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General Submissions

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Letter from the Editors

Michael A. Dover and Maureen O'Connor

Abstract: This letter from the editors introduces Volume 20, Number Two. It contains summaries of the narratives in this issue. It also contains some discussion from the editors as to one way of thinking about the nature of the narratives published in this unique journal.

Keywords: Narrative, exposition, storytelling.

Reflections: Narratives of Professional Helping is a journal that focuses on the narrative style. We recognize that there are many forms that the narrative style can take. We eagerly look forward to each unique story that makes its way to us. We want to make sure that each story is told in the best way possible.

We are often asked what we are looking for in a submission. To that end, what we are looking for in a submission is writing that leans heavily towards the narrative, story-telling style and keeps away from an expository style that lacks the details, emotions, and scene setting that the narrative style beautifully portrays.

Speaking just for the present editor, and not necessarily for the journal of the future or for other members of our growing editorial team of associate editors and section editors, our definition of a narrative is very broad. It encompasses any form of story, regardless of how long or short the piece. Because of this, expositions and narratives will often overlap. Narratives require some amount of exposition in order to tell the story, after all. However, a narrative requires much more description. In order to tell her/his story, a narrator has to "show" the reader what happened, as opposed to simply "telling" the reader what happened. "Showing" is the hearing of the narrative style in Reflections. "Telling," on the other hand, tends to be exposition.

Exposition sets the scene of a story in order to provide the background information that the reader needs to understand in order to follow the story that comes after the exposition. Unfortunately, in many submissions, the narrator never seems to leave the expository writing style and never seems to develop the piece into more of a narrative. The exposition simply "tells" the reader what happens, without showing the reader. Although exposition is important, it should be used primarily to set the stage for the narrative interspersed within it.

For example, the following is exposition:

> I realized the families at our agency needed a support group. However, there were no support groups in the area to which I could refer them. So, I needed to start my own. I went to my supervisor, and after some discussion, he approved it.

When Reflections asks for a narrative, we are asking for more than what the above example provides. There is so much more that needs to be told here. How did you realize the families needed a support group? Who had said something that made you realize that and what did they say? Who, what, when, where, and how was it said? If you want to add reflection to that narrative, why do you think it was said?

Thinking back, what was the actual moment when you had that epiphany? How did you feel when you realized you had to start your own support group? Write a vignette of this and you have narrative to add to the exposition. Next, what was the discussion with your supervisor? How did you convince your supervisor to approve it? Don't just "tell" us what happened, "show" us what happened. Here is an example:

> It was Friday, and the clock's hands slowly moved to 4:30 p.m. It would be dark in a couple of hours. I was feeling the call of Shabbat. I should have been disengaging from work. But the pain of a week of roadblocks pounded in my head. I knew my supervisor was probably also tired and ready to go home. But I thought she probably would go along with the suggestion. Perhaps it was selfish of me, but I wanted to able to have a green light to think about how to make this happen. So I stopped by and shared the idea.
>
> "I suppose you want to spearhead this,"she observed.

> "I would be glad to, but I'd be happy with anyone doing it, as long as it could be available to our families," I replied, knowing full well that this project was not going anywhere unless I took the initiative.
>
> "Do you think you have time for this?" she asked, turning away from her computer monitor to address this question to me.
>
> "I'm sure I can find the time, and if not, I'll make time," I replied, "It's for the families." She sighed. But, most importantly, she approved it.

There is a clear difference between the previous expository style and the above narrative style. It doesn't have to be long or extensive, and you don't have to go into more detail than you're comfortable with. However, you need to draw the readers in and put them right there in that room with you. Most importantly, give yourself a voice, and give those you are with a voice.

When you write your narrative, make it clear that only you and nobody else could tell it the way you tell it. Let us hear you, understand you, and get to know you. This is your story. Make it come alive!

So, now, get over to that pad of paper, typewriter, or computer. Tap into that narrative deep in your memory that the world needs to hear.

Reflections is always accepting submissions , but don't use that as an excuse to put off perfecting that manuscript of yours. Get at it the moment you feel inspired. If you feel blocked, think back to those moments, and write your vignettes around them. Once you're finished, we will be happy to work with you to make sure the manuscript is the best that it could be.

This issue is the second issue published in November 2015, and the second in Volume 20, originally scheduled for 2014. Yes, we are behind, but not for long! Due to the over 100 articles in various stages of peer review and copy editing, including dozens of articles for several upcoming special issues, we will be publishing one issue after another in the months to come. We will be up to date in our publishing schedule by the end of next year. Volume 21, 2015, will be complete during the current academic year. However, this remains a good time to write for *Reflections.* Now that we are an online journal, we don't face barriers related to printing costs. We are committed to publishing any and all quality narratives. The last issue was over 100 pages in length and contained eleven articles. The present issue is just under 50 pages and contains just six articles. We foresee much variation in issue length. Out mottos are no issue before its time and no article until it is ready.

Before moving on to discussion of the articles in this issue, we want to revisit the powerful and disturbing article in Volume 20#1, "Cold: A Meditation on Loss." More than most, this article illustrates the degree of emotional labor that it takes to serve as an author, reviewer or editor of this journal. The reader may have noted that the g in the three letters, God, which are used in present standard English to refer to Yahweh, Allah, or God, was not capitalized in all cases! In some cases, where the author was providing a narrative account of conversation and where the word was used casually, it wasn't capitalized. Neither in the case of God, nor in the case of Jesus, were the words always capitalized. Since they were being used conversationally, rather than as a proper and formal name, they weren't capitalized. We thought about this, and concluded that this was truly the respectful thing to do. If the words are used casually or even profanely, should they be capitalized? We thought not.

But the decision to leave the narrative alone in that regard was more complicated than that. There were other issues, such as the use of swear words in the manuscript. And we left them alone as well. We think that deserves comment. The fact is *Reflections* is not the *New England Journal of Medicine*. It is a journal that believes in telling it like it is and showing things as they are. We give broad leeway to our authors to write in the style they feel is best for their narrative. And we believe in giving voice to the people portrayed in the narratives. If there is an occasional reader offended, this is something we must live with, along with other egregious errors, such as allowing a sentence to end with the word with!

That said, next we discuss the wonderful articles in this issue.

The Miracle within Michael: A Barn, a Boy, and a Horse

Using her experience working with children who have been victims of abuse, Marian Swindell writes about the healing power of animal assisted therapy. She draws on the transformation of one specific child from withdrawn and shy, to light hearted and relaxed. Marian describes how the experience of bonding with and riding a horse enables a young boy to develop greater trust and confidence. This narrative is an inspiring story that highlights the healing power of animal therapy.

Service Dog Training by Service Members & Veterans: Reflections on the Need for Empirical Evidence

Five interdisciplinary researchers collaborate on developing a formal evaluation to measure the impact of animal therapy on reducing PTSD symptoms on service members/veterans with PTSD and mild Traumatic Brain Injury. In working with the director of the Warrior Canine Connection and reviewing earlier research on the human-dog connection, they learn about prior research on animal therapy, and work to create a pre and post test for veterans who undergo the animal assisted therapy program. The article gives details on the ways in which animal therapy with dogs can be beneficial to veterans. The authors cite the difficulties veterans have with reestablishing emotional intimacy with their partners and connection with their children. By training and bonding with a dog, they relearn how to regulate their emotions and strengthen their relationships. The evaluation is still in a stage of development at the time of this article, however the researchers share their experience of looking for hard data to measure “warm and fuzzy” outcomes.

Helping Those Who Learn to Help: Addressing Stress during a Community Disaster

This article, written by two social work educators, Roni Berger and Orly Calderon, is about their experience teaching social work students during and after the Hurricane Sandy disaster in New York. They describe their attempts to remain in contact with students during and after the disaster, and the steps they took to help the students process their reactions. The authors draw on research that details the effects of trauma on people in the helping role, and discuss how this shaped their efforts in helping the students cope with the disaster. They also examine how trauma affects many domains of one’s life, and discuss their findings of using a myriad of methods for remaining in contact and supporting their students during and after Hurricane Sandy.

My Journey Toward Anti-Oppressive Work in Child Welfare

The authors, Kimberly A. Brisebois and A. Antonio González-Prendes, highlight the internal struggle social workers may face while building trusting relationships with families and still carrying out their agency’s mission of protecting child welfare. One author shares a personal narrative from her first position as a child welfare worker, and the power hierarchy that develops client and social worker. Social workers may feel pressured by their agency to watch out for child abuse, but in the meantime, may fail to become true allies to families, especially those of different cultures and class backgrounds. The author details her process of first starting working in child welfare, and her developing awareness of the power hierarchy that can be perpetuate between workers and families. This article raises an important issue for all social workers, especially those that work in child welfare.

From Healer to Transformed Healer: Relearning Lessons in Grief

Social workers may find that if they have gone through a similar experience as their client, they are better able to understand their client’s grief. Erica Danya Goldblatt Hyatt describes her own transformation as a therapist, after experiencing such a traumatic loss. She writes how her own personal challenges inspired her to pursue a career as a social worker for children with terminal illness, and how this directed the course of her career. She shares her own painful experience with loss and how it helped her gain a better understanding of the feelings of her clients and families that face with grief and loss. In addition, she outlines major themes in her experience and the elements that helped her. This article is a deeply personal and descriptive story of one social worker’s loss and how it ultimately brought her closer to understanding her own client’s grief.

Learning From and With Humility

Mari Alschuler reminds us that, as social workers, we will make mistakes. Her narrative discloses her own tale of choosing the wrong therapeutic intervention for a client in a poetry therapy group. She highlights that while social workers can carefully plan and choose the "right" therapeutic tool for clients, we cannot foresee everything and will make mistakes at times. Although the interaction with her client brings on her own inner critic and deep feelings of doubt, she moves through this by sharing the experience with her supervisor. By being transparent and vulnerable with her supervisor, she receives her supervisor's support and guidance instead of internalizing her error. Social workers may struggle with openly admitting faults or "failures" to supervisors. However, in Mari's narrative, she writes how being honest about mistakes can be an effective way of building competency, self knowledge, and remaining open to learning.

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The Miracle within Michael: A Barn, a Boy, and a Horse

Marian Swindell

Abstract: Working with children who are survivors of abuse and neglect can be both rewarding and heartbreaking. Animal assisted therapy utilizing dogs, rabbits, horses or cats facilitates amazing progress on the journey of healing and recovery. This article describes one such progression in the life of an eight year old boy who began his journey of healing while riding a horse named Dumbledore.

Keywords: child abuse, child neglect, social work, animal-facilitated activity.

Introduction

Animals used to enhance the therapeutic and helping process is not a new nor novel idea in the field of social work. Animal-assisted therapy dates back to the 18th century in England. Patients housed at a mental institution were often allowed to wander freely around the grounds and play with domesticated animals on the property, including dogs and cats. Facility administrators noticed that patient's moods improved and they appeared visually happier during and after their interacting with the animals (Serpell, 2006). The field of animal-assisted therapy now includes work with dogs, dolphins, horses, cats, rabbits, and birds and has expanded into hospitals, prisons, nursing homes, hospice homes, juvenile detention facilities, homes, and schools. The animals used in these programs are assessed and certified as physically and mentally sound. This requirement protects the patients and clients whom interact with the animals. The protection and welfare of the animal is equally important.

Therapists who bring animals into their practice are also required to become certified in their area of animal expertise to ensure the safety and well-being of the animals. My propensity to be around horses began as a young girl when I rode horses nearly every summer. One summer, however, I developed an allergic reaction to horse dander and hay and could not be around my horse. I was devastated, sad, moody, and mad. The next summer, after my doctor informed me I had apparently grown out of the allergy, I returned to the barn. Before I even got to the barn, my horse, sensing I was coming, put both front legs on his door and was whinnying uncontrollably. Until that day, I had no idea the strength and intensity of the bond between a child and a horse. The literature explains that such a bond exists due to the instinctual nature of the horse as a prey animal and its heightened sense of its environment and especially humans, since humans are predatory. Horses have an uncanny skill way of reflecting human behavior and emotions back to us and it is in this reciprocal relationship that the bond between human and horse is formed (PATH International, 2015). The following story is a true story, in which I witnessed the miracle of that bond, between a young boy named "Michael" and his horse, "Dumbledore."

The Day of the Miracle

My day begins at 5:00 a.m. Temperature today is a hot 102 degrees with sweltering 100% humidity. A typical day. I am not ready for today. My body is not ready for today and it knows it. I ache all over from my work from yesterday as I lean over to put on my boots. Coffee in hand, I get in my SUV, loaded with drinks, sandwiches, art supplies, horseshoe games, paints, coloring books, jump ropes, riding helmets, stirrups, bridles, horse blankets. My SUV smells like an old wet, dank, musty barn. My shirt is wrinkled. I know 12 hours from now I will be covered in dirt, mud, sweat, and will be aching. And so my day begins.

I get to the barn at 5:45 a.m. and start setting up the tables. I have two hours. Not enough time….not enough time. My volunteers from the Navy base will be here at 7:30 a.m. They can help set up too. I spend the next two hours setting up painting and art stations, horseshoe/activity stations, getting the round pen ready, disinfecting the riding helmets and blankets, putting basketball hoops all around the riding pasture. At 7:45 a.m., ten horses, saddles, riding blankets and stirrups are delivered. My volunteers and I begin to tack the horses and line them up. I stop and gulp down a bottle of water. I am tired and hot and sticky and sweaty all ready. The Navy Shipmate volunteers, all 30 of them are here, trained, and ready. Our first bus of 10 children with special needs pulls up, blowing up dust from the trail to the barn. The children are quiet as the bus rolls in and comes to a stop. My staff and all 30 volunteers are getting excited to see these children and spend an hour with them. The bus driver turns off the engine, the teachers give directions to the children, the bus doors open, and the children cheer.

The Children Arrive

All 10 children get off the bus and meet their volunteers. This is a part of the day that the children love. THEY get to choose three volunteers to be on their team from a huge group of military soldiers. THEY are in charge! Slowly, children point or nod their heads in the direction of the soldiers they select. The military volunteers are assigned to stay with that child for the next hour. The volunteers tell me they love helping these children because they remind them of home, remind them of their little brothers or sisters. Because they enjoy working with these children so immensely, these soldiers often sacrifice their vacation time away from the base to come volunteer with us. The soldiers also tell me they enjoy giving back to the community and being part of a worthwhile program and being around children who are happy and smiling. The soldiers help the children get on the horses, sit straight in the saddle, and adjust their stirrups. One volunteer holds the lead rope, which guides the horse, and the other two volunteers walk beside the horse, holding onto the child to make sure they remain balanced and safe on the horse.

Michael, a slight, shy eight year old little boy, is riding Dumbledore today. Michael is a beautiful little boy whom I have yet to see smile. A survivor of severe chronic abuse and neglect and school bullying due to his short stature, he rarely makes eye contact. Michael also has trouble with balance due to a damaged eardrum and has slight brain damage. The first day he ever came to this program, I could barely get him to come close to Dumbledore, one of the larger of the horses. He was afraid to touch the horse, did not want to groom him, and did not want to look in his eyes. Michael's spirit had been broken and I knew Dumbledore could and would heal and strengthen this little boy's spirit. Dumbledore and Michael would bond and that bond would change Michael forever.

There are hundreds of research studies and books written on the unique and special bond that develops between horses and humans, going back to the intense and reciprocal relationship of prey and predator, and the emotions and behaviors that horses could sense in humans. I was confident that bond was going to move mountains. I felt it. I had taken a special interest in Michael. I don't know why. I just looked at him the very first time and my heart lurched. I loved this little survivor, head hung low, sad empty brown eyes, stick straight brain hair, little arms, little hands. I just loved him.

So I loaded all the other nine children onto their horses and the riders and their team of volunteers walked into the pasture. Today's class was the 4th week out of 8 weeks these children were coming to my program. They knew what to do so I stayed behind to work specifically with Michael. Michael was just standing there and his team was looking at me like "we don't know what to do with him." I smiled and kind of jogged over to Michael. Michael's head wasn't hanging low today. He was actually watching me jog/run over to him. As I bent down next to him, I told him I was tired of running and asked if I could sit down. He nodded and I sat on the hard, wet dirt. In this position, Michael would be looking down at me as we talked, putting him in a power position.

I told him that Dumbledore had been sad all week and had missed Michael and was so ready and happy for Michael to ride him. His little brown eyes began to twinkle. I told him that two of the other horses has not been nice to Dumbledore and had been picking on him all week and that I had hoped that Michael could help Dumbledore feel better about being bullied. I explained that I really thought Michael had this magical gift of helping animals and people and that I think Dumbledore had been waiting on him all week to help him. More twinkles. A little hopeful, not acting scared, Michael put on his riding helmet and walked over to Dumbledore. I leaned forward and said to Dumbledore that Michael was going to be talking a lot while he was riding him and that Dumbledore needed to listen super carefully to everything Michael was saying. I then blew a little breath toward Dumbledore's nose, knowing that would make him nod his head up and down. I looked over at Michael and winked.

The Miracle

Michael climbed up on Dumbledore and we walked into the riding pasture. I was one of the side-walkers so I could hear everything that Michael told the Dumbledore. Michael shared that some people are mean sometimes and some people are nice. Michael explained that his dad and brother were mean and didn't always give him food or let him sleep in his bed. This was cue for me to pull out a small baby carrot from my satchel and ask Michael if he wanted me to feed Dumbledore. He said yes. We stopped and I gave Dumbledore some carrots. Michael told Dumbledore to stay away from the mean horses and stay with the happy ones and then he would be happy. The conversation lasted about 30 minutes. All we were doing was rhythmically walking around this big open pasture. No exercises, no games, no arm raises, just walking. My arms were aching from holding onto Michael while he was in the saddle, helping him work on balance. Finally, I told Michael he had to hold onto the reins and sit up straighter because I and the other volunteer were going to let him ride the horse without us holding on. I said "Dumbledore told us you are ready." I told him that he needed to ride Dumbledore, unassisted, with no help from me or the other side-walker for about 1 minute.

For an abused child to be in charge of a 1000 pound animal for 1 minute can seem like an eternity. I looked up into Michael's eyes to see if there was fear or hesitation. Nope. Just more twinkling. Man!!!! I love this little boy! So we dropped the reins and took one step away from the horse. And Dumbledore began to walk. My heart lurched and melted. I was actually seeing it. I was seeing this miracle of a broken little boy beginning to revive his spirit, heart, and soul with this horse. It really was happening, right in front of my eyes and I was part of it! The other side-walker and I counted to three and dropped our hands. And Michael rode that 1000 pound horse all by himself. There was no talking. Just riding. After about 2 minutes, I asked Michael what he was thinking and he said really nothing, just about bringing his sleeping bag to the barn and sleeping in the stall with Dumbledore. We all smiled. I told Michael that that was a fun idea and that one day I would take him on an official cowboy trail ride and he would have to stand up to sleep, just like Dumbledore does. He giggled and told me that was silly. He giggled. He finally smiled and on that day, in that pasture, his teachers watched Michael smile for the first time. Our session ended and Michael hopped down off of Dumbledore, head held high, eyes just twinkling, and said he would be back next week and would ride the entire time without help. I nodded and said that I expected nothing less from my favorite little cowboy. Michael looked up at me with those ridiculously adorable eyes and reached his arms out to me. I leaned down and hugged him. My heart melted and twinkled.

It is now 5:00 p.m. and the temperate is a chilly 99 degrees with only 100% humidity. My day is done. About 50 children rode horses today. I witnessed miracles. I saw smiles and heard laughter. The day flew by. I am filled with joy. I am happy. I am no longer tired. My body does not ache. I saw the first smile on a little boy's face. I saw and heard an adorable chuckle. I was silly. I made a difference. I facilitated that difference. I don't care if I smell like a musty old barn and am covered in dirt from head to toe. I am filled with joy from being part of a miracle that day. The reflection back on my day overwhelms me, aches my heart, and refills my spirit. I did change a life. I actually really did do it. A little boy with a broken spirit started to smile today and actually chuckled. It was a good day……way too short, a mere 12 hours, but still a good day.

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Service Dog Training by Service Members/Veterans: Reflections on the Need for Empirical Evidence

Norman B. Epstein, Rick Yount, Cindy C. Wilson, F. Ellen Netting, Jeffrey Quinlan

Abstract: Five members of an interdisciplinary team reflect on the development of a service dog training evaluation designed for service members/veterans with PTSD. We describe the process of working together as a team to learn the principles of dog training and the practicalities of designing a human-animal intervention in order to generate empirical evidence of the human-animal bond.

Keywords: human-animal interaction, PTSD, program evaluation, interdisciplinary team, human-animal bond.

We sat in a circle, in the old stone country house that serves as the headquarters for the Warrior Canine Connection (WCC), where we had come to learn firsthand about a remarkable program directed by Rick Yount that engages service members and veterans with Post-Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI) in training service dogs for partnerships with other Wounded Warriors. At first we fidgeted a bit as we listened to Rick explain how important early socialization is for purpose-bred service dogs. A yellow lab watched us, showing no signs of concern but monitoring our nonverbal cues. Rick, who trains the active service members and veterans as dog trainers in the program, handed each of us a tiny recently born puppy, whose eyes were still closed, as we murmured all the appropriate adjectives: "So cute, so sweet, so cuddly, so soft . . ." The mother lab continued observing us closely, coming up to each pup in our arms and sniffing. As we gently stroked the heads of each small creature, Rick talked about how these new puppies would become the next group of dogs to be trained by service members and veterans at the National Intrepid Center of Excellence (NICoE) at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland. Among us there were three university professors who at the moment were thinking very little of academic pursuits but instead were in close touch with the warm feeling of how calming stroking a tiny puppy could be.

After we returned the pups to their mother, four one-to-two year old dogs were led in on leashes and introduced to us. Their distinctive personalities were immediately obvious as Rick talked about their respective predispositions and temperaments. We were each given a pouch of treats, as we had agreed to participate in a training simulation to better understand Rick's WCC intervention and get direct exposure to the challenges and joys of working with the dogs. Rick stood behind our semi-circle of chairs, a tall, gentle and soft-spoken man, guiding our attempts to work with our assigned dogs. We laughed at one another as it became obvious that some of us were better disciplinarians than others and at how quickly the dogs identified those who demonstrated a lack of experience at training by simply indulging them with treats. Rick emphasized the importance of consistency in conveying limits to the dogs.

This exercise in service dog training was the beginning of what would become part of an interdisciplinary effort to design an evaluation of a long-established intervention with service members and veterans who have suffered from PTSD and mTBI. Rick's extensive work with both service dogs and individuals who have experienced physical and psychological trauma had demonstrated to him that the bond that forms between dog trainer and animal has powerful therapeutic effects in reducing PTSD symptoms of anxiety, irritability, depression, and emotional numbing. Furthermore, he has noted that the empathy and interpersonal skills that an individual develops while training a dog improve his or her relationships with family members. We couldn't help but share Rick's infectious enthusiasm for the value of the WCC; however, we were concerned that there is a need for more scientific evaluation of the program, especially regarding its effects on family relationships. Therefore, we established the goal of figuring out how to evaluate its effectiveness, especially in improving Wounded Warriors' relationships with their spouses/partners and children. In this reflection we share what we have learned about the WCC intervention as well as the complexity of designing evaluations in the "real world" of practice.

The Intervention

Rick, a social worker and certified service dog trainer, designed the WCC to remediate symptoms of combat-related PTSD and to improve overall social and emotional functioning in Wounded Warriors. His goal was to harness what anecdotally appears to be the healing power of the human-animal bond in alleviating the trainers' own debilitating symptoms and help Wounded Warriors establish more positive connections with their family members. The program model was piloted for two years at the Menlo Park VA's Men's Trauma Recovery Program. In 2011, Rick established the WCC program at NICoE at WRNMMC, as a voluntary adjunct treatment for active-duty service members and veterans with PTSD and mTBI.

We were brought together because all of us were impressed by Rick's passion and commitment to the program, and by his strong belief that there was a need to back up with empirical evidence the consistent observations by himself and his colleagues that individuals who develop skills for training service dogs become more connected and effective parents, as well as spouses/partners. As a practitioner, it was impossible for Rick to manage the oversight of training multiple service dogs and puppies, raise monies for his nonprofit, take the dogs to various facilities, and systematically collect data to demonstrate the effectiveness of his program. Therefore, he was enlisting the support of an interdisciplinary research team to focus on how to assess and evaluate the effects of the WCC intervention in improving Wounded Warriors' family relationships through reducing PTSD symptoms and building interpersonal skills.

The WCC is based on the assumption that interactions between Wounded Warriors with symptoms of combat trauma and dogs who have strong attachments to humans, low emotional arousal or reactivity, and favorable responses to positive training strategies can counteract debilitating PTSD symptoms and enhance the Wounded Warriors' comfort and interpersonal skills to interact with their children in a more emotionally connected way. The empathy, patience, and skills learned through training a dog also generalize to more constructive child-rearing behavior. In addition, their WCC experiences are hypothesized to enhance their relationships with their spouses/partners by reducing PTSD symptoms that interfere with intimacy and improving their interpersonal communication. Thus, the WCC program not only produces valuable service dogs that can be placed with physically disabled service members; it is designed to reduce the symptoms of combat trauma in the Wounded Warriors who train them and improve their function within their family circle. Everyone benefits. Rick notes that many Wounded Warriors are motivated to participate as dog trainers based on their dedication to the mission of helping other service members in need. In short, Rick's vision of the WCC is to bring hope and healing to the tens of thousands of Wounded Warriors who will continue to seek treatment through the thousand-plus Department of Defense (DoD) and Veterans Administration treatment centers in the United States.

Our team became engaged in developing a design for a formal evaluation of the program's effects on the Wounded Warriors' symptoms and the quality of their relationships with their family members; to empirically examine the positive effects that Rick had observed on participants' symptoms and abilities to relate to significant others. Rick had consulted with Norm (a professor of family science, clinical psychologist, and family therapist) who directs the couple and family therapy training program at the University of Maryland and has expertise in both couple and parent-child relationships. He and Norm had talked at length about how the skills and enhanced attachment needed to train a service dog could potentially transfer to improved family relationships of combat-stressed service members who were experiencing challenges as they re-engaged with their family members in life beyond the battlefield. Through networking with board members from WCC, Rick made contact with Cindy, a public health educator/researcher, and Ellen, a social work educator/researcher. Cindy and Ellen had worked for over 30 years on human-animal interaction research. Cindy's colleague Jeff, a family physician with experience in working with patients and families with diagnoses of PTSD and mTBI in service members, was recruited in order to cover all the bases in understanding the problem, the intervention, and the pathways through which training the dogs could lead to closer and more constructive family relationships and potentially reduce the Wounded Warriors' need for medical services and medications.

The WCC program focuses on the great importance of the relationship between trainer and dog (i.e., that dogs are motivated by attachment to the trainer and by the trainer's praise much more than by punitive discipline techniques), empathy with daily variations in the dog's moods and arousal level, emotion regulation skills for responding to stressful situations during the training process, the importance of touch (e.g., grooming) in building the bond, and patience and gradual shaping of desired behavior. It is assumed that as the Wounded Warrior forms an attachment with the dog and learns to be sensitive to the dog's needs and personality while implementing constructive training techniques, the constructive bond with the dog will reduce trauma symptoms, and the skills will generalize to the individual's significant human relationships.

Driving Forces to Capture Empirical Evidence

As Cindy and Ellen reflected about how we came to this project, we recognized that it was not the first time we had worked with others to design an evaluation of an existing program. When we teach program evaluation in our respective university/college, we preach that effectiveness-based program planning incorporates how the program will be incorporated into the program design (e.g., Kettner, Moroney & Martin, 2013). But often we have observed that, in the world of practice, programs emerge in response to a need, and program emergence is anything but a linear design. Intellectually we know that the practice world does not work in a neat, linear fashion. Often interventions happen as a confluence of forces - someone having a hunch that something might work - and based on experience and anecdotal observations, the program evolves, and it is modified based on feedback about aspects that seem to work well and others that need tweaking. Rick certainly had an incredible level of commitment, as well as years of experience and observations of how various populations responded positively to interaction with animals. In addition, he knew that decades of conceptual and empirical work had focused on human-animal interaction. Rick and his colleagues had published articles about their program, always with the caveat that there is a "need for empirical study of the Warrior Canine Connection Intervention" (Yount, Olmert, & Lee, 2012, p. 67). Their work and observations had begun to be published in the peer reviewed literature, but as yet there had been no opportunity for a formal test of the effects of the WCC intervention on Wounded Warriors' relationships with their family members. Rick wanted us, as a team, to figure out how to capture that needed empirical evidence.

Designing the Program Evaluation

As a team, we knew that research has shown that interaction with animals has positive physiological effects (e.g., reduced heart rate, reduced blood pressure) on humans, as well as inducing improvements in psychosocial functioning (Braun, Stangler, Narveson, & Pettingell, 2009; Knisely, Barker, & Barker, 2012). In addition to the widespread use of service dogs to provide various forms of physical assistance to individuals with physical disabilities (Sachs-Ericsson, Hansen, & Fitzgerald, 2002; Winkle, Crowe, & Hendrix, 2012; Zapf & Rough, 2002), we also knew that forms of animal assisted therapy (AAT) have been increasingly used in treatments of a variety of psychological disorders with children and adults (Chandler, 2012; Friesen, 2010; Mills & Yeager, 2012; Reed, Ferrer, & Villegas, 2012).

Cindy and Ellen had cut their academic teeth with a colleague from the University of Tennessee College of Veterinary Medicine in the early 1980s, designing a program to place dogs with older people (Netting, Wilson & New, 1984). Although a distinction has been made between service animals that primarily perform instrumental tasks for humans and animals that are used in AAT to meet patients' psychosocial needs, in fact the two types of functions commonly overlap. Service animals also have effects on patients' psychological functioning, whereas therapy animals commonly assist patients with some behavioral tasks as well (Shubert, 2012).

Our present work group talked about the considerable evidence that interaction with service dogs helps physically disabled patients carry out tasks of daily living and enhances the patients' psychosocial functioning, including increased social contact, interpersonal skills, and experiences of pleasure (Camp, 2001; Hart, Hart & Bergin, 1988; Sachs-Ericsson et al., 2002; Winkle et al., 2012; Zapf & Rough, 2002). Individuals with physical disabilities who participated with service dogs in Camp's (2001) qualitative study reported strong emotional bonds that they developed with the dogs. Those self-reports are consistent with increases in blood oxytocin levels in people and animals as they interact, as well as reduced experiences of anxiety (Olmert, 2009). Patients also described how being out in public with their dog facilitated their interactions with other people (Camp, 2001; Hart et al, 1988). Thus, even when the stated major goal of human-animal interaction is the accomplishment of instrumental tasks, significant socio-emotional processes seem to occur. Whereas some forms of AAT involve only passive exposure of patients to the presence of animals (e.g., Marcus et al., 2012), others produce therapeutic effects through patients' actively interacting with the animals and forming relationships with them (e.g., Pedersen, Martinsen, Berget, & Braastad, 2012). It has been hypothesized that positive effects occur both through the establishment of a secure attachment bond with the non-threatening animal and the patient's increased sense of self-efficacy as he or she takes on the responsibilities of working with the animal and develops better relational skills (Shubert, 2012). The WCC program takes those beneficial effects further by systematically instructing and coaching Wounded Warriors in training service dogs.

The last decade of military conflict has taken a devastating physical and mental toll on hundreds of thousands of Wounded Warriors, who have brought these conflicts home with them. Based on DoD figures through July 15, 2013, 6,733 Americans had died and 51,179 had been wounded in action since the onset of conflict in Iraq and Afghanistan. Additionally, through October 2012, 253,330 servicemen and women had suffered traumatic brain injury. Finally, in just the Army, 73,674 had been diagnosed with PTSD according to the U.S. Army Surgeon General Report from Fall 2012. PTSD symptoms associated with specific combat exposures are frequent and persistent (e.g., Smith et al., 2008). Symptoms have been found to cluster into four groups: Re-experiencing in memory and perception of traumatic events, effortful avoidance of stimuli that remind the individual of prior traumatic experiences, emotional numbing, and hyper-arousal (King, Leskin, King, & Weathers, 1998). These symptoms commonly are associated with problems of disturbed sleep, anger management difficulties, and distancing from situations that might trigger distressing flashbacks and anxiety (e.g., interactions with people who ask about the Warrior's deployment experiences, driving in congested traffic that elicits concerns about the ability to escape danger, the odor of diesel fuel), among others.

Further complicating the identification and treatment of these injuries, service members are trained to suppress emotions in order to function in combat situations, and they may persist in using this coping response long after returning to their home life, where family and friends look to them for emotional connection. In addition, traumatic experiences during deployment can substantially increase Warriors' level of emotional numbing, as well as the other symptoms of PTSD described above that can interfere with his or her relationships with significant others. Service members come home to their children and spouses, attempting to transition back to civilian life, but they often have great difficulty re-engaging with their families. Their spouses can be affected very negatively, as the Warrior's PTSD symptoms commonly create marital dissatisfaction and conflict, as well as the danger of domestic violence. Jordan et al. (1992) demonstrated that veterans suffering from PTSD and their spouses both engaged in higher levels of violence than similar couples in which the veteran did not have PTSD. Veterans with PTSD have increased levels of fear of intimacy (Riggs, Byrne, Weathers, & Litz, 1998), lower levels of self-disclosure and emotional expression (Carroll, Rueger, Foy & Donahoe, 1985), and difficulty in creating intimacy (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Monson, Fredman, & Taft, 2011). If in addition to experiencing these disruptive symptoms the Wounded Warrior lacks interpersonal skills for intimacy with his or her spouse/partner, the risk is high that the couple's relationship will deteriorate. The WCC program is intended to enhance empathy, patience, and communication skills that can improve couple relationships.

In addition to the risks for significant distress in the couple relationship, the Warrior's PTSD symptoms can contribute to emotional distancing from his or her children, as well as impatience, irritability, and harsh parenting behavior. In addition to negative effects from the PTSD symptoms, an overall lack of knowledge about and skills for parenting children is a common risk factor. Substantial research and development of programs for constructive parenting (e.g., Kazdin, 2005) has occurred over the past few decades, due to widespread problems with parenting in the general population, and it is likely that many Wounded Warriors, as members of that larger population, would benefit from parenting training. Any pre-existing deficits in parenting knowledge and skills easily can be exacerbated by PTSD symptoms, resulting in significant problems that Wounded Warriors may have in interacting with their children. Jordan et al. (1992) also reported that veterans suffering from PTSD had more parenting problems, poorer adjustment, and a higher incidence of children with behavioral problems than did the cohort without PTSD. More contemporary research has demonstrated that the veterans' emotional numbing was the strongest predictor of parent-child relationship problems (Ruscio, Weathers, King, & King, 2002).

Thus, there are major risks for couple and family stress and instability among Wounded Warriors with PTSD and/or mTBI. The WCC service-dog training program is intended to provide a safe, effective, non-pharmaceutical adjunctive treatment for PTSD as well as provide lessons for the Warrior in highly nurturing and effective methods for building bonds with their children, partners, and other people outside their families. The goal of the WCC program is to remediate symptoms of PTSD and improve the social and emotional functioning of Wounded Warriors, especially in their significant family relationships. Through the therapeutic stress-reducing processes previously documented to occur in AAT, the WCC was designed to reduce the trainers' own debilitating PTSD symptoms. It also was designed to improve the Warrior's relationship with his or her spouse/partner and the Warrior's child-rearing skills, as he or she develops patience and empathy in learning to train a dog. The dogs' strong attachments to humans, low emotional arousal, and favorable responses to positive training strategies are expected to facilitate the Warriors' comfort and capacity for close interpersonal relationships, especially with their children and significant others.

Determining How to Go About the Project

Our areas of expertise were certainly complementary to one another, and in the process we have become a learning team. We work very well together as a team of senior professionals who were all convinced that the intervention was well worth evaluating. Norm and Jeff's expertise with the population to be served (including the family relationships of the Warriors) combined with Rick, Cindy, and Ellen's knowledge of human-animal interaction and program evaluation fit together well. Initially we had to overcome differences in professional backgrounds, in terms of variables we typically look at and the language we use to describe the processes that we study, in order to fully explicate the WCC program's purpose. We agreed that the program involves educating and coaching a Wounded Warrior with PTSD symptoms in effective approaches to training a service dog. Training programs world-wide include teaching dogs to carry out a variety of activities such as opening doors, carrying and retrieving items, turning lights on and off, pushing elevator buttons, assisting patients with support for walking, helping the patient dress, making a bed, and helping the patient do laundry (Miura, Tanida, & Bradshaw, 1998; Zapf & Rough, 2002).

We agreed that our project's initial stage had to begin with Rick training a set of clinical staff members at the Center for Healthy Families outpatient family therapy clinic within Norm's Department of Family Science at the University of Maryland, College Park, regarding the principles and procedures of training the service dogs, as well as in the processes through which the WCC intervention is designed to improve Wounded Warriors' psychological and interpersonal functioning. Subsequently, those clinical staff members would work with individual Wounded Warriors as they each learned to train a service dog for eventual assignment to a physically disabled war veteran. The staff members would conduct education and coaching activities with the Wounded Warriors, involving didactic explanations of principles of dog training and information about the cognitive and emotional life of dogs that trainers must take into account. They also would present live demonstration/modeling of specific training strategies with a dog and positive feedback to the Wounded Warrior as he or she practiced.

Based on the existing literature regarding positive effects of animal assisted therapy (AAT) and anecdotal examples of positive outcomes that have been observed in the WCC program, we hypothesized that Wounded Warriors who participate in the program will experience a decrease in PTSD symptoms and improvements in relationships with family members. They will develop greater understanding of learning principles and more refined behavior management skills for training the dog, which we hypothesize will generalize to more constructive interactions with their children and spouses/partners.

Specifically, we hypothesized that our pilot service dog training study would result in Wounded Warriors who complete the WCC program, compared with those who only receive the standard of care treatment for their PTSD, exhibiting reduced PTSD symptoms, increased knowledge and use of positive dog training principles, and increased warmth and emotional regulation during interactions with the dog. Additionally, we hypothesized that, in comparison with those who receive only the standard of care, the WCC participants will exhibit a larger increase in use of authoritative parenting behavior and decreased use of authoritarian and permissive parenting behavior with his or her children; increased warmth conveyed through verbal and nonverbal behavior toward their spouse/partner and child; increased emotion regulation during interactions with their spouse/partner and child; increased verbal and nonverbal behavior by the child reflecting comfort interacting with the Warrior parent; and, increased couple relationship satisfaction reported by the Warrior and by the spouse/partner.

Consequently, measures of these domains of functioning will be administered immediately before Warriors take part in the program and at the end of the program. In this pilot study involving a randomized controlled clinical trial, Warriors who are screened as meeting inclusion criteria (current clinical levels of PTSD symptoms, ongoing relationships with a spouse/partner and at least one child between the ages of 4 and 12, not currently engaged in any other form of animal assisted therapy) will be randomly assigned with their consent to either standard treatment at their current treatment center or to treatment as usual plus the WCC program. Those who are assigned to standard treatment will be given the option of receiving the WCC program after the post-treatment assessments are completed, in a cross-over design.

We agreed that during the pre- and post-treatment assessments, participants will be administered standard validated measures of (a) PTSD symptoms, (b) current life stressors, © authoritarian, authoritative and permissive parenting styles, (d) positive attachment to the dog, and (e) couple relationship satisfaction. In addition, each Warrior will be asked to engage in structured behavioral interactions in which they are given the tasks of (a) instructing a dog, (b) instructing one of their children in completing a task, and © discussing with their spouse/partner a conflict topic in their couple relationship. All of these behavioral interactions will be video-recorded for subsequent rating by trained coders. Interactions with the dog and with the child will be coded for forms of constructive communication and training/parenting skills, as well as emotion regulation. Interactions with the spouse/partner will be coded for forms of constructive versus avoidant and/or destructive communication, as well as emotion regulation.

All pre- and post-therapy assessments will be conducted at the Center for Healthy Families (CHF) at the University of Maryland, College Park. The WCC dog training sessions with Wounded Warriors also will be conducted at the CHF. The CHF is a modern outpatient clinic with a large comfortable waiting room and eight therapy rooms equipped with digital video and audio recording equipment. The WCC treatment protocol will be the same as Rick has implemented at NICoE. Each session will be standardized, and clinicians who deliver the training to the Wounded Warriors will be trained extensively in the protocol components. The clinicians will video-record all of their sessions with the Warriors so the clinicians can receive supervision from Rick and Norm on their implementation of the session protocols. In addition, recordings of sessions will be rated subsequently for treatment protocol adherence.

Lessons Learned

As we reflect about our experiences, we have learned a number of lessons about community-university partnerships, nonprofit organization and university/government partnerships, human-animal interaction, and program design and evaluation. Based on our prior participation in community-university partnerships, we had learned to expect the unexpected, and further complexity in implementing our project arose because the WCC cuts across public and private sectors. Recent regulations issued by the Veterans Administration have forced programs that are "warm and fuzzy" to articulate their results in the form of hard data. In order for a program to be recognized as valuable and receive sustained support within the larger system, these data must be collected in multiple ways, using standardized self-report tools as well as behavioral observations. We can all speak to what we observe when we walk through a clinic and see a Service Member training a dog. But can those Warrior-dog interactions influence the Service Member's psychological well-being and how he or she interacts with family members? Does the program truly reduce the debilitating effects of service-related PTSD? This is what we will be testing, and we have learned that a challenge faces us in engaging support across organizational lines for conducting this needed evaluation of what some might consider an interesting but tangential intervention. Community-university partnerships are time and financially costly, and locating funding to support these partnerships is always challenging. Yet, in order for public sector (governmental) organizations to continue to engage in these types of adjunctive interventions, there is no choice. Their participation requires having exactly those types of empirical data that take so long to collect.

Human-animal interaction has been a field of study for many years now. Yet, we marvel at how difficult it has been to build a body of empirical evidence. Certainly the military has used animals in multiple capacities, but it seems likely that it has been assumed that service dogs only become valuable in meeting needs of Wounded Warriors after the dogs have completed their training. The expenses involved in the training may seem to be prohibitive when compared to effects of their long-term placements with individual Wounded Warriors. It is difficult to conduct this cost-benefit analysis, because it is time-consuming to follow over time the Wounded Warriors who received service dogs and compare their functioning to that of those who did not receive dogs.

However, in Rick's program, the training of the dogs has dual functions, and there is little lag time before benefits begin to accrue to the Warriors who train the dogs. The beauty of Rick's WCC program is that well before the dogs are placed and provide the second set of benefits, they may help heal hundreds of Wounded Warriors struggling with symptoms of PTSD and mTBI as those Warriors become engaged in the process of training them. The systematic controlled outcome evaluation that we are planning can provide data needed to understand the effects that service dog training has on Wounded Warriors who participate in the front end of the process.

As we work on this evaluation project, we are constantly reminded about how we have to impress upon students and practitioners that program design and evaluation are essential if interventions that we personally value based on personal experience are to survive and flourish in the context of various interests competing for funds and patients' time. Furthermore, program evaluation is not a linear process, and there always is an element of the unknown as researchers do their best to measure the effects of a program. Even though we have designed a way to capture those empirical data, we can already forecast a number of issues and unintended consequences. We ask ourselves questions such as what happens if those empirical data indicate that this intervention doesn't produce significant improvements in Wounded Warriors' psychological and interpersonal functioning? What if this program that Rick is so passionate about simply doesn't do what he thinks it does? The lack of statistically significant effects can be due to a variety of factors in addition to a program being ineffective, including the possibility that the researchers' choices of assessment instruments were not well-suited to capture meaningful changes. We have used our expertise to select measures, but there are no guarantees that they tap the changes that Rick and his patients have observed.

As an interdisciplinary team of researchers, we are biased too. We would not have engaged in this journey had we not hoped that the WCC program will prove to be effective. We admit that bias and understand our great responsibility to conduct the research in the most rigorous way possible, with built-in protections against the risk of our enthusiasm for the program influencing the data. We think Rick has a lot of courage to enlist us into this adventure, because it is possible that service members/veterans only get a temporary jolt from training these dogs. But it is also possible that his observations may be supported and that service dog training does make a difference in service members/veterans/families' lives.

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Helping Those Who Learn to Help: Addressing Stress during a Community Disaster

Roni Berger and Orly Calderon

Abstract: This article discusses lessons learned from working with social work students in the context of the encounter with Hurricane Sandy that hit the Caribbean and the East Coast of the US in late October 2012, and that can be defined as a community disaster. The literature documents the multifaceted impact of such disasters, and the special challenges faced by students in the helping professions who must cope with community disaster on both professional and personal levels. As social work educators, the authors have found ways to help their students process their reactions to, and cope with aftermath experiences. This article, rather than presenting an analysis of empirical data, describes strategies the authors have used to help students cope with the devastation caused by Sandy, students' responses to these strategies and suggested next steps.

Keywords: Community disaster, post disaster stress, coping strategies, training social work students, traumatic stress in health providers

This article discusses lessons learned from working with social work students in the context of the encounter with Hurricane Sandy that hit the Caribbean and the East Coast of the United States in late October 2012, devastating communities in Haiti, Jamaica, and Porto Rico as well as along the shores of New Jersey lower Manhattan and Long Island, New York. Sandy was a community disaster, also conceptualized as a collective disaster. In this situation a large group of people who share geographical or another characteristic such as religious or ethnic background are exposed to a stressful event (Berger, 2015). The concept has been used to describe situations human-made situations such as war or failure of a nuclear plant, as well as caused by natural forces such as a tsunami, an earthquake, or a hurricane.

Social, financial, health, and mental health effects of exposure to such events have been extensively discussed (MacFarlane & Van Hooff, 2009; Norris et. al., 2002). Reactions may appear immediately following the exposure or be delayed (Bonanno & Mancini, 2008). It has also been recognized that the impact of such exposure and coping with it depend on contextual and personal factors. Contextual factors include cause (nature or human made; developmental or circumstantial), magnitude, proximity, and duration (one-time, repetitive, or chronic) of the event, controllability, and degree of actual damages and losses. In addition, availability of instrumental (i.e., provision of advice, referral, services such as help in care giving), informational (such as advice about relevant issues) and emotional support, leadership, cultural context and community response also shape the effects of the event. Thus, human made, proximate, repetitive, on-going and uncontrollable stressors, especially when support is limited, lead to more severe outcomes (Berger, 2015). Personal characteristics include gender, age, previous exposure to stressor events, a sense of mastery, competence and self efficacy, degree of optimism, differentiation of self, religiosity, interpersonal trust and hostility, such that women, young people and those who experienced previous traumatic exposure are more vulnerable (Gabert-Quillen, Fallon & Delahanty, 2011; Galea et. al., 2002; Lechner, Antoni & Carver, 2006; Neria, Nandi & Galea, 2008).

Studies reported on the effects of trauma exposure on students (Hawdon & Ryan, 2012) and on helping professionals in general and social workers in particular (Arvay 2001; Bride, 2007; Cornille & Woodard Meyers, 1999; Meldrum, King & Spooner, 2002). For example, mental health professionals engaged in direct practice were highly likely to be secondarily exposed to traumatic events through their work with traumatized populations and develop symptoms that were similar to those of direct survivors (Arvay, 2001; Bride, 2007). Social work students are a unique group within the communities of the helping professions and of the student body. Like seasoned social workers, they are caught between their personal exposure to the devastation and the demand to help their clients; however, they have not yet acquired the knowledge and skills that more experienced workers have access to for addressing this challenge (Badger & MacNeil, 1998; Huber, 1999).

However, with a few exceptions (e.g. Baum & Ramon, 2010; Marlowe & Adamson, 2011; Tosone et. al., 2003), literature about preparing social work students to address trauma related content is limited. Lemieux and her colleagues (2010) found that, following Hurricanes Katrina and Rita, social work students experienced numerous stress reactions. Almost a half scored at or above the clinical level for depression, 6% showed clinical Posttraumatic Stress Disorder (PTSD)-like symptoms and 16.9% reported consequent substance use, which might be seen as an effort to self-medicate. The authors concluded that it was critical to closely assess students' reactions, inform them about on-going self assessment, and provide them with psycho-education, information, and supportive supervision to address disaster-related issues and maximize resilience. Baum (2004) found that social work students who experienced terror related to the Israeli-Palestinian conflict reported feeling torn between their personal and professional needs, having doubts about their professional competence and difficulties performing fieldwork under the stressful conditions. Finally, Boyer (2008) reflected on the effects that being a social work student in New Orleans when it was hit by hurricane Katrina had on the development of her professional identity.

Both authors of the current article are social work educators in schools located on Long Island, NY, an area that was severely devastated by the storm. Homes were flooded or sustained other damage, and 95% of the island experienced power outage, leaving the residents without electricity, heat, hot water, or communication means. Four days after the storm hit long Island, some communities regained power while others remained disconnected for another week or two. As the majority of our students live on Long Island, they were affected to various degrees both directly and indirectly.

Consequently, as social work educators, we found ourselves facing students struggling simultaneously with their personal experiences and those related to their being evolving professionals, with heightened anxieties about their own families, their school work, and their clients (in internship or paid jobs). We thus had to find supportive and constructive ways to help them process reactions to, and cope with, this diverse plethora of aftermath stress. The unanticipated and evolving nature of the situation dictated the flexible nature of our responses and activities. While we did not follow any particular model and reacted to events and needs as they occurred and materialized, our actions were informed by principles of crisis intervention as described below. While some may view our activities as crossing boundaries between the educational and clinical spheres, it is common in social work education to address personal aspects of students' situation as they may affect what students "bring to the table" and how their issues are manifested in their practice with clients.

This article describes the issues we have identified and the strategies we have developed. It includes four parts. First, we provide description of who the students are, while remaining cognizant of the need to de-identify individual reactions as per IRB guidelines. It is important to note that at the time we were focusing on providing help to the students rather than on collecting data systematically. Therefore, we did not seek permission from students to quote them and thus could only include limited direct narratives where students later granted us permission to do so. As a result, this article is written utilizing what Kanary (2012) describes as "expository style" (p. 5). Second, we discuss the strategies we have used to help students cope with the devastation caused by Sandy. Third, we present a summary of students' responses to these strategies, and where permission was given, share specific individual reactions. Finally, conclusions and next steps are offered.

The Students

The literature (Berger, 2015) emphasizes the importance of personal characteristics that may impact the reaction to traumatic exposure. Because this report is anecdotal rather than a product of an empirical research, we do not have access to systematic information about students; however, we can present some general characteristics of the students while protecting their privacy as per IRB guidelines. This report is based on the interaction with 96 students. Sixteen were BSW students, 28 foundation year MSW, 44 advanced year MSW and eight doctorate students. They varied in age (early 20's to 60's), phase in the educational process, personal and professional experiences, and storm-related professional responsibilities. They also met various degrees of challenges. The gamete of negative effects on students ranged from losing power and internet access, interfering with their ability to do school work, absence of public transportation and gas to allow getting to classes when these finally resumed after a week, the loss of possessions, destruction of cars, being evacuated, having to leave their homes to live with friends or relatives, and in some cases losing their homes and cars. Some students were living in areas where looting and breaking into homes were abundant; many had children at home as schools were closed, as well as elderly and sick parents or other relatives who were in desperate need for care.

The Strategies We Used

While we did not follow the model of crisis management per se, our strategies were informed by our familiarity with its principles and components that are common in diverse models in different combinations and variations (Berger, 2015). These strategies can be conceptualized along two dimensions: (1) a stage-based approach, and (2) differential types of help. The two were interlinked in that the initial strategies focused on addressing diverse immediate needs that students expressed, whereas second-tier communication and/or strategies focused on helping students to resume their school-related work. Below we describe the nature and process of implementing and executing help to students.

Initial Reach Out

In crisis situations, rapport is a major vehicle for help (Roberts, 2002). As we already were about half way into the semester and rapport and relationships with the students were established, our efforts of reaching out focused on ascertaining everybody's circumstances. Instantly after the storm passed the region, we began reaching out to all students enrolled in our classes by utilizing the e-mail tool of the learning management systems (LMS) utilized at the respective universities for all courses. We sent collective e-mails to all students letting them know that we were thinking of them, inquiring after their safety and inviting them to respond back to the group or privately to the instructor. We encouraged them to share, to the degree that they felt comfortable, challenges related to power loss, possible damage to homes and property and staying location in the aftermath of the storm. We also asked whether they were in need of any help that the faculty member could provide. One of us who lives on Long Island also took the opportunity to assure the students that she was safe and would continue to communicate via e-mail on a regular basis.

Being aware that many students may have lost power, we suggested that they contact their classmates by mobile phones (landlines were not working) and any other means, and advise those who could not respond about our availability. As students began responding to these initial e-mails, we replied to each student individually and promptly, tailoring the response to the issues raised by each. One of us made an extensive effort to identify contact information of students who did not respond to the collective e-mail and texted or called them. While the universities started to organize collective reaching out to students, we felt that an individualized reaching out by a teacher with whom students had a connection was of special importance to enhance feeling supported.

Providing Support via Technology

Subsequent strategies were informed by the emerging needs of students as they responded to the initial reaching out and included encouragement, instrumental support, psycho-education about typical responses and effective ways of coping (e.g. limited TV watching, for those who had access to TV) and information about support services available in the community.

Encouragement

As reports about the devastation in the region became available, we were seeking means for students to share and process their experiences and reactions to the storm and its effects. One of us established informal discussion forums on the LMS for her classes, inviting students to communicate. The instructor monitored the discussion forum several times daily and posted responses to each student right away.

Because the discussion forum on LMS is public, the instructors invited students who wished to share confidentially to reach out via the individual e-mail tool of the LMS or mobile phone, to which we responded promptly. Thus, our interventions at this stage were informed by students' needs as they were expressed in the various posting on the LMS or e-mails as described in the following section of the article. This included validation of expressions of frustration or in contrast, feeling of gratitude for surviving, efforts to calm students' worries regarding their ability to submit assignments in a timely manner and meet course expectations, and reassurance that we would work with each student to develop a study plan that was suitable to her or his circumstances. Our communication also expressed appreciation and encouragement of students who shared stories about their volunteering experiences in their respective communities, and information about available resources, particularly support and counseling services (mostly in response to personal e-mails).

Instrumental Support

This type of support focused on imparting information regarding school closure, class schedule, and changes in due-dates of assignments. Although much of this information was available to students via the universities' web sites, the instructors' e-mails were meant to personalize the university-wide messages and help students feel less anonymous. One of us followed this up with more formal documents detailing the syllabi changes for each course. These documents were e-mailed to each student, and were also posted on the course LMS. The other instructor followed up with frequent updates as the situation continually changed, including information regarding closing of the university, changes in location of classes when school resumed, and opportunities for volunteering activities organized by the school.

In Class Processing

Consistent with findings that face to face interaction increases the sense of support for survivors of traumatic exposure (Hawdon & Ryan, 2012), one of us had the opportunity to augment the electronic communication with in-class discussion a few days after the hurricane. Each of the classes opened with checking in with students where they were, the effects of the storm on their lives, their families and their communities. Time for discussion was unlimited and students were encouraged to express as much (or as little) as they wished. Cognizant of the potential for vicarious traumatization by listening to stories about other students' experiences, the discussion was led in a supportive invitational style, affording a voice for those who wanted to share and respecting those who did not. Students were also invited to comment on how they felt listening to their classmates' stories.

Students' Responses

Students' responses varied. Some did not respond at all whereas others responded overwhelmingly, including some of those who were extremely affected by the storm. Thus, a number of students who reported the most devastating stressors (two who lost their homes and other who were forced to evacuate to shelters) resourcefully managed to be in touch against all odds by developing creative strategies for communication and manifesting how important it was for them to be connected.

Students' responses revealed their appreciation and gratitude for the strategies employed by faculty and included mostly two types. One was narrative responses, where students basically related their stories without explicitly asking for advice or help beyond the opportunity to share. The second type of response was information-seeking, where students were asking for specific details about course material, and more seldom, about resources to help them cope with their distress.

Students' Responses to Initial E-Mail

Responses to initial e-mails included appreciation, emotional sharing, and information seeking. Overall, students were very appreciative of the faculty's reaching out to them. They thanked the instructors for their care and concern, and often extended good wishes to them and their families' welfare, displaying a sense of mutual regard. Some said that this was the first post-storm e-mail that reached them and it made them feel a bit better that somebody cared. One student wrote that it was hard to believe that in the middle of all the chaos, the instructor found the time to reach out to students and how meaningful it was. Those who shared their feelings expressed mostly worries, fear, concerns being emotionally distraught and full of anxiety; however, the dominant tone was self contained and revealed that students tried to gain some perspective. Some pointed out that despite the inconvenience of power loss they were happy that they were not physically hurt. Information seeking responses inquired about course schedule and assignments due-dates. A review of these e-mails indicated that many were sent from students' personal e-mails, suggesting that they were accessing their university-generated e-mail addresses only to a limited degree. Thus, it is possible that many students have missed some of the initial e-mails sent by the faculty and were initiating contact with the faculty on their own accord, possibly demonstrating the need to connect in times of stress.

Students' Responses to Discussion Forum

Students displayed a differential pattern of response to the LMS discussion forum. Out of the three courses in which this forum was offered, students availed themselves of the opportunity in only one course, where weekly posts were part of the pre-storm routine assignments. Possibly, the culture of communication via this tool was already embedded within this cohort, although the e-mail introducing this forum clearly stated that these were voluntary and informal threads, not associated with the course curriculum. Students' responses whether on the discussion board or in emails to the faculty members shared narratives of the storm's impact, personal challenges and emotional reactions, volunteerism, and socio-political aspects.

Narratives of the Storm's Impact

Students described the magnitude of the storm's impact in their respective communities: homes flooded or burned, neighborhood destroyed, people displaced. This theme was common to all the posts, suggesting that students needed an opportunity to share their trauma narratives

Challenges and Emotional Reactions

Students described personal challenges they experienced and coping with damage to their homes or/and loss of property. Others wrote about the challenge of managing family members with special needs in the absence of electricity, heat or cooking facilities. Many described their feelings during the storm and their emotional reactions to its impact. These ranged from annoyance, describing the storm's aftermath as a "nuisance" and "inconvenience", to emotional distress. Students wrote about being scared during the power outage and their sense of dismay, using expressions such as "hard to conceptualize," and "humbled" when they described the destruction in the aftermath of the storm. At the same time, many students also expressed gratitude that they survived, saying that they felt lucky, grateful or blessed to be alive. Students also compared their experiences and losses with those of others who were less fortunate, and expressed awareness of their own fragility. They compared their state of crisis with that of clients they helped, and reflected on the challenge of being a social worker and a person in need at the same time. Others wrote about gaining insight into the needs of their own agency's staff who were experiencing stress and privation even as they were involved in providing food and supplies to clients in the community. Students also noted that the main message derived from the storm was that it served as a "great equalizer."

Volunteerism

Several students described actions they took to help others in their communities. These ranged from volunteering in shelters or churches located in communities that experienced serious flooding and home destructions, to preparing care packages for displaced persons, to hosting friends and families in their homes once they regained power. Some students wrote about the importance of helping others and about the satisfaction they have derived from it. Others, however, discussed the stress involved in hosting relatives and strangers in their homes.

Socio-political Context

One student discussed the storm in the context of the presidential elections. The student noted the importance of voting in these elections, especially in light of the candidates' different opinions about the role and status of the federal Emergency Management Agency (government vs. private agency).

Responses to In-Class Discussion

The high rate of class attendance immediately following the storm suggested that students felt the need to be together and struggled to get back on track in spite of persisting difficult situations. Reactions to the discussion were initially emotional, gradually focusing on the challenges followed by a more practical and action-focused direction. Like responses to on-line forums described above, in-class reactions included sharing of storm-related narratives, emotional reactions to the storm and its aftermath and personal challenges, whereas volunteerism and the socio-political context were not. One possible explanation may be that the class discussion took place a few days after the storm when information about the scope of the damage was emerging, and many were still in initial shock and disbelief, which was characterized by one student's statement "I am learning the positive effects of dissociation." One student shared that following the report about damage to a neighborhood and a church, a classmate mobilized recruitment of donations and showed up at the site with a car packed with food and clothes. This may indicate that as time passed, students were more able to initiate and participate in recovery activities.

Storm-related Narratives

Students provided descriptions of what happened to them, their families, neighbors, friends, and communities. Reports regarding damage done to their own homes, evacuation and hosting others were abundant. Stories varied in degrees of detail and reported impacts. Some related to their direct personal experience and others to effects that they experienced indirectly such as family members who were forced to seek refuge with relatives.

Emotional Reactions and Challenges

Students expressed great appreciation for the opportunity to tell their stories and to be heard. They stated that sharing in class and hearing other peoples' stories helped them to process their own experiences. Some of the content was painful and evoked considerable emotional reactions, to which other students were able to respond by comforting, displaying empathy, and offering support. Where indicated, the instructors (both of whom are licensed mental health providers) met with students in private and offered referrals. A typical statement by many was that the hurricane and related issues threw students off in terms of their school work and while they were struggling to get back on track, they found it difficult to do so. Several students shared their delight at the opportunity to become closer with family members with whom they were forced to co-habit, whereas others felt stressed by the need to share crowded quarters for prolonged periods of time. Some expressed feeling guilty for this reaction.

The discussion gradually shifted to sharing stories of challenges. A major topic was the shortage of gas, which was a serious problem because of lack of effective public transportation in the area. Most gas stations ran out of gas and where it was available, lines were long and fights frequent. Some students reported waiting on line for six or seven hours, only to encounter a "no more gas" sign and pumps wrapped by yellow ribbons. Some expressed anger about incidents when first responders abused their eligibility for priority in getting gas intended to allow them to fulfill their duties, to fill their families' and friends' cars. Others offered practical advice such as addresses of helpful (and not so helpful) web sites, strategies to approach FEMA, and locations where gas was more easily available.

Some students discussed what they learned about social workers' role and interventions in time of crisis from the modeling by the faculty. However, there were differences between MSW and doctorate students, as the latter serve in supervisory and administrative positions and thus experienced responses of workers and staff in their agencies. One doctorate student (who gave permission to share the following) thanked the faculty "for encouraging me to hold a discussion with my staff. The results were very enlightening." The student reported that after a staff discussion inspired by the conversation in class, one worker privately reported relapsing in light of the stress; another shared that she had no food available at home for a week, even while distributing food to others. The doctorate student, who was their director, referred the former to an emergency counseling and encouraged the latter to take food bags home. The student-director concluded "I am amazed; I just assumed that they would have asked for food if they needed."

Delayed Responses

A few weeks after the storm, several students started to manifest delayed responses, communicated in class or to the instructor in person or via e-mail. Students expressed anxiety and feeling "exhausted" and "drained," complained about inability to concentrate, comprehend readings and complete written assignments, and sometimes became agitated in class, and displayed fatigue, all of which suggested stress reactions. Sometimes, these reactions were accompanied by shame and survivors' guilt such as a self identified disproportionate grave reaction to a perceived minimal inconvenience caused by a brief loss of power and internet access. When such responses occurred, the instructors met with students privately to collaboratively develop individualized plans for completing course requirements as well as provide referrals when indicated.

Conclusions and Future Directions

Consistent with previous literature about the response to crisis exhibited by social work students (Lemieux et al., 2010), students described in this article reported a myriad of stress reactions to Hurricane Sandy. Similar to findings by Badger and MacNeil (1998), and Huber (1999), our students reflected on the relationship between their own stressful experiences and those of their clients. In agreement with the literature that the availability of support has the potential to ameliorate negative impact of traumatic stress (Berger, 2015), students' responses also revealed their positive reactions to the strategies employed by their instructors. Our experiences with our students, as described here, suggest that, in time of crisis, there is room for effective strategies in the non-clinical environment of the classroom. In fact, it seems that the instructor, because of on-going rapport with the students, is in a prime position to offer initial support and guidance to students as well as modeling effective behaviors at the time of community crisis, inventing new uses for communication strategies usually reserved for pedagogical use.

This report's unique strength lies in the fact that it describes information that has been gathered in real time, thus validly reflecting the students' experiences, as opposed to experiences that are reported after a time lapse and may be colored by distant reminiscence and later coping strategies. Further, this report reflects the experiences of students from diverse backgrounds, educational levels as well as various degrees of proximity and direct exposure to the traumatic event.

Some suggestions can be offered on the basis of our experience. Similar to literature about helping clients (Roberts, 2002), students' response patterns suggested that they too benefitted from reaching out to them as soon as possible and by as many means as possible. It is useful to adopt a stage -based approach beginning with initial reach out and support, followed by addressing the differential needs of students (encouragement, instrumental support and psycho-education) as they cope with diverse stressors and on-going follow-up even as the circumstances normalize. Moreover, encouraging students to remain in touch with each other (e.g., establishing their own discussion threads) even in the aftermath of the crisis can be helpful in providing continuity of peer support.

Consistent with the literature, (Hawdon and Ryan, 2012), face to face communication is recommended when possible. Furthermore, receiving a message that their teachers cared about them and were willing to extend themselves at time of crisis beyond their formal role was also meaningful. It has the practical benefit of modeling to students behaviors that they should adopt with their clients. While this needs to be done in a careful manner to avoid crossing the boundary between teaching and counseling roles, it is important to remember that unusual times call for unusual measures. Still, questions remain as to how far beyond the formal role is appropriate and who gets to decide. Second, upon return to class after a community disaster, faculty may want to consider dedicating time to discuss students' experience. This may be the first, and sometimes only, opportunity where students are given the message that it is acceptable to process their own experiences and take care of their own needs before they are well positioned to take care of their clients. Systematizing a period of sharing once school resumes is important although it may mean missing more instruction time. Giving students the opportunity to talk about their experiences has numerous benefits for them as evolving health care professionals. Moreover, given the chance that students may experience delayed reactions (which is consistent with the literature about the impact of stress, e.g. Bonanno & Mancini, 2008), it is important to monitor students' reactions during subsequent classes.
Third, interventions should use a diverse range of strategies and address both emotional and practical aspects of students' experiences by listening to their narratives, providing support, and psycho-education, calming, validating, and normalizing. Fourth, schools may consider developing and implementing faculty training in crisis intervention. Some faculty with practice background and especially those with group

work and trauma knowledge are better equipped to understand and effectively address students' stress reactions. It may be beneficial to share this knowledge and skills so that the school, or department as a unit, is ready to identify and address students' needs at times of crisis. Fifth, based on the students' differential use of the LMS discussion board, related to the course routine, it may be useful to include the use of the discussion board tool of LMS as a platform for informal communication among classmates and with the faculty as a preventive measure in all courses.

This report has several limitations. First, it is based on the interaction of a non representative group of students as only those who had some access to power and the internet from their home, public libraries and mobile phones were able to be in contact, and only those who had means of transportation could attend class. Thus it is plausible that some of those most badly hurt who might have been in most need, might also not have access to communication devices or to the instructor and classmates during the crisis. Second, while it is based on quite a large and diverse group of students, it is anecdotal and the suggestions offered here require systematic evaluation as well as examining short- and long- term outcomes. For example, we do not have exact numbers representing students' attendance and responses. In retrospect, it would have been useful to keep better records of these outcomes. However, as mentioned before, at the time our focus was on offering support to the students and not on systematic data collection. In addition, in spite of their diversity on many dimensions, all students come from suburban and urban environments in a large metropolitan area. Examination of the applicability of the aforementioned strategies and necessary adjustments to students in different contexts (e.g. rural areas) is called for to develop more nuanced principles for tailoring interventions to the unique characteristics and needs of diverse student populations exposed to stress.

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My Journey Toward Anti-Oppressive Work in Child Welfare

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Abstract: The following narrative describes a social worker's journey of critical analysis and struggle as a worker in the bureaucratic framework of child welfare. The narrative describes a process of self-exploration that led the social worker through an evaluation of personal and professional values. The outcome of this journey was a reinforced commitment to the self-determination of clients, to rebalance power inequities, and refute systemic inequities.

Keywords: anti-oppressive, social work, child welfare, power, self-discovery

It is not uncommon for social workers practicing in the fields of child welfare or mental health to unwittingly participate in oppressive practice with clients. This happens whenever we engage in coercive social control of the individuals we serve thus we move away from social justice, empowerment and egalitarianism and instead create an unequal balance of power (Wilson & Beresford, 2000). Oppression in social work practice can surface at multiple levels when we fail to recognize the practice implications that grow out of the complexity of the intersections of our clients' race, gender, class, age, sexual orientation and ability among other factors (Danso, 2009).

Self-reflection is a cornerstone of anti-oppressive social work practice as it allows social workers to begin to understand the inherent power and privilege related to her or his social location and how this may contribute to the unwitting oppression of the client (Danso, 2009). However, we argue that reflection that leads to increased awareness alone is not enough. For anti-oppressive social work to occur, awareness must lead to a change in practice reflected in greater power sharing and egalitarianism. Our professional experiences in child welfare (KB) and mental health (A G-P) have reinforced the notion that as social workers we have an ethical and professional responsibility to actively work to create and nurture an anti-oppressive environment when working with our clients. In this article we focus on the experience of one of the authors (KB) to reflect on the various factors that gradually and unintentionally may contribute to oppressive practices and the transformational process to anti-oppressive social work practice. The second author (AG-P) served as a mentor in the development of this manuscript and provided me (KB) guidance in my journey of self-discovery and through the process of conceptualization of anti-oppressive practice.

My (KB) journey begins with a critical examination and self-exploration of my struggles as a social work professional working within the bureaucratic framework of child welfare in Canada. These struggles lead me to the belief that there is a deep-rooted systemic nature of oppressive practices in that system. This realization did not come easy for me and resulted from a series of circumstances that caused me to re-consider my work with families. Although the core of the social work profession encompasses underlying values that guide our principles and the service we provide to vulnerable populations, the nature of child-welfare practice is, in itself, oppressive to the very populations that we aim to serve (The Child Welfare Anti-Oppression Roundtable, 2009). The Code of Ethics of the National Association of Social Workers (NASW) embraces values that highlight the need for a non-judgmental attitude of unconditional acceptance. In reality, however, the child welfare system is full of evaluation and judgment of clients and child protection workers. In my work, I have used my position to control the dynamics of my relationship with my clients. I have acted oppressively. I have intervened as the expert and judged parents for their perceived failures. I excluded parents from decision-making processes and minimized self-determination. I am not proud of these actions. I now see that as I tried to cope with the severe responsibilities and incredible pressures inherent in child protective work, I lost sight of my ethical obligations as a social worker.

My Personal Journey

Although my oppressive work with clients likely resulted from a culmination of factors, there are certain situations that stand out as pivotal for me. One particular event that stands out as the beginning of my drift into oppressive practice happened years ago when I was assigned the "Smith" family. I was a relatively new worker at the time, bright-eyed and full of hope.

The Smith family was a somewhat chaotic family. The mother, "Tina Smith," was a single mother struggling to parent four young children. I received several referrals on the family surrounding issues of child neglect and lack of supervision. I worked hard to help Tina parent more responsibly. One evening the children were found wandering a busy street in the middle of the night. Tina was sleeping and had no knowledge of their whereabouts. The following morning, my supervisor called me into his office. I anticipated his direction of removal of the children and I had my checklist in hand why I believed she deserved another chance. I argued that Tina was simply exhausted and doing the best that she could despite her situation. I highlighted her strengths and argued that with continued work, she could keep her children safe. My supervisor reluctantly agreed with me. I felt victorious! Less than a week after that supervision session, the two year old fell out of a second story bedroom window. The toddler had several broken bones and a punctured lung. After hearing the news, I hung my head low and entered my supervisor's office. I knew what had to be done. I didn't argue with my supervisor this time. In fact, I found myself angry with Tina - as if she let me down and I was angry with myself for being so gullible. When I gave Tina the warrant to apprehend the children, I was void of any understanding or compassion for her situation. With tears in her eyes, Tina tried to tell me that her landlord was supposed to fix the window screen. I couldn't hear her excuses. From this day forward, I began to doubt my clients' abilities to make healthy choices and became more skeptical in my work. Instead of promoting power sharing and inclusion of parents and families in the decision-making process, I gradually took it upon myself to decide what I thought was in the best interest of the client.

As is the case with all serious events involving children, my work underwent critical review. My perceived failure in the Smith case created a heavy burden on me personally and professionally. As a result, I became hyper vigilant in my work and I became exceedingly concerned with eliminating any possibility of child harm. This concern was exacerbated by my work with the "Clint" family. The Clint family was involved with our agency for ongoing issues of excessive corporal punishment. For months, I ensured that I saw the 4-year old unclothed and checked for marks on a regular basis. I became less concerned with education or discussing the options and alternatives for discipline. Instead, I was more focused on "catching them." On one particular home visit, I noticed the child walking tenderly on her feet. I realized that the entire time I was checking the child for marks; I never looked at the bottom of her feet. On this day, I found the soles of the child's feet to be covered in marks. This situation reinforced my belief that my clients would inevitably fail. A controlling attitude began to underscore my interactions with families more and more. Once again I was motivated by my fear of failing to protect the vulnerable children I was expected to safeguard. Over time, the power imbalance with my clients became more evident. My oppressive work was epitomized in my work with "Elliot", a First Nations family. The mother, "Clair", had 3 young children and an abusive partner who struggled with alcoholism. While I was aware of some of the First Nations history of trauma and oppression, I failed to see how this history might have contributed to the mother's lack of trust in me. By neglecting to understand the complex intersection of her cultural history, gender and social location and the influence of such interaction on her perspectives and actions, I missed the opportunity to build a more just and egalitarian relationship and instead unwittingly contributed to replicating a power imbalance in our relationship that likely mirrored her past experiences with authority figures. Consequently, my meetings with Clair were especially difficult. Clair was extremely quiet and obviously agitated with my presence. Rather than trying to understand her, I saw her lack of engagement with me as a lack of motivation for change. Clair continued to associate with her partner who I deemed as a risk to the children. I warned her that her continued association with him would result in the children's removal from her care. My assessment of her was deficit-based and I failed to recognize her contextual circumstances. On the day of the apprehension, she had to be taken down by police when she refused to let go of the children. She continually called me a "White bitch." It was an incredibly emotion-charged day and I found myself sobbing in my car after the event. In order to get through it, I told myself that I was simply "doing my job."

Unfortunately, my oppressive work was never questioned by my colleagues or supervisors. Oppressive practices are entrenched in child-welfare practice and they typically remain unchallenged

(Wong & Yee, 2010). Power imbalance is inherent in child-welfare service delivery and the application of sanctions to noncompliant parents is commonplace in our work (Wong & Yee, 2010). When child welfare standards are based on the premise that child maltreatment is a result of the parent's lack of capacity to be an appropriate caregiver, the act of judgment is never an issue. As child protection workers, we are trained in the use of actuarial instruments to "assess" parenting ability and we subjectively judge parents' value as caregivers on a regular basis. To be honest, it would have been easier for me to continue my work within a "power over" framework than to question my oppressive practice. Self-examination can be threatening and difficult (Horejsi, 1982). However, I realized that my personal values and inability to face criticism led me down a self-serving path that was adversely influencing my work with families. Somewhere along the line, I lost sight of the social work values of self-determination, client empowerment, and social justice. When I reflected on the power that I had over the families to determine the trajectories of their lives and on the relationships that parents had with their children, I knew that I was at a crossroads and that I needed to make a change. This change started with a process of self-inquiry that focused on trying to understand how my past experiences in child welfare had come to shape my present reactions in my work with families. This insight opened the path that eventually and gradually led me to increased awareness of key factors that began to shape the foundation of my anti-oppressive philosophy and practice, these included: acknowledgment of how my attitudes and behaviors had contributed to oppressive practices; recognition of the privileges of my social location due to race, education and profession; and awareness of the influence that my clients' socio-cultural-economic-political context had on their lives. Consequently, I began to consciously make a concerted effort to create healthier interactions rooted in shared power and respect.

Seeking Balance

As I continued in the field of child welfare, my cynicism began to take a personal toll on me. I felt an incredible amount of despair in my work. I was uncertain of my values, and I knew that such uncertainty was affecting me. I sensed that clients were becoming guarded and unresponsive. As I questioned the worth of my work, my commitment to the field was becoming tenuous. My need for critical self-examination came to a head after one incredibly difficult and emotionally charged visit with a family. During this meeting, my clients accused me of being "cold" and asked if I was always so "harsh and judgmental" in my work. That evening I found myself re-evaluating my personal and professional values and my approach with families. I turned to the NASW Code of Ethics (2008) for answers. Specifically, I reflected on:

1. As a social worker, my values compel me to protect the weak and the mistreated. I must "enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable" (NASW, 2008). As I read this section of the Code of Ethics, I clung to this statement and used it to reinforce my past decisions to remove children from their families in my attempt to protect them from harm. After all, children involved in the child welfare system are incredibly vulnerable. They are often the recipients of abuse, neglect and maltreatment. However, I knew that I needed to dig deeper. My past decisions with families went beyond my desire to protect the vulnerable. I knew that I had a professional responsibility to continue to reflect and understand the factors that influenced my decisions.

2. The NASW Code of Ethics (2008) also advises social workers of the importance of human relationships. In this sense, social workers have an ethical responsibility to strengthen relationships, so as to promote and restore the well-being of individuals, families, groups and communities. Clearly, protecting children while enhancing the well-being of families requires a constant balance. Upon reflection of some of my past decisions, I was ashamed to admit that I did not always engage in a purposeful effort to promote, restore, maintain, and facilitate the wellbeing of individuals and families (NASW, 2008). Rather, my choices were driven by a system that placed a high level of accountability on my decisions and sought to place blame in times of crisis.

3. Lastly, I turned my attention to the need for social justice. I reflected on the current child welfare standards and how they may in fact perpetuate

judgments based on globalized standards that reflect Western, middle-class values (Parrot, 2009). My practice clearly required more work in this area. My decisions were based on dominant and mainstream values that failed to recognize the marginalization of certain groups. I recognized that, in my work, I needed to make a greater effort to prevent and eliminate the exploitation and the discrimination of others. Moreover, I realized that, if I was going to be true to the values of my profession, I needed to work to empower families by actively including them in decisions that affected them.

The Code of Ethics does not specify which principles may outweigh others when they conflict. My ethical decision making is an ongoing process of self-reflection and it compels me to continually reassess whether my work is consistent with my values as a social worker. For instance, I have specifically questioned how might child welfare employees balance their values and make decisions with families in a manner that upholds their ethical responsibilities? I have considered whether it is possible to protect children, while respecting the autonomy and uniqueness of families who struggle with their parenting practices. Although at the time I grappled with finding the answers to those questions, I knew that if I wanted to practice as an ethical and effective social worker, I would need to realign my values, my use of power, and redefine the nature and quality of my relationships with the families I served (Callahan & Lumb, 1995).

I began this process by engaging in a systematic and introspective process of exploration and critical analysis of my feelings and attitudes toward decision-making. My first step was to stop assuming full responsibility for making the decisions that impacted families. I also came to accept that in child welfare, no matter what I do, or what direction I take, my actions may come under criticism. Turnell and Edwards (1997) have suggested that child welfare services are often addressed by professionals who may assume an authoritarian and paternalistic approach that leads them to take on full power and responsibility for assessing the nature of the problem and deciding on the “solution.” In my evolution as a child welfare worker I worked to divest myself from such attitude and beliefs. Gradually I saw a shift in my decision-making processes. I began moving away from making judgments that were motivated by the fear of criticism, and instead I focused on deciding what was in the best interest of families. I strived to develop partnerships and cooperation with the families I served. This led me to incorporate more family-oriented decisions in my work. I also became more aware of the impact that my own power, privilege, and social location had on my decision-making processes. I was not always perfect. Nevertheless, I began to examine my clients concerns within the wider sociocultural context of their lives (Pollack, 2004). Now, before I engaged in any decision-making, I began to work from a place where I could truly listen and understand the needs of my clients (Wong & Yee, 2010). This was a significant change for me.

Anti-oppressive Work in a Child Welfare Organization

While I recognized that I needed to make changes and conscientiously worked at doing so, I also realized that practicing within the current social structure of the child-welfare system inevitably leads to reproducing power imbalances in the worker-client relationship. Child-welfare advocates working from an anti-oppressive framework have identified many mechanisms by which families can be marginalized and oppressed by the child-welfare system (Wong & Yee, 2010). For instance, there is an inherent power dichotomy that is maintained through the constant spoken or unspoken word that parents may lose their children if they don’t comply with the rules of the child-welfare system (Callahan & Lumb, 1995). Although I was beginning to make personal changes in my work, I questioned whether it was possible to empower clients within a disempowering framework (Pollack, 2004). I saw that, embedded within the current child welfare system, are policies that are not informed by anti-oppressive principles. Such policies can deepen the inequalities experienced by families (Wong & Yee, 2010) and entrench oppressive assumptions and practices. The impact of structural inequalities is rarely, if ever, considered in our work. We are trained to employ the values of the organization, to evaluate and make judgments. According to the Child Welfare Anti-Oppression Roundtable (2009) “As part of the process of defining users, the systems has relied upon binary language such as good/bad, fit/unfit, safe/dangerous, and normal/abnormal” (p. 3). Such judgment stigmatizes the individual, embodies the privileged social location of child-welfare case workers, perpetuates dominant discourse and reinforces our power role. To challenge deficit-based assessment in this system is not an easy task and my work to maintain strength-based, social justice themes throughout my practice is a constant struggle. When the very standards of practice that I am proscribed to follow reinforce client vulnerability, I grapple with my efforts to continually engage and empower parents. Nevertheless, I continue to examine how my own power perpetuates the marginalization of others.

Conclusion

My journey has led me to understand that there are no risk-free decisions in child welfare and that mistakes are part of the human condition. Moreover, often despite my full attention, preparation and best intentions, the outcome of a case is beyond my control and some adversity may come to the children. This is an unfortunate reality that child welfare workers face. It is my hope that this narrative may allow other social workers to recognize that adversity and, at times, tragic consequences are aspects of the field of child welfare. When faced with such circumstances I believe that it is also important for social workers to avoid falling into the pitfall of toxic blame and self-condemnation. If I burden myself with worries and fears this would only reduce my abilities to serve my clients effectively. This process of self-exploration has helped me understand that practice based on fear of scrutiny does not epitomize the core values of the social work profession. In the end I must know that I have worked to the best of my ability to fight oppression, promote partnership and cooperation, and support families and protect children.

As a social worker I am committed to work with vulnerable populations and, in that work, I must continually determine if my actions rebalance power inequities and refute systemic inequalities. The importance of examining my own values cannot be understated. Our values form the basis of what we choose to do with our clients (Horejsi, 1982). Therefore, it is important for me that I continually and explicitly engage in a critical examination of my values to ensure that they influence my work with marginalized families in a manner that promotes self-determination, empowerment and social justice. Through my mentorship with A G-P, we explored the process of developing an anti-oppressive philosophy and practice perspective and how it poses a significant challenge for social work practitioners at all levels of experience. Honest self-reflection, a key aspect in the development of anti-oppressive social work (Denso, 2009), can be uncomfortable and at times brutally painful. We also believed that having a framework of principles to guide anti-oppressive practices is helpful. Larson (2008) has suggested seven principles to help build a framework to guide anti-oppressive practice. Here we present an adaptation of these principles to make them more reflective of child welfare practice: (1) ensure that parents and/or families are included as full participants in the identification and implementation of the services that they receive including the goals and strategies implemented to resolve the problem; (2) when communicating with parents and/or families use empowering, egalitarian and respectful language as the basis of communication; (3) be cognizant and respectful of indigenous practices and strategies (e.g., parenting strategies) and when applicable encourage the use of such; (4) establish a just and collaborative working relationships based on trust and power sharing; (5) promote education and professional development among child welfare workers to increase awareness of individual and institutional biases as well as discriminatory and oppressive attitudes and practices; (6) promote cultural diversity and a strength-based perspective in practice (rather than a deficit-based perspective) that recognizes the parents and /or families innate capacity to make choices and change; (7) promote social justice that goes beyond intellectual awareness of injustice and instead transforms into action to challenge and reform oppressive practices that impact upon parents and their children.

Finally, we suggest that the challenge that social workers face is the development of effective anti-oppressive practices. It has been suggested that a critical issue facing anti-oppressive practices is that the perspectives and debates around such practices often reflect more the views of academics and practitioners rather than the lived experiences of oppressed individuals and groups (Danso, 2009; Larson, 2008; Wilson & Beresford, 2000). Wilson and Beresford (2000) have called for a more active involvement of service users in research and the analysis of their perspectives in the development of anti-oppressive theory and practices. Robbins (2011) however, points out that conducting quantitative research in the area of oppression and anti-oppressive practices is difficult due to the focus on assumptions, premises and variables that do not readily lend themselves to quantification and empirical validation. Consequently, qualitative research with service users as well as service providers may be the means to deliver the type of rich narrative and detail to help us generate knowledge on the lives of and challenges faced by oppressed individuals; the complexity of the intersection of factors such as race, class, gender, age, ability and sexual orientation among others; and the structural barriers that perpetuate inequality. Such knowledge would help in the development of empowering and effective anti-oppressive practices.

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From Healer to Transformed Healer: Relearning Lessons in Grief

Erica Danya Goldblatt Hyatt

Abstract: Neophyte and experienced clinicians alike often question whether so-called "wounded healers" are more effective therapists than those who cannot personally relate to what clients have experienced. This narrative discusses my professional and personal development in the field of death and dying from the perspective of an individual academically proficient in grief theory but devoid of personal experience, to that of intimately informed bereaved mother. The healing effects of narrative, personal observations of grief, and implications for clinical practice are discussed. Please note that some details from clinical practice, all names and identifying features of patients have been altered to ensure complete confidentiality.

Keywords: neophyte, "wounded healers", death and dying, grief theory, bereavement, fetal birth defect, CHAOS

We are all called to serve as agents of change for various reasons. I have spoken with colleagues who experienced significant childhood trauma and thus were motivated to work in Child Protective Services (or, conversely, avoid this area of social work and seek employment in agencies focusing on serving the elderly or medically compromised, for example). I know of others who battled eating disorders and determined that their most significant contributions to the field would be housed within residential day programs for similar populations. In school, we're often evoked to discuss the "wounded healer" paradigm: is personal experience of a particularly tragic event, hardship, or life transition a prerequisite for becoming a gifted clinician? Alternatively, is it enough for clinicians to maintain an active, empathetic presence with patients and clients as they reveal their stories, ask for details, and work to ensure that they are truly heard, even if we are not personally familiar with the paths they have walked? How much self-disclosure is too much? When does the therapeutic relationship become the narrative of the clinician, and not the populations we serve?

These questions are not unusual, and when I initially embarked upon a career in social work, I had very little context of being "wounded." Admittedly, in adolescence I struggled with self-image and an endemic form of Obsessive-Compulsive Disorder that has snaked through the genetics of my ancestors and has been repeatedly passed down along the line, but I subjectively never felt I had experienced Hardship with a capital H. I have always carried a deep love and respect for others who struggle, and just as strong a desire to alleviate suffering and inequity.

Why did I become a social worker? The answer to that comes down to one word: Death. As a young child growing up surrounded by a loving family, I often stayed up late into the night pondering the meaning of life and my own existence. What would happen when I died? Was there truly an afterlife? What did eternity mean, and what would happen to my soul when the sun died out, the earth turned cold, and there was no habitual planet to hold my eternal energy? One night, I ran into my parents' bedroom after the thought of it made me physically sick.

"What happens when we die?" I asked my parents, shaking them awake. Their room was dark and clammy, but their bed sheets felt oddly cool.

"What are you doing awake right now? Go back to bed." My father's response came more from the instinct to rest and, perhaps, far too many late nights of doing parental duty tending to one of three children.

"I'm not going to be alive forever. What happens when the sun blows out?" I asked, ignoring his instructions. I could never just return to bed. Despite losing my dinner, my stomach still felt heavy and my mouth was sour. "I don't want to die," I began to cry. "No, make time stop. I don't want to die!" I was young, but the memory is powerful. I remember the frantic, helpless feeling that something was very wrong and I was unable to fix it. My parents were giants, they were smarter, worldlier. Maybe they had the solution?

By that time, I'd had my father's attention. He peeled back the covers so that I could snuggle in between him and my mother, and I was enveloped in the safety of their smells and their welcoming arms. For the first time, but not the last, my father explained many theories of death: from the mystical: "some say the soul has a certain weight, and when a person dies, the body weighs that much less" to the spiritual: "I know a man who drowned as a child. He said he went to heaven and was never afraid of death again" to the one that made me the most frightened: "Jews don't believe in an afterlife. We become dust. That's why living this life to the fullest is so important."

I did not want to be Jewish if this was the case. How could I be so very alive, only to turn to dust? It sounded like a cheap deal. I was more comforted by the possibility of the afterlife and hoped there was one. By the time I completed college I was so consumed by these questions that I decided the only way to understand death was to get as close to it as possible. In response, I embarked on a career in social work, specializing in death and dying. I spent my early career working with adult and child oncology patients, neonates, and survivors of horrific forms of trauma. I became intimately acquainted with the process of dying itself. I watched the young and old pass away before my eyes.

At the beginning of my clinical journey, I was fresh to the world of pediatric oncology, and optimistic that I could make a difference in the lives of the suffering children I met. I have many happy memories from my clinical beginnings of "tattooing" stars and hearts on the bald heads of teenaged girls with the help of liquid eyeliner pencils, of sharing the poetry of Pablo Neruda with lovesick patients who longed for intimacy that didn't put their delicate immune systems into haywire. I felt connected to most of my patients. But one death stands out to me as a moment of self-discovery and perhaps of brushing by a soul transitioning to something intangible: that of a child who had barely turned twelve at the time of her passing.

Maria had been hospitalized on and off with a very severe and rare form of cancer since she turned 10. She was a quiet girl, and was often unaccompanied during her admissions due to her mother holding two jobs to support the family. Whenever I entered her room, I was struck by the powerful alone-ness of this child: she lay in her bed, staring at the ceiling, silent tears streaming down her face. I wanted so badly to connect with her, make her laugh, infuse her with some joy to counteract the toxic brews snaking through her body for the purpose of extending her life. Maria barely ever responded to me. I bought her music, did art projects with her. She accepted my presence but truly, never spoke. I perceived her as a child in slow motion: every move was labored, every inhalation felt dense and every exhalation fell to the floor. Inside her room, time stood still. The colorful paintings of children playing that decorated her wall served as a stark contrast to the child in the bed before me. The artwork felt mocking: here were colorful characters twirling, upside down, without bodily restrictions: and there was Maria, invisibly chained to her bed. I sang her songs and she stared at me. I helped her get dressed, pulling her IV to the bathroom, her tiny naked bottom exposed and she without worry for it. I held her under her arms as she balanced on the toilet, imagining her bones as frail as a baby bird's, hollow, and threatening to collapse beneath the weight of my fingers.

As the cancer became more invasive, Maria would cry and scream on her way to the operating room, filled with terror, but no parent by her side to smooth her forehead or kiss her fears away. I would experience the return of that sick, heavy-stomach feeling from childhood: that I was powerless to stop this event from happening, that Maria was dying, would soon cease to exist. The surgeons attempted to carve the cancer out of her, but it grew and she became infected, the unseen viruses rampant in hospitals feasting on her vulnerable physical status. When I was called to the intensive care unit because she was dying, I knew Maria would be alone.

She wasn't. A small cousin, no older than ten, was by her side, eyes wide and terrified. I searched for the parent who had brought the cousin here, and when I found him I was told for reasons that were not clarified that Maria's cousin deserved to be there. I'd never met the cousin before, and felt that this kind of exposure to Maria on her deathbed would be traumatizing for the cousin. I argued that the cousin not be present, or that the parent, who himself could not be in the room, come to Maria's room to assess the situation. He would not and told me that I would have to "deal with" the cousin. In my newness as a social worker, I helplessly retreated to Maria's room, and together the cousin and I watched her vital signs drop. We watched her heartbeat fall. We heard the high-pressure ventilator pummeling Maria's lungs with air, a sound I can only liken to that of a car on a bumpy, uneven road. The cousin reached for Maria's hand. I said "go ahead, hold her hand while she goes", and we both did, just as the cousin's father came in and began to wail hysterically. It didn't feel real to me. Perhaps it was the shock and sadness of this very isolated child, dying without her mother nearby, or the sounds of the machines working to preserve her fleeting life. Perhaps it was my anger at family being present to witness her death, but not her life, and that it was family I never knew existed. With the sound of the machine still bumping away into Maria's now-dead body, I stopped thinking and started feeling. There was a wordless transition happening there, one that if I rationalized or tried to explain too much, I would miss altogether. I maintain to this day that Maria's soul left her body, and I caught the slightest feeling of that happening while I held vigil by her bedside. I was sad but on a level that evaded words, I knew that in some way, Maria's life endured.

Two weeks later I would watch another child die: this one, a formerly happy and vivacious baby with a brain tumor that transformed her into an angry, aggressive, screaming bundle of a little girl. I watched her take her last breaths, unconscious yet automatic, as her mother and boyfriend cried over the loss of life, potential, and hope that engendered their beautiful daughter. I kissed her cold forehead goodbye. She was still, pale, with purple lips and I was reminded of Maria's transition: this little girl's body felt like a shell, a deeply-loved shell, but her true essence, the immeasurable stuff that made her wobble on unsteady legs, pull at my hair, giggle at the ducks in the hospital pond, was now somewhere else.

I watched death happen: I held departing hands and said prayers with their families. I carried tiny bodies to the morgue. I remember the details of each death, the stark division I felt between living and dying, the pain I felt for mothers, fathers, and siblings, and the desire to say just the right thing when I knew there was nothing truly right that could give my patients and families what they wanted above all else. Nevertheless, by the time I completed my doctoral degree, I considered myself somewhat of an expert in dying, and had comforted so many family members that I felt I truly understood the grief process. I supervised new clinicians and always encouraged limited self-disclosure, allowing patients and families to speak freely, for themselves, without the burden of knowledge of a clinician's loss. Ultimately, my dissertation about adolescent sibling bereavement was a testament to my perceived expertise in death, dying, and bereavement. It was a conceptual approach to summarizing and categorizing the grief of teen siblings in multiple research studies, creating new pathways of identity that teens developed as they struggled to cope and move forward with life. I knew there would always be important grief work to do, and I continued to feel called to it as I embarked on my new career as an Assistant Professor of Psychology at a small college north of Philadelphia and maintained my work as a private clinician.

The Appeal of Narrative

Throughout my career, as patients and families in medical environments told me their stories, I searched for the best methods to ensure trusting, caring relationships that facilitated the flow of narrative that helped my clients create meaning and understanding from their personal experiences. My mother is a storyteller, with a doctorate in education earned after her children were grown. Throughout our lives she focused on storytelling, whether through reading the work of others, creative writing, or invoking the spontaneous creation of songs on long car rides. Her influence sparked within me a true appreciation of the importance of storytelling. Narrative brings meaning to life; truth is unfolded as we tell our stories, and we create perspective as our words, artwork, poetry, and song unfold.

When I became a clinician, the narrative approach felt "just right." I appreciated its foundation drawn from the philosophy of a post-modern approach to clinical practice (Caverhill, 2002). Within the therapeutic relationship, the use of narrative allows a space for the co-construction of reality between client and clinician, where events of the past are enacted to inform the present, and collaborative efforts are embarked upon to interpret meaning (Leighton, 2008). Content within narrative is empathic, boundaries are malleable, and the context within which a story is told is avoidant of hierarchy (Caverhill, 2002).

Yet, I never believed that I would find myself in the position of formulating my own tale of loss and healing. This is ironic, due to my history of specializing in grief and loss. However, I must be honest with myself, and therefore, with my audience: I fell into that trap that so many clinicians do: I thought my life would never be personally touched by death.

Perhaps much of it was ignorance, and having been blessed with a genetically healthy family, losing grandparents to the illnesses and complications inherent in old age and being very sheltered from premature deaths by caring parents. Still, I believe that some of it was a defensive reaction: I needed to be immune to death to do my job, while also living with it very closely. I regarded death much as a colleague or scientific specimen to acknowledge and gain mastery over in order to be an effective clinician. As a professional I had familiarized myself with the bereavement literature of the giants in the field: Kenneth Doka's (1989) *disenfranchised grief*, Neimeyer, Burke, Mackay and van Dyke Stringer's (2010) *reconstruction of meaning*, William Worden's (2008) *four tasks of mourning*. In studying teens, I especially valued Hogan and DeSantis' (1992) *ongoing attachment studies*, where the authors expressed that for grieving adolescent siblings, death occurs within a context of continuing bonds between brother and sister. Despite the loss of a physical presence, teens in Hogan and DeSantis' (1992) research actively worked within a present framework to integrate grief by regretting, endeavoring to understand, catching up, reaffirming, influencing, and reuniting. I appreciated in my academic research and clinical practice that Hogan and DeSantis' model was applicable to more than just teenagers. So, I was enriched by many discussions and theories of death, and death was not an enemy: she was a permanent fixture in my life and work. I toiled alongside her eventuality, with the goal of comforting my surviving clients as best as possible. I believed, at the time, and still believe that this form of professional distancing is common and often necessary in order to be as attentive as possible to those who needed me. Finally, I think I was so steeped in the theory of loss that I never truly thought about my own *practice* of it. I was young, happy, and at the beginning of my career. Where would death fit into that?

It's true, many deaths are expected. We hold vigils over the bedsides of the old, the terminally ill, the young who tragically fall victim to horrible circumstances. And still other deaths are more sudden: they traumatize us with their shocking immediacy, without time to prepare for the event. I suppose my loss falls into the latter category.

From Caregiver to Patient

Contentedly married, I was five months pregnant with my first child when we received the devastating diagnosis. Prior ultrasounds revealed a healthy, appropriately-developing and active baby. My husband and I visited my hometown of Toronto where we were privileged to have an early anatomy scan, hoping to find out more about our little one. We made small talk with the ultrasound technician, who jauntily waved her magic wand over my gooey belly, and produced images that she deemed were "cute." I felt my first ever experience of parental pride: my fetus was cute! Surely not every ultrasound could reveal that. Our child must be special indeed. When the exam was complete, without an inkling of worry on her face, the technician rose and told us she was going to show the doctor the images.

We waited, and waited, and waited. The night before I had told my husband, "I worry something's wrong with the baby." He dismissed my fears as typical Erica anxiety, and told me "you'll see the baby tomorrow and you'll see that everything is fine." Now, caged in this sterile diagnostic cube, with the blue of the exam room sheets creating shadows on the wall, I asked my husband: "Do you think there's something wrong? Or are we victims of the slow pace of the Canadian healthcare system?" My husband, ever practical and rational, assured me it was the latter. The technician popped in about an hour later and apologetically told us, "I'm so sorry for the wait! It won't be much longer." Much longer turned into another hour and a half. When the doctor finally arrived with a fresh-faced medical student in tow, I breathed a sigh of relief.

I was in no way prepared for the doctor's gentle disclosure. He had a soft Swedish lilt to his English and he gently placed his hand on my arm. "Your baby has a very serious birth defect. It is called Tracheal Atresia, or CHAOS, which stands for Congenital High Airway Obstruction Syndrome." He flicked on the computer by the exam table and an image of my baby's throat zoomed into view. The doctor pointed at the image as if it were so obvious, anybody could see the defect. "Here. You can clearly see here, he has no airway. Where his airway is supposed to be, the tissue is completely sealed. And here"- he flicked on another image: "do you see the diaphragm? It's upside down. The lungs are full of fluid, strangling the heart, and inverting the diagram. Do you see?" I nodded that I saw. But what was visible to me was only bright white lines against inky black, like those nighttime traffic photographs, where the cars are perceptible only as indistinguishable lines of colored headlight.

I felt the need to tell the doctor that I had worked in a fetal surgery center, and that I had a master's degree in bioethics. I wanted to tell him that I'd encountered CHAOS before but the truth was, even with my exposure to neonatology and birth defects, CHAOS was completely new to me. I clung to my rational, academic side, trying to form the words to ask the important questions. I wanted to know if my baby would live or die, what his life would look like if he didn't have the anatomy of an airway. But instead, I felt a shade of embarrassment when I asked, "is it a boy or a girl?", as if I hadn't heard what he had said and if my child was a boy or girl, he or she was a person whose light couldn't just be so easily extinguished. It was magical thinking on my part: that a gender, a name, an identity could ward off the evil eye. I recalled my parents' stories of Jewish lore, that the sick and dying were often renamed to fool the angel of death. It didn't make rational sense, but not much felt rational and I was looking for something tangible to cling to, other than the deadly diagnosis that was invisible to my eye.

The doctor flipped to another image. "Congratulations," he said. "It's a boy." Congratulations. Your son is dying inside you.

The day sped up as we shuttled to genetics to learn more about the diagnosis. Congenital High Airway Obstruction Syndrome (aptly nicknamed CHAOS), affects 1 in 50, 000 births and there are very few survivors documented in the limited clinical research on the disorder. CHAOS, like other birth defects, occurs on a continuum and some babies have better outcomes if there is enough tissue to create an airway at birth. These more fortunate babies must still be delivered by a revolutionary form of C-section, the EXIT procedure, under high-risk conditions, spend several months in the neonatal intensive care unit, and, if they do not die of infection and are not cognitively impaired due to lack of oxygen to the brain, must spend life with a tracheotomy. The windpipe is reconstructed throughout childhood in many painful surgeries, but as of yet no child born with CHAOS has survived without a permanent "trach." We were told that our diagnosis was on the early side, and thus, all the more fatal. After embarking on an intensive route of assessment that included fetal MRIs, echos, ultrasounds, and genetic testing, we were told that while the diagnosis was a "fluke," our son's case was very severe and fetal or perinatal surgery was not recommended. He was going to die, and our decision was, in a sense, one of those made with the assistance of palliative care teams for those who are on the other side of the womb: did we want our son to perish in-utero as his heart was forced into silence by ballooning, menacing lungs? Did we want to attempt birth with a likely result of a brain-dead child who would likely require the withdrawal of life support within months of his birth? Did we, unfathomably, prefer to terminate the pregnancy of a much-loved, and much-wanted, child? All of the plans we made for the birth, for the arrival of a healthy baby, disappeared. We phoned my parents, and I told them through tears: "The baby has a birth defect. It's called CHAOS." I relayed the details to my father when he came to pick us up after nearly twelve hours at the hospital. He asked, "Are you going to terminate the pregnancy?" I wanted to slap him in the face. He was reeling from shock, too. But this was my son. It wasn't "the pregnancy" and he wasn't something I could just end. Up until that day, I was prepared to have a healthy, living baby. It was a given. And then, suddenly, my son became a cluster of symptoms, a ticking time bomb. Something that I could choose to end.

Ultimately, our son, our forever adored first child, who we named Darby Joss, died shortly after his diagnosis. To say that we were devastated, heartbroken, and crushed, would be an understatement.

As a result of Darby's death, I was plunged into a newer, deeper, more intimate understanding of bereavement than ever before. I found that all of my years of expert experience amounted to very little. Having academic knowledge of bereavement, and even experience as a counselor and abiding with the dying and their survivors, did not prepare me in the least for my own grief. The pain was deep, isolating, and very physical. As I bore witness to my aching soul, I could recall counseling so many other grief-stricken parents: "It's normal to feel physical pain after a loss. Your body is exhausted. You have experienced the physical departure of someone you love. That loss is absolutely physical. And that emotional pain can be expressed as real, physical pain in your body." Yet, still I was so surprised by how very much my entire body hurt. The muscular aches and pains lasted for well over a month, and occasionally these 'grief aches' come back, almost two years after his death. My husband flitted in and out of our bedroom, sometimes holding me, sometimes sitting with me, telling me that I could take all the time

I needed, as if there were a finite amount of grief available to me, and I would naturally know when closure occurred. I stayed in bed and while two of our three dogs refused to come near me, our gentle, brindle rescue pit-bull mix curled up in bed beside me. He was seeking more than a warm spot on a comfortable duvet. He rested his great head on my shoulder and I wrapped my arms around his patient neck, sobbing into his greasy coat. He would sigh, ruffling his oversized lips and tickling my hair, withdraw to lick a few tears off my face, sigh again, and nuzzle closer.

Initially, in a haze of frustration and anguish, I turned on myself. I determined that I had never been a good therapist; I was naïve and couldn't have possibly helped those who walked the path before me. In the true fashion of cognitive triad (Beck, Rush, Shaw, & Emery, 1979), I felt hopeless, acted hopeless, and believed that I was. There were so many dark days.

Personal Reflections and Validations

As the initial grief evolved into longing, heartache, and an asking of deeper spiritual questions, I began to turn away from self-loathing to learn again. In hindsight I was able to see that some validations of theories of and responses to loss I had learned before my son's death held true. I have listed a few of these below, though with the forewarning that I am making some generalizations based on my own clinical practice and the specific nature of my prenatal loss. I cannot apply these conclusions across the board regarding grief and to do so would be ignorant and insensitive.

Peer support is invaluable. Early in my process of bereavement, I stumbled upon an online forum for women who have experienced a similar type of loss as I have. I believe that the community I found there was a key factor in my healing process. Therein, I encountered friends who reserved judgment about me, to whom I expressed my deepest, darkest, most honest contemplations about grief. They understood and supported me. On one occasion, wracked with guilt, I posted my "confession" that one night near the end of Darby's life, I felt him kick. There he was, swimming around in the womb, living and dying all at once. I hated the kick. I hated the imminence of all of it. I thought, "Stupid baby." And then, I felt horrid, cursing my son in such a way, not tenderly appreciating our limited time together or receiving his kicks as a boon. I carried this self-disgust to the chat room, where I was sure that I'd be called a monster. But I was met with understanding. Kindness: "You are not alone. I hated the kicks too. Hated that my child was living even though he'd soon be dead." I was told, "You loved and love your son. The thoughts you had do not mean you didn't love him." They normalized my experience and reflected it back, advising that I wasn't alone in my symptoms of suffering. There were many tough days when I posted just asking for support, with tears clouding my vision. I was buoyed by outpourings of messages encouraging me with strength, compassion, and unlimited understanding. I felt true kinship with strangers, who truly "got it." My peer group provided me with a safe space and a language to explain my feelings to my husband. I told him about my "stupid baby" comment. He said "While Darby was inside you, he was a scuba diver with a lifeline to mommy. It was false. The kicks made him seem like he was healthy but it was you, for as long as you could, keeping him alive." I was grateful for his depth of understanding.

I grieved differently than my husband did. My husband was deeply saddened by my sadness. His was a more physically detached grief, as he had not carried our first child and experienced the union of life within oneself. Certainly, we both grieved over the destroyed potential of our little boy's life that would never grow before us, but my husband's bereavement was enhanced by feeling he was ill-equipped to comfort me. Having spoken with other mothers in my shoes, I can acknowledge that many (though once again, not all) of them have noticed the diversity of ways their husbands or partners grieve. Male partners became more task-oriented, and coped with the loss by resuming with the rituals and routines of life and work as powerful distractions. We bereaved mothers, on the other hand, tended to be physically and emotionally immobilized by our grief. Some of us found it hard to get out of bed, let alone go back to work immediately. My husband's brain appeared to process the grief in binary equation of zeroes and ones. There was cause and effect, past and present. It was efficient and effective to return to previous, consuming tasks and achieve results. My brain was holistic and like an old tree with many roots tangled beneath the surface: what was the meaning of this loss, why did it happen, what were the implications on future pregnancies, and how could I recover while maintaining an appreciation for what I had lost?

There is a significant amount of guilt attached to healing. Preferring to return to work six weeks after our loss, I immersed myself in the tasks of being a professor: creating syllabi, attending committee meetings, and making time for students. Suffice it to say, Darby was a fixture at the forefront of all my thoughts in those early days, but there were times when I needed to move his memory or my grief aside in order to focus on issues that arose around other aspects of my life. This was very challenging. I felt that if I was not keeping a constant mental vigil over my son's life and death, I would somehow lose him, forget about him, or feel unfaithful to his memory. I silently apologized to him every time I looked away from his ultrasound picture on my wall to tend to an email. When my husband and I started talking about trying to conceive again, I felt I was betraying our angel boy. He warmed up my womb for 5 months. He could never be replaced. It took a significant amount of self-forgiveness and tenderness to move away from these angry and judgmental feelings. Most of my colleagues did not speak about my loss, with some exceptions. One day at a faculty meeting, where I situated myself near the back of the room, an older professor came and asked when the baby was due. I told her we'd lost the baby and she was silent for a moment and then said, "Well, I didn't know", got up, and moved away as if I were contagious. Whether her reaction was motivated by the triggering of her own intimately painful personal losses, a cultural tradition that encourages individuals avoid deeper discussion of death, or feeling ill-equipped to respond to my pain, I cannot say. But I stumbled to the refreshments table blinded by tears and embarrassment for feeling as though I had made her uncomfortable, frustrated that I had been so honest and wondering what I should have said instead. At that moment, another colleague, a male, came up to me and patted my hand. "I'm so glad to see you. I'm so glad you're here," was all he said, but somehow, it was exactly what I needed to hear. The return to work was challenging and the self-loathing I felt was not helpful in my healing process. With time, I have also come to realize that nothing and no one could make me forget about my son and that moving forward does not mean moving away from him.

Loss can cause a reevaluation of close friendships and relationships in life. I was, and remain, surprised by who was helpful and who was not, and my loss forced a serious recalibration of my friendships and relationships. My cousin, all the way out in California, whom I hadn't spoken to in some time, emailed me every single day. She elicited my reactions and responses, and had a desire to understand. She took everything I gave her, and came back for more. She asked if she could help out with the practicals: "Have you signed up for a daycare waitlist, or a baby registry? Would you like me to take care of it?" She broached the taboo questions: "Are you looking forward to trying again? Is it a scary thought or a welcome one?" She helped me cope with the mundane: "I can't even imagine how difficult everything must feel right now. Small tasks must seem so unimportant and insurmountable. And leaving the house sounds like a minefield where you have no idea whether you'll see someone who makes you terribly upset because their pregnancy is a bitter, in-your-face reminder of the unfairness of it all." She spoke the unspeakable: "NOTHING you did caused this. I don't think anyone could go through something like this without having their faith severely tested. This isn't fair, and you and hubby are good, caring people who don't deserve this (not that anyone does), and the search for a reason 'why' simply leaves you with no answers. I hope you aren't hearing the 'everything happens for a reason' thing from people, that is something people say when they don't know what to say, but it just doesn't seem helpful or productive."

While I treasure those emails and the unlimited understanding extended my way, some of my best friends, who gently inquired at the beginning how I was doing, fell to the wayside and didn't pick up the phone or write back. Some were therapists themselves and had the same theoretical training as me. It was deeply painful, but I also believe it was painfully necessary to know who would be an advocate and a supporter during my time of need, and who only showed up in a superficial way.

Time does not *heal*, but it does *help* in some ways. It is very commonly asserted that time heals all wounds. Antiquated grief theory tells us that our sadness should be resolved. Grievers should experience closure of symptoms, and relocate the dead to their proper place that is incompatible with the world of the living. Today, thankfully, clinicians and academics know better. We understand that grief is a process and those of us coping with loss often seek continuing bonds with our departed loved ones, just as Hogan and DeSantis (1992) suggested. However, I have noticed that as time has marched on, my loss has transitioned from a raw, open, and bloody wound to developing a protective scab to a scar that is still visible for me, but less visible to others. The pain is more of a dull ache, though at times the scar tissue is opened anew (usually by a hurtful comment) and I bleed out and throb once again. But for the most part, with the passage of time, I was able to celebrate the 5-month pregnancy and lessons learned therein. I have reached for meaning, implications the death holds for my professional practice, and ways to memorialize Darby and explain his brief life and death to my son, Rhett, who came a little less than a year after the loss.

Implications for Professional Practice

My life and practice have been enriched by a new narrative. While I maintain my post as an assistant professor and now department chair of psychology, at the time of this writing I still carry a clinical license and over the past two years have provided therapy as a member of group practices and as an individual provider of pro-bono services to needy community members. Given the triad of roles I now serve as mother, wife, and academic, I maintain a very small caseload and am very selective regarding the types of cases I accept. Naturally, I'm still most drawn to death, dying, and bereavement though with a new perspective. I would hesitate to call myself a "wounded healer" because while Darby's death shook my foundations, I do not envision my scar tissue as an evident wound for all to see. I prefer the term "transformed healer": while I have now experienced loss, this loss has provided me with a deeper, richer perspective to approach patient narratives. I am transformed by my grief and believe I better understand the experience; however, my clinical practice techniques themselves have not truly changed. Surprisingly, perhaps, I adhere to many of the maxims in clinical practice that I once followed as a personal-death-inexperienced provider. Below is a brief discussion of how my practice has remained virtually unchanged. Again, this is not meant to generalize to cases outside my own. For the purpose of my narrative, these observations constitute my own perception of reality:

Self-disclosure is still limited. I do not believe that my clients need to hear my story in order to perceive that I understand theirs. My eye contact, body language, probing, gentle questions, and reasoning may indicate to them that I have experienced a devastating loss, but I am still as careful as I always was to let client narratives form on their own. The questions I ask are informed, at times, by my own experience, but I very rarely tell clients of the loss I experienced. One time, I was hired by a woman who had been given a serious diagnosis late in her pregnancy. At 8 months' gestation, she told me: "Nobody could ever understand how I feel. Not my husband, not my mother. She said she knows how it feels because she had a miscarriage. It's not the same. I feel so alone." I had heard this many times from many patients. Still, my heart ached for her and I yearned to wrap her in my arms and say, "I get it. It happened to me too. I understand." I wanted to ask her how she felt when the baby kicked, and tell her I'd had moments of overpowering anger. I wanted to tell her I knew. And yet, my child did not have the same diagnosis. We did not have the same kinds of relationships with our families. We weren't equal members of an online peer support forum. To tell her that my story was equivalent to hers seemed to be a desire on my part to find a kindred spirit, as opposed to provide her with therapeutic assistance. I avoided telling her Darby's story, though I did tell her that I had lost a child and though I could not ever experience grief exactly in the same way she had, I could appreciate how it felt to feel so very isolated and misunderstood.

More than ever, I believe in disenfranchised grief (Doka, 1989), since the loss of a child in the second trimester is not readily acknowledged by society. Individuals struggle with language: was he a fetus? Symbolic of something more? How do we address him? Why did he have a name? And the solution is usually to avoid uncomfortable answers by never speaking of Darby at all. Similarly, in clinical practice I now endeavor even further to name the grief my clients experience, whether over the suicide of an ex-boyfriend, the loss of a childhood pet, early miscarriage, or other less societally-sanctioned events of grief. I more strongly encourage narrative and the creation/validation of my client's lived reality: by abstaining from judgment and labeling grief, I find the individuals who sit across from my chair feel free to celebrate, memorialize, and give voice to their own stories of loss.

I still search for support group resources, and I still encourage marital counseling when appropriate. I appreciate the diversity of approaches to grief therapy that includes the collection and dispersion of a variety of resources, from peer support to additional reading and homework exercises. I did this before, with a constantly-updated list of files to refer to when clients required supplemental support. Now, however, I'm even more aware of how valuable these resources truly are.

As a supervisor, I reinforce the importance of eliciting narrative and the co-construction of reality with a patient. My core belief that storytelling is the stuff of life and healing has not changed. Neophyte clinicians who abide strictly by interventions that follow rigid homework, scheduled interventions, or approaches that rely solely on quantitative research methods are encouraged to explore the value of qualitative approaches to healing. Of course, there is tremendous value in evidence-based interventions and the research behind them. However, I encourage flexibility in my supervisees and a willingness to explore storytelling through methods that include poetry, dramatic reenactment and Gestalt empty chair techniques to enhance the logotherapeutic, meaning-making aspect of coping with loss. I have struggled with supervisees' desires to tell their own stories, to self-disclose and turn the session into a healing one for them alone. Working with a new social worker who was also a recovering addict, my supervisee once expressed frustration at how, in his work as an emergency room mental health clinician, the same addicts came in near-dead from overdoses and always said they'd go to rehab but would return to their lives on the streets. My supervisee told me, "I think it's time to tell him my story." He felt that by self-disclosing, explaining how he got sober, he might provide inspiration and true motivation to change. I asked my supervisee to recount his story for me once more, though I'd heard it several times. As he recounted his narrative, I gently pointed out the circumstances of his recovery that might be challenging for his patients to appreciate: my supervisee was white, upper-class, well-educated. He had never been homeless. He had engaged in some very risky and self-destructive activities, but was faithful to the tenets of his twelve-step programs and had a good support network of sober friends. His reality and his struggle was a poignant narrative in itself, but I was unsure as to whether his decision to self-disclose was appropriate or would be well-received. I asked him: "how might a disenfranchised, chronically homeless patient feel about the inspiration factor of your story? You've told me that the repeat offenders, as you call them, are high school dropouts who make a good living selling drugs. They don't have family support the way you do. How might hearing your narrative elicit change from their end?" My supervisee considered this and we discussed post-modernism, differences in perspective, and whether self-disclosure was the right road to travel down. Together, we decided on a path of eliciting the life narratives from some of his clients who continually returned to the emergency room, exploring strengths, significant relationships, areas for problem-solving, and of course, recounts of grief and loss. It was our hope that asking for stories: life stories, death stories, and stories of addiction: this would be the connecting piece that, if nothing else, allowed my supervisee to experience a shift in how he conceived of his "repeat offenders": as real people with their own tales of love, loss, and hardship, that were so much more than abusers of the healthcare system. I can appreciate how this element of practice can be challenging for clinicians in managed care environments, where standards are dictated by evidence-based outcomes, time limitations, and paradigms that have not evolved to include an appreciation for the rich flow of unstructured narrative. This is an area of advocacy, and one that is deserving of further research, which we must continue to promote and encourage among new practitioners. Simply including the question, "Tell me your story" on an intake form may open doors for creating meaning, connection, and better therapeutic outcomes.

To sum it all up, very little about my approach to clinical practice has been altered from when I first entered the field. This in itself validates that my approach was effective: I didn't need to change how I sat with the bereaved, observed their losses, and encouraged them to tell me more. My own loss only reaffirmed what I knew all along.

I do believe that, through my experience, I have become a deeper and more compassionate woman, professor, and therapist. I have promised Darby that his brief life will not have been for nothing. Truly, while his life and death have deeply enriched my own, the gift of his journey, and mine, was in the message that from the beginning, whether wounded or not, my calling to help the bereaved and observe the dying was the right path for me. Now, as an educator and administrator, too, I hope to transmit this knowledge and love of clinical practice to my students, regardless of their own personal experiences.

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Learning From and With Humility

Mari L. Alschuler

Abstract: Being vulnerable enough in supervision to admit our mistakes is the theme of this brief article. When I was a trainee in poetry therapy, I learned how to use empathy and to consider potential consequences of my interventions. By examining an incident of an unintended consequence, I hope to share with other educators, supervisors, field instructors, and practitioners the importance of humbly sharing one's mistakes in supervision.

Keywords: supervision, poetry therapy, self-awareness, humility

Practitioner, field educator, supervisor, and faculty member: I have now worn each of these hats and have found that one thread runs through each: humility in admitting when I don't know something or have made a mistake. It's a platitude to say that "we learn from our mistakes," but trial and error is how we develop as reflective practitioners. I have found that sharing my errors with supervisors, mentors, colleagues, and students has made a profound difference in becoming a more open and present social work professional, supervisor, and educator.

I first learned about poetry therapy while I was working toward an MFA in Poetry at Columbia University. I often hung out in bookstores, reading and writing. One day I came upon a book title that intrigued me: *Poetry as Healer: Mending the Troubled Mind*, edited by Dr. Jack J. Leedy (1985). I had been writing poems since I was eight years old, and was interested in how they helped me cope with my feelings. I had taken some introductory psychology courses as an undergraduate. The title alone gave me an "aha" moment: I had found my 'tribe.' I bought and read the book and wrote the publisher, asking if I could write to the editor, Dr. Leedy. I was given his phone number on Long Island and called him. He spoke with me at length about poetry therapy and invited me to attend the next annual conference of what was then called the National Association for Poetry Therapy (NAPT). Thus began my immersion in poetry therapy, and where I met the woman, Dr. Deborah Eve Grayson, who became my poetry therapy Mentor/Supervisor.

Training to become a poetry therapist follows most of the same protocols as becoming other types of creative arts therapists (dance, art, music, drama). One reads didactic materials; attends workshops and conferences; attends and takes turns leading a peer consultation group; and practices under supervision. For poetry therapy, Mentor/Supervisors are accredited by the International Federation of Biblio/Poetry Therapy (www.ifbpt.org) or by the International Academy of Poetry Therapy (www.IApoetry.org).

Two of the primary differences in poetry therapy, as compared to the other creative arts therapies, are that we are required to read a large amount of poetry, and that we have to consider the literacy level of the populations we serve. While we do not have to be poets ourselves, many poetry therapists are creative writers; we all become close readers of poetry. Under supervision, trainees learn how to select poems, song lyrics, or other literary works for use with clients.

Empathy in Training

Similar to other mental health professionals, clinical poetry therapists have to consider the consequences of our interventions, and the use of empathy in developing rapport and a therapeutic alliance. Our ability to enter into the mindset and emotional climate of another is used empathically to choose poems that relate to issues clients may be dealing with, and to create writing prompts for clients' further emotional expression during or between sessions.

Much as Method actors use memory and body-sense to recreate emotion in a scene, we learn to use our experiences, memories, and body (propriocentric) awareness in order to bring ourselves to the lyrics, poems, and prose we use with clients. We consider the poem as a whole, its lines and phrases, even individual words, and use our empathy and imagination to consider how it might be perceived by our clients. Dr. Leedy (1985), who was an early developer and theorist of poetry therapy, used the term 'isoprinciple' to indicate a kernel of meaning within a piece of literature that might be linked emotionally or through association to the client's perception of its meaning (p. 82).

Stainbrook (1978, as cited in Lerner) described the poetry therapist as a meaning-maker who extends that role to the therapy client: "Reading or listening to poetry either by oneself or in the special social context of psychotherapy is influenced, of course, by the general cultural assumptions about the meaning of poetry and by an individual's attitudes and characteristic reaction to poems" (p. 7). As trainees learning to select poems for use in poetry therapy, we may journal about the poem, think about the associations we have to certain words or images, and discuss them with our peers or supervisors.

Accepting Mistakes

Unfortunately, many social workers and other mental health professionals are loathe to admit mistakes to supervisors or field instructors (Abernathy & Cook, 2011; Borders, 2009; Mehr, Ladany, & Caskie, 2010). Becoming a clinician takes time, but we often find it humiliating that we haven't achieved the immediate skills yet. We want to be an automatic expert. We are enthusiastic and think we've mastered something new before we really have.

Many trainees and students have difficulty accepting fallibility. We first have to admit to ourselves that we made an error. Perfectionism is not an option! Our treatment decisions may be influenced by countertransference; an intervention may not work out the way we planned; our client relapsed; we met what we perceived as 'resistance' with our own anger and frustration (Borders, 2009).

Training to be a mental health professional is rife with instances where we make mistakes. Admitting our errors is difficult for many students and supervisees. I feel it is important to teach my students that supervision is the place where we learn from our mistakes. Through use of self and honest sharing of my own mistakes, I hope to teach my students and trainees to develop authentic self-awareness.

Opening ourselves up to a supervisor, then, and being ruthlessly honest with her means we have to enter into the role of one who does not know. Supervision should be a place where we can admit our errors and request help in improving our skills (Mehr, Ladany, & Caskie, 2010). This submission to someone more experienced than ourselves does require a certain amount of humility. While sharing the same etymological root, there is a wide difference between humiliation and humility. To me, the former implies an internal feeling of not being good enough or shamed by others, while the latter indicates a sense of having more to learn. As mental health professionals, we all have more to learn about our clients and ourselves.

Poetry Therapy Training in a Free Cancer Program

During my supervised training in clinical poetry therapy, I volunteered at Gilda's Club, a supportive, comprehensive cancer wellness agency named for comedian Gilda Radner, who died of ovarian cancer. This nonprofit provides free programs, activities, and groups for people with cancer, their families and significant others in various U.S. states. Gilda's Club clients may be newly diagnosed, in the midst of treatment, or in remission. Significant others may have lost someone to cancer, while others are in current relationships with partners, spouses, siblings, parents, children, grandchildren, friends, or colleagues; all these significant others are welcome to participate.

I was the first person to provide poetry and journal therapy at Gilda's Clubs, first in New York City and then in Fort Lauderdale. One of the most enjoyable poetry therapy activities I led was a Woodstock themed party that included journaling, musicians, and dressing in 60s outfits. I had selected song lyrics and writing prompts related to that event and its music. It turned out that two of the women-both cancer survivors-discovered that they had both attended that phenomenal event. They shared how Woodstock had been a turning point in their lives, and connected it to how cancer had now become another turning point in their lives.

Because services are free, one never knows who or how many people might attend any activities other than weekly, scheduled cancer support groups (for people living with cancer or for their significant others). I never knew who would show up for a poetry therapy session, or how many might attend. It might be people with cancer, a family, or a mix of the two. I always came prepared with a fully packed "toolbox" of poems and writing prompts. Thus, I tried to select literature and writing exercises that could be used by a variety of people. I wanted to keep an open mind, in order to be flexible and present.

An Unintended Consequence

I derived pleasure from providing expressive writing activities at Gilda's Club as I trained in poetry therapy as a specialization. I anticipated having meaningful, useful, group sessions each and every time. That is not always what happened, however. One experience in particular taught me the true meanings of empathy and humility.

On this particular afternoon, I had been thinking about the theme of life after cancer, during remission. What are the emotions one might have knowing one is in remission? Thankfully, I have never had cancer, but it has touched my life as it has countless others. I considered how life had been for my maternal grandmother before she succumbed to lung cancer. During her remission, I observed her perseverance doing exercises: moving the arm that had withstood lymph node excisions up and down a wall, or her hand clutching and releasing a rubber ball.

One of the poems I had selected for Gilda's Club was "Transplanting," by Theodore Roethke (1948/1975, p. 40). In this short, lyrical poem, the poet describes a plant which has overgrown its pot and requires removal and replacement into a larger one in which it would extend its reach and ultimately flourish. After rereading the poem and using the 'isoprinciple' concept, I identified the theme of a journey which ends with blooming and growing. I then tried to imagine how someone dealing with cancer might react to it. To do this, I remembered what my own family and I had experienced losing members to cancer, how the person with cancer had rallied and struggled to live, and how the surviving family members picked themselves up and moved on with their lives at their own paces. In my naiveté, I perceived that this would in fact be a good poem for the Gilda's Club toolbox.

When I arrived at the program one afternoon, only one woman came to my scheduled poetry therapy group. We introduced ourselves. I will call her Carly. I welcomed her and explained that poetry therapy is the intentional use of literature for healing purposes, and that I'd be asking her to read and respond to a few poems, and if she wanted to, to write in response to what she read. We waited to see if anyone else would join us but no one did. Carly said she had breast cancer. Although weakened by her first rounds of chemotherapy and radiation, she stated she wanted to express herself. When it appeared we were alone, I handed Carly a copy of the Roethke poem and asked her to read it aloud. What I had planned as a group session had become an individual one. Poetry gets to the core quite immediately when used therapeutically. Without the synthesis of a group for peer support and processing, images and feelings are undiluted and much more intense, direct, and personalized for an individual client.

Carly recited the poem with some difficulty due to its phrases punctuated by many commas. She then became enraged at me. "Why are you making me read this?" she yelled and rose to leave.

I was puzzled: What was she so upset about? I'd read this poem over and over again before putting it in my backpack for use this day. I believed it aligned with my intentions and my own interpretation of the poem's themes. So why was she so angry-at the poem, and at me?

As Carly gathered her belongings and headed for the door, I reread the poem. I stopped her and asked if we could talk about her reaction. She shook her head but sat down again, clutching her bag and jacket in her lap as departure was imminent. "Carly, I'm so sorry if this poem upset you. It certainly wasn't my intention…"

She interrupted me angrily. "Don't you get it?"

I replied, "I meant this poem to talk about moving on with life after cancer, to see how life can get bigger and stronger after…"

"Don't you think it might mean something different to someone dealing with cancer?"

I asked her to show me which words were so upsetting. Carly pointed out several phrases: "single twist of the thumbs," "third thump," "long days under the sloped glass," "young horns," "Creaking their thin spines," and "the smallest buds/Breaking into nakedness,/The blossoms extending/Out."

Oh dear. The poem had reminded her of her diagnosis, biopsy, mastectomy, chemotherapy, radiation, and her current fear of the cancer coming back and spreading (the final line: "Stretching and reaching"). What she had taken from the poem, the theme she had identified, the meaning she had made of it, was cancer.

In all my thinking about "Transplanting," negative connotations had never crossed my mind. Where I saw health and healing, alignment with nature, and positive growth, this cancer patient saw her first tumor, its excision, diagnosis, treatment, and death. She was not a survivor, not yet. I felt I had made an empathetic failure. I had failed her. I felt awful and began to apologize.

"Just don't use that poem again with anyone else with cancer, ok?" she made me promise. I agreed and she left. I returned the unused copies of poems and writing prompts into my backpack and hurried to a private office to call my poetry therapy Mentor/Supervisor. I was anguished: I had no right to think I could ever become a poetry therapist. Just because I'm a poet and a clinical social worker doesn't mean I can marry the two successfully. In trying to help, I had caused more harm to Carly. What was I thinking? How could I have made such a horrible mistake?

A Teachable Moment

When I reached my poetry therapy supervisor, Deborah, on the phone, she quietly asked me to stop and take a breath. Then she asked me if I thought I was allowed to make a mistake. Did anyone get hurt? I said I thought I'd hurt the client's feelings, how angry she was. I told her how stupid I felt for misperceiving how a cancer patient might respond to the Roethke poem. I said maybe I should quit the poetry therapy training.

Deborah reminded me that mistakes are how we learn and that it is just as important not to beat yourself up for being human. We reviewed my process of poetry selection for that specific client population. She explained that reaching for associations was always a tricky set of mental acrobatics: projecting one's thoughts and feelings onto an unknown client. We are often too close to our intentions for a session so that we can lose sight of alternate perceptions or associations. Being prepared requires not doing things perfectly. We need to be able to extract the best possible outcome from however clients respond to what we provided. We have to be prepared to be surprised, which requires humility.

We talked about how to handle a client's anger and how to take care of ourselves so we can meet clients where they are at, instead of pushing our agenda. We discussed how I might use the Roethke poem for other client populations. I swore I'd never use it again with anyone, ever. I felt burned by it.

Through supervision I was able to step outside myself and evaluate what had happened more objectively, without self-blaming or feeling humiliated. I had had good intentions and tried to implement the isoprinciple but it blew up in my face. Carly was where she was. But I couldn't see that until discussing it with my supervisor. There is a lot of humility in being human, my supervisor said.

I had had lofty ideals that one poem could make a difference. We think that by giving clients a poem it would change their lives. Instead, they might chew it up and spit it out. Changing perspective by talking out loud with a supervisor helps trainees analyze intentions and redirect efforts in gaining new skills.

Summary

When I train people interested in poetry therapy, I always tell the above story. I believe it is intrinsic to becoming a reflective practitioner and empathic human being to admit when we've misjudged, misinterpreted, or made an error. While empathy is an important part of developing a therapeutic alliance with clients, having humility about one's fallibility is equally important. As mentors, supervisors, field instructors, educators, and practitioners, we have to be humble about the limitations of our minds in trying to know what a client might be thinking or feeling in every given moment.

While it is advisable to predict to some extent how a client might react to an intervention, we have to remember that there is always a level of projection involved in developing empathy. So it is important not to berate ourselves or feel humiliated when an intervention backfires. Supervision provides the opportunity to learn more about ourselves and the space in which we can humbly admit when we have made an error. My mistakes have kept me humble and open to new learning.

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