Lessons from the Secure Care Ward

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Abstract: My first fieldwork assignment for my MSW was at our local state psychiatric center. I was to split time on both the admission and secure care wards. Fortunately, I had a good field instructor, one that helped me to learn some important practice lessons from both wards. I'd like to relate the lessons that I learned from my experience in this setting, and how that learning opened pathways for further learning as I came to practice on my own.

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My first fieldwork assignment for my MSW was at our local state psychiatric center. I was to split time on both the admission and secure care wards. Now, the admission ward didn't seem to scare me too much at this point in my career, but I had more than a little trepidation about that whole “secure” thing. After all, I was reading the DSM (III-R, back then) in my practice class, and as I was able to find at least one friend or family member to meet most of the Axis I criteria (and quite a few Axis II, by the way). I imagined that the admission ward would be pretty manageable. But, I wasn't too sure that I had much to offer to the chronically mentally ill folks, ones that might just be hospitalized for the rest of their lives. And besides, they were scarier. Fortunately, I had a good field instructor. One that helped me to learn some important practice lessons from both wards. I'd like to relate to you, the reader, the immediate lessons that I learned and how that learning opened pathways for further learning as I came to practice on my own.

Now, I don't know how typical of a first year student I was, and I don't mean to speak for the profession of Social Work. I just hope that my experiences can be helpful to some of you. I entered the MSW program right out of undergraduate school, though it took me a few years longer than most to first get into college (guess I was busy, or something). I spent the first couple of years after high school bouncing around doing manual labor (really, discovering just how much I didn't want to do manual labor). So (there is a point to all this), even though I was older than most undergraduates, I didn't enter the graduate program with much human service experience. Therefore, to those of you who have this practice experience, I apologize for the upcoming statements of the obvious.

Anyway, let's get back to my then recently discovered alleged diagnostic capabilities. As I said above, and like most of us, I think, when I first got my DSM (funny that it was the first book I started reading that semester) I began to leaf through the illnesses and was able to see in myself, and the people around me, the signs of the various criteria. There was my friend Julie who was clearly obsessive-compulsive, poor depressed John, and a family member (I'll call him Uncle Bill) and his alcohol dependence (actually I was right about that one – he's sober five years now). Even I didn't escape my diagnostic prowess. I had a sneaking suspicion that I had my own obsessive-compulsive disorder, (I had to re-check if I had put the gas cap back on after almost every fill-up – could never remember if I put it back on), and surely I had an anxiety disorder (I got nervous every time I talked to a girl that I was attracted to).

So, there I was, two or three weeks into my diagnosis frenzy, when suddenly I was asked to go talk with a patient that had come in to the ward last night to try and get some basic psycho-social information. At first, this patient (I'll call him Rick) didn't seem to be acknowledging me. He kept saying random words, occasionally stringing together a sentence or two about the dogs that were trying to hurt him. This, of course, was very distressing to him, and I could sense his frustration at not being able to complete a thought. Rick was experiencing some very real psychotic symptoms, and for the first time I came to see the reality of the words in the DSM. I can still remember that feeling of “Oh, that's what they mean” that I experienced. To see the words lived out, in very human terms, was an enlightening experience. The concepts that were represented in that book began to change, from

purely intellectual form, used to characterize and classify people, into a functional way to begin to understand a person's suffering – a kind of road map that could begin to take me where a client was.

The lesson that I learned for later practice was coming to understand that the words in a book were just words until experienced. This included all those social work skills so eloquently described in my practice books. Skills like attending, showing empathy and genuineness, being concrete and warm, demonstrating unconditional positive regard and respect, etc. It was through reflecting on my DSM fiasco that I started to be able to internalize social work concepts in a different way. You see, as I was being bombarded with all these ideas, the concepts became yardsticks with which to measure my inadequacy, rather than the helpful instruction that they were meant to be (I know, by this point you've broken out your own DSM and are starting to diagnose me, let's see – insecure, must be in the affective section…). The point that I'm trying to make, and I'm going to get a little philosophical here for a minute, is that phenomena exist, and then later they are named, defined, and categorized. We feel warm and safe when our parents hold us, but it is often many years before this phenomenon is defined as "security" for us. We experience the state of security long before we call it that. And so it is with helping skills.

Well-experienced practitioners, the ones who write the practice books, have practiced and perfected things like reflective listening and compassion by living these phenomena in countless interactions with clients. As they have looked back and reflected on these interactions, they name the phenomena and describe them in writing. However, because they were, in fact, in writing, I saw these skills as a prerequisite to practice, thus the yardstick analogy. The reality is that, as a beginning social worker, I was not expected to be able to be attentive, empathic, genuine, etc., all the time with all of my clients. These skills had to be grown into (yes, you'll grow into them). This is not to imply that there is no effort involved, only that new skills don't become second nature overnight. In fact, they usually only arrive in retrospect. So, if you are feeling overwhelmed, wondering how in the world you're going to be able to remember to act in all these new ways and still be able to hear a word that your clients are saying (and I think I'm not the only one who felt this way), relax. Listen first, and the rest will follow.

Now, if you will, I would like to return us to the psychiatric center, to the secure care ward, and tell my tale of Lenny (be prepared, this is one of those sappy social worker stories – why else would I be telling it?). Lenny was one of the clients on my caseload. I'll describe his case very briefly, mostly due to confidentiality, but also since it has been a few years past now and not all of the details are still clear. Lenny had schizophrenia. He had murdered someone several years before (details not important), and he was non-verbal. I'll spare you all the trials and tribulations that I encountered in trying to connect with Lenny, just know that I spent many hours in supervision discussing the relationship that I wasn't developing with him. I was frequently frustrated and felt quite unhelpful, believing that I was at best wasting Lenny's time. But since my supervisor kept emphasizing the importance of relationship and therapeutic alliance and kept reassuring me that any time spent truly being with a client was never wasted, I pressed on. I kept talking, smiling, trying to engage – not believing, but trusting.

Anyway, cut to my last session with Lenny, as I was preparing to finish my internship. After saying good-bye, Lenny took me by the arm and led me to his locker (I had the key). I rightly assumed that he wanted a candy bar (he loved Baby Ruth bars). I wasn't sure what to do, but I decided, why not; I'm almost done and can't get into too much trouble. Besides, I had really come to care about Lenny and wanted to do something nice. I was more than a little surprised when I turned back after re-locking the locker to find Lenny handing his candy bar to me. He just handed me the candy, hugged me quickly, and walked away (I still get a little choked up thinking about it). I said thank you, but like I said, Lenny was non-verbal. I don't know if my words reached him, but he did see the smile on my face and the tear in my eye.

So, what was the lesson here? No, not that it's alright to accept gifts from clients. I did talk to my supervisor about the candy, and we decided to slip the candy back into Lenny's locker when he wasn't around, though we both felt that it would have been

bad practice for me to not accept Lenny's gift. The candy was Lenny's most prized possession. To have declined the gift would have been to deny the giver. The lesson, of course, is that we need to lead with our hearts (not that we don't need to have appropriate professional boundaries, of course). You see, I really didn't do much therapeutically with Lenny (after all, he was highly medicated, non-verbal, had no family involved, and was never going to leave that ward). What I was able to do was to provide some human companionship, some connection. Lenny, despite my belief that I wasn't doing enough, was a pleasure to be around. He had a natural playfulness and a smile that could fill up a room. So I played with him and found myself smiling back an awful lot. Once I was able to put aside my fears of not being a perfect social worker, I was able to become a better social worker.

The long-term lesson was, similarly, that it really is the relationship that matters most. Techniques, methods, and skills are very important; in fact, they are the means by which we effectively express the relationship. But they cannot overshadow that connection, else we find ourselves cold technocrats.

So, as this little essay winds itself down, let me summarize. These two lessons may be helpful to you and your practice. Remember to give yourself a break; what you are learning now will take your entire career to perfect (and then, of course you'll retire). Also, lead with your heart; clients can deal with many technical mistakes if they believe that you care. I hope that you all have many Baby Ruth bars in your future.

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