Profiles in Social Work

Episode 9 – Zoe Levitt

Intro - Hi, I'm Charmaine Williams, Associate Professor and Associate Dean, Academic, for the University of Toronto, Factor-Inwentash Faculty of Social Work. Welcome to Profiles in Social Work. This podcast series is produced by our Faculty and Alumni Association. In 2014 the Factor-Inwentash Faculty of Social Work is celebrating 100 years of contributing to Social Work Practice and Education. You can find out more about us by visiting us online at www.socialwork.utoronto.ca We're glad you could join us today. The series Profiles in Social Work highlights how social workers are making a positive difference in our communities by presenting stories of how social work graduates are using their degrees. We hope you will enjoy this series. Especially if you are thinking about a career in social work or interested in hearing about what social workers do.

Profile – Zoe Levitt

My name is Zoe Levitt and I graduated from the University of Toronto, Factor-Inwentash Faculty of Social Work in 1985.

When I was about seventeen or eighteen, I ended up volunteering at a group home. I didn't know about group homes, I really didn't understand the purpose of a group home, who came to group homes and I really enjoyed it. I understood the purpose of a group home, the troubles these kids and families were having, and before knew it I was hired as staff. That's how I became involved in social work, I just really tripped upon it. I remember really learning about social work, I didn't know very much. I knew about children and families in crisis but I didn't know anything else really, I must admit, and what the faculty offered me was an understanding was an ability to explore and learn about the breath of social work. I learned about social policy, I learned about gerontology, group work, families and children, research. It really opened my mind to understand the various fields and areas that social workers that could pursue, it was very exciting to me.

For me, I love the group work and gerontology, both really spoke to me. The professors at that time were very exciting and had a lot of initiative, presented work in very interesting ways and were really enticing, so that was a big drawing card for me. The

other reason I chose geriatrics is because older people in society are looked upon as incompetent, inept and demented and unable to make decisions, they're slow to express themselves, they're not thinking individuals anymore, they can't learn and I never believed that. I wanted to be able to help them overcome those stereotypes on a one-to-one basis but also publicly as well and I've gone around and talked about various aspects of aging in order to de-stigmatize to society the horrible black cloud that hangs over older people.

I have for most of my career worked in geriatrics and in acute-care hospitals. Up until about four years ago, I worked just what we call general medicine geriatrics where older people are admitted to hospital with falls or some sort of medical problem or dementia and we worked as a multidisciplinary team to be able to help these people get better medically, improve on whatever problems they have and help them be able to get home. I also did outreach visits, I would do home visits. So I would get referrals from family doctors about an older person that isn't attending her appointments or they have concerns about their cognitive functioning, their ability to continue living independently and I would go in and see them and perform a complete geriatric assessment and then make recommendations to the family doctor. Sometimes help them to get into hospital or into a rehab hospital or get them hooked up with other services in the community.

Currently, I'm working in an acute-care hospital in the Department of Geriatric Psychiatry, which is a very fascinating area of geriatrics. We have inpatient beds where our geriatric patients are admitted with mental health problems such as bipolar disease, clinical depression, schizophrenia, a whole variety of mental health problems and they're given treatment and treatment could be medicine/medication, it could be electroconvulsive therapy depending on the degree of their mental health problem, and while they're receiving their treatment I provide as a social worker, psychotherapy with both them and their families and I work with a multidisciplinary team which means we have an occupational therapist, a pharmacist, we operate groups for these older patients as well and the types of groups that we run are coffee groups and that's really an opportunity to help our patients get out of bed in the morning to feel comfortable socializing with other people and eating and drinking in front of other people, and it's really an opportunity for them to learn how to redevelop their social skills so that when they do go back home that transition hopefully will be a little bit easier for them because we don't want our patients to be isolated when they go home.

As a social worker I also work in the area of discharge planning. I'll sit with the patient and their family to talk about what problems they might anticipate when they finally do go back home. Are they going to be able to bathe independently, are they going to be

able to make your own meals and grocery shop, banking, would they like to be able to be involved socially in say a seniors program or attending programs of at U of T for example auditing programs, lecturers depending on the educational level of the person or their cognitive level, psychological level, and I help them to be able to get the services they need.

Another interesting area for me is I developed an expertise in the area of elder abuse. I've learned over the years, that that really truly is a hidden social problem and I've kind of taken it upon myself to bring it out to the forefront. I look for what we call "red flags", every patient that comes in I do a full social work geriatric assessment with them and their family and that involves looking at their social functioning, who they live with, what are the relationships with family members or friends or informal caregivers, how they interact or get along with their family members if there are family members. Most often older people are very reluctant to talk about elder abuse or to admit that a family member is intimidating them by yelling and screaming or pushing them or stealing their money, neglecting them, not bring them to the doctor. They're reluctant, because the abuser threatens them with institutionalizing them. They say “if you tell anyone that I do this to you I'm going to put you in a nursing home”. You have to be very careful in terms of how you address elder abuse, if I suspect it. For example, we have a patient who lives with her daughter who's physically and verbally abusive. She actually was able to admit and talk to me about the verbal abuse, she didn't want to talk about the physical abuse. That's okay, because at least she's admitting to the verbal abuse and I've been able to speak with her about safety planning at discharge and getting her hooked up with a social worker in the community that can continue to work with her. This patient was forthcoming, she was willing to talk about it with me, for older people that aren't willing and I suspect that they are living in situations of elder abuse, I'll normalize it. If I worry that maybe someone in the family is being physically abusive or psychologically abusive I'll say to them "You know, sometimes in families when everyone gets stressed, kids will yell at their parents. Do your kids ever yell at you?", and that's often enough because I normalized it for them to say "Yeah, sometimes that happens", or they'll say, "No" and that's a clue to me that I'll just put it aside but I’m not let go of it I'll reintroduce it in another way and another context.

For me, the rewards of my work can be summarized in a comment that an older person said to me. She's an eighty-three year-old woman, and I'd been working with her for two years helping her to become more assertive and more self-confident and to feel deserving to be on this planet. To feel deserving to be able to ask a relative of a favour or even to be able to pick up a phone and call a relative and say "Hi, how are you". She

said, "I don't know why you're spending time with an eighty-three year-old woman, like why do you bother?". And I think that's what social work does for me, for this population to realize that just because they're older doesn't mean that they're no longer capable of learning, of addressing whatever psychological problems they have and they're as important as anyone else.

When I first started at the Faculty of Social Work, I kind of put my hands in every pot that was possible. It's okay to say I don't know or I'm not sure or I don't like working with pedophiles, but I might try it to see why I don't like working with pedophiles, to explore your own self in your own biases, your likes and dislikes and to come to school and play them out and understand them further.

It's important for social workers to feel that what they do has such a significant influence in helping people with difficulties, helping vulnerable people, people who are marginalized in society; that what we do is of tremendous value and that we are making a contribution with society's difficulties. Making a difference.

Outro - This is Charmaine Williams from the University of Toronto Factor-Inwentash Faculty of Social Work. Thank you for listening to our podcast. In 2014 our school is celebrating 100 years of social work research, teaching and community service. For more information about the faculty and our programs we invite you to visit our website at www.socialwork.utoronto.ca