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PRIVATE PRACTICE

SECTION CONNECTION

Letter from the Chair

Affordable Care Act & Clinical Social Workers in Private Practice: Opportunity or Obstacle?

The passage of the Affordable Care Act (ACA)—or, colloquially, ObamaCare—is a major triumph in providing affordable health coverage to millions of Americans who would otherwise remain uninsured or, potentially, receive substandard care. The implementation of the ACA paves the way for important improvements in health care delivery, including reduced cost to consumers, promotion of wellness and prevention, and enhanced quality of care. The ACA is consonant with social work's core mission of advocating for equal access to health and mental health care for all Americans.

As has been enumerated in many professional social work articles, Council on Social Work Education's Affordable Care Act bibliography, (www.cswe.org/File.aspx?id=70935), the ACA offers social workers ample opportunity to assume important roles in care delivery. For example, Andrews, Darnell, McBride, and Gehlert (2013) contend that social workers play three pivotal roles—patient navigators, care coordinators, and behavioral health counselors—all of which contribute to the achievement of ACA objectives.

These social work roles are generally carried out in hospitals, institutions, and agencies that comprise accountable care organizations (ACO), allowing for patient-centered coordination of care across providers, social work participation in the larger health care field, partnership building with community organizations and their leaders, and outreach to at-risk populations. As part of integrated behavioral health care (IBHC) practice, these social workers contribute to the delivery of quality coordinated patient care.

What role do clinical social workers in private practice play in the implementation of the ACA? How, if at all, will the ACA impact the nature of private practice? These important questions remain largely unanswered. As the demand for social workers in ACOs increases with the rise in insurance and Medicaid coverage, there may be a trend away from private practice and toward providing psychotherapy in integrated behavioral health care and medical settings. If subject content in clinical social work and psychoanalytic social work listservs is any indication, private practitioners frequently complain about the difficulty of maintaining a quality standard of living in private practice.

Increased paperwork, denied or delayed claims, unpleasant interactions with managed care reviewers, decreased reimbursement rates, and difficulties interpreting and adhering to Health Insurance Portability and Accountability Act (HIPAA) regulations all contribute to making psychotherapy difficult in a practice environment dominated by managed care. Potential patients often prefer to use in-network providers for financial reasons, yet in-network

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IT'S A FACT: Professional self-care is an essential

Private Practice Committee Members

NEUROSCIENCE COMPETENCE FOR CLINICAL SOCIAL WORKERS IN PRIVATE PRACTICE: Memories Change

MICHAEL ROGAN, PHD, LCSW

It is challenging for social workers to keep up with the abundance of literature directly related to their own expertise in social work practice. It is even more challenging to understand and make use of research from other, potentially relevant disciplines, such as neuroscientific findings about brain and behavior, social and emotional function, and learning and memory.

As I developed from my work as a research neuroscientist to a clinical social worker in private practice, I welcomed the social work concept of *cultural competence* and how it may be usefully generalized beyond issues related to language, lifeways, and nation of origin to encompass similar kinds of cultural issues that exist across domains of specialized knowledge.

When dealing with specialized research, everyone—social workers and neuroscientists alike—must be aware of the boundaries of their own expertise and the limits of using information derived via unfamiliar methods and techniques. Research rests on decades of related peer-reviewed literature, which frames how relevant issues are discussed and how new information fits into the existing body of knowledge, and it requires a domain-specific understanding of the nature and value of certain measurements and analysis methods. It is this hidden history, which cannot be articulated in each research article that makes me think of this domain-specific understanding as a kind of cultural competence. This article will explore neuroscience research about a phenomenon central to clinical social work practice: the nature of memory—and, in particular, what some neuroscience findings suggest about what happens when memories are recalled by clients in treatment.

underpinning to best practice in the profession of social work.

MEMORY IS NOT A VIDEO RECORDING

As an adaptive function, memory has presumably evolved to retain, and then make available again, information that is useful to guide current actions. We know that there are different kinds of memories, including those related to motor skills, for example, and those that involve storage recall of events, and emotional qualities—the goodness, badness, or "importance" of events. This purpose cannot be well served by a rigid and exhaustive video-like recording, which would have to be replayed to be of benefit. Indeed, our experience indicates that memory is both selective and changeable, or *plastic*. For example, people who are present for the same events remember different things, and memories that once were painful to recall can become less so over time. A broad range of research efforts have explored these issues in the laboratory, and though a social worker may be familiar with some of the more interesting findings about neuroplasticity that have entered into clinical discussions, it is important to be clear about the limitations of this knowledge and its relevance to treatment. "Neuroplasticity" describes a general characteristic of neural function: that brain function undergoes constant change in adaptation to new information and to internal and external events.

MEMORY STORAGE, RECALL, AND RECONSOLIDATION

There is good evidence that memory storage, or *consolidation*, involves a physical change in neural structure and function that is dependent on the manufacture of proteins; to use a computer analogy, this is how information is written into the "hard drive" of the brain. The primary evidence for this is the finding that administering drugs (protein synthesis inhibitors) that temporarily prevent the manufacture of new proteins will prevent the storage of new information (new memories), if the drugs are administered in a certain time window after the learning experience. Importantly, the ability to use a drug to block memory storage has allowed us to explore how memories change after they are recalled.

For example, the recall of memory could take place in different ways: the memory could get "copied" into current awareness during recall, and afterward the copy is discarded, leaving the original memory intact. Or the recalled memory could be stored again (*reconsolidated*), replacing or updating the memory that had existed before. It turns out that two lines of molecular-based evidence indicate that recalled memories can be not only reconsolidated but also updated by new information.

These studies were pioneered in rodents, using classical conditioning. In a typical experiment, a rodent shows fear responses to an auditory tone the day after training in which the tone was paired with a mild aversive shock; the tone is now experienced as threatening due to the information recalled about the training experience. This basic experimental procedure has been used to investigate memory reconsolidation and plasticity.

First, administration of protein synthesis inhibitors after recall (of the fearful tone, for example) can cause amnesia regarding the original memory (so that the tone memory loses its threat information), indicating that blocking reconsolidation results in the blocking or erasure of the original memory (Nader & Einarsson, 2010). Second, one can modify the experience of the recalled memory without blocking reconsolidation, and this leads in the memory to an enduring change, which can be noticed when it is recalled the next time. This has been done by inducing recall of a fear memory in the presence of a beta-blocker, an anxiolytic that greatly reduces the aversive experience of the recalled memory; this much-less-threatening experience is then stored during reconsolidation, replacing the original threat memory. Such manipulation results in a significant reduction of aversive response upon subsequent recall of that memory. A clinical example of how this may occur in treatment is provided below.

MOLECULAR/PHARMACOLOGICAL EVIDENCE FOR MEMORY UPDATING IN PEOPLE IS NOT COMPELLING

As a general rule, it is important to remember that here, as in most areas of neuroscience, the most detailed knowledge about memory at molecular, cellular,

Letter from the Chair… *continued*

providers are often paid considerably less than their customary fee for patients not using insurance. Listserv content often focuses on tips for dealing with managed care reviewers who scrutinize treatment plans, question standard therapeutic interventions, curtail the number of requested sessions, and insist on the use of evidence-based practices for a specific diagnosis.

These are just some of the many factors contributing to the tone of dissatisfaction echoed on the listservs and in the halls of professional meetings. Private practice will likely become increasingly daunting with the continued implementation of the ACA and the processing of electronic and personal health records as required by HIPAA. Clinicians who value autonomy and have the luxury of fee-for-service patients only will likely weather the changes better than those who must rely primarily on managed care referrals.

The potential ramifications of the ACA for private practitioners afford each of us the opportunity to rethink our priorities, our values, and ultimately our professional identities.

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and behavioral levels has derived from work with nonhumans. Similarities in neurons and neural systems across species show a remarkable degree of conservation of molecular and structural function throughout evolution, and in many cases this has led to direct translation of findings to human experiments and to human experience; however, in the case of memory, this translation has been challenging (Schiller & Phelps, 2011). For example, it is not possible to administer these protein synthesis inhibitors to humans and directly test this question, and though the use of beta-blockers to modify recalled traumatic memories has been done in people (e.g., Brunet et al., 2008), it has been significantly less efficacious, and subject to alternative explanations (Schiller & Phelps, 2011).

BEHAVIORAL INTERVENTIONS SUPPORT MEMORY UPDATING IN PEOPLE

A different line of research has emerged in recent years as the best evidence yet for reconsolidation and plasticity of memory in humans: *behavioral interference.* Though less compelling than molecular manipulations from a neuroscientific and mechanistic point of view—and more subject to problems of interpretation—behavioral interference paradigms bear analogy to commonly accepted models about how painful memories are ameliorated during talk therapy. In one study of classical conditioning, a person recalls a fear memory, and during the time in which the fear memory is present in mind it is combined with new safety information (Schiller et al., 2010). This treatment results in a lack of fear responsiveness to the original fear memory for a year afterward. Now, it is very attractive to view this as a substantiation of our clinical goals and experience in a therapeutic session—particularly given that traumatic memories recalled in a safe therapeutic context become less distressing over time. This phenomenon may, in fact, underlie some of the efficacy of long-standing experiential treatments. However, this specific line of research has begun only recently, and replication and refinement of findings are in the future (compared to the molecular/pharmacological studies of reconsolidation in nonhumans, which have been going on for decades and tend to dominate discussion of these issues in texts related to therapeutic approaches).

RELEVANCE TO YOUR THERAPEUTIC SESSIONS

Despite the lack (so far) of strong, replicated experimental support, given the suggestive nature of these findings and their congruence with "boots on the ground" clinical experience, a practitioner would be well advised to assume that such reconsolidation and updating opportunities may be common occurrences in the therapeutic session. And though it is not a novel clinical idea (Parsons & Ressler, 2013), it may be considered a new priority that in treatment for trauma, for example, effort be made so that the client is always aware of being safe in the present moment. This makes good clinical sense and may also recruit valuable neurobiological mechanisms that can foster recovery from trauma.

In my psychotherapy practice, mindfulness techniques play an important role in this process. Mindfulness, as a clinical intervention, involves training in attentional flexibility, which supports grounding in present experience and disrupts habitual cognitive and emotional reactivity. Specifically, integration of mindfulness techniques in the client/clinician alliance can promote a reliable orientation to current experience during the session. Establishing with the client an ability to be mindfully present in session together, before engaging in traumatic material will enable the safe therapeutic alliance to remain intact with the onset of traumatic memories. For example, a client with a history of complex childhood trauma, frequent extremely distressing re-experiences, and dissociative episodes was able to develop an effective mindfulness practice in session and further develop this practice at home. Afterward, when traumatic memories were recalled in session and generated distress and dissociation, we were able to use mindfulness techniques to reorient to the present safe circumstance and continue a productive exploration of the difficult material and integration of it into his present adult life. In this way the client can be aware of being present, in relationship with the clinician and in the absence of the original danger, as well as being aware of the problematic memories being recalled and explored. Mindfulness can thereby provide a practical means by which a beneficial "mix" may be brought about and reconsolidated, though this is of course dependent on the quality of the client/clinician relationship and the ability of the clinician to collaborate in holding a safe place with the client.

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PERSONAL TRAUMA AND ITS IMPACT ON Professional Practice

CAROL TOSONE, PHD, LCSW

There's a plethora of professional literature about the impact of the client's trauma on the clinician, and various terms have been forwarded to give voice to this experience, including "compassion fatigue," "secondary trauma," and "vicarious traumatization." While these terms aptly describe the clinician's response to bearing witness to the client's trauma narrative, none sufficiently capture the experience of clinicians who have been exposed to the same traumatic events as their clients.

Consider traumatic events, both of a personal and a collective nature. A clinician with a history of sexual abuse working with a childhood sexual abuse survivor knows intuitively the nature of the difficulties encountered by her client; the client may perceive a resonance, a knowing glance, or an eerily accurate interpretation from the therapist. Unless queried by the client or self-disclosed by the therapist, the client cannot know for certain that he or she shares a history of childhood sexual abuse. In this moment, a self-reflective clinician needs to grapple with the potential therapeutic value of self-disclosure, and determine whether such a decision emanates from her subjective countertransference or the developmental and relational needs of her client. Does self-disclosure help the client to feel better understood? Is he or she able to gain a deeper and transformative understanding of his or her painful experience? Is he or she able to access dissociated traumatic content and be more capable of developing deeper intimacy in his or her personal relationships? Or does the therapist's revelation make the client self-conscious and hesitant to speak openly because of the perceived negative impact on the therapist? In essence, does the client now feel the need to take care of the clinician?

The decision to self-disclose alters the therapeutic frame, creating an "intimate edge" (Ehrenberg, 1992), as the therapist's vulnerability and unconscious responsiveness reflects a countertransference enactment. The clinician's confessional disclosure of her affective response reflects an empathic interpretation of another's traumatic experience as well as a subjective, deeply personal association to the traumatic content. While the therapist may rationalize that revealing a childhood trauma history is in service of empathizing with the client, it may, in fact, be imposing one's harrowing narrative and unwittingly retraumatizing the client. Self-disclosure can also give voice to another's lived experience, helping a reticent or alexithymic client access somatic and affectively toxic memories. "Know thyself" is an aphorism especially germane to therapist survivors of childhood sexual trauma, as it can help them evaluate the principal reason for disclosure, anticipate potentially negative and long-lasting consequences, and guide their decision of whether to self-disclose.

This type of personal shared trauma stands in sharp contrast to shared trauma experienced by clinicians exposed to the same collective traumatic events as those of their clients. In this country alone, notable examples include Hurricane Katrina, the Midwest tornadoes, forest fires of the mountain states, California mudslides, and the Pacific Northwest floods. These events are illustrative of the increasing number of natural disasters linked to climate change. September 11 stands out as a chilling national example of the pervasive acts of terrorism and war that have increased worldwide. In these situations, clinicians are not afforded the same privacy as when the trauma is solely personal. During the aftermath of the September 11 attacks, for instance, a common question asked by clients of their New York City therapists was, "What were you doing when the planes hit the towers?"

In this instance, the unprecedented and overwhelming nature of the collective trauma left clinicians ill-prepared to deal with the boundary alterations and exposure of vulnerable emotions in the therapeutic situation. I was with a patient in my lower Manhattan office as the first plane to hit the World Trade Center towers flew over the building. Without the visual cues, my client and I struggled to make sense of the cacophony

The National Association of Social Workers (NASW) offers its condolences to the families and friends of the nine people who lost their lives in the June 17 mass shooting at Emanuel African Methodist Episcopal Church in Charleston, South Carolina.

of disturbing sounds, including the plane hitting the building, observer screams, and police and firefighter sirens. My curiosity about how colleagues handled the horrific moments and aftermath, as well as my constructive attempt to work through the traumatic experience professionally, led to my study of the long-term impact of 9/11 on Manhattan NASW members (N=481). Notably, social work respondents with insecure attachment styles, and with greater exposure to potentially traumatic life events in general, and 9/11 in particular, were at greater risk of developing primary and secondary (shared) trauma. Surprisingly, clinician resilience played only a modest role in mediating the relationship between these variables. A replication study (Tosone, McTighe, & Bauwens, 2014) of the long-term impact of Hurricane Katrina on New Orleans social workers (N=244) found similar results, with the exception that those who were insecurely attached and reported greater levels of stress related to Hurricane Katrina were less resilient and more prone to shared trauma.

The narrative responses to the 9/11 and Hurricane Katrina studies support and supplement these findings. The 9/11 study respondents, for example, reported engaging clients on a deeper level of therapeutic intimacy and disclosing more personal information than under "normal" circumstances, a change that was considered transformative and anticipated to continue indefinitely. Other themes that emerged from their post-9/11 practice experience included: (a) a change in the collective consciousness, such that there was a loss of innocence, an increased sense of vulnerability, and living in fear of another terrorist attack ("I have accepted the fact that I will never be quite the same when I hear an ambulance go by or a fire engine attending to an emergency"); (b) their past traumas either served as preparation for or complicated recovery from 9/11 ("Being a veteran helped inoculate me… been there, done that"); (c) traumatic reactions continued to persist long after September 11 ("I'm afraid that if I look up at a plane, I might see it explode"); and (d) the collective nature of the trauma brought about blurred roles and a sense of sharing the traumatic experience ("My patients and I were 'in the soup' together…and talked about our thoughts, feelings, and experiences") (Tosone, McTighe, Bauwens, & Naturale, 2011; Bauwens & Tosone, 2010).

Shared trauma has also been referred to as "shared traumatic reality" (Dekel & Baum, 2010) and "simultaneous trauma" (Seeley, 2008) in the professional literature. Shared trauma and its kindred constructs can be viewed as the affective, behavioral, cognitive, spiritual, and multimodal responses that social workers and other mental health professionals experience as a result of primary and secondary exposure to the same trauma as their clients. As with vicarious traumatization, these reactions have the potential to lead to permanent alterations in the clinician's existing mental schema of self and others, as well as one's general worldview—the difference being that having experienced the trauma primarily, these clinicians are potentially more susceptible to posttraumatic stress, the blurring of professional and personal realms, and increased self-disclosure with clients. Also, therapists experiencing shared trauma may resemble those faced with compassion fatigue or secondary trauma in terms of common symptoms such as exhaustion, depletion of empathy, and identification with the client. These experiences are attributable to the dual nature of the trauma.

Importantly, as with shared trauma of a personal nature, collective shared trauma does not imply that the clinician's trauma response is identical to that of the client. Clinicians and clients can be variably impacted by the same simultaneous event, and it must be kept in mind that each dyad takes place in a unique intersubjective context, one influenced by the individual histories and current interpersonal realities of the participants, and subject a specific transference-countertransference matrix as a result of these interactions. Dual exposure to collective trauma does not afford the clinician the usual anonymity of the clinical hour, and may foster a mutual emotional contagion as the clinician and client potentially traumatize and re-traumatize each other. Shared trauma, however, also underscores the relational, communal nature of the event, providing opportunity for mutual reparation and the fostering of *shared resilience* (Nuttman-Shwartz, 2014), both at the office and in one's personal life.

Social supports, both personal and professional, can mitigate the negative symptoms of shared trauma. At such times, personal needs should be prioritized over professional responsibilities; that

is, therapists too overwhelmed by their primary traumatic experiences need to self-protect and take the necessary time to heal, as they may not have the emotional bandwidth to assist others going through a similar experience. These clinicians need to be supported in this decision by loved ones—and provided with formal individual, group, or peer supervision by colleagues. NASW and other professional organizations can provide the necessary leadership to ensure that the holding environment extends beyond the usual confines of the therapist's office and into the professional community of its members. With such supports, clinicians can realize opportunities for personal and professional posttraumatic growth and transformation.

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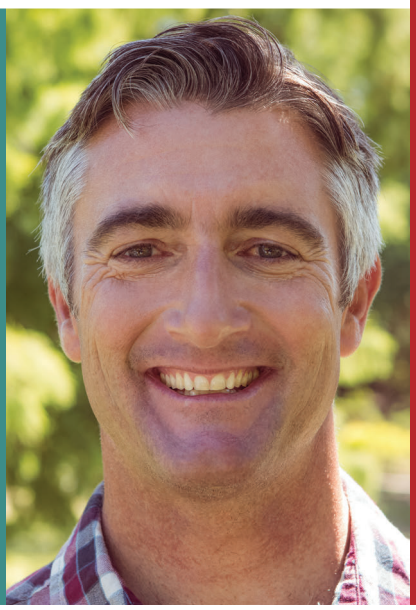

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