Social workers know that there is no standard response by clients for the diverse and complex challenges of life after cancer. Since there is an obviously worse alternative to surviving cancer, the challenges facing a cancer survivor are often overlooked or minimized by some. Prostate cancer is the most commonly diagnosed carcinoma among men in the United States (American Cancer Society, 2006); and the practice and research done by the authors of this article suggest that different types of emotional, concrete, and informational support are indicated. In this article, we discuss social support at the intersection of naturally developed helping networks and social work intervention.

Social workers may be able to best help clients with prostate cancer, as well as other types of cancer, by helping them identify and strengthen their social support networks. Support has a salutary effect across the cancer trajectory, according to research by Bloom (1996). The majority of survivors do not face cancer alone (Hedestig, Sandman, & Widmark, 2003). They are surrounded by social workers and other health care providers, and often also have a considerable naturally developed network of support, including family members, friends, and others (Ka’opua, Gotay, Hannum, & Bunghanoy, 2005; Mitschke, 2006). Helping survivors tap into this potentially rich source of support is an important part of the social worker’s role.

In assessing the social support network of cancer survivors, social workers should begin by examining with the client the closest individuals and those who may have expressed concern or provided assistance. For instance, naturally developed helping networks often include spouses, adult children, family members, friends, and close neighbors.

- **Spouses** - In our research on the coping methods of prostate cancer survivors, spouses played a critical role in the overall functioning of the family unit (Ka‘opua et al., 2005; Mitschke, 2006). Survivors said their spouses helped maintain daily routines, offering them normalcy in times of uncertainty (Mitschke, 2006). Their spouses reported helping them access medical care by coordinating and providing transportation to and from appointments.

See Prostate Cancer, Page 3
Welcome to the latest edition of the SectionConnection. It has always been the intent of the Mental Health Specialty Practice Section Committee to provide our readers with professional articles that are informative and useful. We hope you find this issue to be consistent with our intended objective.

The articles in this edition remind us that illnesses requiring mental and psychosocial intervention can apply to both professional social workers and their clients. These articles are written from individuals’ personal and professional experiences.

First, Diane Mitschke and Lana Sue Ka’Opua compare research and practice with prostate cancer survivors undergoing psychosocial intervention. This issue demonstrates that both personal and professional experiences provide social work practitioners with valuable information that can be utilized in developing treatment strategies for our clients. Then Lee Ann Ripstra, an undergraduate social work student, and I write about Lee Ann’s treatment journey after she was diagnosed with anorexia nervosa. These shared experiences are from a survivor and a professional. In the final article of this edition, we explore the personal and psychosocial intervention of Mark Smith, a professional social worker diagnosed with prostate cancer.

I want to take this opportunity on behalf of the entire Mental Health Specialty Practice Section Committee to thank our members and readers for their continuing interest and support of our newsletter. We try very hard to provide you with unique and interesting articles.

Enjoy.

Gwendolyn Scott, ACSW, LCSW
Prostate cancer is a disease typically diagnosed in older men, and the reliance on a longtime partner as a source of love, support, and companionship is evident. Partners provide stability and trusted advice that is often accepted by survivors as an important part of coping. Mitschke (2006) found that partners helped survivors maintain positive attitudes and encouraged them to reach out to others for help.

- **Adult Children** - While survivors rely on partners most heavily for support, they also reported receiving extensive help from their adult children in coping with the cancer (Mitschke, 2006). Adult children can provide respite for the caregiving partner and become the family spokesperson or liaison between the survivor, others in the support network, and health care professionals.

- **Concerned Neighbors and Friends** - Strong social support networks often include a cadre of concerned neighbors and friends who provide companionship, spiritual support, and occasional assistance with transportation, meals, and errands (Mitschke, 2006). In tapping into the reservoir of naturally developed helping networks, social workers might assess if neighbors and friends are willing to provide additional support to the survivor and family members.

**Overcoming Barriers**

While the assessment of naturally developed client support networks is important, prostate cancer survivors can sometimes present with resistance. It can be a challenge for social workers when the survivors are unwilling to develop a social support network or unaccustomed to relying on the assistance of other people. Research by Hedestig and colleagues (2003) suggested that survivors will often try to protect their loved ones by not emotionally upsetting them with information related to the cancer. In doing so, however, survivors may internalize much of the stress related to their illness and ultimately feel alone in experiencing the burden of the disease. This self-imposed isolation, or protective buffering, can also include avoidance of discussion with significant others about the cancer diagnosis or treatment.

Protective buffering is a common phenomenon, and social workers can play an important role in helping survivors and significant others to resist this tendency. This is easier said than done since prostate cancer is associated with erectile dysfunction and urinary incontinence—conditions that are difficult to acknowledge and discuss.

**Strategies to Enhance Communication**

When protective buffering is encountered, social workers should consider the individual needs of each client and ultimately respect the clients’ right to self-determination (NASW, 1999). There are strategies, however, to consider that might lend themselves to assisting cancer survivors.

Survivor support groups are a promising means for addressing protective buffering. In our practice, survivors derive great value from discussions with those whom they feel have experienced similar feelings. Through participation in support groups, survivors often develop a greater comfort in discussing sensitive issues and may be encouraged to discuss them with those in their natural networks. In addition, psychoeducational counseling provided by the social worker can emphasize the fact that most prostate cancer survivors experience better health outcomes when they seek and attain support from family and friends. Ptacek, Pierce, and Ptacek (2002) found that men with family support tended to cope more effectively with the psychosocial sequelae of the cancer diagnosis and ultimately experienced higher levels of well-being and marital satisfaction than those who did not seek support. Social workers might assist survivors in identifying their needs for support and, as necessary, facilitate discussions between survivors and significant others. Communication training that specifically focuses on cancer-related issues may be helpful for individuals, couples, families, and survivor groups.
Support for partners and family members also needs to be recognized. Mellon and Northouse (2001) found that families tend to view support in terms of giving rather than receiving it—despite their own need for support. Other research indicates that supportive interventions for spouses and others in natural networks are often neglected by professional helpers (Isaksen, Thuen, & Hanestad, 2003; Ka'opua et al., 2005). This is a critical omission since support may be needed across the cancer trajectory; ongoing assistance aimed at preventing caregiver burnout is indicated.

Important Considerations

- Assess protective buffering, which may hinder functioning of support networks.
- Promote communication and understanding between survivors and those in their natural support networks.
- Check in periodically with spouses, partners, and adult children. Their inclusion in supportive and psychoeducational counseling may be helpful, if not necessary, to sustain natural support networks across the cancer trajectory.

Helping survivors develop strong support systems of family, friends, and others is an important part of the social worker’s role in working with cancer survivors. Helping survivors identify and utilize these networks can have long-lasting effects.

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References


An increasing number of young American adolescent girls are resorting to starving themselves by restricting their food intake, depriving their bodies of essential nutrients, and causing their heart beats to slow and menstrual periods to stop (Urbszat, Herman, & Polivy, 2002). Eating disorders are estimated to affect as many as 3 percent of young women in the country, according the 1999 report by the U.S. Surgeon General (Satcher, 1999). The specific eating disorder known as anorexia nervosa commonly associated self-starvation and emaciation is estimated to affect at least 1 percent of female adolescents (Urbszat et al.).

It is important that social work practitioners understand anorexia nervosa. The disorder has one of the highest mortality rates of any mental illness (Satcher, 1999), and without effective treatment has serious physiopsychological consequences. While anorexia nervosa has been previously associated primarily with young white females, more recent research indicates that it affects both genders and all cultures, and the disorder is increasingly occurring in our society (Smolak & Streusel-Moore, 2001). Social workers should equip themselves with the knowledge and skills necessary to assist clients suffering from this disorder.

The Disorder

Anorexia nervosa, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 1994), is a mental health disorder that is characterized by a refusal to maintain at least 85 percent of the normal height-to-weight body size; extreme fear of becoming fat; and distorted perception of body size and shape. Additionally, females are affected by loss of their menstrual cycles.

No generally recognized therapy for eating disorders exists, but there is evidence of some promising interventions (Barlow & Durand, 2005). Since eating disorders are often associated with low self-esteem and depression, some clients may benefit from treatment with antidepressant drugs. Others find psychotherapy, including family therapy, helpful. About half of the cases resolve themselves without relapses (Barlow & Durand).

The most successful treatment for anorexia nervosa includes both individual and family treatment (Logan, 2004). Other programs include multifamily group treatment as well. Treatment intervention initially seeks to stabilize the physical symptoms. Once medically stable, the client can receive mental health treatment to resolve the underlying cause(s) of the disorder (Logan).

This article focuses on one of the author’s experience as an undergraduate student in recovery from anorexia nervosa. The information provided is gleaned primarily from the personal vantage point of her relationships, years of direct observations, and conversations with others with the illness. This information is not a cookie-cutter treatment plan or evidence-based strategy; it does offer a client’s personal insights into social work practitioners working with clients diagnosed with anorexia nervosa.

The Client

LeeAnn Ripstra is a 26-year-old white female student at the University of Houston-Downtown who has been battling anorexia nervosa for approximately eight years. Like many others with eating disorders, LeeAnn required professional help of a licensed clinical social worker. She took part in an outpatient treatment program with a multidisciplinary approach. Individual psychotherapy, nutrition counseling, and medical and psychiatric care—all provided by practitioners specializing in eating disorders—has helped LeeAnn maintain a healthy weight for the
past five years and abstain from anorexic behaviors for one year. Sharing her story with others has proven to be an effective part of her recovery plan. The following suggestions to social workers reflect her personal experience recovering from anorexia nervosa and her conversations with others with the illness:

- Don’t be discouraged—or fooled—by an argumentative client. The client may feel overpowered by the eating disorder and may, in turn, have trouble asking for help when it is most wanted and needed.
- Recognize that an extremely agreeable client needs your help just as much as one who acts out. He or she may be directing anger and frustration at himself or herself instead. It is important not to overlook the client’s inner turmoil.
- Don’t be discouraged by setbacks. Clients often will feel discouraged, and they need you to be positive in order to help them learn from relapses and find their voices again.
- Recognize common comorbidities of anorexia nervosa, including depression, self-mutilation, and anxiety disorders, and address these in treatment.
- Steer conversation away from food and weight whenever possible. This is crucial in order to uncover and address underlying issues. An increase in food and weight talk indicates something is going on with your client that needs to be addressed. Remember, these actions are often unconscious to the client, so do not blame them.
- Look beyond the anorexia nervosa to uncover underlying struggles and help clients express these in a productive way. Anorexic clients, for example, often struggle silently with the notion that they are losing control, but they have trouble communicating this and other feelings.
- Recognize that the eating disorder may be a primary symptom, but it is not the primary problem. Anorexic clients, who already feel unworthy of treatment, often fear that if they stop using anorexic behaviors they may lose the help they are receiving. It is important to let the client know that you realize they are not “all better” just because their behaviors disappear. It is also crucial to communicate this to the client’s outside network of friends and family members.
- Understand that clients may need different types of programs depending on their circumstances. An intensive inpatient eating disorder program may be best for clients who would benefit from treatment away from their normal environment or for clients who found little success with long-term outpatient treatment. An outpatient multidisciplinary program might be helpful for a client who does not have the ability to pay for inpatient care. Outpatient supportive therapy, combined with supportive assistance from family members seems to suggest there may be no discernable difference in recovery outcomes for inpatients and outpatients. Both inpatient and outpatient programs are most helpful to clients if they specialize in the treatment of eating disorders.
- Be aware that clients with anorexia are often intelligent and adept at rationalizing to defend their actions. Do not buy into these explanations. Eating disorders thrive on such rationalizations, and the client needs you to be a force against them.

The idea that a young, seemingly-happy, teenage girl would restrict her food intake, essentially starving her body of nutrients and causing her heart beat to slow, in order to appear thin doesn’t sound logical to most people. That is, however, what more and more young adolescents girls are doing. According to Barlow and Durand (2005) young females are especially susceptible to developing anorexia nervosa during the adolescent years when their bodies are changing and the social pressures to be thin are overemphasized. Consequently, social workers must also be alert to the messages their clients are receiving and willing to disclose the miscues young females are getting.
This information is not intended to be a cookie-cutter treatment plan or strategy, but could be a valuable resource for social workers in developing effective treatment and recovery plans with clients. Eating disorders are treatable, and clients do have the power within themselves to recover. Although the final decision to live a healthy life is up to the client, social workers can play an important part in her or his road to recovery.

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LeeAnn M. Ripstra is currently a senior at the University of Houston-Downtown. She is an active public speaker and is the public relations coordinator for the Eating Disorders Association of Houston.

References


RESOURCES

National Eating Disorders Association
http://www.nationaleatingdisorders.org

Academy for Eating Disorders
http://www.aedweb.org/

Anorexia Nervosa and Related Eating Disorders
http://www.anred.com/

Eating Disorders Coalition for Research, Policy, & Action
http://www.eatingdisorderscoalition.org/

National Women’s Health Information Center
http://www.4women.gov/

Maguire’s approach shows social workers how to combine the use of social support systems with cognitive, psychodynamic, problem-solving, and task-centered interventions. He instructs readers about integrating case management, networking, and natural support systems to provide better services. Useful as both a classroom text and a practitioner resource, *Social Support Systems in Practice* describes the theory base of interventions and illustrates their application to diverse problems.

- Numerous figures and tables illustrate approaches and their effects
- 16 case examples demonstrate how social supports help clients
- Questions at the end of chapters test the reader’s comprehension
- Readable, useful, and research-based guidelines help social workers strengthen their practice

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I am a licensed independent social worker, a 54-year-old male, and a prostate cancer survivor. The first two characteristics are ego syntonic, and the last is ego dystonic.

I went for a routine prostate-specific antigen (PSA) test at age 48 at the request of a friend. What followed were seven months of medical treatment and, at age 49, a radial prostatectomy. A year before most men are tested for this condition, I had entered into a phase of life that included becoming a cancer survivor, having sexuality greatly altered, and experiencing a great deal of pain and emotionality.

After having spent more than 15 years as a mental health professional, I found myself living in the aftermath of the most commonly diagnosed (American Cancer Society, 2006) form of cancer for men, knowing many people in the mental health field, and still not finding very many resources on how to cope with the trauma I was experiencing.

I want to change that.

My writings emerge from my experiences and ideas as a mental health social worker. As you read, please remember that each man experiencing prostate cancer is on a private and unique journey. For the emotional wellbeing of the prostate cancer patient, consider the following areas related to the impact of the diagnosis and subsequent treatment, including:

- Decisions that need to be made regarding treatment options.
- Secondary wounding that occurs during these times.
- Impact on the spouse, partners, and family.
- Long-term effects of being a prostate cancer survivor.

Impact of Diagnosis and Subsequent Treatment

It is best to treat prostate cancer patients as trauma survivors. Although men deal with diagnosis and treatment differently, the potential for trauma, “…an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others” (DSM IV-TR, 2004) is always present.

The patient may be indecisive, tense, fearful, fretful, tearful, irritable, or angry. He also may have trouble concentrating, find it difficult to fall or remain asleep, become socially withdrawn, perseverate about issues, or experience other symptoms of anxiety and depression.

Treatment options are increasing as research unravels the mysteries of cancer. The number of options depends on the course and stage of the illness. I faced the options of not intervening and dying, a radial prostatectomy, radiation seed implants, or radiation therapy. I felt frustrated that if the onset of my prostate cancer had been a few years later, my treatment options might have been less intrusive.

Social workers can help clients at this stage of treatment by:

- Enabling the patient to be assertive in obtaining information to make treatment decisions;
- Facilitating decision making so decisions are made based on objective criteria instead of emotions;
- Coordinating with physicians and others providing prostate cancer treatment to ensure the emotional aspects are considered;
- Providing linkages to the spouse or partner and other family members to facilitate support and open communication, and to make sure their mental health needs also are addressed;
• Ensuring ongoing patient support is available for times of confusion and decision-making moments;
• Managing the patient’s secondary wounding experiences, including things such as people comparing prostate cancer to other cancers, jokes about sexual dysfunction, and negative descriptors of men who have undergone prostate cancer treatment; and
• Recognizing that support is needed through the phases of shock and disbelief, sorrow, anger, and fear.

**Understanding Cancer Survivorship**
When treatment begins, there is potential for strain on the psyche. There are no interventions that are fail-safe against sexual dysfunction and other side effects. Life during and after treatment often includes periodic re-examination and waiting for results of tests to determine the presence of cancer. This phase also brings with it some additional challenges, such as the following ones noted.

**Secondary Wounding**
In interactions with others, I was not prepared for the jokes about sexual dysfunction and the strategies available to counter them. For example, I listened to others unabashedly tell the latest Viagra joke. The point of bringing up this issue is not to degrade others, but to illustrate that secondary wounding can be painful in many surprising and unanticipated ways.

Every man is different in his regaining bodily functions, gaining strength, and coping. Support in these stages of recovery is very important. Sorting out the manageable and unmanageable concerns with the prostate cancer survivor helps.

**Long-term Coping Strategies**
Author Irving Yalom in 1931 suggested that all humans are trying to master four dilemmas: death, responsibility, isolation, and meaning (Winell, 1994). I explore these constructs with prostate cancer survivors. Therapy is directed at sorting out distortions that might occur with the meaning clients give to their experiences. I attempt to understand isolation issues imposed by self or others and clarify and resolve issues that relate to responsibility. For example, if I had eaten better, bicycled less, had different genes, etc., would I have gotten prostate cancer?

I assist prostate cancer survivors in self-evaluation. Does this affect a man’s view of his mortality? I often find one of these dilemmas is more paramount for the person than others around him. Knowing that there is great uneasiness about responsibility, for example, can help guide therapy.

A number of stress management techniques are helpful during treatment. For example, the stress management and relaxation techniques outlined in *The Relaxation and Stress Reduction Workbook* (Davis, Eshelman, & McKay, 1995), outlines a number of these methods, including thought stopping, breathing exercises, and progressive relaxation.

As a social work professional, I long have been intrigued with the Jewish custom of paying attention to sadness before experiencing joy—the purpose of the breaking the wine goblet beneath the groom’s heel before the wedding celebration begins. I find that my clients and I benefit in developing rituals paying homage to sadness and then moving into joy.

Finally, I find long-term benefits to the development of a credo or statement of “I believe” to help synthesize the person’s feelings and actions. Credos consist of three statements to which the person can answer “yes,” followed by a transition statement, and finally the person examines strategies to implement changes.

Prostate cancer took a toll on me by entering my being at a fairly young age. It is my hope that sharing my personal experience and discussing
this serious illness will assist you in treating not only men with prostate cancer but also other clients living with serious illnesses.

Mark Smith, ACSW, LISW, is director of special projects at the Substance Abuse Treatment Unit of Central Iowa (SATUCI). He is a mental health professional who is in his third term in the Iowa House of Representatives and is the ranking member on the House Human Resources Committee. Mark is also a member of the NASW Board of Directors and a former member of the Specialty Practice Sections Mental Health Committee.

References


NASW GOVERNMENT RELATIONS UPDATE

The 109th Congress is coming to a close at the end of 2006. The National Association of Social Workers promoted a number of bills and worked to defeat others. Following is a quick recap of the status of bills of interest to social workers in the 109th Congress.

Paul Wellstone Mental Health Equitable Treatment Act of 2005
H.R. 1402 would provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits. Currently there are 229 co-sponsors. The bill sponsor is seeking to push this bill to a vote by filing a discharge petition. NASW supports this legislation for equal treatment of mental health and physical health services.

Clinical Social Work Medicare Equity Act
This act would allow social workers to bill Medicare for services that they cannot currently bill for under Medicare Part B. This has been a major priority for NASW over the past several years, and we will continue to push for this in the coming Congress.

Health Information Technology
Efforts to establish a central database of health care information did not include necessary safeguards to protect the health care privacy of consumers. NASW worked with a coalition to stop passage of H.R. 4157.

Labor, Health and Human Services Appropriations
NASW pushed to increase funding for the Promoting Safe and Stable Families Program through the appropriations process. The appropriations process provides funding for discretionary government programs such as some child welfare programs, the elementary and secondary school counseling program, and the social services block grant. To date, the Labor, Health, and Human Services appropriations bill has not passed the House or the Senate. All appropriations bills outside of defense and homeland security were delayed through a continuing resolution, which allows programs to be funded until November 17.

Tax Cuts
Efforts to permanently repeal the Federal Estate Tax have been halted by advocacy organizations that see the repeal as a threat to funding of health and human services programs. The Congressional leadership may try to pass the Estate Tax repeal during the current lame duck session.
The safety of social workers across the country is brought to the attention of the public when a social worker is killed in the line of duty. This is an issue of great importance to the National Association of Social Workers and its 56 chapters. The October 18 murder of a child welfare social work aide in Henderson, Kentucky, brings to light the diminishing resources of social workers and the increasing complexity of client issues.

Social workers in all practice settings deal with the threat of harm on a daily basis. Our jobs are often with involuntary clients. As a result, our interactions may be fraught with tension, conflict, contention, and animosity that can escalate to physical violence.

In certain professional social work settings, this likelihood of violence is acknowledged. Many child welfare agencies, hospitals, and mental health institutions are staffed with security personnel. However, the work of social workers is not the sole province of agencies—or schools, as we well know. A critical amount of social work is in the field. Clearly, the risks escalate when there are home visits with contentious clients. Police escorts are usually reserved for high conflict situations such as child removal, but as was recently witnessed in Kentucky, any situation, such as a routine home visit has the potential for escalation.

As a result, it is imperative that as Hurricane Katrina sent shock waves reverberating throughout all social welfare agencies, schools, and hospitals in the nation that evacuation and safety plans must also be put in place. It is important to urge schools to create safety plans to protect workers.

If your agency, school, or hospital does not already have a safety plan in place, consider advocating for the following ideas:

- Home visits conducted in teams;
- Agency-supported self-defense training;
- Risk assessments for violence: Currently, we do risk of harm assessments for children and elderly adults but not social workers;
- Improved and more collaborative working relationships between local law enforcement and social welfare agencies; and
- Personal security items, such as pepper spray or whistles, provided to social workers.

Utilizing violence as a means of handling conflict has become common in recent decades. No sector of America has escaped this dynamic. Violence was once viewed as only occurring on the street or in the home; It now has permeated the workplace. As social workers practicing in a violence-prone society, we must continue to strongly advocate for improved safety precautions.

Yan Searcy, PhD, MSSW, is an associate professor in the Department of Social Work, Chicago State University. He is chair of the NASW Specialty Practice Sections’ Child Welfare Committee. He can be reached at ysearcy@csu.edu
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