervision as fundamental sources of emotional support" as well as being crucial to the integrity of their roles (Cleveland et al., 2019, p. 1441). Given the importance of such support, one would think that much attention and resources would be directed toward this function; however, providers' experiences have proven to be varied. Negative perceptions of supervisory experiences have centered mostly around the glossing over (if not complete dismissal) of staff's emotional needs (as they relate to the performing of job duties), the inconsistency of regularly scheduled supervisory sessions, and the overwhelming distractions and demands on supervisors' time that pull their attention away from staff during scheduled supervision sessions. Those with positive perceptions of supervision, interestingly, often suggested that their experiences were

likely attributable more to luck than to any other factor. In fact, many of these social workers did not perceive their situation to be one of normal expected practice.

Although the role of supervision in the development of social worker resilience is clear, one must also remember that its benefits extend beyond transferring practice wisdom and providing emotional support. Developing confidence, especially in practitioners who are just embarking on their social work journeys, is a process that requires time and attention. Indeed, knowing what to do and how to do it in any given situation can define one's success (present and future) in the field, as well as in individual practice. However, if one is uncertain of their own skill set, tackling challenging and unfamiliar situations may become too ominous an obstacle. Through ongoing mentorship and guidance, offered via direct supervision, social workers can develop the self-assurance they need not only to meet the work-related challenges they face each day, but also to remain steadfast within their commitments to their vocational choices and to the profession.

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References

Cleveland, M., Warhurst, M., & Legood, A. (2019). Experiencing resilience through the eyes of early career social workers. *British Journal of Social Work, 49*(6), 1434–1451. https://doi.org/10.1093/bjsw/bcz064

Mack, B.M. (2020). The resiliency-focused supervision model: Addressing stress, burnout, and self-care among social workers. *Advances in Social Work, 20*(3), 596–614. https://doi.org/10.18060/23897

Sturt, P., & Rothwell, B. (2019). Implementing the integrated model of supervision: A view from the training room. *Aotearoa New Zealand Social Work, 31*(3), 116–121. https://doi.org/10.11157/anzswj-vol31iss3id652

Nature: Ways for Us to Reconnect and Rebuild after a Pandemic

Julie M. Wilcox, LCSW

The pandemic's sudden and massive impact cannot be understated. In March 2020, the world shut down. Parents scrambled to become teachers in the wake of virtual schooling. Restaurants struggled to stay in business. Toilet paper flew off shelves. Providers adapted to an overwhelming need by offering services online. Social distancing brought acute isolation, loneliness, and depression. Domestic abuse, suicide, and substance use all increased (Boserup et al., 2020).

Fortunately, slowly but surely, the isolation of the pandemic has decreased. Children are back in school, travel has resumed, and people are engaging more. However, transitioning to in-person activities has not been easy for all. So, how do we, as a society, connect and rebuild after a pandemic that left people with loneliness, anxiety, and lasting changes to their day-to-day lives?

Engaging in nature. It can be the first step to reconnecting with ourselves and others. Spending time outdoors was a mental health lifesaver for many during the pandemic. Nature offered the opportunity to have one's own space and a change of scenery. As we transition to a new normal and share more space and activities, embracing nature will continue to have many benefits, such as providing space for people to feel safe, connected, and fulfilled as they engage with their community.

Grow

Growing something allows us to be with nature, improve dexterity, develop a skill, and have a sense of purpose; it can elevate mood. Gardening has been an effective complementary therapy method to aid in the treatment of dementia and anxiety. It has been used with veterans with PTSD and with many other mental and physical conditions and populations (Thompson, 2018). Think about how you can implement growing in your personal space, place of employment, or community.
- Community gardens can be found on public lands, at places of worship, within housing communities, and even in jails.
- Container gardens, whether they be small, large, simple, or elaborate, are great in urban areas, on rooftops and patios, or in other small spaces.
- Indoor gardening can increase access for some people as well as allow for year-round growing.

And be sure to share your abundance. Swap or give away extra plants or produce, host a community meal or event, or deliver plants and flowers to isolated individuals.

Move

Being active is important for maintaining good health. Nature provides many opportunities for activity. Being in nature is a time to breathe in fresh air, put away electronics, and engage in the outdoors. Here are some ways to increase movement while enjoying nature and human connection.

- Volunteer. Consider volunteer sport opportunities to engage in movement. Most sport programs do not require any experience other than being a positive mentor and support.
- Take meetings outside when possible. Those difficult-to-talk-to individuals may communicate more while tossing a ball outdoors.
- Join a club. Many likely exist in your community, and social media can be a great way to find them. Consider a running club, a walking group, or even a pickup soccer team; create one of your own if necessary.
- Enroll in classes. Many yoga and training programs have moved outdoors during the pandemic, and several are staying there. Check out social media, local trainers, and club websites. Keep in mind that there are beginners in every activity; you are not alone in this journey.
- Visit a park or safe neighborhood. Walk, bike, or even skateboard outdoors.

Make sure to explore free or discounted events. Also, many instructors will come to you. Bring an activity to your office parking lot on nice days.

Sit

Sometimes we just need to be, enjoy the world around us, take in the moment, bask in the sun. Time spent in nature has long been identified as being positive for mental and physical health. Multiple studies have shown that nature helps decrease anxiety, depression, and cardiovascular health issues (Wen et al., 2019). Consider which of the following ways you will choose to sit in nature—alone or with others.

- Forest bathing has been shown to significantly lower stress and anxiety (Wen et al., 2019) and is even an area of certification.
- Find a "sit spot," a place in nature where you can—comfortably and often—observe nature changing around you. This will increase mindfulness and focus, and it will build routine.
- Expose your feet or hands to the natural elements for grounding, mindfulness, and calming. Remove foot coverings and put your feet in the grass, sand, water, or dirt. Few adults do this—you'll be surprised at the impact!

Play

Adults typically look puzzled when I ask them when was the last time they played, but play is important. And nature is a great place to do it. Whether you are chasing your toddler, playing a sport, or engaging in other fun activities, remember to embrace your inner child. Throw your head back, allow yourself to be free, and move as you desire. Smile and laugh as you enjoy nature around you. If playing freely is too much, start with some more structured play like in these suggestions:

- Go on a nature scavenger hunt. Find one online or make one up; teams can use phones to take pictures so as not to disturb nature.
- Play a game—anything from a large-team sport, like kickball or capture the flag, to smaller-group games, such as horseshoes or bocce. You can even play a game of tag or Simon Says.
- Play on something. Climb rocks, go down a slide, or use other equipment or items in nature as your playground.
- Use your imagination. You never know what you might find!

Engage

Mindfulness is all the buzz, but it is not about seeing how long you can meditate or quiet your mind. It is about being present using your senses to intentionally take in your surroundings. Next time you go outside, really be in nature. Consider each of your five senses as you engage with nature, regardless of whether you are alone or with others.

- Watch a bug. Have you ever watched toddlers fascinated by a bug? Just standing there and watching it for what seemed like forever? They are being mindful. Learn from them—watch how insects move and notice their colors and how they feel (if you dare).
- Observe water. Watch rain fall or observe a creek or river. Water can stimulate so many senses.
- Feel the wind. Notice how it feels and smells and how it moves things around you.
- Identify the colors. Really note the colors around you, the subtle differences in shades, and how hues shift throughout the seasons.

SPS WEBINARS YEAR IN OVERVIEW

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Clearly, nature offers us countless activities. Many of the examples here not only lead to increased self-care but also allow time, space, and freedom to reconnect with others in low-pressure and enjoyable ways. These nature-focused activities can also have added benefits such as team building, mindfulness, improved physical and mental health, decreased isolation, and communication and skill development. Many people even find these activities give them a sense of purpose and a way to be a part of something beyond themselves.

So, while rebuilding after the pandemic—no matter if you are alone or with others, are sedentary or active—if you are engaging in nature and embracing all that it has to offer, you will find rejuvenation for yourself, opportunities for connection with your community, and many self-care strategies and activities that you can not only teach but also use to engage with your community, coworkers, and clients.

How have you spent time in nature today?

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References

Boserup, B., McKenney, M., & Elkbuli, A. (2020, December). Alarming trends in U.S. domestic violence during the COVID-19 pandemic. *The American Journal of Emergency Medicine, 38*(12), 2753–2755. https://doi.org/10.1016/j.ajem.2020.04.077

Thompson, R. (2018, June). Gardening for health: A regular dose of gardening. *Clinical Medicine (London), 18*(3), 201–205. https://doi.org/10.7861/clinmedicine.18-3-201

Wen, Y., Yan, Q., Pan, Y., Gu, X., & Liu, Y. (2019). Medical empirical research on forest bathing (Shinrin-yoku): A systematic review. *Environmental Health and Preventive Medicine, 24*, 70. https://doi.org/10.1186/s12199-019-0822-8

Resource

Jones, S.E., Ethier, K.A., Hertz, M., DeGue, S., Le, V.D., Thornton, J., Lim, C., Dittus, P.J., & Geda, S. (2022). Mental health, suicidality, and connectedness among high school students during the covid-19 pandemic—Adolescent behaviors and experiences survey, United States, January–June 2021. *Morbidity and Mortality Weekly Report, 71*(Suppl. 3), 16–21. http://dx.doi.org/10.15585/mmwr.su7103a3

School Social Workers: Navigating Through the Trauma of COVID-19

Kashera Guy Robinson, LCSW
Kennesha J. Smith, LMSW

COVID-19 not only disrupted the lives of students, teachers, and parents across the nation, it also shattered the way that school social workers serve families. School populations experienced a noticeable decline in both student enrollment and attendance as the pandemic dragged on. Declines in enrollment were driven by factors such as fewer children being enrolled in kindergarten, students leaving public school for alternative learning environments, and students with excessive absences being removed from school rolls (Belsha et al., 2020). The pandemic forced the closure of schools nationwide, causing school social work practitioners to shift their practice to align with students' and families' new needs (Daftary et al., 2021).

School social workers are known for providing direct service to students. Since the pandemic, the role has expanded to include new methods of resource allocation and increased communication with parents (Daftary et al., 2021). This pivot was necessary to promote the socioemotional development of students within their homes. In many instances, school social workers stretched beyond their comfort zones by using technology to engage with students and families. For example, many schools social workers created interactive Google classrooms complete with lifelike Bitmoji characters and used virtual platforms (e.g., Zoom, Webex, GoogleMeet) to conduct group sessions with students and parent meetings. They even participated in daily school meal distributions to ensure that students continued to receive breakfast and lunch while learning at home. As we adjust to the new normal, the role of the school social worker will continue to evolve.

It may appear that the COVID-19 pandemic has ended, but remnants of COVID-19 persist. During the 2020–21 academic year, 85 percent of U.S. school districts offered a virtual learning option for students, and one in four districts plan to continue offering remote learning opportunities beyond the pandemic (Pitts et al., 2022). Students continue to participate in online learning opportunities for various reasons. Some students fear contracting COVID-19. This fear can be the result of a personal bout with COVID-19, but it can also surface from observing the impact of COVID-19 on the health of family and friends. Other students remain virtual because it is a learning style that works well for them. As a result, many school districts have created virtual learning academies to accommodate growing rates of students who desire to learn virtually.

As virtual learning expands, school social workers will undoubtedly continue to be tasked with ensuring that students remain engaged. Some districts, in fact, have hired school social workers to assist with various student needs in these virtual learning academies. Research shows that students who are engaged in online learning can be successful if they have consistent access to computers and the internet (Garcia & Weiss, 2020). As a result, school social workers are often charged with tasks like taking laptops and hotspots to youths who do not have homes. School social workers also offer support by making phone calls and home visits to connect with students who consistently engage in the virtual learning environment.

Anxiety, fear, emotional distress, maladaptive behaviors, and depression are psychological responses that students have for various reasons. Pandemic-related stressors have only exacerbated these concerns (Talevi et al., 2020). According to a public health advisory issued by U.S. Surgeon General Vivek H. Murthy in December 2021, reported incidents of depression (25 percent) and anxiety (20 percent) among youth doubled during the pandemic (Blume & Gomez, 2021). School social workers must be prepared to address these mental health–related challenges.

The National Association of Social Workers (NASW) recognizes competence as a value and emphasizes the development of professional expertise as an ethical principle (NASW, 2021). To ensure such competence, school social workers must become lifelong learners; this effort includes participating in professional development opportunities that enhance their skills in areas such as mental health. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a two-part curriculum for secondary students, aims to reduce symptoms related to trauma exposure (e.g., posttraumatic stress disorder, generalized anxiety, depression, reduce self-esteem,

behavioral concerns, and aggressive or impulsive behaviors) through the provision of peer and parent support for trauma victims (Center for Resiliency, Hope, and Wellness in Schools, 2022). School social workers must also be prepared to engage with distressed students at a moment's notice to address such mental health stressors as self-mutilating behaviors, suicidal ideations, and displays of anxiety. Some nontraditional approaches that school social workers can use to help students include expressive arts techniques like drawing, play therapy, dance, and rhythmic breathing exercises (Malchiodi, 2020).

The pandemic compounded financial strain and food insecurity in school communities; community systems that were already facing serious challenges were hit particularly hard (Phillippo et al., 2022). Record numbers of families lost jobs and housing during the pandemic. Consequently, many Americans are rebuilding amid a time of major financial distress and uncertainty. The process of rebuilding varies by family, and often school social workers stand in "the gap" by connecting families to resources that can alleviate additional stressors.

Inflation has been apparent since May 2020 (Ha et al., 2021). Research indicates that inflation has not been transitional but more persistent (Gharehgozli & Lee, 2022). For the families that school social workers serve, inflation means increased prices for necessities like food and gas. It also means increased housing costs. In many cases, families in transition are being forced to move to communities where housing is more affordable; they may have to transfer their students to new schools. Although living expenses are increasing, citizens' wages, in general, are not. As such, school social workers—while dealing with the impact of inflation in their own lives—must find creative ways to help families navigate various financial challenges. Combatting inflation is an ongoing challenge for school social workers in all communities, and providing support for the allocation of available resources is a way to alleviate this challenge.

Social work as a profession is "highly adept" in managing crisis situations (Bright, 2020, p. 83). However, the COVID-19 pandemic was new territory for everyone. School social workers were forced to find creative ways to serve families. For some, it meant pivoting from traditional roles like group facilitation to more community-based roles, such as hosting food pantries and partnering with community stakeholders like faith-based organizations. As they always do, school social workers rose to the challenge and met it head-on, supporting students academically, emotionally, and financially.

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References

Belsha, K., LeMee, G.L., Willingham, L., & Fenn, L. (2020, December 22). *U.S. public school enrollment dips as virus disrupts education*. AP News. https://apnews.com/article/us-news-home-schooling-mississippi-coronavirus-pandemic-bf3984a4be2679de28b7770e50ff0616

Bright, C.L. (2020). Social work in the age of a global pandemic. *Social Work Research, 44*(2), 83–86.

Blume, H., & Gomez, M. (2021, December 7). Surgeon general warns of emerging youth mental health crisis in rare public advisory. *Los Angeles Times*.

Center for Resiliency, Hope, and Wellness in Schools. (2022, May 9). *Training manual*. https://traumaawareschools.org/index.php/learn-more-cbits/

Daftary, A., Sugrue, E., Gustman, B., & Lechuga-Peña, S. (2021). Pivoting during a pandemic: School social work practice with families during COVID-19. *Children & Schools, 43*(2), 71–78. DOI 10.1093

García, E., & Weiss, E. (2020, September 10). *COVID-19 and student performance, equity, and U.S. education policy: Lessons from pre-pandemic research to inform relief, recovery, and rebuilding*. Economic Policy Institute. www.epi.org/publication/the-consequences-of-the-covid-19-pandemic-for-education-performance-and-equity-in-the-united-states-what-can-we-learn-from-pre-pandemic-research-to-inform-relief-recovery-and-rebuilding/

Gharehgozli, O., & Lee, S. (2022). Money supply and inflation after COVID-19. *Economies, 10*(5), 101.

Ha, J., Kose, M.A., & Ohnsorge, F. (2021, July). *Inflation during the pandemic: What happened? What is next?* CEPR Discussion Paper No. DP16328, Available at SSRN: https://ssrn.com/abstract=3886814

Malchiodi, C.A. (2020). *Trauma and expressive arts therapy: Brain, body, & imagination in the healing process*. Guilford.

National Association of Social Workers (NASW). (2021). *NASW Code of Ethics*. Retrieved May 09, 2022, from www.socialworkers.org/About/Ethics/Code-of-Ethics

Phillippo, K., Lucio, R., Shayman, E., & Kelly, M. (2022). "Why wasn't I doing this before?": Changed school social work practice in response to the COVID-19 pandemic. *Qualitative Social Work*. https://doi.org/10.1177%2F14733250221076061

Pitts, C., Pillow, T., Dusseault, B., & Lake, R. (2022). *Virtual learning, now and beyond*. Center on Reinventing Public Education.

Talevi, D., Socci, V., Carai, M., Carnaghi, G., Faleri, S., Trebbi, E., & Pacitti, F. (2020). Mental health outcomes of the COVID-19 pandemic. *Rivista di psichiatria, 55*(3), 137–144.

Resource

Jaycox, L.H., Langley, A.K., & Hoover, S.A. (2018). *Cognitive behavioral intervention for trauma in schools (CBITS)* (2nd ed.). RAND. https://doi.org/10.7249/TL272

Called to Lead: Building from the Strengths of a Shared Experience

Carrie Freshour, LCSW-C

The impact of the pandemic has been far reaching and overwhelming. It has disrupted systems and infrastructures and intensified existing cracks in those infrastructures. Additionally, it has highlighted the need for more behavioral health supports and services nationwide.

The pandemic has spotlighted the barriers and burdens of the providers and individuals seeking our services; however, the problems are not new. But problems bring opportunity to reflect, refine, rebuild, and do what social workers are trained to do—help relieve suffering in people and communities, fight for justice, and improve the systems that work to remove the bias and leave people and communities better off.

We are trained to deal with hard things, have hard conversations, and empower others in the face of injustice. We know the best practices, yet we default to the same cognitive traps and defense mechanisms that the people and communities we support also experience.

As administrators and leaders, we are exhaustively doing all things for all people and managing our tasks, fieldwork, and clients—not to mention tending to our families and personal responsibilities.

As the flight attendants tell us, we must give ourselves oxygen first; right now, we are forgetting to do so. As a result, the resources (people) are overstretched. The system needs work, and many areas need reform; however, one strength we have gained is perspective.

Perspective on how we work, where we work, and new ways to meet people where they are gives us a shared experience, a baseline. As a nation, we are experiencing something together with the pandemic. Even if we had no prior experiences with epidemics, we have some now. More perspective means more opportunity for change and effect, and we need to strike when the iron is hot.

Together with our clients, colleagues, peers, family members, and communities, we now have a shared experience from which to start and rebuild. Where we might have had empathy, we now have a more profound perspective on the challenges and barriers that exist when we experience adversity. These experiences have increased our awareness of the effects of adverse childhood and community experiences, further normalized mental health topics, and broken down historical stigma walls.

We are experiencing effects not unlike that of posttraumatic stress or other toxic stress; Moog (2022) calls it post-COVID stress disorder. Trauma is a reaction to a terrible event, and for some people, this pandemic was their first experience with adversity. Trauma can also have lingering impacts on emotional well-being and can lead to fear, anxiety, and isolation. The pandemic has shifted our views. We see communities increasingly triggered, reactive, impulsive, and sometimes explosive. Many are exhausted, isolated, self-medicating, and self-harming. Where there were once cracks, there are now gaping holes. Communities need social workers more than ever. We must begin to value their troubles and triumphs and provide space for their humanness.

When we talk about being trauma aware and trauma informed, that sounds good. But, when colleagues are balancing the mental health of their family members, or themselves, while carrying out the work, we need to recognize the signs in them as we would in our clients. We need to stop being complicit in silent cultures in workplaces and give people space to reflect, refine, and reset. We cannot move forward in the same ways before the pandemic, and we cannot undo what is now our reality.

We need to take the strength-based training rooted in social work and implement the well-researched practice guidelines and theories such as resilience theory (Moore, 2019), the Adverse Childhood Experiences study (Centers for Disease Control and Prevention, 2014), and other trauma-informed systems of care and apply them to our behaviors and practices.

Society's need for mental health services has exceeded our capacity, which was underfunded and undersupported long before, leaving cracks in the infrastructure that we now have an opportunity to correct. To do so, we must first address our own unhealthy environments. Social workers are trained and agree to the same ethics and standards. Yet we mistreat each other. We slip into the "do as I say, not as I do" mentality. We (systems, organizations and people) do not show empathy for our mental health, adversity, or reactions to the trauma we absorb daily. We write policies that sound good. We put procedures in place that protect people and are rooted in values, ethics, and equality. Yet, we find ourselves in these toxic work environments or immersed in passionate disagreements on the other side of an issue. As a result, the best practices, conflict resolution, and trauma-informed framework dissipate.

We are too busy to meet the person (or the moment) in front of us long enough to pause and reflect on what happened rather than think, "What is wrong?" We forget to do as we are trained. We need to implement these three Rs: realize the impact of trauma, recognize the signs and symptoms, and respond if something seems off or someone is out of character (SAMHSA, 2014). We need to have conversations and not react, assume, or be too quick to judge others' behavior.

It is overwhelming and seemingly never ending, but we do not reinvent any wheels here. Instead, we have a basis for building our theories, and we need to put that into practice with our colleagues and peers. It can be simple pebbles of change. We can create space and put effort into our meetings and business practices by implementing small and intentional actions that build emotional resilience. We need to invest in the people around us. We can observe organizations drafting those missions and visions that are the framework for actions. We can work diligently to ensure we provide high-quality, accessible, and inclusive community-based behavioral health services within the workplace.

Staff is not only burnt out at higher rates, but they are also leaving the field altogether. When our country is in a mental health crisis, we must look differently at how we provide leadership and supervision, create teams, and lead. Creating an inclusive, accessible, and high-quality culture that supports all social work staff is just as critical as the programs we advocate for and make.

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References

Centers for Disease Control and Prevention. (2014). *About the CDC-Kaiser ACE study*. www.cdc.gov/violenceprevention/aces/about.html

Galaitsi, S., Kurth, M., & Linkov, I. (2021). Resilience: Directions for an uncertain future following the COVID-19 pandemic. *Geohealth, 5*(11), e2021GH000447. https://doi.org/10.1029/2021GH000447

Moog, M. (2022). *Understanding PTSD in uncertain times*. Health Matters. https://healthmatters.nyp.org/understanding-pandemic-related-ptsd/#:~:text=More%20than%20two%20years%20into,called%20post-COVID%20stress%20disorder.

Moore, C. (2019). *Resilience theory: A summary of the research*. Positive Psychology.com. https://positivepsychology.com/resilience-theory/#:~:text=Resilience%20theory%20argues%20that%20it's,all%20there%20is%20to%20it

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Resource

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245–258.

Reducing Compassion Fatigue Through Animal-Assisted Intervention
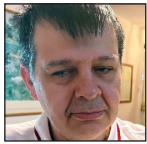
Michael Beattie, LSW

The pandemic and opioid epidemics have dramatically increased compassion fatigue among social workers and other healthcare professionals. According to the Kaiser Family Foundation (2021), the attrition rate for social workers in the healthcare sector has increased by 35 percent during the pandemic.

Diet, exercise, sleep, mindfulness, support groups, and yoga are some ways to prevent compassion fatigue. However, this article focuses specifically on the benefits of using animal-assisted interventions (AAIs) to prevent and alleviate compassion fatigue.

Compassion fatigue creates emotional numbness as a defense mechanism. Stamm (2019) explicated two categories of compassion fatigue pointing to burnout caused by "chronic stress in the and "secondary trauma," which is work-related exposure to others who have been traumatized. Burnout typically causes symptoms such as cynicism, negativity, anger, and withdrawal. Although symptoms of secondary trauma and burnout sometimes overlap, secondary trauma can precipitate sadness, headaches, avoidance, grief, nightmares, depersonalization, and altered belief systems. Burnout develops from prolonged exposure, while secondary trauma can develop from a single exposure and dissipate more quickly. In contrast to secondary trauma, which springs from client contact, burnout can be caused by excessive paperwork, long work hours, or lack of protective equipment. Sometimes employers' use of the term "self-care" can be a convenient way to place responsibility on the employee rather than evaluating the impact of their policies on the workforce.

A study of 306 social workers by Kinman and Grant (2020) found compassion fatigue can precipitate dire effects for organizations, including increased turnover, lower morale, higher absenteeism, and impaired decision making. A study by Cook (2021) in the Harvard Business Review reviewed 9 million human resources records and found that the Great Resignation was fueled by professions with high burnout rates related to the pandemic.

A metanalysis by Lluch and colleagues (2016) of 76 studies of compassion fatigue during the early stages of the pandemic found that although all healthcare professions experienced high rates of exhaustion and depersonalization, nurses, women, and those directly involved in treatment of COVID-19 patients showed particularly high rates of burnout. Meanwhile, employer-provided coping skills training helped reduce the prevalence of compassion fatigue.

Stamm (2019) studied "compassion satisfaction," the opposite of compassion fatigue, and described it as a positive feeling derived from helping others in distress. Compassion satisfaction mitigates compassion fatigue; however, the pandemic eliminated many protective factors. For example, to a great extent medical professionals lacked any effective treatment methods for the coronavirus during the period of February 2020 through February 2021, and, as a result, workers had few opportunities to accrue compassion satisfaction.

Social isolation is a risk factor for compassion fatigue, but social support is a protective factor. Glover-Steif and colleagues' 2020 study of nurses found that support from family and coworkers was inversely related to incidents of compassion fatigue. The pandemic had the perverse effect of increasing social isolation and reducing social support. Through relational coping, social workers used to share their experiences and defuse stress caused by secondary trauma. The increased use of telehealth from the therapist's residence during the pandemic resulted in a dramatic decline in contact with coworkers.

In my previous and current job as an outpatient therapist, not only have I had almost no contact with coworkers, but I also do not know who is working under my supervisor—much less have a mechanism to contact them. Social workers who are required to see clients in person, such as those working in hospitals or elder care, risk exposure to COVID-19 and have had to reduce interactions with family and friends in order to prevent spreading the virus. As a result, these workers receive less social support at a time when they most need it.

These increases in social workers' workplace challenges suggest that new strategies to deal with compassion fatigue are needed. A synthesis (Brooks et al., 2018) of studies related to the impact of pets on mental health found that pets were able to provide unique emotional support as a result of their ability to respond to their owners in an intuitive way, especially in times of crisis and periods of active symptoms. A related impact on loneliness was achieved

through physical contact which reduced feelings of isolation, providing a source of physical warmth and companionship.

Not only do pets directly provide social support, but pet ownership is also statistically shown to increase both the quality and quantity of the owner's interactions with friends and family. After getting a pet, research participants reported increased confidence, self-efficacy, and self-esteem. These findings are noteworthy because sufficient levels of social support and resilience are key factors in preventing compassion fatigue.

The ability to share painful events could be especially beneficial for health professionals, because the Health Insurance Portability and Accountability Act (HIPAA) restricts them from disclosing patient data to friends and family. AAIs have proven particularly successful in treating PTSD. Because many of the symptoms of compassion fatigue mimic those of PTSD, it's reasonable to extrapolate that AAIs could be effective in alleviating compassion fatigue.

Unlike emotional support dogs that are owned by clients with a diagnosed mental illness and therapy dogs that are attached to an individual clinician in private practice, facility dogs are trained and certified to support clients in facilities such as hospitals, juvenile detention centers, and courts. Clark (2022) interviewed nurses working at hospitals with a facility dog. Although the hospital used dogs to support young patients, nurses reported that facility dogs they were also a buffer in stressful days. Nurses attributed reduced symptoms of compassion fatigue to their interaction with facility dogs; however, Clark's study did not include a control group.

AAIs are not for everyone. Highly trained facility dogs can be expensive. Yet such cost is likely lower than the cost of compassion fatigue in terms of workers' compensation, attrition, morale, and compromised patient care when clinicians become emotionally numb and unable to

effectively empathize with clients and create a therapeutic alliance.

AAI results can vary depending on the breed and the dog's temperament. Handlers need to be trained and certified by an organization such as Pet Partners. Staff need guidance about infection-control procedures. Clients must be informed of potential risks. Clinicians can protect against risk of liability by paying a fee to cover potential animal-created injuries. Employers need to prepare clients and employees before introducing a dog and screen for allergies and animal-specific phobias. More research and controlled studies are needed. The University of Denver (UD) School of Social Work offers a certificate in AAI and is one of the leaders researching AAIs. Currently, UD is analyzing biomarkers for stress in blood and saliva to prove AAI reduces stress levels.

In summary, AAIs should be added to social worker's toolbox to alleviate compassion fatigue.

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References

Brooks, H.L., Rushton, K., Lovell, K., Bee, P., Walker, L., Grant, L., & Rogers, A. (2018). The power of support from companion animals for people living with mental health problems: A systemic review and narrative synthesis of the evidence. *BMC Psychiatry, 18*, 31. https://doi.org/10.1186/s12888-018-1613-2

Clark, K. (2022). *How early education and pet therapy may help nurses with compassion fatigue* (Paper 444) [Doctoral dissertation, Abilene Christian University]. Digital Commons @ ACU, Electronic Theses and Dissertations. https://digitalcommons.acu.edu/etd/444

Cook, J. (2021, September 15). Who's driving the Great Resignation? *Harvard Business Review*. https://hbr.org/2021/09/who-is-driving-the-great-resignation

Glover-Steif, M., Jannen, S., & Cohn, T. (2021, February). An exploratory descriptive study of compassion fatigue and compassion satisfaction: Examining potential risk and protective factors in advanced nurse practitioners. *Journal of the American Association of Nurse Practitioners, 33*(2), 143–149. https://doi.org/10.1097/JXX.0000000000000357

Kaiser Family Foundation. (2021). *What impact has the coronavirus pandemic had on health employment?* Peterson-KFF Health System Tracker. www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment/

Kinman, G., & Grant, L. (2020, March). Emotional demands, compassion and mental health in social workers. *Occupational Medicine, 70*(2), 89–94. https://doi.org/10.1093/occmed/kqz144

Lluch, C., Galian. L., Domenech, O, & Sanso, N. (2016). The impact of the COVID-19 pandemic on burnout, compassion fatigue, and compassion satisfaction in healthcare personnel: A systematic review of the literature published during the first year of the pandemic. *Prof Psychol Res Pr. 2016 Aug; 47*(4): 255–260. Published online 2016 Jun 2. Retrieved July 19, 2022 from doi: 10.1037/pro0000083.

Stamm, B. (2019). Professional quality of life measure: Compassion, satisfaction, and fatigue Version 5 *(ProQOL)* Center for Victim Research; Washington, DC:. [Google Scholar].

Racism Is a Public Health Crisis: Social Workers Leading the Charge

Tara D. Wallace

"I am over this pandemic! I just want things to get back to the way they were!" This has been the sentiment of many who were inconvenienced by the pandemic that trapped us in our homes, away from family, friends, and colleagues. The pandemic that forced us to wear masks and engage in physical distancing. Is it over? Can we just get back to normal, back when the biggest challenge was deciding where to go for summer vacation? For many people, however, life has been a bit more complicated. COVID-19 underscored the stark reality of the inequities that have persisted throughout the history of our country—and those inequities were now staring us in the face and targeting our most vulnerable citizens. As a society, we were powerless to stop it.

Putting the Pandemic in Perspective

Nationwide, frontline social workers have collectively focused on advocating for, coordinating, and facilitating access to personal protective equipment (PPE), vaccines, food, and other valuable resources. The effectiveness of these efforts was overwhelmed by the significant demand and limited supply. Again, two very different scenarios played out. For some people, access to resources meant a slight departure from the norm; for others, it was an entire shift in household climate, which fundamental cause theory attributes to socioeconomic status (Gay et al., 2020). With increased access to material and social capital comes better access to critical resources to address challenges like a pandemic. The inverse is also true—and felt by minority communities.

Systemic factors contributing to health and socioeconomic disparities do not magically disappear in response to a pandemic. In fact, they become, glaringly, "the most shocking and the most inhumane," because death often results (Gay et al., 2020). While urging legislators to address racial inequities in the healthcare system, Gay and colleagues (2020) quoted these words spoken by Dr. Martin Luther King Jr. more than 50 years ago. Very little has changed since Dr. King's time. Holtzman and colleagues (2022) recognize the continued misclassification of minority health conditions, including death, as a primary factor in racial disparities. Essentially, it is impossible to address health disparities in a community of individuals if those individuals are misidentified or underreported.

Long-Term Consequences of Stress

Allostatic load represents "physiological wear and tear on the body in response to stress" (Van Dyke et Al., 2020). The natural aging process becomes amplified by limited or no access to adequate healthcare, clean air, and healthy food. Environmental stressors such as crime, racism, and poor housing conditions also exacerbate it. Van Dyke and colleagues (2020) found that minorities have greater levels of allostatic load, with cumulative effects contributing to adverse health outcomes. False negatives related to health disparities, devaluation of race-specific health conditions, and insensitivity to cultural factors have resulted in significantly higher incidents of breast cancer, cardiovascular disease, and diabetes in minority communities (Dhanani & Franz, 2021; Doan, 2021; Holtzman et al., 2022; Van Dyke et al., 2020).

When Dr. King spoke of racism and inequities in 1966, he was not just addressing access to healthcare (Gay et al., 2020). Living wages, freedom from implicit bias and discrimination, and access to quality housing, transportation, and food deeply intersect to create physical, mental, and emotional stability and the opportunity for optimal health (Acosta, 2020; Calvente, 2021; González et al., 2022; Krieger, 2020). Socioeconomic, environmental, and physiological vulnerabilities were no match for COVID-19.

Minority deaths from COVID-19 are underreported or misrepresented due to gaps in data management (Holtzman et al., 2022). Very little if any information is collected from the dying or their living relatives. Assumptions are made and recorded by individuals who have had no contact with the deceased, leading to hardships with insurance companies or withholding of valuable resources to remaining family members. The lack of sensitivity afforded to the dead and dying is a significant factor in mistrust of medical professionals among the living.

Dr. King's Challenge

How, then, can the health and well-being of minority communities be improved in ways that respond to the charge issued by Dr. King more than 50 years ago? Social workers on the

frontlines have advocated for increased access to PPE, vaccines, and other resources in minority communities. They have sought to increase awareness of the needs of vulnerable communities, especially access to childcare, changes in work options, and expansion of unemployment benefits to cover basic household expenses (Liebow & Rieder, 2022). Although every person has an individual responsibility to challenge racism, we, as social workers, have a moral obligation to extend those efforts beyond ourselves—to change the systems in which racism exists. Not doing so is tantamount to no action at all. Communities across the United States have engaged in efforts to declare racism a public health crisis (Centers for Disease Control and Prevention, 2021). These petitions and resolutions call for decolonization of White sovereignty, antiracist education, and dismantling of racist assumptions (Calvente, 2021; Holtzman et al., 2022; Liebow & Rieder, 2022). The National Association of Social Workers (2021) emphasizes the profession's ethical responsibility to the general welfare of all—from the local to the global level. "All" includes the social work professionals who have continued to maintain their positions on the frontlines while carrying allostatic load and facing vulnerabilities to COVID-19, racism, and discrimination (González et al., 2022).

Conclusion

The COVID-19 pandemic was catastrophic to minority communities. For many people, the recovery period is estimated to take decades, if recovery occurs at all (Dhanani & Franz, 2021). Systems of inequity and racism will persist until a collective and relentless effort is made to dismantle them. The challenge to social work professionals is how to provide education and demand action that will prevent those systems in which racism exist from being continuing.

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References

Acosta, K.L. (2020). *Racism: A public health crisis. City & Community, 19*(3), 506–515. https://doi.org/10.1111/cico.12518

Calvente, L.B.Y. (2021). Racism is a public health crisis! Black power in the COVID-19 pandemic. *Cultural Studies, 35*(2–3), 266–278. https://doi.org/10.1080/09502386.2021.1898017

Centers for Disease Control and Prevention. (2021, November 24). *Health equity: Racism and health.* www.cdc.gov/healthequity/racism-disparities/index.html

Dhanani, L.Y., & Franz, B. (2021). Why public health framing matters: An experimental study of the effects of COVID-19 framing on prejudice and xenophobia in the United States. *Social Science & Medicine, 269*, 113572. https://doi.org/10.1016/j.socscimed.2020.113572

Doan, S.N. (2021, July). Allostatic load: Developmental and conceptual considerations in a multi system physiological indicator of chronic stress exposure. *Developmental Psychobiology, 63*(5), 825–836. https://doi.org/10.1002/dev.22107

Gay, T., Hammer, S., & Ruel, E. (2020). Examining the relationship between institutionalized racism and COVID-19. *City & Community, 19*(3), 523–530. https://doi.org/10.1111/cico.12520

González, T., Etow, A., & De La Vega, C. (2022). An antiracist health equity agenda for education. *Journal of Law, Medicine & Ethics, 50*(1), 31–37. https://doi.org/10.1017/jme.2022.6

Holtzman, G.S., Khoshkhoo, N.A., & Nsoesie, E.O. (2022). The racial data gap: Lack of racial data as a barrier to overcoming structural racism. *The American Journal of Bioethics, 22*(3), 39–42. https://doi.org/10.1080/15265161.2022.2027562

Krieger, N. (2020). Enough: COVID-19, structural racism, police brutality, plutocracy, climate change—and time for health justice, democratic governance, and an equitable, sustainable future. *American Journal of Public Health, 110*(11), 1620–1623. https://doi.org/10.2105/AJPH.2020.305886

Liebow, N.K., & Rieder, T.N. (2022, March). "What can I possibly do?": White individual responsibility for addressing racism as a public health crisis. *Bioethics, 36*(3), 274–282. https://doi.org/10.1111/bioe.13004

National Association of Social Workers. (2021). *Code of ethics.* www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Van Dyke, M.E., Baumhofer, N.K., Slopen, N., Mujahid, M.S., Clark, C.R., Williams, D.R., & Lewis, T.T. (2020, April). Pervasive discrimination and allostatic load in African American and White adults. *Psychosomatic Medicine, 82*(3), 316–323. https://doi.org/10.1097/PSY.0000000000000788

Resource

Nowaskie, D. Z., & Roesler, A. C. (2022, March). The impact of COVID-19 on the LGBTQ+ community: Comparisons between cisgender, heterosexual people, cisgender sexual minority people, and gender minority people. Psychiatry Research, 309, 114391. https://doi.org/10.1016/j.psychres.2022.114391

Seniors and Suicide

Jocelyne Fliger, MSW

To care for those who once cared for us is one of the highest honors. —Tia Walker

The American Association of Suicidology estimates that 9,173 people ages 65 and older completed suicide in 2019 (Dapeau & McIntosh, 2020). As with most statistics about suicide, the real number is likely higher than reported, as many deaths are not categorized as suicides for various reasons, the most common being stigma and inconclusive determinants. The number of senior suicides is significant because seniors make up 12 percent of the population but represent 18 percent of all suicides (National Council on Aging, 2021).

Besides the outstanding number of seniors dying by suicide each year, the time needed to attempt intervention with seniors is much shorter compared with that of other age groups. In a 2019 national survey, 1.4 million U.S. adults reported attempting suicide in the past year (Substance Abuse and Mental Health Services Administration, 2020). After age 65, there is one suicide for every four attempts, compared with one suicide per 200 attempts in youth (National Council on Aging, 2021). This tells us that not only are seniors dying by suicide in greater numbers, but the time to identify their ideations and to provide assistance is also far briefer. Add in the social stigma that comes with aging concerns, and one can easily see the crisis that is seniors and suicide.

While providing suicide prevention trainings, I noticed that many myths still surround suicidal ideation that are critical to dispel, especially regarding seniors. These inaccurate narratives can lead practitioners and concerned individuals to make faulty assumptions about care for those struggling with suicidal thoughts. One misconception is that those seniors who complete suicide must be terminally ill or are facing grave health circumstances. It is estimated that only 7 percent of completed senior suicides were by those facing a terminal diagnosis (Cheung et al., 2015). In the same vein, it is often misunderstood that aging itself leads to depression. Although many physical and emotional changes occur later in life, depression is not a guaranteed component of aging. All mental health concerns should be

addressed with seniors because it should not be expected that aging begets suffering.

One often surprising fact is that men over the age of 65 have the highest suicide rate along the life span. Several factors can explain this (Hedegaard et al., 2021). The Protestant work ethic that drives our economy is a significant factor in this phenomenon, as one's work is a hardwired component of identity and can be seen as a detrimental loss for men at retirement. In addition, most senior men were not socialized to build strong friendships or emotional bonds outside of their nuclear families, often leaving them without coping skills or social support during major life transitions. Last, men repeatedly choose more lethal means for suicide, as they are

often more familiar with firearms because of military service, careers in law enforcement, or pastimes like hunting.

Myriad factors lead seniors to contemplate suicide, but at its heart is a feeling of loss. Social isolation tops the list of concerns for seniors, as this loss of interaction can lead to physical and mental decline. A life review, which is encouraged for many seniors, might bring up feelings of perceived failure or a lack of achievement. Elder victimization, be it physical, mental, emotional, financial, or sexual, could be viewed as a loss of one's dignity or independence. Any changes in physical ability could be a loss of self-sufficiency or independence. Seniors also face grief from losing loved ones, be it spouses, family members, or friends. Cognitive impairment may also play a role in a higher risk for suicide because as mental activity declines, a person's decision-making abilities decline and impulsivity increases. These losses, perceived or real, can lead seniors to think of suicide as an option, often the only option.

When they begin to think of suicide as a means of escaping pain, many people report feeling hopeless— that nothing will change their circumstances for the better—and helpless about their ability to bring peace to their situation. This can often spiral into feelings of inadequacy and depression, bringing about the belief that suicide is the only way to escape the despair. Often the first step to helping someone who is contemplating suicide is being aware of and responding to any warning signs. These "red flags" mean different things to different people; however, anything that is out of character for someone could be perceived as something to be further explored. Common warning signs for suicidal ideation include making a will, disposing of or giving away personal items, "tying up loose ends," and talking or writing about death.

Adding to the complexity is that these are things we encourage seniors to do to prepare for end-of-life care or during life reviews. Even though we anticipate seniors doing these things, it is important to explore why someone would decide to do these activities at a specific time. Does it coincide with noticeable depression or major life changes? If so, then a further conversation about suicide is warranted. Directly asking seniors about suicide not only clarifies what they are thinking about but also shows an openness to a discussion on suicide, further reducing suicide stigma.

Considering the prevalence of attempted and completed suicides, senior care must include a mental health component with a focus on suicide prevention. In a society so heartily focused on youth, many aspects of aging are derided. Unfortunately, that often leads to a whole faction of the population being overlooked. Prevention efforts customized for the unique considerations and strengths of seniors will have a lasting effect on the entire population.

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References

Cheung, G., Merry, S., & Sundram, F. (2015). Medical examiner and coroner reports: Uses and limitations in the epidemiology and prevention of late-life suicide. *International Journal of Geriatric Psychiatry, 30*(8), 781–792.

Dapeau, C.W., & McIntosh, J.L. (2020). *U.S.A. suicide: 2018 official final data.* American Association of Suicidology. https://suicidology.org/facts-and-statistics/

Hedegaard, H., Curtin, S.C., & Warner, M. (2021). *Suicide mortality in the United States, 1999–2019.* NCHS Data Brief, no. 398. National Center for Health Statistics. https://dx.doi.org/10.15620/cdc:101761

National Council on Aging. (2021). *Suicide and older adults: What you should know.* www.ncoa.org/article/suicide-and-older-adults-what-you-should-know

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health.* Center for Behavioral Health Statistics and Quality, SAMHSA. www.samhsa.gov/data/

An Overview of Addiction Treatment and the Disability Community in the United States
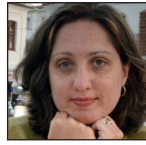
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Addictions are prevalent in the United States and are legally considered a disability. However, not all people who live with these conditions may be perceived as disabled or consider themselves disabled. For disabled people diagnosed with a substance use disorder, disability may or may not be their primary concern. Disabled people with addictions often encounter obstacles in accessing services and supports. The stigma, prejudice, discrimination, and oppression experienced by disabled people with addictions create devasting impacts on quality of life. As our field moves forward with lessons learned in the first few years of the pandemic, it is important that this population is acknowledged and understood and that it has increased access to services.

Prevalence

Twenty-seven percent of the U.S. adult population is disabled, and 4.7 million adults have addictions comorbid to disabilities (Office of Disability, 2006; Varadaraj et al., 2021). Addiction prevalence rates are double among disabled adults versus nondisabled adults (Krahn et al., 2007). Of 250,000 people receiving services at licensed addiction programs in New York, 22.4 percent were listed as physically or mentally disabled (Office for Alcohol and Substance Abuse Services, 1998). All these estimates are likely undercounts.

Access to Addiction Treatment

Barriers to treatment are documented for many people with disabilities across addiction service settings. Significant access barriers have been reported for the d/Deaf community, people with intellectual and developmental disabilities, and people with mental health conditions. Although we do not have national access data for the disability community in treatment, there is a robust population-based study by Krahn et al. (2007). This Oregon study documented that disabled adults with Medicaid coverage are only half as likely as other Medicaid enrollees to enter treatment during any year. Therefore, although addiction treatment needs are higher, entry into care is lower. Physical access barriers, inappropriate or inaccessible educational materials, and the lack of sign language interpreters can prevent people from receiving treatment (Addiction Center, n.d.).

Treatment Outcomes

Overall, addiction treatment is just as successful for disabled adults who can gain access to treatment as it is for those without disabilities (Krahn et al., 2007). In the Oregon study, disabled adults were about as likely to remain in treatment, meet treatment goals, and abstain from using their primary drug of choice. Individuals were tracked for six years, and disabled adults remained in treatment for as long as those without disabilities. Regarding outpatient readmission, disabled adults were equally or slightly less likely to be readmitted than were

those without disabilities. Disabled adults self-reported slightly less success in abstaining from their primary drug of choice during the last month before discharge.

Addiction Treatment within the Disability Community

Although no one set of guiding principles covers how to provide addiction treatment for the entire disability community, a central tenet of practice is the need to create the foundation for treatment by eliminating access barriers, whether physical, communication related, or attitudinal (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). One important principle to remember is that a disabled person's reasons for entering addiction treatment may not be related to the fact that they have a disability, a common misconception among social workers who often list a disability as a "presenting problem" without asking clients first. Disabilities may not always be something that social workers are aware of when beginning work with clients, so screening for disability is a best practice. Different addiction screening techniques exist for different populations, such as the d/Deaf community, whose languages may differ from the English used in standard written tools. Another critical factor to consider is the experience of oppression in the form of ableism, sanism, stigma, and exclusion, which may be correlated with higher rates of seeking treatment. More population-specific treatment guidance is available in the literature. See the Treatment Improvement Protocol (TIP) series developed by SAMHSA, such as TIP 29: Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities. It is important to note that although these TIP documents are based on evidence when it is available, much of the material in these documents is also drawn from anecdotal clinical impressions from clinicians and are not technically data driven in the classic sense of the term.

Applying the Tenets of Disability Social Work Practice to Addiction Treatment

Across addiction treatment service settings, five principles are central to the care and support of the disability community:

- The disability community should be based in the least restrictive environment possible because of the extensive history of overinstitutionalization, especially for disabled people of color (Yohanna, 2013). Community inclusion, in the context of treatment for disabled people, should focus on placement decisions and integration with nondisabled people in activities.
- The disability community values self-determination as a core principle. This is about allowing people to make their own choices, set their own goals, and solve their own problems. During recovery, this may relate to how people engage with those in their life who use substances while trying to maintain sobriety.
- Many note that the learning that comes along with everyday risk—or greater than everyday risk—must be allowed for disabled people, too. To allow learning to happen, social workers need to let their clients to face the consequences of their own choices, such as socializing with old friends who are still using, despite the risks.
- Circles of support are groups of people that may include formal staff, family, or friends who encircle and support a person. As people enter recovery, circles of support are central resources for monitoring symptoms, providing feedback, and giving comfort.
- Embracing the "nothing about us without us" principle of the disability rights movement, especially at the goal-setting stage of treatment, is vital. No decision should be made without the disabled person's input. All too often, social workers set clinical goals without client input.

These core principles align with social workers' ethical principles and core values. The code of ethics obligates us to respect individuals' inherent dignity and worth and to challenge social injustice (National Association of Social Workers, 2021a).

The disability community is a microcosm of the larger society and faces challenges in accessing treatment and engaging in treatment. These challenges are often magnified with inequities in treatment for racialized groups within the disability community. Social workers have often been perpetrators of ableism, oppression, and racism against people of color in treatment (Elkassem & Murray-Lichtman, 2022; National Association of Social Workers, 2021b). This negatively impacts the entire disability community, which has a high prevalence of people of color. Social workers must critically examine policies and practices that negatively impact historically oppressed groups within the disability community to ensure that they are furthering social justice (Murray-Lichtman et al., 2022).

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References

Addiction Center. n.d. www.addictioncenter.com/addiction/disability/#:~:text=Individuals%20with%20disabilities%20often%20develop%20SUDs%20to%20offset,have%20both%20an%20SUD%20and%20a%20co-existing%20disability

Elkassem, S., & Murray-Lichtman, A. (in press). Roadmapping an integrative critical race and anti-colonial framework in social work practice. *Advances in Social Work.*

Krahn, G., Deck, D., Gabriel, R., & Farrell, N. (2007). A population-based study on substance abuse treatment for adults with disabilities: Access, utilization, and treatment outcomes. *The American Journal of Drug and Alcohol Abuse, 33*(6), 791–798. https://doi.org/10.1080/00952990701653750

Murray-Lichtman, A., Aldana, A., Izaksonas, E., Williams, T., Naseh, M., Deepak, A., & Rountree, M. (i2022). Dual pandemics awaken urgent call to advance anti-racism in social work: Pedagogical illustrations. *Journal of Ethnic and Cultural Diversity in Social Work.*

National Association of Social Workers. (2021a). *Code of ethics.* www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Association of Social Workers. (2021b, June). *Undoing racism through social work: NASW report to the profession on racial justice priorities and action.* www.socialworkers.org/LinkClick.aspx?fileticket=29AYH9qAdXc%3d&portalid=0

Office for Alcohol and Substance Abuse Services. (1998). New York State. *Management systems data.* Internal report.

Ore, J., Dingwall, D., & Goldman, B. (2019, May 30). *After the overdose.* CBC. www.cbc.ca/radiointeractives/whitecoat/after-the-overdose

Substance Abuse and Mental Health Services Administration. (2012). *TIP 29: Substance use disorder treatment with physical and cognitive disabilities.* https://store.samhsa.gov/product/TIP-29-Substance-Use-Disorder-Treatment-for-People-With-Physical-and-Cognitive-Disabilities/SMA12-4078

Varadaraj, V., Deal, J., Campanile, J., Reed, N., & Swenor, B. (2021). National prevalence of disability and disability types among adults in the US, 2019. *JAMA Network Open, 4*(10): e2130358. doi:10.1001/jamanetworkopen.2021.30358

Yohanna, D. (2013). Deinstitutionalization of people with mental illness: Causes and consequences. *History of Medicine, 15*(10), 886–891. https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10

Resource

Substance Abuse and Mental Health Services Administration. (2021). *Behavioral health treatments and services.* www.samhsa.gov/find-help/treatment

"I Feel Like I'm Playing Life on Hard Mode": Clinical Observations, Research, and Resources for Supporting Transgender and Nonbinary Young Adults in the Therapy Setting

Ezra Stone, MFA, MSW, LCSW

Transgender (trans) and nonbinary young adults, already a group at high risk of mental health challenges (The Trevor Project, 2020), have had their transitions to adulthood upended by the COVID-19 pandemic. In my clinical practice, I spend significant time discussing the effects of the pandemic and other social and economic issues with my clients, who are predominantly college-age trans and nonbinary people. These observations from my clinical practice align with the minority stress model (Meyer, 2003; Mongelli et al., 2019) as well as with social work's person-in-environment approach, in which we, as social workers, take care to understand how family, community, and society affect a person's well-being, to support clients in developing resilience and achieving their personal goals.

Clinicians working with trans and nonbinary young adults need to take special care to understand this population's developmental stage and unique needs (including the ways the pandemic may have exacerbated existing mental health challenges), make comprehensive assessments of their psychosocial functioning and goals, skillfully apply evidence-based cognitive-behavioral forms of therapy, and use local and online resources to educate themselves and support and empower clients.

To paraphrase Joan and Erik Erikson, the developers of the eight stages of psychosocial development, the tasks of late adolescence and early adulthood are to understand one's identity and to form relationships (Cherry, 2022). In my clinical experience, validating that young adulthood is a strange and challenging time even under the best of circumstances often helps clients to feel less shame and self-blame about their personal challenges—it puts them into context. Consider and explore the ways that social, economic, and pandemic-related factors have affected your client's development, including experiences with coming out, finding and maintaining a stable living situation, making friends and meeting people, exploring identity, finding work, and attending school. Early in therapy, get an accurate picture of how your client spends their time, whom they live with, and the benefits and challenges of their living situation. How do they afford things? Are their classes synchronous or asynchronous? How often do they leave the house? Is their schedule the same from week to week, or does it vary? Do any of your client's goals relate to becoming more independent—for instance, finding a new place to live, finding a new job, or going back to school? Is the client seeking medical transition or to legally change their name? To support the client in achieving their goals, think creatively about how logistical tasks (sometimes jokingly referred to as "adulting") can align with therapy goals (e.g., improving communication skills, decreasing procrastination). Does the client need help making a budget, setting up a planner, or making a chore list? Do they struggle to make phone calls due to anxiety or dysphoria about getting misgendered on the phone?

How can therapy support them in building the skills to become more independent, to explore and understand their own identity, and to forge meaningful relationships?

Once you've made your thorough assessment of a client's needs, you can begin to use evidence-based therapy frameworks to help clients build insight and develop their skills. In my practice, I use primarily cognitive and dialectical behavior therapy (DBT) concepts to empower and support clients. In the therapy setting, social workers must be cautious to address the mental health impacts of political and social dynamics while still acknowledging that the source of these problems is social and systemic in nature—that is, that having a good attitude is not going to change the cost of living in one's city or a parent's deeply held religious beliefs. That said, trying out a new way of thinking can often help a person handle a situation better and feel more in control. This is the time in therapy when I discuss the DBT concept of radical acceptance and work with the client on developing distress tolerance skills for managing those things they cannot control.

DBT is particularly helpful for exploring how individual behavior affects one's life and for contextualizing a person's behavior in terms of structural forces. Some examples include the fact that housing is ridiculously expensive, and impulse-buying video games when you're manic makes it harder to save money; higher education is a confusing bureaucracy, and you can learn skills to make phone calls to figure out your financial aid or how to register for classes. Exploring these dialectics in therapy can decrease clients' feelings of helplessness and emotional reactivity.

As Craig and colleagues suggest in their article on modifying cognitive behavioral therapy for LGBT youth, I shy away from using the terms "irrational" or "distorted thought" in session, preferring to use the term "unhelpful" instead (2013, p. 263). (A person's unhelpful thoughts might be perfectly rational, especially as they relate to unsupportive family members and social hostility toward transgender people.) My clients and I can then move on to acknowledge the effect of the unhelpful thoughts, exploring how these thoughts can reinforce behaviors like self-injury, avoidance, and isolation; we can then come up with more helpful self-talk that focuses on coping skills, social support, and breaking down goals and tasks into small, manageable pieces. This approach works to decrease feelings of hopelessness and helplessness, making it easier to use DBT skills like opposite to emotion action, distress tolerance, and interpersonal effectiveness.

In addition to such work in session, social workers should know local and online resources so they can effectively refer clients for other forms of support. Investigate whether your local community has an LGBT center and learn what services, groups, or social opportunities they offer. Universities too often have trans- or LGBT-specific offices, groups, and clubs. If possible, find out which primary care doctors in your area are LGBT affirming and whether your town (or a larger city nearby) has an LGBT-specific health clinic and/or a

Planned Parenthood (many of which offer gender-affirming healthcare). Young adults may not have experience arranging their own healthcare, so role-playing and discussing what to expect when seeking care can be very helpful and relieve some of the anxiety of these situations. Being able to provide effective, culturally competent referrals also reinforces the dialectic that although structural barriers and limitations do exist, a person can build individual skills to seek help and self-advocate.

Additionally, to be culturally competent providers, clinicians—especially those outside the LGBT community—ought to commit to ongoing education, reading, and study on transgender issues. The National LGBTQIA+ Health Education Center has free online trainings on LGBT issues for healthcare providers, and your state likely has an LGBT advocacy group (such as Equality Florida, in my home state) that you can follow on social media to learn more about trans and nonbinary people and issues in your community. Understanding social issues affecting clients will help you to support their mental health and flourishing.

We, as social workers, must understand the social and economic factors that affect our clients' lives. Nowhere is this clearer than in therapy with trans and nonbinary young adults, whose social development, lives, and mental health have been affected by the COVID-19 pandemic and other current events. I hope that the information and resources here will empower you to provide effective assessments, culturally competent care, and meaningful referrals to your clients and that you continue to educate yourself on trans and nonbinary issues.

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References

Cherry, K. (2022, August 3). Erikson's stages of development: A closer look at the eight psychosocial stages. www.verywellmind.com/erik-eriksons-stages-of-psychosocial-development-2795740

Craig, S.L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. *Clinical Social Work Journal, 41*, 258–266. https://doi.org/10.1007/s10615-012-0427-9

Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mongelli, F., Perrone, D., Balducci, J., Sacchetti, A., Ferrari, S., Mattei, G., & Galeazzi, G. (2019). Minority stress and mental health among LGBT populations: An update on the evidence. *Minerva Psichiatrica, 60*. www.semanticscholar.org/paper/Minority-stress-and-mental-health-among-LGBT-an-on-Mongelli-Perrone/de67fa538a13c875a6ead0b2bdf3aad7e00bdc72

The Trevor Project. (2020). *National survey on LGBTQ youth mental health 2020*. www.thetrevorproject.org/survey-2020/?section=Introduction

Rebuilding Stronger: Lessons in Resilience from the Pandemic

Robin M. Gilmartin, LCSW

On March 12, 2020, I saw my last in-person client and posted a sign to myself that read "Improvise, Adapt and Overcome." Adopting this unofficial Marine Corps slogan was a reminder to me to meet the unexpected with resilience. Faced with the pandemic, everyone was improvising in virtually every area of life—attending work, going to school, providing childcare, shopping for groceries, and safely caring for the elderly. Later, we, as a society, would learn to communicate with loved ones in the hospital and conduct virtual memorial services and funerals. We did this for ourselves and helped others do the same.

Two and a half years later, many of us in the social work profession are eager to "get past the pandemic" and "get back to normal" in our personal lives, even as we might advocate for needed social change. But it's a fitting time to take stock, not move on. How did we, as social workers, meet the challenges we faced during the pandemic? How did we cope with adversity? How resilient are we? By asking ourselves and our clients or students these questions, we can reinforce resilience factors, becoming stronger to face whatever is next.

In their book *Resilience: The Science of Mastering Life's Greatest Challenges*, Steven Southwick and Dennis Charney (2012) present the current science of resilience, illustrate 10 resilience factors via interviews with highly resilient people (such as trauma survivors and former prisoners of war), and emphasize that every person can build individual resilience through awareness and practice. Although numerous definitions of the term exist, resilience, at its core, is the ability to weather adversity. Southwick and Charney's resilience factors are having realistic optimism, facing our fears, possessing a moral compass, practicing religion and spirituality, giving and receiving social support, emulating resilient role models, practicing physical fitness, keeping our brains fit, enhancing cognitive and emotional flexibility, and finding meaning and purpose.

Socratic dialogue is well suited to the task of assessing resilience in meeting challenges of the pandemic. Socratic dialogue is also known as "Maietic" (Greek for "midwifing") dialogue. It uses thought-provoking, often open-ended questions that elicit, or midwife, an individual's own wisdom. Socratic dialogue is used in various psychotherapies, including cognitive behavioral therapies and existential therapies. One existential therapy in particular, logotherapy, uses Socratic dialogue as one of its principal methods.

Logotherapy, which literally means in the Greek language "healing through meaning," was developed by Holocaust survivor Viktor Frankl, who believed that discovery of meaning is central to humans and that meaning can be found even in the most dire of circumstances. Frankl's meaning-centered psychology is future oriented and focused on individual strengths; it emphasizes the human spirit and a capacity for self-transcendence. Frankl believed each client already possesses inner wisdom and through dialogue is able to access it (Frankl, 1992).

In this case, a good Socratic (and Franklian) question might be "What will you say years from now when a young person asks, 'How did you overcome the challenges of the great pandemic of the 2020s?'" Answers will likely reflect one or more resilience factors. Consider the following examples drawn from my own therapy practice and life since 2020. Resilience factors are in parentheses:

> "It was especially isolating since I had just moved to town, but my neighbors and I started a

regular neighborhood outdoor gathering around firepits, and those are friendships I have to this day." (Social support)

"I always wanted to be that person who helps others in a crisis, like my Uncle Frank who was part of the Cajun Navy during Hurricane Katrina. So, I started volunteering at the food bank and vaccination clinics, and it felt good to help." (Resilient role models and moral compass)

"I completed a challenging master's program online and started distance running and got in the best shape of my life." (Brain fitness and physical fitness)

"It just seemed like the pandemic would never end, but then I started thinking how there have been plagues and pandemics before. People survive, and you come out of it—maybe even stronger for it. From then on I kept thinking, This too shall pass." (Realistic optimism)

One resilience factor in particular— meaning and purpose—may draw out others, for example, when taking meaningful action requires someone to face a fear. Leaning into fears to achieve meaningful goals has been used effectively in clinical settings with individuals who have chronic PTSD or phobias (Southwick et al., 2006). There are many celebrated examples during the pandemic of people facing hard realities and risk of infection to accomplish profoundly meaningful work.

Frontline physicians and nurses have rightly garnered admiration and gratitude, but these roles make up only 20 percent of essential healthcare workers (Kinder, 2020). So many others took disproportionate risks with less fanfare, respect, or pay, including nursing assistants, home health aides, housekeepers, transportation and food service workers, and other essential workers like social workers. The importance of this work has been highlighted by circumstances of the pandemic—for example, holding the hand or praying with an isolated COVID-19 patient whose loved ones were unable to be there to provide comfort. Resilience is evidenced in those personnel responding to the urgent needs around us and meeting the moment when called upon. Over these past two years, I found resilient role models among colleagues, clients, and the certified nursing assistants who cared for my mother at the end of her life.

Frankl wrote about fate, freedom and responsibility: fate being what happens to us, freedom to choose how to respond, and responsibility to meet the moment. Southwick and Charney conclude: "Ultimately, resilience is about understanding the difference between fate and freedom, and learning to take responsibility for one's own life." We can't know what's in store, but it's up to each of us to prepare to meet whatever the challenges with resilience.

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References

Frankl, V.E. (1992). *Man's search for meaning: An introduction to logotherapy* (4th ed.). (I. Lasch, Trans.). Beacon.

Kinder, M. (2020, May 28). *Essential but undervalued: Millions of health care workers aren't getting the pay or respect they deserve in the COVID-19 pandemic.* Brookings Institution. www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/

Southwick, S.M., & Charney, D.S. (2012). *Resilience: The science of mastering life's greatest challenges.* Cambridge University Press. https://doi.org/10.1017/CBO9781139013857

Southwick, S.M., Gilmartin, R., McDonough, P., & Morrissey, P. (2006). Logotherapy as an adjunctive treatment for chronic combat-related PTSD: A meaning-based intervention. *The American Journal of Psychotherapy, 60*(2), 161–174. https://doi.org/10.1176/appi.psychotherapy.2006.60.2.161

Social Work and Provider Stigma toward Individuals Living with Mental Illness

Julie Fanning, DSW

As social workers, we strive to assist individuals in living their best possible life. Social workers advocate for the marginalized and amplify the voices of those who are not heard. During these past few years, social workers were among the essential workers assisting in an ever-changing world. Many people struggled with mental health during the COVID-19 pandemic. One study showed that the stress of the COVID-19 pandemic increased (hypo)mania symptoms in individuals diagnosed with bipolar disorder (Koenders et al., 2021). Individuals who had COVID-19 found that the disease affected both their physical and mental health, which in turn affected their relationships and stages of living (Stamu-O'Brien et al., 2020).

Despite being trained to work with individuals' mental health and to improve their well-being, social workers struggle with understanding and working with people who are living with a severe mental illness such as major depression, bipolar disorder, or schizophrenia (Watson et al., 2017). Social workers number more than 715,000 in the United States, making them the largest provider of mental health services (U.S. Bureau of Labor Statistics, 2022). This is concerning when individuals living with a severe mental illness indicate that people who provide mental health care still attach significant stigma to their issues (Watson et al., 2017). Even though most social work students complete a psychopathology class, they, as well as pharmacy and nursing students, continue to stigmatize individuals with mental illness (Sherwood, 2019). A provider's negative beliefs about people with mental illness could inhibit recovery. Individuals with mental illness report that their providers treat them not as complex human beings but with condescension and derision. Although social workers often express more positive opinions about people with mental illness than the general public does, this positivity is not apparent in the some social workers' behavior (Wang et al., 2018). Mental health professionals kept social distance and showed reluctance to interact with individuals living with mental illness (Wang et al., 2018).

Social workers can take steps to ensure they offer respect and dignity to each individual they work with who is living with mental illness. Social workers who are knowledgeable and hold more optimistic views of recovery positively affect those with mental illness (Mötteli et al., 2019). The first step is to allow and encourage others, including students and other professionals, to speak about their mental health concerns. Sometimes social workers have been discouraged from speaking about their own mental health. Those teaching social work sometimes promote detrimental views of individuals with mental illness (Charles et al., 2017). Under the assumption that students want help for their own conditions, social work professors have censured students who disclose mental illness in the classroom.

For a more balanced view, social workers may benefit from educators who integrate the students' experience and use it to model cultural appropriateness (Charles et al., 2017). Shutting down social workers' discussion of their mental health struggles can be detrimental. As one study illustrated, social work students believe will fall short as professionals if they have any mental health needs of their own (Kotera et al., 2019).

Be mindful and use person-first language. Calling a person schizophrenic rather than saying they have been diagnosed with schizophrenia or have schizophrenia or saying someone is "a borderline" rather than "struggling with symptoms of borderline personality disorder," dehumanizes the person, thus increasing stigmatizing behavior and attitudes (Granello, 2019). The language that social workers use is a social justice issue because language that diminishes someone's dignity can be harmful to individuals already disenfranchised and discriminated against. Granello and Gorby (2021) found that seeing the term "mentally ill" rather than "person with mental illness" makes a provider more likely to use stigmatizing interventions that are restrictive and authoritarian.

Believe in and empower clients living with mental illness. Providers frequently have low expectations of clients with mental illness, which inhibits the clients' belief in the possibility of their success (Dell et al., 2021). Individuals living with mental illness who feel empowered have lower internalized stigma than do other individuals (Lyon & Mortimer-Jones, 2021). Assisting clients with gaining the power to change their own lives and believing in the possibility of their success will afford clients the possibility of success.

Review personal and professional values. Social work is a values-based profession, and providers' values affect their beliefs and actions with clients (Lassen-Johnson, 2021). One

way to review values related to mental illness is to create a personal mental health history detailing moods, events, and interactions with mental health systems throughout a person's lifetime (Fanning, 2021). Using critical reflection to examine values is helpful because critical reflection helps maintain boundaries and healthy relationships with clients (Koh & Boisen, 2019). Assess social work values, determine which values are most important, and reflect on how the value is embodied when working with individuals with mental illness.

Embrace ongoing education about mental illness. Whitley et al. (2020) found that learning about everyday interactions of people living with mental illness and heard real stories decreased stigma and promoted Providers' understanding of the individuals. Another study showed that nursing students became more interested and positive about engaging with people with mental illness after an intensive educational program (Stuhlmiller & Tolchard, 2019).

Education can help minimize the microaggressions that people with mental illness experience. These microaggressions often come from providers, therapists, and healthcare professionals (Peters et al., 2017). Microaggressions are more problematic when the multiple identities of someone living with mental illness are taken into account, such as being part of a sexual minority group or being a person of color (Holley et al., 2019). The increase in microaggressions is consistent with more negative outcomes for individuals with mental illness.

Social workers are integral to helping individuals with mental illness. By being willing to continually learn, engage in self-reflection, embody social work values, and honor the dignity and worth of each individual, social workers will enhance rather than harm people with mental illness.

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References

Charles, J.L.K., Holley, L.C., & Kondrat, D.C. (2017). Addressing our own biases: Social work educators' experiences with students with mental illnesses. *Social Work Education, 36*(4), 414–429. https://doi-org.library.capella.edu/10.1080/02615479.2017.1297393

Dell, N.A., Vidovic, K.R., Vaughn, M.G., & Sasaki, N. (2021). Mental health provider stigma, expectations for recovery, and perceived quality of care provided to persons with mental illness. *Stigma and Health, 6*(2), 247–250. https://doi.org/10.1037/sah0000227

Fanning, J. (2021, August). Using social work students' perceptions to impact individuals living with mental illness: A doctoral capstone project presented in partial fulfillment of the requirements for the degree doctor of social work at Capella University.

Granello, D.H. (2019). The r word is more than hate speech: Differences in counselors' level of tolerance based on language and labels. *The Journal of Humanistic Counseling, 58*(3), 170–183. https://doi.org/10.1002/johc.12118

Granello, D.H., & Gorby, S.R. (2021). It's time for counselors to modify our language: It matters when we call our clients schizophrenics versus people with schizophrenia. *Journal of Counseling & Development, 99*(4), 452–461. https://doi.org/10.1002/jcad.12397

Holder, S.M., Peterson, E.R., Stephens, R., & Crandall, L.A. (2019). Stigma in mental health at the macro and micro levels: Implications for mental health consumers and professionals. *Community Mental Health Journal, 55*(3), 369–374.

Koenders, M., Mesbah, R., Spijker, A., Boere, E., Leeuw, M., Hemert, B., & Giltay, E. (2021). Effects of the COVID 19 pandemic in a preexisting longitudinal study of patients with recently diagnosed bipolar disorder: Indications for increases in manic symptoms. *Brain and Behavior, 11*(11). https://doi.org/10.1002/brb3.2326

Koh, B. D., & Boisen, L. S. (2019). The use-of-selves interdependent model: A pedagogical model for reflective practice. *Journal of Social Work Education, 55*(2), 338–350. https://doi.org/10.1080/10437797.2018.1513880

Kotera, Y., Green, P., & Sheffield, D. (2019). Mental health attitudes, self-criticism, compassion and role identity among UK social work students. *British Journal of Social Work, 49*(2), 351–370. https://doi.org/10.1093/bjsw/bcy072

Lassen-Johnson, K. (2021, April). *Supporting those with mental health diagnoses: An evidence-based practice guide for social work practitioners.* DigitalCommons@USU. Retrieved May 25, 2022, from https://digitalcommons.usu.edu/eb_socialwork/9/

Lyon A., & Mortimer-Jones, S.M. (2021) The relationship between terminology preferences, empowerment and internalised stigma in mental health. *Issues in Mental Health Nursing, 42*(2), 183–195. https://doi.org/10.1080/01612840.2020.1756013

Mötteli, S., Horisberger, R., Lamster, F., Vetter, S., Seifritz, E., & Jäger, M. (2019). More optimistic recovery attitudes are associated with less stigmatization of people with mental illness among healthcare professionals working on acute and semi-acute psychiatric wards. *Psychiatric Quarterly, 90*(3), 481–489. http://dx.doi.org.library.capella.edu/10.1007/s11126-019-09642-3

Peters, H.J., Schwenk, H.N., Ahlstrom, Z.R., & McIalwain, L.N. (2017). Microaggressions: The experience of individuals with mental illness. *Counselling Psychology Quarterly, 30*(1), 86–112. https://doi.org/10.1080/09515070.2016.1164666

Sherwood, D.A. (2019). Healthcare curriculum influences on stigma towards mental illness: Core psychiatry course impact on pharmacy, nursing and social work student attitudes. *Currents in Pharmacy Teaching and Learning, 11*(2), 198–203. https://doi.org/10.1016/j.cptl.2018.11.001

Stamu-O'Brien, C., Carniciu, S., Halvorson, E., & Jafferany, M. (2020). Psychological aspects of COVID-19. *Journal of Cosmetic Dermatology*, 2169–2173. https://doi.org/DOI: 10.1111/jocd.13601

Stuhlmiller, C., & Tolchard, B. (2019). Understanding the impact of mental health placements on student nurses' attitudes towards mental illness. *Nurse Education in Practice, 34*, 25–30.

U.S. Bureau of Labor Statistics. (2022, April). *Occupational Outlook Handbook: Social Workers*. Retrieved May 23, 2022, from www.bls.gov/OOH/community-and-social-service/social-workers.htm

Wang, K., Link, B.G., Corrigan, P.W., Davidson, L., & Flanagan, E. (2018). Perceived provider stigma as a predictor of mental health service users internalized stigma and disempowerment. *Psychiatry Research, 259*, 526–531. https://doi.org/10.1016/j.psychres.2017.11.036

Watson, A.C., Fulambarker, A., Kondrat, D.C., Holley, L.C., Kranke, D., Wilkins, B.T., Stromwell, L., & Eack, S.M. (2017). Social work faculty and mental illness stigma. *Journal of Social Work Education, 53*(2), 174–186. https://doi-org.library.capella.edu/10.1080/10437797.2016.1260506

Whitley, R., Sitter, K.C., Adamson, G., & Carmichael, V. (2020). Can participatory video reduce mental illness stigma? Results from a Canadian action-research study of feasibility and impact. *BMC Psychiatry, 20*, 1–12. http://dx.doi.org.library.capella.edu/10.1186/s12888-020-2429-4

The Crisis in America: The War on Children and Families in the United States

Jessica Price, LiCSW • **James L. Scherrer**, PhD, LCSW

The COVID-19 pandemic has exposed weaknesses in the child welfare system as it exists in the United States today. We as social workers have a real concern that the child welfare system has morphed into a surveillance system of poor, minoritized communities. (Detlaff et al., 2021; Roberts, 2022). Child welfare has become the system most at risk to be politically manipulated—and most in need of protection and dramatic overhaul.

Mass Shootings

Recent tragic events in the United States include the school shooting in Uvalde, Texas, on May 24, 2022; the race-motivated shooting in Buffalo, New York, on May 14, 2022; and just one day later, on May 15, 2022, a church shooting, also hate based, in California indicate it is time for social workers to stand up to the messaging that mass shootings are simply a mental health issue. This is a political issue whereby a minority of the population (about 30%) impose minimal control of and access to guns. The National Public Radio reported on July 4, 2022: "[Today] is day 185 of the year, and the country has already experienced at least 309 mass shootings so far. At least 309 in just over 26 weeks. This averages out to more than 11 a week" (Ahmed, 2022). Some politicians, to deflect and distract from the primary issue of mass shootings or gun reform, have pushed the propaganda that mental health is at fault. Nevertheless, in Texas, Governor Greg Abbott cut $211 million from the state's mental health budget. Texas is rated number 50 of the 50 states for access to mental health services.

Unfortunately, schools across the country continue to be underfunded and under resourced; now they are under attack while community mental health agencies struggle to stay staffed and deliver services. Mental health professionals face labor shortages, burnout, and significant resignation from the field. They are caving under the weight of their ever-increasing crisis-laden caseloads.

It is not acceptable for an isolated and alienated 18 year old, who could not finish high school and was expelled from his family, to be able to buy multiple AR-15 rifles and hundreds of rounds of ammunition on his birthday. School shootings are one of the biggest threats to the physical and psychological health of children. According to *The Washington Post*, "more than 311,000 students have experienced gun violence at school since Columbine. Beyond the dead and wounded, children who witness the violence or cower behind locked doors to hide from it can be profoundly traumatized" (Cox et al., 2022).

In the United States, the chronic trauma state of millions of students from more than two decades of mass shootings is unlike anything anywhere else in the world. Ongoing participation in active shooter drills multiple times a year leaves millions of American students from pre-K to college traumatized. More than a generation of students have had increased levels of anxiety as the number of school shootings and deaths continues to rise each year—both in frequency and fatalities. Things have only worsened since the tragedy at Sandy Hook. Families remain bewildered, afraid, and angry.

According to the Children's Defense Fund, (CDF) child and teen gun deaths hit a 19-year high in 2017 and have remained elevated since. CDF reports that gun violence is the leading cause of death for children and teens ages 1 to19 today even surpassing motor vehicle accidents for the first time. In 2019, 3,371 children and teens were killed with guns—one every 2 hours and 36 minutes.

Social workers should know that Black children and teens had the highest gun death rate, followed by American Indian/Alaska Native children and teens. Black children and teens were 4 times more likely to die from gun violence than their white peers. Also, overall, the United States has more guns than people—and nearly 1 in 5 are sold without background checks (Children's Defense Fund, 2021).

These facts place the United States in clear violation of the United Nations Convention on the Rights of the Child's Article 6, which recognizes that all children have the inherent right to life. Gun ownership is not an inherent right; it is a political right that governments are obligated to regulate and control.

Satisfactory actions include universal background checks on anyone wishing to purchase a gun. Central registration of all guns is essential. People purchasing a gun must undergo, and successfully complete, safety training to receive a renewable license. Persons renewing their license (every three to four years) must demonstrate continued gun safety knowledge. Certain types of weapons must be banned from ownership by persons who are not in the military. Guns in or around schools must be prohibited unless carried by law enforcement officers. These are only some suggestions of actions that could be taken to increase children's safety in schools. The children of the United States need its leaders to take these actions (Scherrer, 2022).

The Weaponizing of Child Welfare

The social service and health care systems in this country are in crisis. School systems and students are in a state of emergency. The government is appearing to be no longer a cohesive system progressing the communities they serve. Rather, it is a divided and unproductive body that is complacent, its members failing the children and families they took an oath to serve. Factual data cannot be denied. States such as Texas weaponize the child welfare system, and states such as

Florida are cultivating unsafe spaces in the classroom.

Examples of the weaponizing of child welfare have largely been hidden. They were brought out into the open with the forcible removal of children from their families who crossed the border in the United States under the previous administration. In April 2022, movement toward seeing children as weapons in political battles was further extended when Governor Abbott issued a directive to childcare workers to investigate parents of transgender children. The new directive was the final offense that pushed many child welfare workers in Texas to resign. The loss of these workers put an already vulnerable child population at an even greater risk. Texas could not afford to lose this many qualified professionals, but they left because they felt this new directive was not about protecting children and was ethically wrong—so wrong that they could not in good conscience continue to practice their profession.

The weaponizing of child welfare has redefined social workers as investigators, creating a juxtaposition between how these workers were educated and trained and how political policy mandates that they perform. We, as social workers, can protect our profession only by following and defending our code of ethics. The transgender community is the new casualty in the war on children and families facing the same fear and uncertainty that families of color and poor families have experienced for decades when interacting with the child welfare system. The child welfare crisis continues to be propagated by a political system looking to distract the public from the real issues. The shift to investigating families and policing communities has led to criminalizing social welfare issues and the families doing their best to raise their children. The ideology of investigating families has changed the dynamics between child protection workers and the families they serve. Child protection has shifted to a system that too often separates children at risk from their

families, often without the same protections as criminals receive from police officers. It is time to move away from transphobia, fear, racism, heteronormativity, and sexism.

In February 2022, Florida Governor Rick DeSantis signed the "Parental Rights in Education" bill, dubbed the "Don't Say 'Gay'" bill, which restricts education about LGBTQ topics in public school classrooms. A Florida high school senior, Zander Moricz, was barred from using the word "gay" in his graduation speech in May 2022. According to the Boston Globe, Moricz was told by his high school administration that he couldn't mention his sexual identity or activist efforts in his commencement address. Moricz claimed on social media that his principal said his microphone would be cut off and the ceremony halted if he spoke out. Zander's creative speech, using the words "curly hair" as a replacement for "gay," went viral. "I used to hate my curls. I spent mornings and nights embarrassed of them, trying desperately to straighten this part of who I am. But the daily damage of trying to fix myself became too much to do. So, while having curly hair in Florida is difficult due to humidity, I decided to be proud of who I was. I started coming to school as my authentic self. Now I'm happy." (Larson, 2022).

What Social Workers Can Do

It is time for the social work profession to understand its importance and put out an emergency call that all humans— "curly haired," Black and Brown, transgender, anyone who wants to help others—are welcome in the United States. In the words of the great John Lewis, "When you see something that is not right like, not fair, not just, say something! Do something! Get in trouble! Good trouble! Necessary trouble!"

Welcome to all who want to join the fight to get into "good trouble."

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References

Ahmed, S. (2022). *Halfway through year, America has already seen at least 309 mass shootings*. National Public Radio. www.npr.org/2022/05/15/1099008586/mass-shootings-us-2022-tally-number

Children's Defense Fund. (2021). *The state of America's children 2021*. www.childrensdefense.org/state-of-americas-children/

Cox, J., Rich, S., Chiu, A., Thacker, H., Chong L., Muyskens, J., & Ulmanu, M. (2022, May 27). More than 311,000 students have experienced gun violence at school since Columbine. *The Washington Post*. www.washingtonpost.com/graphics/2018/local/school-shootings-database/

Detlaff, A., Weber, K., Pendleton, M., Bettencourt, B., & Burton, L. (2021). *How we endUP: A future without family policing*. UpEND Movement. https://upendmovement.org/

Larson, S. (2022). Florida student says he was barred from using the word "gay" in his graduation speech. So, he referred to his "curly hair" instead. *Boston Globe*. www.bostonglobe.com/2022/05/26/nation/florida-student-says-he-was-barred-using-word-gay-his-graduation-speech-so-he-referred-his-curly-hair-instead/

Roberts, D. (2022). How the child welfare system is silently destroying Black families. *In These Times*, 05/24/2022.

Scherrer, J.L. (2022, fall/winter). Notes from the chair. *Child Welfare Section Connection*. National Association of Social Workers.

Evidence-Based Application

Elisabeth Joy LaMotte, LICSW

As private practitioners rebuild, recalibrate, and move forward, we may want to consider the important principles of evidence-based practice. Even as we persevere to provide quality care, we and our clients are enduring a collective trauma. Staying abreast of evidence-based strategies could help us revitalize our approach to the work.

Many of us in private practice are largely sheltered from shifts in the fields of managed care and social service agencies. As a result, we may not always be exposed to evolving research, and we may not feel the same pressure as do our colleagues in other settings to stay current on evidenced-based strategies.

The website of the National Association of Social Workers (NASW, n. d.) defines evidence-based practice as "a process in which the practitioner combines well-researched interventions with clinical experience, ethics, client preferences, and culture to guide and inform the delivery of treatments and services."

Clinical social workers in private practice who prioritize evidence-based practice therefore emphasize clinical interventions that have been researched and proven to demonstrate a scientific measurable benefit to client outcomes. The term evidence-based practice is not one I recall learning about while in graduate school in the mid-1990s, so I was excited to have a chance to speak with Dr. Jacqueline Corcoran, the first social worker to publish a book

on this topic.

Dr. Corcoran published Evidence-Based Social Work Practice with Families in 2000. She is the director of the Clinical Social Work doctoral program at the Social Policy and Practice (SP2) school at the University of Pennsylvania and is the author of several books, including a forthcoming volume on evidence-based social work practice.

Below are excerpts from our conversation; I hope that private practitioners will enjoy and learn from them.

Dr. Corcoran, you have published 18 books, you have two more under review, and you direct the Clinical Social Work doctoral program at SP2. You also have a private practice and have written books of fiction, yet you seem very calm. I'm so curious—how do you do it all?

Well, I don't like to be bored, and I have a lot of energy, despite my calm exterior. I like to be busy and involved in multiple projects. That way, if I start working on an academic book and I stall, I can shift to another

project. I can keep jumping back and forth as my interest and energy for particular topics change.

As you jump from one to the other, how does each inform and shape the other?

It depends. This semester, I'm teaching "Child and Adolescent Mental Health Challenges," and I'm writing a book on treatment in social work of children and adolescents, so the teaching informs the book. I have to be thinking about how my students are receiving the material and what they find useful. The teaching shows me how my material is developing and where the students need to know more. Many times, teaching a certain class will start off a project. When I teach it again, I revisit the topic and can go deeper each time; that informs the writing.

And how does that [process] carry over into private practice?

I do a lot of cognitive behavioral work, and I see trauma, and that's of great interest to the students. I teach a specialized cognitive behavioral interventions class, and I can tell them about how clients receive the treatment. Students work with these de-identified [case files]. Because I know the background, [these files are] better than a case study that I get from somewhere else. I can answer questions and even role play, if necessary.

What are you finding with virtual therapy?

My clients are comfortable being online, so I am doing that. I haven't taken on new clients [since going virtual]. There is quite a bit of

research—many systematic reviews—based on pre-Covid conditions, indicating that online and face-to-face are equivalent in terms of outcomes. Anecdotally, I've observed in myself and other providers that we don't like it as much, unless someone has personal circumstances, such as cost of office space or childcare, that make it convenient for them [to remain virtual]. I'm always on the computer, and so I was motivated to see clients face-to-face, being in the room with them. I don't really like telehealth because it is more of what I do all day—work on the computer—and that's why I haven't taken on anyone new. So, that's my hypothesis: that providers have a harder time with the online than clients do.

How might you apply evidence-based practice to virtual practice?

I think you can do it. You have to rely more on verbal reports because you can't detect some things on the computer, like body language and those relationship factors and client reactions that you can pick up in a room. I'm talking about the part of evidence-based practice that involves tracking progress to see whether the approach you've taken, based on the research, is working with this particular client. You have to decide on a tool you will use with a client—whether that's a self-anchored scale or a professionally developed tool that has been standardized. Also, you might need to be checking in with the client more about how they're receiving the work. For example, if I was doing trauma exposure, I would have to be checking in more to make sure that people were handling it OK. I haven't done that work online, but I think it can be done.

How do you think social workers in private practice can best use evidence-based qualitative and quantitative information to enhance their therapy practice?

Private practice practitioners can access PubMed, which is available to the public. Not every article on there is available to the public, but if there is federal grant funding behind them, then the articles are publicly available. A lot more is online than there used to be. And sometimes you can get information from abstracts, too. You don't always need the full article. Google Scholar is another option. There are some PDFs available there. Articles there are sorted by the number of times they've been cited by other authors. PubMed is probably better for relevance, as a result. Do a search for "systematic reviews," which are at the highest level in a hierarchy of evidence. If there are no reviews that address the topic you're looking for, go to "randomized controlled trials," which is at the second tier of evidence. Qualitative studies are at the lower end of things. You wouldn't go there first, but you might work your way down to that level. And there might not be anything else. But often there is more information available than people think. A lot of times students will say to me, "There's nothing on [a particular topic]." And I'll do a quick search and find reviews.

So, the steps that you outline in your upcoming book tell you exactly where to go, and social workers in private practice can take those same steps. What might be an example?

There was a doctoral student working with a woman who had a family member die by suicide and the client was experiencing post-traumatic stress disorder . The student looked for evidence-based guidance, starting with a qualitative study that she found. I did some brief research, however, and noticed that there was a systematic review about interventions for people who had a family member die by suicide. So, I shared it and said that the systematic review should be her starting point. The advantage of using a systematic review, if available, rather than a qualitative study, is that somebody else has already collected all the information, and you don't have to hunt down all of the studies.

What would you observe as the pitfalls that social workers in private practice can fall into?

I don't think they make enough use of the research that is out there. I do cognitive behavioral therapy work, and a lot of times people contact me knowing that I am oriented in that way. I tend to get a lot of people who say, "I was seeing another clinician, and she was super nice, but we kept talking about the same things, and it didn't really go anywhere." That tells me that they are looking for a more action-oriented kind of approach. I think having a framework—a theory you're operating from—is helpful. You don't always have to stick to it like glue, but clients can get confused if there are too many different approaches. Then they're not sure what we're doing.

And where would you place psycho-education in this, in terms of teaching a client about the background and evidence of the theory?

I think that is important. I do a little intro to CBT. I keep the information minimal to keep people engaged. Sometimes I will draw a triangle to show the connection between thoughts, feelings, and behaviors, using an example in their life they've been talking about. I think it is important to do a little bit of teaching to show that there is a rationale for what you're doing. It shows that you have a plan, it comes from somewhere, and there is a reason it can be effective. That can be reassuring to the client.

I really enjoyed reading your upcoming book. The material is interesting and different than when I was in school. Some of the terms are new to me, having graduated in 1995. It seems like a practical and deeper approach that clinicians can use more of.

The evidence-based practice process is a newer one. Some of us think it's a better way to train social workers rather than studying how to do research, because most people don't do research. It has more relevance and more practical application. You still have to understand the research, but it allows you to be a consumer rather than an actual researcher. And you learn about the use of measurement tools as a part of practice.

Like the OQ-(45?

Yes. It gives you a lot of information about whether the client is benefitting. Sometimes a measure like the OQ-45 (may tap into an experience of the

client's that they weren't verbally aware of. If the questions are brief, like those on the OQ-45, then it's not so onerous. It's another part of using evidence-based practice.

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References

Corcoran, J. (2000). *Evidence-based social work practice with families: A lifespan approach.* Springer Publishing.

Corcoran, J. (2020). *Case-based learning for group intervention in social work.* Oxford University Press.

Corcoran, J., & Walsh, J. (2019). *Mental health in social work: A casebook on diagnosis and strengths-based assessment* (3rd ed.). Allyn & Bacon.

Garcia, A., & Corcoran, J. (in press). *A guidebook for formulating and implementing the evidence-based practice process with diverse systems and populations.* Oxford University Press.

Lambert, M.J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy, 52*(4), 381-390. http://dx.doi.org/10.1037/pst0000027

Now Is the Time

Dorothy Van Soest, PhD, MSW

On June 18, 2022, in Washington, DC, and virtually across the country, perhaps one of the largest gathering of poor and low-income people and their allies in our country's history took place (Poor People's Campaign, 2022a). People from more than 40 states told their stories about loved ones unnecessarily lost to COVID-19. Participants also talked about children lost to gun violence, suicide, drugs and how those who survive lack the resources to grow and thrive. They told of the formerly incarcerated denied dignity, jobs, and the right to vote; of immigrants and asylum seekers humiliated, shackled with ankle-monitoring bracelets; and of workers fighting for fair wages and union representation.

People discussed being denied food, healthcare, shelter, jobs, decent wages, and education. As person after person testified about how they had been affected by the interlocking injustices of systemic poverty, racism, ecological devastation, a war economy, and a distorted moral narrative, their stories merged into one resounding declaration:

> *We are here, we are poor, we have come together, and we will stay together until we transform this nation from the bottom up. We will not be silenced and we will not be unheard!*

Therein lies the answer to the question of how social workers and communities can rebuild and thrive after this pandemic: Do not rebuild the past.

Everyone's lives depend on not going back to normal, on not rebuilding or sustaining the preexisting inequitable systems that created the conditions for the negative outcomes associated with the virus in the first place (Center on Budget and Policy Priorities, 2022; Perry et al., 2021; Quinn et al., 2022; Wilson, 2020). The pandemic pulled back the curtain and exposed what is normal in our society.

Normal is 140 million poor and low-income people living in the richest nation, 700 people dying every day from poverty, and millions living without somewhere to call home. Normal is cutting child tax credits so people do not have food but at the same time daily throwing out more

food than it takes to feed every hungry person in the world. Normal is 87 million people uninsured and underinsured, with their ranks growing by tens of millions because people lost jobs and health during the pandemic (Theoharis, 2022).

Before the pandemic, poor and low-income people were rendered invisible to society and not considered to be a priority concern. During the pandemic they remained invisible because there was no systematic way of knowing the poverty status of those who died or fell ill from COVID-19—until the release of a Poor People's Pandemic Report (2022b), a joint study of the Poor People's Campaign: A National Call for Moral Revival in partnership with the United Nations Sustainable Development Solutions Network. A central finding of this study is that poverty was not tangential to the pandemic; rather, the pandemic was deeply embedded in the topography of poverty—that is, the pandemic became largely a "poor people's pandemic." Poorer communities grieved nearly two times the losses of richer communities during the second wave of the virus. In the waves after that, death rates spiraled even more. Poor counties saw up to five times the deaths of more affluent counties. Furthermore, vaccination rates did not explain the whole variation in COVID deaths. (Quinn et al., 2022).

The reason that more poor people die is that the powers that be put their lives in jeopardy. This is a form of murder—a social murder that is more malicious than individual

murder because it is rendered invisible (Garcia & Van Soest, 2021). So many of the COVID-19 deaths didn't have to occur. So many deaths from poverty don't have to take place. Unnecessary deaths are rooted in a myth of scarcity that demands that we ask, "Whom are we willing to exclude?" And for social workers there can be only one answer:

> *Everybody in! Nobody out! We need a Third Reconstruction to build a nation that lifts from the bottom, starting with the 140 million poor and low-income people, and everybody will rise.* (Poor People's Campaign, n.d.)

We, as a nation, were already in crisis before COVID-19. And now that the pandemic exposed that crisis, it is time to use our full power as social workers to force our democracy to reckon with the plight of its people. That will require not only a new way of acting but also a new way of thinking. Here are some suggested steps, a beginning road map, to help us on the journey.

- Educate yourself about racism, historical and collective trauma, sexism, privilege, intersectionality, and other social justice issues that exacerbated the disparities during the pandemic (Quinn et al., 2022).
- Examine the ways you have internalized the distorted moral narratives on which our unjust systems depend (e.g., the myths that poverty is the fault of the poor and that there is not enough for all of us to survive and thrive).

- Listen and learn from people who are poor; changing the narrator changes the narrative, and that changes your understanding, your beliefs, and the policies and actions you support.
- Intentionally prioritize the voices of those who are poor when making and implementing policy decisions.
- Connect the issues. The most pressing problems of our time are inextricably linked and cannot be tackled separately.
- Approach the work of reconstruction (Poor People's Campaign, n.d.) in terms of context, strategy, and solution. Learn how working for reforms in the context of late-stage capitalism exposes the current system's inability to deliver them and confirms the need to create a new system, and how that requires new strategies and solutions (Ford, 2019; Hennelly, 2021).
- Act in coalition with groups and movements that are working to create new nonoppressive systems (e.g., long-established organizations like the National Welfare Rights Union and the National Union of the Homeless, as well as the Poor People's Campaign.
- "Turn thinkers into fighters and fighters into thinkers," as Gen. Baker (2022) often said. If you are prone to jumping into action, study more. If you are prone to studying, take more action. Be willing to be uncomfortable. It's human nature to stay in safe and familiar zones; however, our comfort zones expand when we go ahead and do what's uncomfortable anyway.
- Engage in self-care practices—not as a retreat or distraction but as essential to sustaining the work of creating a better life for all (Garcia & Van Soest, 2021). For example, the newly formed SWEPT initiative (Social Workers Ending Poverty Together) is a way to do self-care by doing the work together. The Black Lives Matter Healing Justice Working Group (2021) shows ways to incorporate healing and self-care into direct actions.

If we, as a society, are to thrive after COVID-19, we cannot go back to normal. We need to avoid rebuilding systems that produce structural inequalities; we need to work to create new systems and structures that put people first. We need to reconstruct society from the bottom up, not from the top down.

Now is the time to make real our professional mission "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 2021, Preamble). Now is the time to transform unjust and oppressive systems into just and nonoppressive alternatives (Garcia & Van Soest, 2021).

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References

Baker (2022). Quote retrieved from www.generalbakerinstitute.com

Black Lives Matter. (2021). *Resources.* https://blacklivesmatter.com/resources/

Center on Budget and Policy Priorities. (2022, February 10). *Tracking the COVID-19 economy's effects on food, housing, and employment hardships.* www.cbpp.org/research/poverty-and-inequality/tracking-the-covid-19-economys-effects-on-food-housing-and

Ford, D.R. (Ed.). (2019). *Keywords in radical philosophy and education: Common concepts for contemporary movements.* www.academia.edu/en/69273866/Keywords_in_radical_philosophy_and_education_Common_concepts_for_contemporary_movements

Garcia, B., & Van Soest, D. (2021). *Social work practice for social justice: From cultural competence to anti-oppression.* CSWE Press.

Hennelly, R. (2021). *Stuck nation: Can the United States change course on our history of choosing profits over people?* Democracy at Work.

National Association of Social Workers. (2021). *Code of ethics.* www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Perry, B.L., Aronson, B., & Pescosolido, B.A. (2021, February 5). Pandemic precarity: COVID-19 is exposing and exacerbating inequalities in the American heartland. *Proceedings of the National Academy of Sciences, 118*(8), e2020685118. www.doi.org/10.1073/pnas.2020685118

Poor People's Campaign. (n.d.). *A national call for moral revival.* www.poorpeoplescampaign.org

Poor People's Campaign. (2022a). *7 steps before the midterms.* www.poorpeoplescampaign.org/june18/

Poor People's Campaign. (2022b). *Poor People's pandemic report.* www.poorpeoplescampaign.org/pandemic-report/

Quinn, C.R., Johnson, S., Jones, K., Parekh, R., Munshi, A., & Boyd, D.T. (2022). Social work and the next frontier of racial justice: Using COVID-19 as a vehicle for healing. *Social Work in Public Health.* https://doi.org/10.1080/19371918.2022.2084197

Theoharis, L. (2022, June 17). *Everyone has a right to live: Memorial service* [Video]. YouTube. www.youtube.com/watch?v=HT1t0dghV0o

Wilson, V. (2020, June 22). *Inequities exposed: How COVID-19 widened racial inequities in education, health, and the workforce.* Economic Policy Institute. www.epi.org/publication/covid-19-inequities-wilson-testimony/