



# Introduction to “Best Practices in Psychosocial Healthcare: Complexity, Compromise, and Innovation”

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Despite the advances of modern medicine in the past century, chronic diseases are now the primary cause of death in most countries of the world (WHO 2005). As the populations of many countries continue to age (Kaneda et al. 2018), we can only expect a growing disease burden on individuals, local communities, and human society as a whole. Public health efforts to focus on disease prevention (e.g., through changes in lifestyle) have been slow to ease this burden. Six in ten Americans live with *at least* one chronic illness (CDC 2019) such as cardiovascular disease, respiratory illness, mental health conditions, and cancer, all of which contribute to long-term disabilities, loss of income and workforce productivity, and rising healthcare costs. These Americans also face multiple challenges in our healthcare system—in gaining access to adequate insurance coverage; locating appropriate providers within their communities; meeting the financial burden of treatment and related expenses; getting sufficient time to engage with providers; and coordinating communication among various specialists in an increasingly siloed system of care.

On a micro level, individuals with serious health problems must manage the inherent uncertainties of disease and an increased risk of anxiety, depression (Chapman et al. 2005), and suicide (Gurhan et al. 2019). Chronic illness takes a toll on their caregivers’ physical and mental health as well (Rees et al. 2001). Furthermore, issues of disconnection and isolation are more prevalent among older adults with illness and those living in rural areas of the United States.

There remains a gap in our healthcare system’s timely identification of co-occurring mental and physical disease and coordination of care among multiple providers (Piane 2015). In order to prevent further marginalization of people made more vulnerable by serious illness, we need to ensure greater accessibility, breadth and depth of psychosocial services.

Parallel to the struggle of individuals with chronic illnesses are the challenges that their healthcare providers confront when trying to deliver truly *patient-centered care*, or the provision of care that respects individual patient preferences, needs, and values (IOM 2001). Medical providers are faced with pressures to see more patients with less staff and fewer resources; to maintain or increase daily hospital or clinic census with a fixed amount of space; to offer treatments and medications that won’t bankrupt their patients or become more toxic than the diseases; and to honor their patients’ preferences when chronic illness becomes acute and cure is no longer the goal. In a vast and complicated American healthcare system, providers are at risk of losing focus on truly patient-centered care.

Navigating between patient and provider, the healthcare social worker has both opportunity and responsibility to find a path through many of the above obstacles. Our essential role is to help patients negotiate major challenges to their health and identity. Together, we problem-solve to alleviate concrete burdens, restore or improve quality of life, and clear space to engage in the psycho-social-spiritual tasks of coping. Healthcare social workers facilitate a deeper exploration of patients’ experience: What does their illness mean to them? What does it mean to be a “patient”? We help them identify how their lives have changed, how they typically cope under stressful circumstances, what still works and what doesn’t, and how illness has impacted their worldview, relationships, and sense of self.

As we increasingly collaborate with other healthcare professionals (e.g., physicians, physician assistants, nurses and nurse practitioners, medical assistants, chaplains, psychologists and psychiatrists), how do we maintain our unique role

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in shaping patients' psychosocial well-being? We encounter scarcity around every corner across healthcare settings—the constant threat of budget cuts, insufficient social and financial resources for our patients, and sometimes a lack of physical space in which to do our work. We are often asked to do more with less. Furthermore, we may encounter an underlying mentality that psychosocial services are desired and ancillary but not essential. How do we demonstrate and maximize our value at the same time?

In an overwhelmed and complicated healthcare system, scarcity forces us as social workers to be creative and flexible, to compromise at times and stand our ground at others, to be more selective about our interventions, and to choose or design best practices that meet our patients' needs. This special edition of the *Clinical Social Work Journal* illustrates several examples of the complexities we face, the compromises we consider, and the clinical innovations we employ to improve the quality of life in people experiencing serious illness.

## Complexity

Beginning with Liz Johnston and Dianne M. Terp's article, "Support Is a Complicated Concept: A Social Work Practice Reflection on Support and Anxiety," this section focuses on the complexities of psychosocial healthcare practice. Johnston and Terp challenge the way we tend to view social support. Informed by their own practice experience, the authors demonstrate that for older adults with illness, more support is not always better. In fact, some types of support may contribute to the decline in quality of life that we're trying to prevent. The authors argue for a more nuanced assessment of social support systems, an assessment that benefits from the in-depth and holistic approach of a social worker.

Similarly, Maria Chi's paper on "The Hidden Cost of Cancer: Helping Clients Cope with Financial Toxicity," examines another area in which social workers may better assess complicating factors in the experience of illness. Citing evidence from the literature as well as her own clinical experience, Chi presents the impact of cancer-related financial stress on quality of life. Noting the potential for financial challenges to interfere with people's ability to manage some of the basic cognitive and emotional tasks of coping with illness, Chi argues for the need to take financial toxicity as seriously as the disease itself.

Next, Camilla Udo, Henrietta Forsman, Marcus Jensfelt, and Maria Flink's article, "Research Use and Evidence-Based Practice Among Swedish Medical Social Workers: A Qualitative Study," explores common obstacles to delivering patient-centered care. Although centered on a different healthcare system, the authors' study reminds us that social workers all over the world face similar challenges. Lack of

time, guidance, and administrative support are all barriers to translating research into real-world best practices in many healthcare settings. The authors remind us that despite the complexity of implementation, engaging in evidence-based practice is a worthwhile pursuit, given that honoring patient preference is a core part of the process.

## Compromise

Douglas Behan's piece, "Demoralization During Medical Illness: A Case of Common Factors Treatment," begins the conversation in this issue on compromise, another important aspect of providing patient-centered care within a complex healthcare system. When practicing within the constraints of various medical settings, how do we adapt without sacrificing quality care? Behan provides an instructive case example of how he applied the common factors approach to ease a patient's demoralization in a results-oriented medical setting. He illustrates the ability to keep the patient-clinician relationship central—and meet patient goals—while adapting to the limits of time and space of a rehab facility.

Moving from hospital bedside to the outpatient primary care setting, Lauren Dennelly also makes a case for flexibility in "Navigating Psychosocial Challenges in Primary Care with an Integrated Behavioral Health Model." Recognizing the connection between mental and physical health, the author offers a strong argument for making on-site behavioral health care providers an essential part of the primary care team. Their inclusion honors the principle of "meeting people where they're at" and reflects an adaptation to patients' comprehensive needs—both medical and psychosocial—in the moment.

The authors of "A Commentary on Compromise" challenge our understanding of compromise and caution against adapting too readily to the growing demands of healthcare settings. Instead, Terry Altilio, Bridget Sumser, and Meagan Lyons Leimena propose that social workers re-affirm what we do best—assess for patients' personal meanings of illness, consider the holistic impact of disease, and neither integrate nor specialize ourselves out of existence. Rather, the authors provide a brief history of our role in psychosocial healthcare as well as a path forward, leading the way.

## Innovation

Krister W. Fjermestad, Yngvild B. Haukeland, Svein Mossige, and Torun M. Vatne's "Children's Perspectives on the Experiences of Their Siblings with Chronic Disorders" is one innovative example of clinical social work leadership. The authors present a qualitative analysis of the unique vantage point of children as they experience their siblings'

serious illnesses. Eliciting the insight and perceptions of siblings is a creative way to understand our patients' world and inform more holistic clinical interventions.

Another innovative approach to working with people with serious illness is proposed in Meredith Hemphill Ruden's "A Call for Hope-Centered Work: A Preliminary Study of Oncology Social Workers' Perceptions of the Role and Value of Hope at End-of-Life." Hemphill Ruden surveys social workers to explore the role of hope in the experiences of people with cancer at end-of-life. The data reveal the extent to which social workers engage with the concept of hope, their felt competency in identifying matters of hope or hopelessness, and their ideas for hope-informed practice in the future.

Finally, "Advance Care Planning: Opportunities for Clinical Social Work Leadership" presents the ultimate example of patient-centered care in the form of advance directives. Shirley Otis-Green, Judy Thomas, Lael Duncan, Anne Walling, Codie Lieto, Jennie Kung, Christopher Pietras, and Neil Wenger elucidate the many ways in which social workers may facilitate conversations with people making deeply personal and meaningful decisions about healthcare. The authors illustrate how social workers, skilled in communication, relationships, and assessing individual, familial, and cultural preferences, may become champions of people in directing their own end-of-life care. Here, the potential proliferation of social work leaders in advance care planning becomes the key innovation.

Each article in this special journal issue demonstrates a complexity of our contemporary healthcare system, the compromises we face, and/or the innovative practices we use to provide patient-centered care. As our healthcare system becomes even more complicated in an ever-changing political climate, social workers will play an even greater role in helping patients navigate treatment, disease, and quality of life challenges. Through comprehensive assessment and skilled interventions, we help people re-stabilize their functioning, strengthen their relationships, mourn the loss of a "healthy self", and face the existential anxiety that may develop when confronting mortality. On the frontlines and side by side with our patients, social workers steer through the complexity of a vast and disconnected healthcare system.

As Americans continue to debate about whether healthcare is a human right or privilege, the conversation about how that care is best delivered may become more complex, not less. Social workers should be at the forefront of that

discussion. With our clinical knowledge about the psychosocial impact of disease and our commitment to social justice, we are in a prime position to "lead loudly" as Altilio, Sumser, and Lyons Leimena assert.

Another important commonality among the articles in this issue is their direct use of patient or practitioner voices. Through qualitative study, survey, or vivid case examples, the contributors bring to life some core psychosocial challenges in healthcare. Both in research and clinical practice, social workers ask the difficult questions. We ask people to share their thoughts and feelings in some of their most vulnerable moments, and we try to help them cope. But to truly honor patient goals and practice patient-centered care, we must do more: ask more questions, engage in more qualitative and inductive inquiry, and continue to develop best practices that treat the whole person, not only the disease.

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