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- Students Face Client Suicide
- A Different Kind of Teacher
- Different Strokes: Art and Photo Therapy
- Coming Home as a Social Worker
- Building Your Private Practice
- An Accidental Job Search
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Third edition of our “best-seller.” 54 social workers tell about their “typical” days in field placement! The students loved it. “Thank you for ... the collection of ‘typical days’ from social workers! The students loved it.” Naurine Lennox, Associate Professor and Chair, St. Olaf College Dept. of SW

Field placement is one of the most exciting and exhilarating parts of a formal social work education. It is also one of the most challenging. This collection addresses the multitude of issues that social work students in field placement encounter. This book brings together in one volume the best field placement articles from THE NEW SOCIAL WORKER. Packed with practical, essential information for every student in field placement!


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Publisher’s Thoughts

Dear Reader,

Happy Spring! Just as the flowers are starting to bloom outside, this issue of The New Social Worker is blooming with creativity and exciting social work happenings. I’m excited to bring this issue to you!

In the last issue, I introduced our new MSW student columnist, T.J. Rutherford. In this issue, T.J. reports on her field placement and setting priorities.

Also in this issue, we have another new columnist—Karen Zgoda has joined us as our new tech expert. Karen’s SW 2.0 column will bring news of how to use all the latest technology to be a better social worker. In this issue, she tells us about CaringBridge, a great free Internet resource.

Speaking of technology, The New Social Worker is now on Twitter and FaceBook. (See page 19.) Also, Karen, T.J., and I are keeping you posted on The New Social Worker’s blog! In between issues of the magazine, you can read our writings and communicate with us at http://blog.socialworker.com.

Barbara Trainin Blank continues her series of articles on creative arts therapies, with a focus on art and photo therapy in this issue. There are a lot of creative social workers out there! This issue also looks at the very serious issues of self-determination, client suicide, and working as a social worker in one’s own community. And we have career-focused articles on changing career focus from teaching to social work, building a private practice, and looking for a job before you’re quite ready!

We are trying something new with our reviews for this issue. Book and video reviews are being published as a separate supplement to this issue. This is part of our transition to an expanded review section. Look for the special supplement soon!

Don’t forget, if you are looking for a social work job, or looking to hire a social worker, check out our online job board at http://www.socialworkjobbank.com. We have just updated our online résumé system, so you can now upload your résumé in Word or PDF format—check it out!

Until next time—happy reading!

Linda M. Grobman, MSW, ACSW, LSW
The publisher/editor

Write for The New Social Worker

We are looking for articles from social work practitioners, students, and educators. Some areas of particular interest are: social work ethics; student field placement; practice specialties; and news of unusual, creative, or nontraditional social work.

Feature articles run 1,500-2,000 words in length. News articles are typically 100-150 words. Our style is conversational, practical, and educational. Write as if you are having a conversation with a student or colleague. What do you want him or her to know about the topic? What would you want to know? Use examples.

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

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

Send submissions to lindagrobman@socialworker.com.
The tribulations of Ashley Nicole Bunnell’s life not only didn’t defeat her; they gave her professional direction. The bright spots underscored her natural optimism.

Bunnell grew up in Munfordville, KY, a town with only two stop lights. She was raised, with the help of a grandmother, great-aunt, and aunt, by a single mother who was pregnant at 15.

When Bunnell was nine, her mother married an Army officer, whose next assignment was in Italy. “It was an experience kids just dream of,” she says. “We were really close to Verona and Venice, and I’d go there all the time. I learned enough Italian to get around an airport.”

Back stateside, the family moved to Fayetteville, NC, where Bunnell’s parents had three more children, all boys. “I’m really attached to them,” she says of her brothers, 7, 5, and 2.

But even a “white picket fence” environment, as she learned, can’t always protect children. When Tyler, the eldest, was three, he was molested by a neighbor. Therapy is helping him overcome the trauma, while Bunnell switched from a psychology major to social work as a result.

“I realized that child welfare was where my heart was,” the University of North Carolina at Pembroke BSW student says. “Switching set me back a semester, but it was what I wanted. I wasn’t able to help my brother, but I want to be a voice for other children. I’d like to apply for advanced standing to the UNC-Chapel Hill MSW program and work in child protection services.”

After college, Bunnell won’t have to look for a job immediately. Designated a Child Welfare Scholar on campus means she’ll owe some time to the Department of Social Services.

At 21, Bunnell has no children of her own. But she did get married last May to Tony Leonard, whom she met during her freshman year. Working on his master’s in educational and physical education, Leonard is teaching second grade.

Prominent on campus in several ways, Bunnell is president of the National Social Work Honor Society and Campus Association of Social Workers and was president of her sorority, Zeta Tau Alpha. She is a member of the Chancellor’s Commendation for Outstanding Scholarship List, the National Scholar Honor Society, and National Social Work Honor Society.

“Even if it’s only a few hours a day a few times a month for each,” Bunnell volunteers for the American Red Cross, Adopt a Needy Family for Thanksgiving, Adopt a Needy Family for Christmas, Martin Luther King Day of Service, Gray Stone Manor Nursing Home, Communities in Schools (CIS), Southeastern Domestic Violence Shelter, Relay for Life, Race for a Cure, and the Susan G. Komen Breast Cancer Foundation.

Bunnell worked her way through college and is still waiting part time. All that leaves little free time for personal interests, which are sometimes reduced to listening to music while she’s driving. Bunnell is “hooked” on the Stephanie Meyers Twilight series and also read the books by Dave Pelzer outlining how his past life as an abused child affected him. “This is a series every social worker should read,” she says.

It’s a daunting schedule, admittedly. “I have so much stuff going on, I have little time for my husband,” Bunnell says with a laugh. “I have no time for myself, honestly. My husband says I don’t sleep, and he doesn’t know how I do it. But we both promised to always be there beside each other. I don’t know what I would do without Tony. He’s very supportive.”

Stephen Marson, a professor of social work at UNC-P who taught Bunnell in a Writing for the Social Services course, describes her as full of energy, bubbly, and enthusiastic. “She’s always looking for things to do and is a real leader,” he says. “It’s been a very long time since I met a student with such initiative and excitement about social work.”

Marson, who calls her “one of the best writers” he’s ever taught, offered Bunnell an assistantship with the Journal of Social Work Values and Ethics. The two are collaborating on a book review of the new Handbook of Social Work. “It’s exciting,” Bunnell says. “I didn’t enjoy writing in college, but now in my major classes, I really do.”

If Bunnell had wanted to, she could have gone in a totally different career direction. She could have been a model. Bunnell appeared in a calendar of a local radio station in Fayetteville and might...
The Day Self-Determination Died: The Challenges of Implementing Self-Determination in Day-to-Day Life

by Liz Cameron

Self-determination. This is a term I throw around a lot in my social work classroom. It is a term familiar in our social work lexicon—a term that flows off the tongue. Yet, how do we really “live” self-determination?

Perhaps facing the intellectual implementation challenges of self-determination in a social work practice context allows for more reflection than I am able to engage in on a personal front. These days, I often feel that self-determination has died, in my personal life, at least. Exploring how we implement this important social work concept in our own lives is vital to engaging in ethical and mindful social work practice.

This essay embraces the dark side. It talks about one family’s experience with applying self-determination to a variety of life situations.

As the sibling of Agnes, a person with mental retardation, the grandchild of fiercely independent Depression-era survivors, the child of an aging parent with Parkinson’s disease, and a researcher interested in disability services, I find the issue of how exactly one should implement self-determination to be a constant puzzle. In some ways, it is completely congruent with my familial culture, and in other ways, it leaves my stomach tied up in knots.

It was only 35 years after my family adopted Agnes from South Asia, who they later determined was a person with moderate mental retardation and seriously challenging behaviors, that I came to read about self-determination. Now, I know self-determination to be the theoretical and human-rights oriented battle cry embraced by disability policymakers, practitioners, and academic researchers alike, of which I am now one. I would say that this was a “no-brainer” for me, given that self-determination was the way my family (and most of my immediate community) lived life, but that would not be politically correct.

Over the past four decades, our family has worked hard to embrace self-determination with vim and vigor—even in the face of the strengths and challenges of three grandparents with dementia and a parent with life-threatening juvenile-onset diabetes and cancer—as many other families and communities in the United States and around the world.

In my New England upbringing, the Yankee traditionalist ideals of individualism and self-sufficiency (fuel of the poverty of the Great Depression my father had experienced as a child) were endemic. These ideals found their way into the very core of my existence, so I did not question them as I became involved in the world of disability policy on my own terms. Community barn-raisings, church fund-raisers, and quilting bees for charity were activities my grandparents had considered a way of life. We spent a month each year at my parents’ far-flung honeymoon-built camp in rural northern Maine, where we lived “off the grid.” This meant that we had no electricity, water, phone, or plumbing. We read by candlelight, caught our own white perch for dinner, lugged pails of lake water uphill to boil for drinking, made basic furniture out of logs and saplings, and foraged for berries and herbs with minimal grocery store trips for the ice that kept my mother’s insulin fresh for her twice-daily injections. Her mother was beside herself that a person with her juvenile-onset disability would engage in such dangerous behavior.

During nights by the fire, Dad would tell Agnes and me stories about the curious-looking man, Benny, who mowed all the lawns in one of the many towns in which my father’s family lived during the troubled 1930s. Benny had just been “a bit slow and different,” supported by local society in this manner in order to avoid the local almshouse, as my grandfather referred to it. On my mother’s side, my Tia Abuela (great aunt) was “crippled” by a fragile bone disease and had remained at home, cared for by her mother well into her 60th year, despite pleas from her doctors for institutionalization. Non-family-based living was not an option. Self-determination reigned supreme in these families, despite the financial challenges of the Great Depression on one side and losing the family’s business and wealth to General Franco in Spain on the other.

My parents adopted Agnes as an infant from a far-away South Asian country. They soon realized that things were not as they should be. Arriving in their arms at the local airport with a bruise on her head, she did not coo, laugh, or cry as a baby should. In fact, she began to exhibit aggressive behavior against other young children before she finally began to speak. Dragged from expert to expert, the last in the line finally said, “She has mild to moderate mental retardation, but your problems will really begin when she is a young adult. Institutionalize her or get her on medications.” These were not acceptable options to my parents, who fell back on their Christian values of “taking what God has given us,” as well as their inborn values of individualism and self-reliance. Agnes remained at home with us, for better or worse, and—call me negative and not strengths-based—there was a lot of “worse.” My mother quit her tenure-track research life fraught with the ravages of sexism in the early 1960s in favor of plowing through child development, parenting, and speech/language texts, all devoted to “the Agnes effort.”

Despite Agnes’ violent and inward-focused tantrums and self-injurious behavior that left smears of blood, hair, skin, and broken furniture around our home, there were beautiful family moments when we laughed together and enjoyed happy times that I wouldn’t take back for.
a million bucks. Throughout, my father always said “we are not going to let drugs dampen Agnes’ sparkle.” And indeed, she did have a special sparkle. On good days, Agnes did indeed exhibit sparkle in her conversations with us, her neighbors, her schoolmates. Maintaining Agnes’ sparkle and supporting her strengths was the goal that sustained my parents in their efforts to keep her in the public schools, attending church, or on regular family trips, be they to the grocery store or vacations. My parents’ efforts and, to a great extent, the incredibly giving and kind efforts of various friends and community members to facilitate Agnes’ community inclusion are at the heart of what I believe self-determination is all about. The acceptance and patience with which Agnes’ odd and sometimes violent ways were handled in my hometown were truly heart-warming, much as Rachel Simon has written about the bus drivers who accepted her sister with mental retardation, in her book Riding the Bus with My Sister.

Of course, all of these activities and efforts took place in the decades immediately after Willowbrook, the de-institutionalization movement, and the realization of what was to come with the baby boom generation. My parents kept on with the self-determination approach in support of Agnes’ life at home, but soon we faced issues with another part of the family that placed a great strain on our proud family tradition of independence and self-determination.

As our mother suffered through cancer treatments, we often found the remnants of Agnes’ forgotten internal fury in the form of blood-stained wooden floors beneath rugs newly moved for Mom’s hospital bed. A year after her second cancer diagnosis, my mother made the informed choice to stop fighting a losing battle with cancer, and soon passed away at home from pneumonia. My father and I were swayed. So, during the process of sorting through Agnes’ stuff while she was in her latest psychiatric ward, my actions resulted in the death of self-determination. I didn’t realize it at the time, as I was not tuned in and it happened in an unsuspecting manner. I came across Agnes’ moldy address book—a wooden box filled to the brim with scraps of paper with names and numbers on it—many from her recent hospitalizations (she made notes of where she met people on the back of each scrap of paper). In a surge of parental-like paternalism and fear for her safety given the people that were, to me, “questionable” friends in Agnes’ life, I trashed the box.

I immediately felt a bittersweet relief. At least she won’t be able to contact someone who might take advantage of her, I thought. That night, I imagined the wooden box, crunched by the garbage compressor at the dump, and I felt as though I had committed a huge violation. I can’t say that I thought long and hard about it before I placed it in the garbage bag. My gut said “protect her,” but the nagging guilt has not left. I feel as though I went against everything I was raised to do, and now, as an adult, was part of my philosophy of life. I spoke with my father and stepmother about it the next morning, both of whom encouraged me by saying, “You did the right thing.” I am not convinced, however. And I have not yet revealed this act of betrayal to Agnes, but she hasn’t asked about her addresses, either. I am skirting some sort of ethical zone.

Now that Agnes and I are entering a new phase under the double-edged sword of sibling and guardian on my part, we navigate “the self-determination question” on a daily basis. I am constantly wrestling with the clear embrace of self-determination nurtured by my familial culture along with my new pseudo-parental role. When will be the day that self-determination dies again? I believe that the field of social work, especially in light of our commitment to self-determination, needs to really wrestle with the dark side of self-determination—the “living” of it in our personal and professional lives. It is only through reflecting on the impact of “living” self-determination in real life that we can truly enable our clients to do the same.

Liz Cameron is a pseudonym for an Assistant Professor of Social Work located in the Northwestern region of the United States.
I’ve been told there are two kinds of therapists: therapists who have had a client suicide and therapists who have not had a client suicide, yet. I was a student the first time I heard this saying, and I thought it was a gruesome statement that had no relevance to me. After all, I would never have a client suicide, I told myself, and furthermore, thinking about it was...I didn’t want to think about it at all.

Since then, I’ve wondered about my hesitance to contemplate such an important topic and why it seemed comparatively easier to think about other issues that often face our clients, like coping with trauma or struggling with physical and mental illness. I’ve also wondered about my denial in assuming I would never have to cope with client suicide. Social workers and social work students face some of the hardest realities, and suicide is a very real and possible one. According to the National Institute of Mental Health, suicide is the eleventh leading cause of death in the United States (2004).

I’ve come up with a few “maybes” to help explain my own reaction to the possibility of client suicide. Maybe it was too difficult for me to acknowledge that becoming a clinical social worker, a profession I loved from the start, had some serious drawbacks. Maybe it challenged my self concept as “helper” to accept that I could be helpless to prevent clients from taking their own lives. I’ve discovered a new “maybe” that seems to make sense: maybe I was not the only one comforted by refusing to think about client suicide. A collective quiet, both in the classroom and in agencies, makes it possible to maintain the safe stance of “it will never happen to me”—a stance that becomes dangerous, if it ever does.

Could It Happen to Me?

For those who would like to maintain the “it will never happen to me” stance, I am the bearer of bad news. In a 2004 study, roughly one third of mental health social workers reported having had a client who committed suicide (Jacobson, Ting, Sanders, & Harrington, 2004). Even if you are among the lucky two-thirds, there is a strong possibility that a colleague, friend, or former classmate will face losing a client to suicide. Further, social workers who do not work in mental health often interact with clients who exhibit psychosocial problems that are among the strongest predictors of suicide, such as substance abuse or unemployment (Feldman & Freedenthal, 2006). Suicide is an issue that will likely affect all of us at some point in our careers, and some of us sooner than later.

While no research is available pertaining to social work students, studies have documented that eleven percent of psychology interns and roughly six percent of mental health counselors in training have reported losing a client to suicide (Kleespies, Penk, & Forsyth, 1993; McAdams & Foster, 2000). Statistics can feel meaningless, so try thinking about it like this: if your class has ten people, one of you has a relatively strong chance of facing this issue before you don your graduation cap, before you’ve mastered listening empathically, and while you still feel like you’re swimming upstream in the challenges of school work and field placements. Unfortunately, you will probably feel drastically unprepared to face what is happening.

Being Unprepared is Not Uncommon

Take a moment to think back on your classes so far, or if you’ve graduated, on your social work studies in general. If you can recall having discussed client suicide in more than a passing way, consider yourself lucky. In a 2006 study of social workers who had graduated from master’s degree programs, most reported having received no formal education, such as courses or seminars, and little informal education, on suicide (Feldman & Freedenthal, 2006). Whereas field placements seemed to do somewhat better with suicide education, roughly 40 percent of the respondents received no training at all about suicide in their placements.

Yet, many social work students are placed in agencies with populations who are at high risk for suicidality. If we’re not talking about it in school, not reading about it in our piles of class reading, and not learning about it at our field placements, it’s easy to let the very idea slip into the background. It is easy to be unprepared, if no one is preparing you.

Students’ Responses to Client Suicide

Students who have lost a client to suicide respond strongly. In a 1993 study, it was found that psychology interns reported feeling shocked, ashamed, guilty, overcome with a sense of failure, and many other powerful emotions after experiencing a client suicide (Kleespies, et al., 1993). They were just as affected, if not more, by losing a client to suicide as their professional counterparts.

Students may face concerns that professionals do not. Students in field placements may fear being blamed and worry that the client’s suicide will impact their success at their placements or at school.
They may begin to question their career choice, become very anxious when working with suicidal clients, and doubt their clinical competence (Kleespies, 1993; Kleespies et al., 1993; Knox, 2006).

Additionally, Brown (1989) has suggested that unlike professional therapists, students may rely more on their personalities when working with clients, because they have not yet developed a full skill set. When they lose a client to suicide, they may experience the loss not only as a professional failure, but as a very personal failure, a failure as a human being. Further, Lafayette and Stern (2004) have reasoned that students have a limited number of client cases on which to base their success, and if one client suicides, it may be disproportionately damaging to their sense of ability.

It is possible that students can also grow positively from losing a client to suicide. They may become more careful in assessing and working with suicidal clients (Knox, 2006). They may realize the limitations of the therapeutic process and the extent to which clients truly do have personal freedom (Brown, 1989; Kleespies, 1993). They will have crossed the line from the category of therapists who have not had a client suicide yet, to therapists who have had a client suicide—with that journey may come a distinct inability to ignore the reality of suicide and, hopefully, a desire to encourage dialogue where it is currently scarce.

What If It Happens to Me?

Gaining support can be extremely helpful in processing a client suicide (Knox, 2006). If you are comfortable with your supervisor, talk to him or her as much as you need to about the client and the circumstances surrounding a client’s death (Kleespies, et al., 1993; Knox, 2006; Spiegelman & Werth, 2005). Talking with colleagues, peers, friends, or family may also be helpful, although some people have found that they feel blamed by those they have looked to for support (Kleespies, et al., 1993; Knox, 2006). Choose carefully the people with whom you share your feelings, and if you don’t receive the support you need from one person, try someone else.

Talk with your supervisor about steps you can take to process the suicide. Many students have found reviewing the client’s death and performing a “psychological autopsy” to be helpful (Kleespies, et al., 1993). Examining the circumstances around a client’s death can help paint a realistic picture of the client, which may counteract imagined scenarios that take the self-blaming form of “I should have....”

You may also want to discuss the possibility of contacting the client’s family and attending funeral services, as other students have found these steps helpful (Kleespies, et al., 1993). Of course, issues regarding confidentiality, and in some agencies, concerns about the possibility of malpractice suits, could have an impact on this decision (Bongar, 2002 as cited in Spiegelman & Werth, 2005).

Educational institutions will likely want to be made aware if a student faces client suicide. Informing your school could be helpful in a number of ways. If you need to change your caseload temporarily, or even long term, your school can help you facilitate changes with your agency. Or, if you find that your school work is being affected, the school can help you find solutions that will minimize long-term effects on your academic
standing. Informing your school increases the supportive structures in your life, giving you more people to go to if you need to talk about the client.

Think about going to therapy yourself, even for just a few sessions. Gaining support and a time and space to process a client’s suicide could be very helpful in coping with the numerous emotions you may feel (KleeSpies, et al., 2003). Many schools have access to free or almost free counseling.

Choosing to Talk About Client Suicide

Clearly, social work schools need to be better at educating students about suicide. Formal courses or workshops should be offered in which students receive training not only in preventing suicide, but coping if a suicide occurs. Students who are in agencies with populations at high risk for suicidality especially need exposure to this issue before having to face it in practice.

Communication between schools and field placements about client suicide could help ensure that students receive the support they need. Protocol requiring agencies to inform schools of student exposure to client suicide, rather than putting students in what could be an awkward position to report it themselves, could allow schools to touch base with students and provide resources. Further, agencies could have internal protocols that help to guide students and professional therapists about the actions taken if a client does commit suicide (Knox, 2006).

Students absolutely have the right to start asking for more of their schools and field placements. Ask your professors and administrators to spend more time talking about suicide. Ask your supervisor if he or she would be willing to share experiences with suicidal clients or about how the agency has coped with losing a client to suicide in the past. Open a dialogue and see where it goes.

Maintaining the “It Could Happen to Me” Stance

All of us who work with clients or train those who do—students, professors, therapists, administrators, and supervisors—have a duty to acknowledge that yes, it can happen. Awful, scary, alarming, and not at all what we want to think, but yet it does happen. Clients commit suicide. Students face client suicide. Once we accept that painful reality, we can start figuring out how to support one another and do what many social workers do best: listen and help each other through it.

References


Mollie Charter, MSW, graduated from Boston University in the spring of 2008. Her field placements were with adults and adolescents with severe and acute mental illness, and involved training in group, family, and individual therapy. She has since moved to Denmark, which has afforded her the opportunity to travel much of Europe, and is keeping up with social work through volunteering for an organization for people with mental illness and for a multicultural women’s organization, in addition to writing. She plans to return to Connecticut in the fall of 2009, where she hopes to begin work toward her licensure.

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Dear Linda,

LINDA MAY GROBMAN – THE OPRAH WINFREY OF SOCIAL WORK

I thought that I would follow up my recent e-mails to you with a letter. I hope it will reach you in time for you to be able to publish it. I have just returned home from school here in London, UK.

I am attending Middlesex University here in London, where I am completing the first year of a three-year Bachelor’s Degree in Sociology and Psychology – Joint Honours. I combine my degree with working part-time as a community outreach support worker/counsellor, working with a diverse range of clients and service users with a range of issues and support needs (e.g., mental health, substance & alcohol abuse/addictions, HIV/aids, ex-offenders, physical health issues, young people, learning disabilities).

I work with different social/supported housing providers and agencies here in London, working mainly in the urban communities in London. I find the job challenging and take great satisfaction in helping people who are deemed vulnerable, who are generally not engaging with society as a whole.

I wanted to say that you are both a great role model and inspiration to me and certainly to many other social work professionals and social work students. You are a pioneer, challenging the conventional stereotypes that exist about social work. Where you lead, many follow. As I said, I think that you are “the Oprah Winfrey of Social Work,” and for me, The New Social Worker magazine provides me with the information, through informative articles and inspiration to be the best that I can be. I hope to attain my goals after I graduate in 2011.

I hope to move to the U.S. to work as a social worker/counsellor specialising in working with clients that have mental health, substance, & alcohol abuse issues/addictions.

Please continue to challenge perceptions and stereotypes in regards to the social work profession.

I look forward to the next edition of the social worker magazine.

Yours sincerely,

Mark Anthony Brown
Student, London, England, UK

Editor’s Response: Thank you, Mark! I am quite honored that you have dubbed me the “Oprah Winfrey of Social Work” and paraphrased my favorite singer/songwriter, Carole King, both in the same letter. I do what I do as a labor of love, and I hope that it does make a difference in people’s lives as social workers, as well as in educating the public about what we do and dispelling some of the myths and stereotypes about our profession.
A Different Kind of Teacher
by Kristen (Kryss) Shane

I never once said that I wanted to be a social worker when I grew up. From the first memories I have, I always believed that I was meant for something great—educating others. I loved to read and write as a child, especially poetry, and sometimes wrote stories and poems about my fated future teaching. All through elementary school, I believed I was going to teach, and by middle school, I was keeping a list of my teachers’ assignments and behaviors so that I would be prepared when I grew up, without making the same mistakes my teachers had made. In middle school, I decided that when I was a teacher, there would be no homework and no detention. By high school, I’d decided that any student who didn’t turn in their homework should get a detention. Of course, I found myself the person who many turned to for help with assignments, family issues, or dating drama, which I gladly advised on while explaining how to count protons or where to find out how many representatives are assigned to each state.

I graduated high school with a plan to attend college and then return to take over the English department of my alma mater. I think I was about two quarters into the program and three weeks into a quarter’s class on British Literature when I found myself dozing off. I realized that if I couldn’t sit through it for four hours each week, I surely couldn’t teach it for forty years!

Having spent more than a decade in charge of a volunteer-run soup kitchen, I decided it made sense to incorporate the two ideas and teach cooking classes, which meant earning a teaching certification in Family and Consumer Sciences (formerly known as “home economics,” although it now included courses in career exploration and job skills). My first experience was student teaching in an urban high school, which had a 42% attendance rate and just over a 50% graduation rate. My instructions were to observe, but I found myself placed under the eye of a cooperating teacher who was nearing retirement and who was quite eager for me to take over, as soon as I felt comfortable, which took less than one month.

Not only did I excel during classes, but soon, my classroom was the place many students came to discuss problems during their lunch periods. As weeks passed, I became frustrated with all of the lesson planning and counting the minutes until lunch time came and my classroom again filled with students eager to talk about themselves and their lives. I learned about students who dreamt of being CEOs but assumed they’d settle for being the secretary for one, those who only came to class twice each week because they had to stay home to care for younger siblings, and those whose own children were the same age as classmates’ siblings. They told me of their uneducated parents who didn’t believe in the worth of a diploma and of their fears for safety when walking home from work in the middle of the night. Although many of their stories were of situations that broke my heart, I enjoyed learning about the students and gaining insight into their lives. At the end of my student teaching time, I received a glowing review from my cooperating teacher, and several students cried when they knew my time with them was over.

Although successful, I found myself hating the idea of writing lesson plans and teaching material required by the Board of Education when I knew there were life skills that students were more likely to use in their daily lives. What I really wanted was to be the kind of teacher who sat and listened to students and helped them figure out what to do to get from where they were to the goals and dreams they had. I was months from earning my diploma before I knew that they called these teachers “social workers.”

Fast forward a few years, and I found myself beginning graduate school, having discovered that my true passion was to focus on the listening to students rather than planning their lessons as I had as an undergraduate. I’d gotten accepted into The Ohio State University’s MSW Program (in part due to the letter of recommendation from that cooperating teacher), and I believed I had a leg up on some of my classmates, as many came from backgrounds without any field experience at all. I was even placed in a setting with teenagers, further convincing me that I would again be the star pupil...except I wasn’t.

When I was learning to become a teacher, I discovered that I was already prepared by many of the qualities I’d learned by being the eldest child, by enjoying public speaking, and by being quick on my feet. I already knew how to explain things in multiple ways, to command the attention of a group when I spoke, and how to avoid ever appearing as if I didn’t know the answer. As a teacher (especially one who often blended in with students, as a twenty-something just barely over five feet tall), students were never to see me as weak, never to think I didn’t know, never to get the chance to question my abilities. As a teacher, I was taught that letting students see you sweat gave them an opening to give them reason not to listen or comply, to never let them think you too weak to dispense advice, to point people in the right direction, to get them to listen. It
took several clients and some feedback from more experienced social workers before I even considered that this might not be the best approach, let alone one that followed the overall beliefs of social work practice. Rather than being the student ahead of her class, I found myself behind the others, having to unlearn the ways of a teacher and then properly learn the ways of an effective social worker. I found myself sometimes biting my tongue not to give my own opinion, not to assume I knew the answers. I struggled with this a great deal, unsure of my abilities and wondering what other certainties should be questioned.

When I first began the program, I was sure I’d breeze through, with much to offer my classmates. Now, after many mistakes and a great deal of feedback, I am learning how much my classmates, instructors, and supervisors have to offer me. I spend a great deal of time reading and listening, working to remind myself that the strength comes in listening to clients without worrying about not knowing the answer and that the best students are those who will ask for assistance rather than being too stubborn or prideful to admit to not knowing. I’ve even become a bit more used to the idea of not being in the teaching field as I’d expected. It still amazes me that I’ve formed some of the best peer relationships in my social work classes with students who have backgrounds in equine science, criminal justice, and psychology. Rather than feeling surprised at ending up in this field, they look at their unique educational backgrounds as pieces to what will make them better social workers. It has taught me not to dwell on not becoming what I’d expected, but rather to see the original plan as another way in which my social worker repertoire is expanded, to consider that maybe what I’d originally thought was only a small part of a bigger life plan rather than veering off the path all together.

Previously, I mentioned that I enjoyed poetry as a small child. By about age six, I’d chosen one favorite poem from a collection of works by many. Each night before bed, I’d read it aloud and it wasn’t long before I could recite it from memory. It was *The Junkbox* by Edgar Guest, the ending of which is this:

A human junk box is this earth  
And into it we’re tossed at birth,  
To wait the day we’ll be of worth.

Though bent and twisted, weak of will,  
And full of flaws and lacking skill,  
Some service each can render still.

Perhaps being a social worker was part of the plan all along.

Kristen (Kryss) Shane is an MSW II student at The Ohio State University in Columbus, OH. She earned her bachelor of science in human ecology at The Ohio State University, having majored in human development and family science, specializing in family studies. She also holds certifications to teach 7th through 12th grade family and consumer sciences. She is on the staff at SocialWorkChat.org, where she moderates the student bulletin board and guest hosts chats.
An MSW Student’s Life

by T. J. Rutherford

As I began my second year of graduate school, I knew it was going to be more challenging. With field practicum, four classes instead of the usual two, and 30 hours at the city magazine where I am an editor, I was not expecting it to be easy. What happened unexpectedly for me and my cohort was that our part-time status became full-time status without our knowledge or consent. And by now we were deep into graduate school, so in many ways we felt a bit duped and trapped. To remain on track for graduation, we had to increase our classes. We did not have a choice in the matter.

I feared losing my job. In the current economy, I was lucky that cutting my hours at work from 40 to 30 was helpful to the bottom line. As I move forward, I will most likely not get my hours back, and that’s okay with me because of the school workload, but I hadn’t really planned on this happening when I still had a year and a half left in grad school.

Since there is nothing I can do about it except advocate for future part-time students, I moved through this and kept my eyes on the prize. The department recently made the announcement that this would change for the incoming part-time students from this point forward. Was I disappointed that it didn’t happen for me? Of course. Should I dwell on something I cannot change? Of course not!

I started my field practicum in January 2009. It was not at the agency I had requested. I thought the perfect place for me would be at a children’s advocacy center. I knew about the place and the director, and I was certain it would be a great generalist field experience for me.

My field liaison thought differently. She sent me to a TANF (Temporary Assistance for Needy Families) women’s residential program. Because my field instructor works at two sites, I am also able to shadow her at a counseling center where she works with children.

What’s the saying? “We plan, God laughs.” And the song lyrics, “I thank God for unanswered prayers.” Both of these apply to the outcome of my field practicum assignment.

Perhaps my biggest lesson this semester is about priorities. I am unable to participate in many of the activities I did prior to this schedule. I can’t even really take a lunch break. And dinner is pretty much on the fly, too, these days. Haircuts, manicures, pedicures? Movies, long conversations with friends? Forget it! I rarely shop for anything that is not groceries, and even this is handled more by my husband lately.

Speaking of my husband, he has become much more self-sufficient. While he has always been a fairly equal partner in our marriage, he now does all the cooking, his own laundry, and he takes care of the dog, too. I am very grateful for his support. We try to have a nightly check-in where we lie on the bed and discuss our days and the days ahead. It helps.

I continue to be comfortable at my HBCU (Historically Black College and University). I fit in, as far as I’m concerned, and I don’t have any issues with being one of very few White students. I continue to learn a lot about my culture and that of African Americans. My cohort and I have blended into the full-time classes, and we still stay in touch with one another. We have each also made new friends, and I have connected with some new people who I really enjoy and respect in the program.

My field practicum is an important part of my education. On Mondays and Thursdays, I intern at a community counseling center. On Wednesdays and Fridays, I work at a women’s residential program. If I could only choose one facility to work in, I would pick the counseling center. I observe one-on-one sessions that my field instructor facilitates. She treats children, and I never thought I would love it so much. While observing, I imagine what I will incorporate of her style and what I will add of mine.

Over the years, I have participated in many healing workshops and treatment experiences, both for personal and professional reasons. I realized the other day, while listening to a young girl recount her horrific rape, that I have tools that I can pull out to use in sessions like this one. Because I am an observer now, I only discuss them with my instructor. After spring break, I will have an opportunity to counsel on my own, first with my field instructor present and then on my own. I am excited about this.

Our class went to DFCS for a visit, and several professionals from different areas of the agency shared their experiences with us. I was fascinated by the adoption department’s presentation. The person who heads the department was very passionate about their work, and the idea of helping a child with a mutually agreed upon permanent placement seemed very rewarding. As with any presentation to a group of students, I am certain that we didn’t hear the inside story. However, I felt as if the workers were honest with the information about investigation and diversion (or family support) that they gave us. I was impressed with the new facility and with the professionalism of the staff. It was helpful for me to be able to ask lots of questions, since I was awarded the Title IV-E grant and will be working for DFCS when I graduate. I believe it will be a great training ground for me, primarily because I have not worked in the field, other than in substance abuse-related positions.

As the semester rolls on, I am proud of myself for the hard work I am doing. I am amazed at times at all that I am accomplishing each day. I have also come to the realization that I do not want to have another semester like this one. After summer school, I need to make some decisions about my job. School is my priority now. Work is important, but not as important as school. I am struggling at times to keep my head above water. I feel stressed, and I am unable to take time out for me. I do not want to be a hypocrite to my clients when I tell them to put self first. I need to put myself first or I will not be able to do this.

I have planned a meeting with my advisor. I know she will give me some sound advice regarding how to proceed this semester and in the future. With all I am learning and doing these days, I welcome advice from those who have gone before me.

T. J. Rutherford is in her second year of graduate school where she is earning a master’s in social work. She is Assistant Editor and Web Manager for a city magazine. T. J. shares her life with her husband and a nine-year-old rescue dog. Read more about her day-to-day grad school experiences at THE NEW SOCIAL WORKER’s blog at http://blog.socialworker.com.
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• What to include in the personal essay or biographical statement
• Which schools are accredited by the Council on Social Work Education and the Canadian Association of Schools of Social Work, and why this is important
• Where to find out about social work licensing in each state or province.

Jesús Reyes, AM, ACSW, LCSW, is Acting Chief Probation Officer of the Circuit Court of Cook County, IL Adult Probation Department, as well as Director of the Circuit Court’s Social Service Department. Formerly Assistant Dean for Enrollment and Placement at the University of Chicago School of Social Service Administration, he has reviewed many graduate school applications and has advised numerous applicants.


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Art therapy with her students differs from that in her private practice. “In the schools, it can be used for social, emotional, and even physical purposes—like eye-hand coordination,” Pizanis says. “It can be used if a student needs to refocus, or it can build self-esteem. Sometimes it can be a social building experience, such as in mural making.”

In her private practice, Pizanis uses art therapy to work with unconscious material, to help patients uncover blocks, gain new perspective on an old problem, or recognize something not realized during talk therapy.

Erin Brazil, a registered and board-certified art therapist and licensed clinical social worker, currently works as an art therapist in a therapeutic day school for students who have been unsuccessful in a traditional school setting. “In addition, the school is unique in offering expressive outlets, such as music, drama, recreation, pet therapy, and the arts,” says Brazil. “I provide individual counseling and conduct art therapy groups for the students.”

Brazil’s interest in art therapy grew out of a personal crisis. Diagnosed with cancer at 20, she used to take art materials to the clinic where she was receiving chemotherapy to “escape from reality.” Brazil found the act of putting colored pencils or pastels to paper “instantaneously therapeutic.”

“One day, a medical social worker at the clinic asked if I knew about art therapy,” Brazil says. “The conversation stayed with me. I had taken a leave of absence from college for my treatment, and when I returned, I decided to get my degree in psychology. I completed an undergraduate psychology internship in a pediatric hematology/oncology unit during my senior year. It was then I realized how valuable the arts can be in helping these children find comfort during this very difficult time in their lives.”

Certified as a clinical social worker, art therapist, psychoanalyst, and couples therapist, Bonnie Hirschhorn obtained a B.A. in fine arts. As she got more
involved with painting earlier in life, she realized that “a lot of feelings came out that were not verbally accessible.”

“Even as an undergraduate, I became interested in the arts as a healing process,” she says. “I volunteered in the psychiatric department of a hospital, and I always knew I wanted to be more than a fine artist. I thought art therapy would be a good thing to explore.”

One of the effective uses of art therapy is with people who experienced early trauma they don’t recollect. “When clients draw, and they’re asked to remember, they start to,” Hirschhorn states. “Art therapy puts them into the mode where they put aside a verbal, logical side to gain memories and insights.”

In all cases, art therapy can connect patients with “raw affect, not bound by logic.” “Some people think art therapy is only for children, but that’s not the case,” the therapist says. “It can be used at different times in treatment and adapted with any particular population, including with ‘normal populations’ in private practice, by integrating art therapy with verbal therapy to help them gain awareness and insight.”

In the late 1980s, prior to training as a clinical social worker, Cathy Lander-Goldberg was a professional photographer who volunteered to teach photography to adolescent females in a residential treatment center.

“The girls were drawn to taking self-portraits in mirrors and taking pictures of each other as well as their belongings,” she recalls. “Then, when I brought them into the darkroom, they began to open up and talk about their worlds. I sensed this work was healthy for them and began looking for articles on art therapy with photography.”

In group work, Lander-Goldberg uses a combination of art therapy, writing therapy, photo therapy, and occasionally music therapy. “Like many of the expressive therapies, photo therapy is a way for clients to access thoughts and feelings that may not come to the surface in talk therapy,” she says.

When working with adolescents who have family problems, low self-esteem, or social anxiety, Lander-Goldberg sometimes assigns self-portraits to help them explore their identities and relationships with others. She has been involved in two special photo therapy projects. “Photo Exploration” is a series of workshops Lander-Goldberg facilitates for adolescent and adult females to increase their self-awareness through journal writing and photography. “Resilient Souls: Young Women’s Portraits and Words” is a traveling exhibition, composed of portraits of young women who have overcome a variety of obstacles and essays they wrote about how they achieved that.

Nirit Lavy Kucik discovered photo therapy serendipitously. The Israeli clinical social worker was doing therapy with a couple who argued endlessly about their families of origin. One day, feeling helpless, Lavy Kucik asked them to bring in photos of their family.

“The outcome was astonishing for me and for them,” she says. “Both of them started to share feelings and childhood memories, and it was the first time they had ever listened to each other in our sessions. As a result, I started to use this technique more and more over the years, in bereavement work and in couples therapy.”

Lavy Kucik realized photographs played a special role in her own family. Her mother had no photographs, because her parents had died in Auschwitz and she herself was hidden with a family in Belgium. Taking photos was not allowed. It was considered dangerous, because it was evidence of her real identity. “My mother’s attitude toward taking photographs of us and my father was deeply affected by her losses,” says the social worker. “So for me, photographs and taking them was always something meaningful.”

After publishing an article in 1991—the first in Hebrew—about her photo therapy work, Lavy Kucik realized there were other practitioners. The opening of a school in Jerusalem offering training in the field, where she now teaches, helped boost growth.

Speaking to the difference between photo therapy and art therapy, Lavy Kucik says, “I understand that usually in art therapy you create an art work, even when you use collages or ready-made materials. But in photo therapy, you can bring in photographs taken by you or other people. What you create is the meaning the photos have for you.”

Lynne Bernay-Roman works with the “Finding Focus Through Photography” (copyrighted) Program, implemented with at-risk kids and also as a mainstream module in critical-thinking classes.

A licensed social worker for 12 years, seeing adults, adolescents, couples, and families with a myriad of diagnoses, Bernay-Roman comments, “I was looking for a more dynamic way than the traditional clinical setting to work with kids—something that would be engaging, experiential, and fun, a more creative way to promote positive change, coping, and growth. To date, I’ve only implemented the program in a classroom setting, but it could be used with an individual just as effectively.”

Originally an art major with a self-taught interest in photography, Bernay-Roman finds that photo therapy taps into “each kid’s innate uniqueness, to recognize that in others, to learn to express and implement that in new ways and in every day.” Photography can also create excitement for learning and empowerment that can enhance a school experience.

She believes photography is especially suited for creative learning and as a therapeutic tool. “Photo therapy differs from other art therapies such as fine art, music, or dance, because it is so simple to do and nonintimidating, and no previous skills are needed,” the social worker says. “Everyone can immediately look and click and get a product that can be enjoyed. Taking a photo is easy, limited only by our perspectives and our focus.”

Lee Carruthers is a Yukon, Canada, photographer who holds a BSW degree and certificates in criminology and conflict resolution. After conducting a photo therapy project a few years ago with aboriginal populations, she saw the benefits and risks more clearly.

“Photography must be done carefully with client populations,” he says. “It is a powerful medium and—especially of late with the obsession society has with celebrity, paparazzi, pornography, and terrorism—its purpose and benefits have been sadly distorted. Many people view it with suspicion, and there are ethical concerns regarding its use with clients.”

Still, photography can bring awareness of self and the environment, providing an opportunity to gain insight and opening doors to healing. “The bottom line,” Carruthers concludes, “is that photography is powerful, so it must be used with thoughtful care. Photo therapy provides an opportunity to demonstrate the benefits of the art.”

So does art therapy with regard to visual art.

Barbara Trainin Blank is a freelance writer in Harrisburg, PA.
The Need to Inject the Social in Addressing Mechanistic Clinical Misconceptions Found in Long-Term Care Environments

by Brian Garavaglia, Ph.D.

To be old is to be demented, and this statement especially sounds in clarion fashion when dealing with older adults in long-term care settings. Yet, although many take this statement at face value, in reality one must pause with concern about the widespread acceptance of such stereotypes. Regardless of how many professionals who deal with the elderly in all phases of health care, including long-term care, consider themselves enlightened and immune toward stereotypic misconceptions, clinical thinking about old age is still filled with misconceptions that often lead to faulty diagnoses. Since the predominant features of long-term care continue to be strongly entrenched in dealing with pathology, often at the exclusion of the social individual, those who are responsible for addressing the social needs of older adults, those involved in “social” work and “social” services need to become vanguards toward making sure misconceptions do not come to minimize the quality of existence of the elderly in long-term care.

Human beings are social individuals, yet as we age or as people enter institutional settings, they often are treated quite mechanically, similar to machines that wear down. In fact, at one time this analogy on the pathophysiological level, called the “wear and tear” theory of aging, was given strong credence toward explaining older adults (Christiansen & Grzybowski, 1999). However, although more recent scientific discoveries have failed to lend credence to this theory, it still comes to hold intuitive appeal toward dealing with aging and issues found in older adults.

Furthermore, long-term care environments such as nursing facilities continue to remain quite institutional. Even with the Edenization movement led by William Thomas, most nursing care facilities continue to be institutional environments that do little to nurture the important social qualities that create the social individual and separate the social person from being a mere biological entity (Thomas, 1996). Nursing care facilities continue to be “total institutions,” which subordinate the older adult’s social existence to the clinical mechanics of palpation and auscultation and allow very little room for older adults to grow and express their unique human qualities as individuals (Goffman, 1961). Moreover, often the paternalistic attitudes found by staff in these institutions further enhance the disempowering self-esteem that older adults come to feel about themselves.

In environments that lack optimal levels of social stimulation, desocialization can become a major issue that leads to decline.

Dementia: Biology versus Social Induction

In the first paragraph, I mentioned that one of the egregious misconceptions about aging is that dementia is inevitable. Although many people, including medical and long-term care professionals, embrace this simplistic and stereotypic thought pattern, it leads to problems that are compounded beyond the mere stereotype (Robb, Chen, & Haley, 2002; Williams, 2000). Most individuals who are older adults do not encounter dementia, and only approximately 25 percent of memory issues can be attributed to aging itself (Garavaglia, 2007). Furthermore, even though individuals in long-term care environments have a greater probability of having an organic brain pathology such as various forms of dementia, patients who are part of long-term care environments are often “assumed” to have various levels of cognitive impairment (Hazen, 1996). Therefore, a norm of cognitive impairment comes to dominate the staff’s perception of how they come to view older adults. In reality, this view is just an extension of the norms in general society that have typically assumed that older adults are slower in their thinking abilities and are likely in the throes of senility. Most of this is based on a poor understanding of the aging process and an inability to distinguish between what I term the senescence versus senility error, with the former indicating normal aging versus pathology indicated by the latter.

If we put together the probability of dementia increasing with age, and add to that most people in nursing care facilities usually have considerable levels of chronic medical conditions, compounded further with stereotypes that assume inevitable and pathological cognitive decline, we now have a labeled population situated in an institutional environment with its own labels that envision any kind of forgetting as a sign of brain pathology. However, although many manifestations of dementia are indeed truly biological pathologies, some are not, and this is where the labels and stereotypes can lead to self-fulfilling prophecies that may influence faulty diagnoses (Becker, 1963; Lemert, 1951; Goffman, 1963; Palmore, 1999; Garavaglia, 2004).

It must be remembered that boredom, lack of sensory and mental stimulation, depression, metabolic instabilities, the increasing number of medications used among this group, and a host of other conditions can lead to memory disturbances and other cognitive symptoms. When these symptoms are found in younger populations, they often lead medical staff to assume some underlying pathology causing the cognitive changes. However, with older adults, it is often assumed that this senile or disease-based symptom is part of normal aging or senescence, or again the senile versus senescence error. When an elderly person experiences these cognitive changes in long-term care facilities, the likelihood of stereotypes and the self-fulfilling prophecy that they carry frequently lead to labels of dementia with very little further investigation into whether it is truly an organic cognitive pathology.

Humans as primates have social skills that are more complex and advanced, ultimately separating humans from all other primates. Throughout life, our socialization, or the learning to be...
social beings, is continuously reinforced by our social interaction and stimulation with our surrounding environment. However, individuals in long-term care environments, or other settings in which individuals experience profound isolation, eventually come to be desocialized, where they lose social skills and not only regress socially, but physically as well. In environments that lack optimal levels of social stimulation, desocialization can become a major issue that leads to decline. In addition, often this is noticed very quickly when many individuals enter long-term care facilities and end up declining both cognitively and physically quite precipitously, leading many family members and staff to think that they brought mom or dad in just in time.

In addition, the social psychological concept of resocialization has to also be mentioned. This happens when individuals have to adapt to an extremely different situation in which normal social behaviors fail to work. Individuals have to adapt autoplastically, through their internally self-based mechanism, to fit into the extreme environment. Nursing care facilities are often total institutions that govern all aspects of a person’s life. This institutional totalization is a marked stressor, both physiologically and mentally, which for even a normal older adult can lead to confusion and, at times, disorientation. An abrupt change to a nursing care environment, coupled with the mechanistic clinical treatment that they are often provided, fails to nurture their social existence. Again, when abrupt changes in mentation occur with the concomitant placement in an environment that is filled with the expectations for cognitive decline, there is often an ineluctable push for diagnoses to fit the accustomed stereotypes that fit with this age group found in this type of institution.

The Need For a Social Advocate

Where does this lead us to this point in this analysis? For one, it is evident that older adults still face a considerable level of discrimination and subsequent stereotypes and labels or what Butler (1969) came to refer to as “ageism” that creates a false understanding of this population. Furthermore, it has been explained how these stereotypes are accentuated in long-term care facilities, which further can lead to faulty clinical diagnoses and cognitive profiles. Finally, when individuals are placed in a mechanistically clinical environment that fails to nurture their social needs, regression of their holistic existence, including their cognitive abilities, can decline quite precipitously.

Therefore, it is at this point evident that there need to be individuals in a long-term care environment who can understand the implications for nurturing the social and not just the physical being. It is here that the “social” worker (I use this term loosely, meaning that it can be not just a degree social worker, but all clinicians who focus their needs on the social aspects of the individual) needs to be more than a clinician involved in taking psychosocial histories. Those involved in the social services and social work area of long-term care have to understand the problems that are faced by older adults in these types of environments. They need to play a key role in making sure that older adults are not pigeonholed into neat and convenient diagnostic classifications without assisting and advocating for a greater holistic understanding and investigation into the older adult’s condition. It is at this point that social services personnel responsible for social intervention, which does not necessarily have to be relegated to just the social worker, becomes the priest of the social soul of the older adult. With so much emphasis on the mechanistically and often depersonalizing elements of clinical medicine, there have to be individuals who remain focused on nurturing, maintaining, and enhancing the social being.

However, there are institutional impediments that they need to be aware of, and that often lead to formidable challenges. Regardless of the new social movements that have been found in nursing care facilities, these facilities continue to be dominated by the physical concerns of the individuals they serve. Therefore, even though there have been recent movements toward introducing greater social factors in these environments, it is far from what Thomas Kuhn would equate with a paradigm shift (Kuhn, 1963). Social factors within long-term care have continued to be subordinated to the physical care that is rendered.

Social service professionals have to continue to remain sensitized to their insensitivity of focusing on social factors. Psychologizing and becoming part of the mainstream mechanistic medical environment in which they work will often lead them to focus on pathology and come to view the social needs of the individual as secondary to their physical ailments. However, it is here where social service professionals working in long-term care situations have to become the vanguard for influencing the paradigmatic shift that is needed in long-term care. The social services worker, being a “social” professional, has to imbue the culture with the need to view individuals as more than just physical entities with pathologies that need to be treated and fixed, but social beings who fail to exist as “human” or “humane” beings without their nurtured social dispositions. In addition to the older adults’ physical ailments, their emotions, thoughts, anticipations, beliefs, values, attitudes, and general understanding of self, all of which fail to be fixed by IV infusions or other pharmacological remedies, need to be addressed for residents in long-term care.

It must also be stated that because medical facilities, including long-term care facilities, emphasize the biological over the social, it subsumes our most important features for health, human existence, and our sense of self to our underlying biological building blocks. However, the essence of our human existence and the development of a healthy sense of self along with healthy cognitive ability is tied intimately and inextricably to nurturing our social relationship and our social self (Erber, 2005; Pruchno & Rosenbaum, 2003; Rowe & Kahn, 1997). This is where the long-term care social services professional needs to exert skill, for biological and social health are dialectical, with both needing to exist in proper proportion to produce a more humane environment in long-term care settings.

Concluding Comments

The intent of this article was to demonstrate the important impact that the social services personnel can have in long-term care settings. However, more than a delegation of services given to a particular professional, the underlying assumption is for movement toward a greater social paradigm for nursing home care. This means that this social paradigm should encompass all long-term care professionals, including physicians.
and nurses. As a result of their unique training and understanding of the social factors of human existence, social service professionals who have expertise in this area need to become important leaders for humanizing the long-term care setting and making sure that others obtain the necessary training to sensitize others toward this very important vantage point. Therefore now is the time for the social paradigm with its “social practitioners” in the long-term care settings to become increasingly involved in the medical environment as social medicine specialists.

References


Brian Garavaglia, Ph.D., is a gerontologist in Michigan with interests in dementia, delirium, and depression, especially within long-term care. He has worked as a long-term care administrator and ethicist, and teaches at colleges in the Detroit metropolitan area.
We also list upcoming events, such as the online chats we are now co-sponsoring with the National Association of Social Workers (NASW) at http://www.socialworkchat.org (see page 21 for more information on this). And we send updates to our fans when there is something interesting happening!

Are you on Facebook? Do you love The New Social Worker? Show us how much you care! Be one of our Facebook fans and help us reach 5,000 (and beyond)!

In addition, we’d like to know how you are using Facebook. Have you found it a useful tool for networking with social work colleagues, searching for a job, or fundraising for your agency? Write to lindagrobman@socialworker.com and let us know.

Bunnell—continued from page 3 have branched out to other assignments. She was Miss Flora MacDonald Academy at her high school and a contestant in both the Miss Teen North Carolina USA and Miss North Carolina USA competitions. “But my heart was truly in social work,” she says. “Still, modeling was a lot of fun. I met a lot of nice girls, and some are still my friends.”

One campus project she’s particularly proud of is Stand Up/Stand Out, a leadership development event involving young women and the workplace. But what gave her even greater satisfaction was participating, along with several students nationwide, in a Webcast with President-Elect Barack Obama. “I’m a huge fan, and it was amazing,” she says. “Mr. Obama accessed the Internet a lot, more than other candidates have done.”

Bunnell had worked for the Obama campaign—making door-to-door visits and phone calls, securing speakers, arranging for shuttle buses to take people to the polls, being a poll watcher, and passing out flyers. “I have no idea how many people I spoke to,” she says.

The two precincts Bunnell worked in were McCain strongholds. “After the election, we learned about the difference she had made,” says Marson. “Obama won one of them by five votes. Ashley learned that she can make a difference, and I suspect she will be politically active the rest of her life.”

And for the rest of her life, Bunnell will express appreciation for the strong women who helped raise her. “My grandmother is 87, and she’s still up on the roof cleaning gutters. Without them, I don’t know where I’d be,” she says.

Barbara Trainin Blank is a freelance writer in Harrisburg, PA.
Coming Home as a Social Worker: A Recent Graduate’s Experience in Professionally Helping Within her Community

by Natasha K. Nalls, MSW

I entered an MSW program immediately following the completion of my Bachelor of Arts degree. I did not personally know any social workers, yet I had a vague, optimistic perception of why I was entering the social work profession. Although I was unsure of my long-term career aspirations, I was sure of one thing: I wanted to help people. More specifically, as a young African American woman, I wanted to use myself both personally and professionally to have a positive impact on the African American community. I wanted to be an agent of change.

Throughout my academic social work training, I closely identified with the profession’s core ideals, principles, and values. The ecosystems model especially stood out to me, as I believed that individuals could not be assessed in a vacuum, but rather as a direct product of their social environments. In terms of program planning and administration, I found myself captivated by my courses on program evaluation and grant writing. I knew that I was being introduced to the theoretical frameworks and concrete practicum experiences needed to fast track my career aspirations and really help people. Combined, my field experience and coursework gave me invaluable insight as to what I could expect once I entered the field as a professional social worker. I graduated on May 16, 2007, in New York, NY. By June 1, I had moved back home to Miami, FL, and was working on a per diem basis for a community-based mental health agency that served highly at-risk children. Shortly thereafter, I acquired a full-time position working with juvenile delinquents who were facing adult sanctions for felony law violations.

As I reflect on my past year as a recent post graduate and new practitioner, my immediate concerns reflect age-old debates that our profession and practitioners have confronted. These include the micro work versus macro change debate, case work and management versus clinical intervention, social workers’ competency to be both line workers and agency leaders, and lastly, maintaining social work principles and values while working within host agencies and non-social service systems.

While these issues remain at the backdrop of my professional experiences, what continues to amaze me most is the experience of working within my own community. I am working at home. The background here is the fact that I had left Miami to attend college in Southern California. Following college, I moved to New York to obtain my MSW. Although I had spent most of my summers in Miami and visited home several times a year, returning home as both a professional and young adult was something totally different. Being a social worker afforded me a particular lens through which to understand and examine my community’s problems. I believed this experience was exacerbated by the fact that I worked with the city’s most vulnerable population—children who had come from some of the most difficult family circumstances imaginable. Moreover, Miami is a very special space in which to practice social work.

Like any other major urban metropolis, Miami is a space wrought with its share of social problems, including substantial crime and poverty rates, high HIV/AIDS incidence, and low high school graduation rates. Although Miami often conjures up images of palm trees and South Beach, the city is largely racially and culturally segregated, as well as economically and socially stratified. Miami’s economic and social diversity aggravates its stratification, as haves and have-nots live within close proximity of each other, but in very separate worlds. In this way, the poorest of the city are highly exposed to the glitz, but have zero access.

Given this context for my work, I began to think about the idea of “community social work practice” and what the term meant. I began to reflect upon my co-workers’ perspectives on clients and consider why I sometimes felt differently. What I also noticed was that most of my professional colleagues, and a majority of my co-workers, were transplants, or non-native Miamians who resided in various suburbs of the city. I concluded that this at least somewhat accounted for their experiences of clients and largely accounted for their “othering.” Often, for example, even their verbal accounting of their work included language such as “these people” or an emphasized “they.” I, on the other hand, often found myself saying “my kids.”

Traditionally, community social work practice refers to an area of social work that focuses on macro social change via policy, legislative advocacy, and community planning, and organizing (Hardcastle, Powers, & Wenocur, 2004). For me, however, community social work practice has come to mean this: the practice of working within a community, as a community member, for the betterment of the community in either a micro or macro capacity. The caveat here is that there is really
little to no space between the professional helper and the client as we literally work, live, share community resources, and possibly socialize together to various extents.

For example, I ran into a client’s mom at a local shopping plaza. On another occasion, during the family history portion of a psychosocial interview, I realized that I knew my client’s family. The ramification here is that my professional work becomes a personal investment. In addition, incidences of vicarious traumatization are perhaps even more exacerbated, as there is a feeling of connectedness to the client’s history and a concern about intervention outcomes. For example, when working with a 15-year-old juvenile offender who has committed an armed robbery, case planning is about more than decreasing his likelihood of recidivism. It is about giving the child the resources that would encourage productive citizenship, non-violence, and goal orientation. And perhaps most importantly, my work is about trying to ensure that this individual will not victimize anyone else in our community—especially me!

To expand upon this particular point, for example, I’ve thought about the term “criminal justice system” and how the system is not designed to rehabilitate, promote prosociality, or effectively deter recidivism. It seems to me that a prosocial and equitable criminal/legal system might be titled something such as “public safety.” This title and the orientation that it connotes would reflect policy, procedure, and planning that aims to protect all community members and promote safety.

I reflectively conclude the following: there is no “Natasha” in community, and at the end of the day, working within my community as a social worker has proved an invaluable experience, as I believe my work will reap benefits for us all. My job, then, is more than helping clients. It is helping my brother, my sister, my grandmother, and myself.

References


Natasha K. Nalls, MSW, received her Master of Science in Social Work from Columbia University in May 2007. She holds a bachelor’s degree in Spanish and Leadership Studies from Claremont McKenna College. At the time this article was written, Ms. Nalls worked at the Law Offices of the Public Defender in Miami, Florida. She currently works for the Alliance for Aging, Inc. in Miami, FL. She enjoys travel and academic scholarship. Her e-mail address is nn2144@caa.columbia.edu.

**The New Social Worker teams up with National Association of Social Workers to offer online chats**

Connect with other social workers online! *THE NEW SOCIAL WORKER* magazine and the National Association of Social Workers (NASW) have teamed up with the Social Work Forum to bring you SocialWorkChat.org, an online community of social workers offering twice-weekly online real-time chats on a variety of topics. The chats are being held on Sunday and Tuesday nights at 9 p.m. Eastern Time.

The site offers:

- An active online community of social workers
- Twice weekly moderated chats on assorted social work topics
- Categorized, monitored bulletin boards
- Colleagues with whom to share ideas and feedback
- A unique and accessible way of getting ongoing professional education

Chats are on a wide variety of social work topics, and from time to time, we will include chats about some articles published in *The New Social Worker*. Chats will last about an hour. Check regularly for chat topics or sign up for e-mail reminders.

Registration is free! Go to [http://www.socialworkchat.org](http://www.socialworkchat.org) to register and participate in the chats and other features of the site.
BPD Conference Offers Opportunities for Students

The annual conference of the Association of Baccalaureate Social Work Program Directors (BPD) offers many opportunities for student participation. The 2009 conference was held in Phoenix, AZ March 18-22. The program listed 74 student volunteers from 22 schools.

Several student poster sessions were presented in the conference exhibit hall. Other student-oriented sessions included “Applying for Graduate School: Navigating the Graduate School Admissions Process Can Be a Challenging Risk,” by Mary Mazzola of the University of Pennsylvania, and “Phi Alpha and You: Tips from the Phi Alpha National Office on How to Make Your Chapter Even Better,” by Paul Baggett and Tammy Hamilton of East Tennessee State University.

Many students from a variety of schools stopped by THE NEW SOCIAL WORKER’s booth in the exhibit hall and talked to editor/publisher Linda Grobman about article ideas, signed up for subscriptions, and looked at books.

Next year’s conference will be held in Atlanta, GA, March 17-21, 2010. Make plans now to attend!

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Linda Grobman, ACSW, LSW, Editor/Publisher
THE NEW SOCIAL WORKER
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or to lindagrobman@socialworker.com
The third volume in the *Days in the Lives of Social Workers* series focuses on social workers’ experiences with older adults. This collection of first-person narratives brings to life the variety of ways in which social workers work with and on behalf of this growing population. The stories describe micro, mezzo, and macro level gerontological social work.

Gerontological social work is a growing and exciting practice specialty! The stories told in this book will transform your thinking about what this type of work entails. You will gain a better understanding of the issues facing older adults and their social workers, and you may be inspired to pursue this career path.

Organizations, Web sites, additional readings, and a glossary of terms are included to assist readers in further exploring these areas of social work practice.

Stunning photographs by social worker/photographer Marianne Gontarz York are featured to expand readers’ visual images of real people as they grow older. These photos depict older adults in a positive and realistic manner, whether they are active, frail, receiving care, or giving care.

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**ABOUT THE EDITORS**

Linda May Grobman, MSW, ACSW, LSW, is the publisher, editor, and founder of *The New Social Worker* magazine. She edited the books *Days in the Lives of Social Workers* and *More Days in the Lives of Social Workers*, and co-authored *The Social Worker’s Internet Handbook*. Linda received her MSW from the University of Georgia and has practiced in mental health and medical settings. She is a former staff member of two state chapters of the National Association of Social Workers.

Dara Bergel Bourassa, PhD, MSW, LSW, is Assistant Professor and Director of the gerontology program at Shippensburg University Department of Social Work and Gerontology. She received her BSW and MSW from the University of Pittsburgh and her PhD from the University of Maryland, Baltimore, where she completed her dissertation entitled, “Compassion Fatigue as it Relates to Adult Protective Services Social Workers.” She became interested in working with older adults during her undergraduate social work field placement in a suburban hospital.

**APPENDICES**

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linda.grobman@paonline.com
When I was in graduate school, I remember a number of students who had plans to begin private practice right after graduation. I myself was intimidated by the idea, because I realized that private practice was a business venture, and graduate school did not prepare me for that aspect of social work practice. After gaining some years of experience under my belt and conducting much research about the business aspects of private practice, I felt confident to venture into this territory of social work, but not without first taking the following steps.

Establish Professional Supports

Social workers who move from agency life to private practice gain the benefits of autonomy and the freedom to set their own schedule and decide the types of clients they serve. You also need to keep up to date with developments and trends within your field. Establishing your practice as a business venture, and graduate school did not prepare me for that aspect of social work practice. After gaining some years of experience under my belt and conducting much research about the business aspects of private practice, I felt confident to venture into this territory of social work, but not without first taking the following steps.

Create a Practice Design

Before you begin recruiting potential clients, you must create a practice design. A practice design is a business plan for private practitioners. As a social worker venturing into private practice, you must ask yourself, “What type of clients do I want to work with?” Consider age, ethnicity, socio-economic background, and specific clinical/social issues when identifying the populations that you serve. You also need to determine where you want to practice. Consider immediate demographic populations, as well as convenience/accessibility to you and potential clients.

When creating a practice design, you must also consider how much time you have to commit to your practice, including office hours and time for administrative duties. This must be weighed against how much you expect to earn and how much you can afford to spend. Take into consideration the number of clients you want to treat, as well as current insurance rates, private pay rates, and sliding scale fees, in addition to expenses such as office space, office furniture/supplies, telephone, Internet, marketing material, malpractice insurance, liability insurance, and so forth.

Create a Professional Profile

In addition to a practice design, you should also create a professional profile. A professional profile is similar to a résumé or a curriculum vitae, but it is much more detailed, personal, and it is written in a narrative format. This profile includes information such as:

- Your name
- Current position
- Past education
- Work experience
- Professional affiliations
- Treatment approach
- Professional goals
- Areas of special interest
- What makes you unique

When creating a professional profile, it is best to include as much information as possible, as it is always easier to cut down on information when needed than it is to re-write or add more details to your profile. Once your profile is created, you will have your blueprint for marketing your private practice. The following are tools/tips for marketing your practice.

Brochures and Other Promotional Materials

Brochures are an attractive way to publicize what you do. Use your professional profile to create brochures about your practice. When designing your brochure, remember to be creative, as it is your means to attracting the attention of potential clients/referral sources. The brochure should not just be a repeat of your professional profile, but also a source of information for the user so that he or she is inclined to read it, keep it, and even pass it along. For example, if you are practicing as a behavioral therapist, then your brochure should provide information about behavioral therapy or how behavioral therapy can help people with their problems, in addition to your qualifications as a behavioral therapist. Also, it may be helpful to have more than one type of brochure targeted toward different audiences with specific information such as “Living with Bipolar Disorder.”

Business cards are another basic marketing tool and an essential for anyone in private practice. They are the least expensive to print and the easiest to distribute. However, many people don’t know how to make the best use of business cards. Most business cards include basic contact information, but because business cards are the most distributed and often the only marketing tool used, they should provide a snapshot of your practice. The following is a list of important information to include on your business cards:

- Name
- Qualifications
- Address
- Phone number
- E-mail address
- Website
- Services offered
- Logos
- Quotes

It is important to have a marketing image, so that people remember you. Other materials, such as your Web site, letterhead, note cards, and envelopes, should be coordinated to have the same...
The service must be something that you can offer a service in exchange for referrals. You should present yourself as a resource to your potential referral sources. Again, you should present your availability and offering your reciprocal service. It helps to informative, letting them know about your availability and offering your reciprocal service. When selecting potential referral sources, it is easiest and most effective to start with providers in your immediate geographic location before branching out further. The letter should introduce yourself, explain about your practice, and attempt to establish a reciprocal relationship. By reciprocal relationship, I mean that you should offer a service in exchange for referrals. The service must be something that is easy for you to provide, so that you do not exhaust your physical and financial resources. Some examples of reciprocal services are:

- Free telephone consultations
- Referrals to their service
- A brief workshop or in-service
- Written material on a topic of interest

The marketing letter should be accompanied by brochures and business cards for distribution and can be followed by other forms of direct mail. Examples of other forms of direct mail are:

- Updates about changes to your practice (i.e., being added to an insurance panel)
- Holiday cards
- Written information/publications (either written by you or articles that you find that may be of interest to them)

Establishing Community Linkages

Although marketing letters and direct mail are important, they cannot stand alone. They serve as introductions to your practice, but are most effective when they are followed up by a phone call or visit. It is extremely important to contact potential providers by phone or in person to establish a relationship with them. The call should be kept simple and informative, letting them know about your availability and offering your reciprocal service. Again, you should present yourself as a resource to your potential referral sources and offer to provide them with services such as telephone consultations, written material, and inservices or workshops.

Creative Use of Computers

In this day and age, the use of computers is essential to any business. Having an e-mail address and Web presence is as important as having business cards and brochures. There are many providers who will give you access to free e-mail, and some also offer a free Web page. Web hosting packages are also easily accessible and start with prices as low as $2.99/month with easy do-it-yourself options. I am by no means a computer whiz and have been able to design some pretty acceptable Web sites. When designing your Web site, you should keep in mind the same basic information as you did when designing your brochure. The Web site must be attractive, user friendly, and it helps to include helpful resources such as mental health or therapy information, articles written by you, or links to other articles that will attract potential clients and referral sources. Your Web site should also include your professional profile, your contact information, and should be designed in a fashion similar to your brochures, business cards, and other materials. If this idea is completely overwhelming to you, you should check out some Web sites of other practitioners and find out who designed their sites. (It is often listed at the bottom of the Web page.) Consider investing a couple of hundred dollars with that Web designer.

Writing and Public Speaking

One of the keys to successful marketing is to make your name familiar by keeping your name in the public domain. You want to be known as the expert in one or two topics related to your mental health practice. This is known as your niche. Your niche should not limit the work you do, but identify you as an expert on a particular subject. When people think of your niche topic (or something related to it), you want them to think of you. The best way to do so is by writing and public speaking. These roles can be intimidating and often careers themselves, but if planned correctly, they can be great ways to build your practice.

You can start by writing articles for local magazines or newspapers. The smaller periodicals are often looking for new ideas and topics that are of interest to the general population. You can also print your own brochure or newsletter that you distribute to local community health centers. Be sure to include your contact information.
You can also begin public speaking by contacting local social groups, churches, and schools and offering to do workshops on topics of interest, such as stress management, healthy relationships, handling peer pressure, and so forth. Again, it is helpful to provide resources that people will keep, use later, and/or pass along that also have your marketing message.

Press Releases

We often forget that good news is newsworthy. If you are planning any speaking engagements, notify the local media (newspaper, radio, television) and get the word out with a press release. Although media coverage should not be the reason why you do charitable work, there is no reason why you should not be acknowledged for any charitable work you do. For example, if you are conducting a toy drive, writing a press release can help support your cause as well as enhance your public image.

You can also create press releases about topics of public interest, such as the national suicide rate and your advice for living with depression. Another strategy for press releases is to respond to a topic already in the news, such as your experiences with teen violence in response to a school shooting. Be sure to include information about your practice, such as a brochure or professional pro-

file, when submitting your release to the media.

You must approach your practice as a business, and businesses are responsive to their environments. It is not a process that you begin and then sit back and it magically replicates itself. Managing a private practice is an active process, and you must maintain a hands-on approach throughout the life of your practice.

With that in mind, you must remember to periodically look over and possibly adjust your practice design, professional profile, marketing tools, and marketing strategies to maintain your private practice.

Keisha Cox, LCSW, MS, has been in practice as a clinical social worker since graduating from New York University’s School of Social Work in 2002 and currently operates a private clinical practice in Mount Vernon, NY. She has postgraduate training in loss and bereavement and in child and adolescent psychotherapy, in addition to more than 10 years of experience in the fields of mental health and substance abuse. Ms. Cox also has an MS in management from the Robert Wagner School of Public Service and is experienced in fundraising, marketing, event planning, program evaluation, program development, and as a social work manager. Ms. Cox is the founding and coordinating clinician of Community Counseling, a consulting firm that establishes linkages between mental health providers and members of the community.

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Social Work Celebrations

School Social Work Week

March 1-7 was School Social Work Week. Mary Kay Longwell, MSW, school social worker at Fox Chase Elementary School in Oswego, Illinois, celebrates the week, even though it comes during one of the busiest times, when special education annual reviews are scheduled. She reports that she takes treats for the staff, lays out a tablecloth in the teacher’s lounge, and sets out juice and coffee cakes, plates, and plasticware. “I have a nice crystal bowl filled with Hershey’s ‘hugs’ and ‘kisses,’ and post the [school social work week] proclamation and the poster on the wall, along with posters from previous SSW weeks. Then somewhere, I put a sign that says something like ‘Celebrate! Happy School Social Work Week!’ ” she reports.

“I know it sounds self-celebratory, but it’s not, really,” says Mary Kay.

Social Work Month Gala in Miami

“Teachers like food (don’t we all?), and I have a good relationship with my teachers. They enjoy the event and wish me a happy week.”

Social work students from Florida International University are shown enjoying the Miami-Dade NASW Social Work Month Gala and Awards Ceremony in Miami, FL on March 5. Attendance was more than 200, including about 50 students.

Shown, left to right: (front row) Saylen Moore, Justine Naylon, Maria Olivia; (back row) Lani Morhaim, Sabrina Prada, Lauren Bosch, Kelly Sydnor, Meghan Skog-Rios.
A woman smiling with brown curly hair, holding a candle in each hand, one candle a “4” and the other a “0,” and a diagnosis of Hodgkin’s Lymphoma. A newborn baby sleeping peacefully in an intensive care unit (ICU), surrounded by soft, cuddly stuffed animals, multiple tubes coming out of his small body, the unfortunate result of a congenital heart condition.

A U.S. Marine Corps soldier back from Iraq without his legs and injuries to other parts of his body. The 14-year-old girl who developed obsessive compulsive disorder (OCD) over the course of a few months and needed to spend two months in a treatment center. A young woman who recovered from a brain aneurysm but who can no longer drive and needs to ask for rides without feeling like a burden to friends and family.

It may seem hard to believe that all these individuals are able to provide regular updates on their conditions, recovery, and maintain relationships with their friends and loved ones. In fact, each of the individuals can receive messages of love and support from their friends and loved ones 24/7. Using a unique technology-driven tool, each of these vibrant, beautiful people struggling and fighting for their health and happiness has his or her own CaringBridge online community (http://caringbridge.org/stories).

According to the CaringBridge Web site (http://caringbridge.org/about): CaringBridge® is a 501(c)(3) nonprofit Web service that connects family and friends during a critical illness, treatment, or recovery. A CaringBridge Web site is personal, private, and available 24/7. It helps ease the burden of keeping family and friends informed. Patients and caregivers draw strength from loved ones’ messages of support.

- 150,000 families have created free, personalized CaringBridge Web sites
- Over half a billion visits by families and friends
- 20+ million guestbook messages of hope and encouragement
- 150+ new personal CaringBridge communities created daily
- Used in 190+ countries around the world

Sona Mehring created CaringBridge in 1997. At the time, a friend of Sona’s had serious complications with her pregnancy. After the birth, the mother remained in critical condition while her baby was born nearly three months premature. Sona then created a Web site to help keep friends and family members informed about their condition. Posting updates on the Web site allowed the mother to rest and the hospital staff to focus on care, rather than address a constant stream of information inquiries. In addition to offering daily news on the mother and baby’s condition, a guestbook feature was added to the Web site, so guests could leave messages of support and encouragement.

Unfortunately, the small baby survived only nine short days and passed away during surgery. The Web site Sona created was then used to share news of the baby’s passing to help alleviate the heavy burden of sharing the news with multiple friends and family members. The parents also used the site to write a final message about their daughter and thank visitors. As a result, a memorial fund was established at Children’s Hospital in St. Paul, Minnesota, to provide a computer with Internet access so that patients and families could create their own CaringBridge online communities.

Lisa Gebo, an editor and friend of many in the social work community, was diagnosed with Stage IV breast cancer and has used CaringBridge since 2006. Here is her story in her own words:

I was first introduced to CaringBridge® when one of my former colleagues invited me to join his circle of friends and family when his young son became very ill. I was honored to be invited (by way of a simple e-mail to a link where I then completed an easy on-line guest registration process). I was impressed by the growing social support network that the family’s Web page came to represent. As my colleague had updates regarding his son’s health status, I would get an automatic notice in my e-mail. I could then go to the family’s personalized site, read the latest news, enjoy adorable pictures of this boy I have never met but love nonetheless, and post encouraging notes to my friend and his family in the guest section.

Not long after that, my dear friend, hero, and former author, Len Gibbs, a social work educator who wrote with passion about evidence-based practice and who sadly died in 2008 after a brave struggle with prostate cancer, invited me to join his CaringBridge® community. Len and his wife, Betsy, took the Web site service to new heights by not only posting Len’s health updates, including information on the clinical studies in which he was participating, but they also provided links (another great function built into all the personalized Web site templates), to important downloadable documents written by Len. Via this link, Len was able to share concrete direction for readers so that they could apply evidence-based practice to their own or their loved one’s healthcare. Lives were literally saved by Len’s detailed ‘lessons learned’ guidelines, urging men to use evidence-based questioning with their doctors to help ensure that thorough and preventative measures were taken.

When I had my own cancer news, I knew that I wanted to set up a personalized CaringBridge® site. Most of my family and childhood friends live back East, and my hus-
biggest losses I’ve faced to date is not having
attended all those BPD, CSWE, SSWR, and
tended to all those events over the years. So, one of
the things I have made life-long friendships after at
scientists... and I derived a great deal
of meaning from my work. I’ve been privileged
to have made life-long friendships after atten-
ting all those BPD, CSWE, SSWR, and
other conferences over the years. So, one of
the biggest losses I’ve faced to date is not having
daily exchanges with my friends in the field.
In sum, my CB site has allowed me to stay in
touch with my dearest friends and family, and
this has contributed greatly to maintaining a
positive outlook and coping with my disease.
For anyone dealing with an illness,
(self, caregiver, partner, family member, close
friend), I highly recommend setting up a per-
sonalized CaringBridge® site. I think that the
service offers social workers an invaluable and
potentially very creative resource to share with
consumers.

All one needs is Internet access to
set up a CaringBridge online community
Web site. In fact, the site itself can be
built in just three steps:
1. Setting up the account: Includes
contact information, address, name
of loved one needing care, care facil-
ity, and login information
2. Selecting a template or look for your
web site
3. Setting privacy options for who can
access your site

There is even a pop-up help menu
(meaning clicking on the Help link opens
in a new window) to help you with any
questions you may have and walk you
through the process of setting up a site.
The folks at CaringBridge say it
should take about five minutes to set
up your site. Sometimes it takes me
five minutes just to log in to a Web site,
so I find this to be most impressive.
To see some sample Web sites, check
out the Web Site Gallery (http://www.
caringbridge.org/stylegallery). Each site
contains a patient care journal where the
person receiving care can update friends
and family, a guestbook for site visi-
tors, and a photo gallery. To get a sense
about how these features are used, check
out the Our Services page (http://www.
caringbridge.org/ourservice). For a small
fee, you can even create what is called a
Caring Book, a full-colored book based
on your CaringBridge site (http://www.
caringbridge.org/caringbook).

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role of technology in
social work, the effects
of information commu-
nications technolo-
gies (ICTs) such as the Internet and e-mail,
povetly and class, aging, social informatics,
socioeconomic development, public policy, and
community practice. Karen is the chief editor
and founder of EditMyManuscript.com, pro-
viding manuscript editing services to students,
faculty, and other social work professionals.
Her Web site is http://www.karenzgoda.org.

Notes about this column
I’m very excited and honored to be writing the SW 2.0 column, previ-
ously in Marshall Smith’s capable hands. I’m always exploring, thinking
about, and reading about new ways that social workers can enhance their
work using technology tools. I’m biased toward exploring technology
tools that are interactive, pragmatic, easy to use, platform independent
(i.e., no PC vs. Mac issues), and are useful to social workers, be they students,
practitioners, faculty, or researchers. Additionally, I’m interested in ways
technology can be used to connect or enhance our connections and how
the human relationship is played out online. This column will be integrated
with the Technology and Social Work board I moderate for SocialWorkChat.
org to enable conversations about columns to take place. I’d love to hear
from you about how you are using technology tools in your work and
your suggestions for the column.

I would like to extend my sincere
thanks to Linda Grobman for giv-
ing me the opportunity to write this
column. Linda is a fantastic editor,
and I look forward to becoming a
better writer under her watchful eye.
I’d also like to extend my gratitude
to the previous writer of this column,
Marshall Smith, without whom this
column would not exist. I will do my
best to add to your insights on the role
of technology in social work.

Karen’s Picks
Notable Web Sites & Resources

The New Social Worker Online Facebook page

The New Social Worker’s Twitter page
http://twitter.com/newsocialworker

Socialworkchat.org Facebook page
http://www.facebook.com/group.php?gid=8238228881
An Accidental Job Search
by Peter A. Kindle, LMSW

By happy accident, my proposal was accepted for presentation at the 2007 Annual Program Meeting (APM) of the Council on Social Work Education. Accordingly, I decided to test the academic job market without my degree in hand. Forty-two e-mails netted 18 conference interviews in San Francisco that led to 27 formal applications, five telephone interviews, two campus visits, and one job offer. This article is an attempt to share the insights gleaned from my roller coaster ride on the academic job market in social work during the 2007-2008 academic year. I leave it to the reader to judge the accuracy of my insights.

The Academic Job Market in Social Work

In 2004, the Council on Social Work Education (CSWE) attempted to collect data on 513 baccalaureate, 186 master’s, and 66 doctoral programs. Enrollment was less than 50 students in 97 BSW and 12 MSW programs. The largest enrollment was more than 1,500 students at Fordham University (Office of Social Work Education and Research, 2007). Obviously, the social work academic job marketplace contains substantial variability.

Jean Anastas (2006) has provided an exceptional analysis of the employment opportunities for new graduates represented by job advertisements in the Chronicle of Higher Education. Her analysis indicated that the number of new openings for assistant professors was roughly comparable to half of new doctoral graduates, suggesting that “the prospects for academic employment . . . seem relatively good” (p. 200).

The competitiveness of the social work academic job market is weighted heavily toward research universities. These programs receive the bulk of applications and assess applicants against high standards. I was told by more than one search committee that tenure required five peer-reviewed publications annually in top journals with external funding in excess of $2 million. On the other hand, I spoke with a number of attendees at the Baccalaureate Program Directors conference in October 2006, who indicated that job postings in small BSW programs often go without doctoral degree applicants. It seems that applicants chase jobs among research universities; in BSW programs, jobs chase applicants.

As one might expect, teaching loads tend to increase as one goes down the Carnegie classifications [see http://www.carnegiefoundation.org]. Research Universities/Very High (RU/VH) productivity are currently at the apex, and applicants receiving offers from programs in these institutions can expect light first-year teaching loads, relocation assistance, high salaries, and research support. There is a tendency for salary, relocation assistance, and research support to decline with each drop in rank; however, this tendency is neither universal nor invariant. I spoke with at least one Master’s Large (ML) institution that provided significant research support with a 2x2 teaching load. In general, however, I believe it is fair to assume that initial salary offers will decline by $10,000 as one moves from an RU/VH to an ML institution. In like fashion, expect full reimbursement of relocation from an RU/VH institution, but only token assistance (e.g., $1,000) from ML institutions.

The typical assistant professor job posting requires an earned doctorate, an MSW, and two years of post-MSW practice experience. Anastas (2006) reported that 81 percent of job postings required an MSW and 62 percent required two years of experience. My personal analysis of job postings in December 2005 suggests that Anastas’ findings may actually underestimate the importance of the MSW and post-MSW experience.

The desired curricula area (practice, field, research, social policy, and HBSE) rarely defines the position completely. What Anastas (2006) calls “substantive areas” (e.g., child welfare, substance abuse, mental health, health, gerontology, etc.) are also important. I was unprepared to conceive of my future place in academe within a matrix defined on one dimension by curricula area and on another by substantive area. For example, the most common substantive area joined with policy is macro practice. Candidates for policy openings may be at a disadvantage without macro practice experience. Doctoral students are advised to review job postings to determine that their interests (i.e., curricula x substantive area) are consistent with search committee desires.

Search committees look for harmony among the applicant’s experience, research agenda, dissertation, and teaching aspirations. Discord among these areas may constitute a barrier to academic employment. Large research universities may be more amenable to discord, but are likely to be more strongly focused on external funding potential. Smaller programs are less likely to embrace discord, but may be relatively disinterested in external funding.

The Job Search Process

When CSWE moved the APM to the fall in 2007, the job search process changed. Not only did the process move online, it also moved forward on the calendar. Last year, online job postings began in August with some closing dates for applications occurring as early as September. Candidates desiring conference interviews are advised to contact search committees prior to APM to schedule an interview.

Search committees ask for a variety of materials from applicants. Without exception, the job seekers can expect to provide a current vita, cover letter, and contact information for references. Additional items may involve letters of reference, transcripts, writing samples, statements on research and/or teaching, and evidence of teaching effectiveness. In advance of a job search, students should obtain copies of all transcripts, student evaluations for classes taught, and, if available, single author publications. The first chapter of a dissertation
is often used as a writing sample. Some programs ask for official transcripts, but I suggest providing only photocopies with the initial application, to avoid the expense. Many programs require an online application, so job seekers may want to consider obtaining electronic copies of all required materials. Conversion of Word documents to PDF files is also suggested, and free software is available online (OpenOffice.org). Comprehensive guidance on all aspects of the academic job search, including preparing statements on research and teaching, is available from the Doctoral Student Center on the SWSR Web site and Chronicle Forums on the Chronicle of Higher Education Web site.

I was asked two questions so often that I believe job seekers should always be prepared with answers for both. A 60-second explanation of one’s dissertation topic and how it is relevant to social work is an absolute necessity. Conference attendees can expect to provide this explanation in hallways, stairwells, and casual conversations, but it will also be useful in more formal interview settings. In more formal settings, the job seeker should also expect some version of the question, “Why our school?” Please note that it is not sufficient to merely have two-sentence responses developed for these questions, because the most interested individuals and search committees are quite likely to ask for further clarification and explanation. Research universities are also quite likely to ask about the external funding potential for the job seeker’s research agenda.

Strangely, I do not think that applicants can expect search committees to look at their qualifications from a strengths-based perspective. Each search committee appears to screen applicants according to a set of idiosyncratic factors. Some of these are, of course, identified as requirements on the job posting, but there are unstated expectations, as well. A single deficiency is more than enough for a candidate to be removed from further consideration. With the possible exception of the strongest institutions, there appears to be little difference in adequately satisfying each factor and exceptional performance. Simply by way of illustration, two publications may be as efficacious in the job search as ten, if all other factors are also adequately met. The candidate with ten publications is unrealistic to expect the strength of his or her publication record to compensate for a deficiency elsewhere. In fact, quantity alone may raise additional questions from the search committee if every publication does not narrowly lead to the focus of the applicant’s dissertation research.

What else can the job seeker expect? One can expect the vita to lead to conference interviews; however, I also believe it is important that the applicant realize the limitations of a conference interview. Search committee decisions are made by the full committee. Many conference interviews are convenience-based preliminary contacts with ad hoc campus representatives. No matter how wonderful an ad hoc meeting might be, it means little to the deliberations of a search committee. Applicants should carefully weigh the potential costs and benefits of participating in conference interviews. The more ad hoc the meeting, the less likely that anything positive will result. Remember, the entire search committee process is focused on deficiency. It may only take one questionable impression to stall a candidate’s further consideration.

In comparison to a conference interview, a telephone interview is solid gold. An applicant who progresses to this point has made it through a substantial vetting process and has probably been rated at least adequate on every significant factor important to the search committee. If successful, the telephone interview will lead to a campus visit.

It is difficult to overestimate the energy required for a campus visit. On my first campus visit, I was involved in a one-on-one interview for over four hours the afternoon I arrived. The next morning, the interview continued with different subsets of the faculty for more than ten additional hours. I believe it is absolutely essential to be well-rested before a campus visit, and to avoid any outside distractions while on campus. The relative importance of a research presentation to a teaching demonstration will depend on the focus of the institution, but I suggest that the applicant insist on utilization of PowerPoint in both cases. Nothing lends the flavor of professionalism to a presentation like PowerPoint, even if nothing is more important to a teaching demonstration than making connections with students. The key is to do both well.

Funding for campus visits should come from the institution, but it is worth confirming this when an invitation is received. I have heard of cases in which the institution did not automatically offer to pay the full cost of the visit. Only the largest institutions will prepay flights. This means that the applicant will often have to spend significant funds to make a campus visit. The wait for the reimbursement check will take at least 30 days after the institution receives the expense report and receipts. I recommend planning on at least $600 of unused credit on a credit card for each campus visit.

Is a Premature Job Search Worthwhile?

My 2007-2008 job search experience was premature for at least two reasons: (a) I had not defended my dissertation proposal, and (b) the date of my final defense had not been set. In retrospect, it may have been a mistake to invest my time and energy in this search. Not only did I lose a significant amount of time that should have been devoted to my dissertation proposal; I also found waiting to be emotionally draining. My quality of life declined substantially as a result of the constant stress, and my writing productivity crashed. I have decided not to return to the academic job market until I have my degree in hand and two years of post-MSW experience.

This does not mean that I regret my decision to enter the job market in the fall of 2007. I think that I learned a great deal about my suitability for a future academic position and the type of position that I will eventually pursue. I also hope that, by sharing my experience, impressions, and insights, my student colleagues will find the pathway toward a tenure-track position smoother than it would have been otherwise.

References


Peter A. Kindle, LMSW, is a doctoral candidate at the University of Houston’s Graduate College of Social Work expecting, finally, to graduate in the spring of 2009.
Suppose you are a person who has been struggling with a heroin addiction for the past twenty years. Treatment providers may have written you off as a hopeless cause, a junkie. You have unsuccessfully attempted treatment for your addiction about ten times in the past ten years. Traditional treatment providers have told you that you need to hit “rock bottom.” However, you can’t imagine being more powerless—you’ve lost your home, your family, your career, and everything that you find important.

These are exactly the sort of clients treated by Stiftung Suchthilfe, a harm reduction agency in the City of Saint Gallen, Switzerland. Harm reduction, a traditionally public health strategy, acknowledges that many people may never stop using drugs, and bases its work upon practical strategies to reduce negative consequences of drug use, usually on a continuum from safer use to managed use to abstinence. Stiftung Suchthilfe offers a number of treatment services for people with chemical dependency, including a medical-grade heroin distribution center. People with heroin addictions who have been consistently unsuccessful with treatment receive the tools they need at Stiftung Suchthilfe to reduce some of the harm that they experience by continuing to use heroin. Stiftung Suchthilfe recognizes that some addicts will not—and in many cases cannot—end their addiction. These clients, too, deserve to be safe, to be healthy, and to not be written off by their treatment providers.

For ten days during January 2009, a group of undergraduate and graduate social work students from Southern Illinois University at Carbondale and a number of other universities from the United States toured Saint Gallen, Switzerland, in addition to other historic sites in nearby Germany. Dr. Elisabeth Reichert, a professor of social work at SIU who specializes in human rights, leads a group of students twice yearly to Germany, to explore how other countries approach human rights and human dignity. Though certainly not without controversy, harm reduction agencies like Stiftung Suchthilfe represent innovative approaches to helping people live with dignity. Social work students attending the trip learned much about how other countries approach human dignity—and realized that social service delivery in the United States has much opportunity for growth.

### Additional Resources

- Trevor Gates, LCSW, CADC, is a clinical social worker and chemical dependency counselor who specializes in work with the lesbian, gay, bisexual, and transgender community. Trevor has been employed as a therapist in medical and behavioral health settings, and has a special commitment to working with people with chronic mental health issues, people affected by HIV/AIDS, and people and families affected by addiction. Trevor is a member of the National Association of Social Workers, Academy of Certified Social Workers, and NAADAC. He lives and practices in Chicago, IL.
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Linda May Grobman, ACSW, LSW, Editor

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The macro roles presented in MORE DAYS IN THE LIVES OF SOCIAL WORKERS fall into several categories. They include political advocacy, community organizing, management/administration, program development, training and consultation, working in national organizations, higher education, research, and funding.

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