REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

General Submissions
Teaching and Learning Reflections
Arlene Reilly-Sandoval, Editor
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Volume 23, Number 4 Fall 2017

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Letter from the Editor

Arlene Reilly-Sandoval

Abstract: This serves as the introduction to Volume 23, Number 4 (Fall 2017). This issue includes general submissions as well as reflections about teaching and learning.

Keywords: teaching, learning, narratives, school-based counseling, expressive arts therapies, narrative therapy, hip-hop therapy, microaggressions, social work educator, incarcerated men

What a treat we have for you in this issue of *Reflections*! The current issue challenges the reader to consider practice on all of its levels, as well as to consider the effect of oppression and privilege on the practitioner and client. We are asked to reflect on the ways that our practice changes us, moves us along our personal and professional paths as we seek to make a difference with our clients in practice.

The challenges faced by at-risk populations on the mezzo and macro levels is discussed in "Schools Fall Short: Lack of Therapeutic Continuum of Care in Public Schools." Here, Ms. De Vito discusses Kyle, the only sibling in a group of five who is living with his paternal grandparents. Kyle perceives himself as different from his siblings and is faced with challenges on a micro and mezzo level. Ms. De Vito is persistent in her engagement with Kyle, and it pays off. Schools are important resources for families, children, and neighborhoods. They provide needed services, a gathering place for the neighborhood, and an identity for the students and parents. However, in the United States, most public schools close for the summer. This disrupts the services for students who may be getting their only meal for the day in this place, or, as in Kyle's case, the only therapeutic intervention for his behavioral issues. The school, as a mezzo system, has a large presence in neighborhoods and can potentially influence the direction of a child's life. Ms. De Vito rightly recognizes the need for summer hours for therapeutic services, which can empower families and centers to focus on client needs rather than agency scheduling.

In "The Ripple Effect in the Expressive Therapies: A Theory of Change Explored Through Case Studies," Ms. Gombert, Ms. Eckhaus, Ms. Kuehn, Ms. Nelson, and Ms. Lee describe the use of expressive therapies to help clients "move beyond cognitive understanding and verbal processing." They found that the expressive arts therapies have potential to affect not only clients, but also their supportive systems. The authors describe their experiences with expressive therapies at the micro level with art and dance, and at the mezzo level with lyrics and art. Their experiences engaging clients who range from non-verbal children to adults with serious mental health diagnoses show that the flexibility and scope of this intervention is limited only by the social worker's imagination.

Ms. Turnbull shares with readers her "Reflections on Narrative Therapy," told through the eyes of a new practitioner. She implores us to remember to notice the "sparkly moments" and the "wait-a-minute marvels" in our interventions with clients. Ms. Turnbull reminds us that therapy can be transformative for the practitioner as well as the client.

The issues of client empowerment and client-centered intervention is discussed in Dr. Estreet, Dr. Archibald, Ms. Goodman and Ms. Cudjoe's article, "Using a Client-centered Approach to Guide the Development of a Culturally-Specific Hip-Hop Intervention for African American Adolescent Substance Users." The authors describe the importance of linking micro and mezzo/macro interventions, and we are treated to a detailed framework of agency intervention to serve clients' culturally-specific needs. Utilizing a person-centered focus and a motivational interviewing framework, the authors discovered that youth were engaged and interested in treatment, but not in its current iteration. The youth were directly involved in the creation of a hip-hop intervention, and preliminary results indicate that the intervention was successful. Instead of viewing treatment as something that is "done to" youth, the authors collaboratively created an intervention program that allowed youth to be involved in their treatment. Expressive art therapies have been shown to be effective with client engagement, therapeutic relationships, and the client's own self-reflection behaviors (Eschenfelder & Gavalas, 2018).

Carvalho-Grevious and Sabbath, in their article, "Uniting Macro and Micro Practice Enhances Diversity Training," remind us that oppression affects social workers as well as clients. We must be cognizant of oppression at all system levels and be prepared to understand and intervene. Social workers often enter the field due to their own life experiences, yet we rarely acknowledge racial or ethnic oppression as one of these experiences. Oppression is often experienced as microaggression in everyday life, and lack of awareness can lead to the development of policies and programs that discriminate or provide further microaggressions. Sue, Capodilupo, and Holder (2008) described microaggression as, "the brief and common place daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group" (p. 273). This "death by a thousand cuts" is a significant contributor to stressors which can lead to physical, emotional, and mental health issues. In my own life as a multiracial person, I can clearly recall the first time I was asked, "What are you?" My early introduction to school was sheltered in a small, U.S. Department of Defense school located in Hanau, Germany. There, most of my classmates knew my parents, and mixed-raced children were common. During my first week in public school back in the United States I was asked, "What are you?" As if I didn't belong. As if I were an outsider. Did they not even recognize that I was a human being? Demographic forms contained neat, monoracial categories, and I was instructed to "select one." At the bottom of each monoracial category was the category I most often checked, "Other: Please describe." Within a few years I had developed coping mechanisms and perfected an answer to the question of what I was, but the memory of being labeled an "other" remains. Later, when my own children were in school, the advocacy of social workers and other groups paved the way for my children to have the option to check as many boxes as they desired to described themselves, instead of being forced to select "other" as an option. Carvalho-Gervious and Sabbath affirm that diversity training and bias must be approached at both a micro and macro level in order to be effective and reduce micro and macro bias.

Dr. Tinucci tells her unique story in "Reflections on the Impact of Privilege, Marginalization, and Story on my Social Work Practice, Research, and Pedagogy." Dr. Tinucci describes her personal journey through a childhood, which she describes as within a context of privilege, into

experiencing marginalization as an adult. Through poetry and a moving narrative, she describes her experience of feeling "different," and she describes the microaggressions she experienced in her youth. While these microaggressions were not directed at her, they illustrate the power of language to stifle human development and self-image even when directed towards others. These microaggressions do not need to be active words; Dr. Tinucci describes the "deafening silence" surrounding discussion of the LGBTQ population in the 1980s, her awakening to privilege and class, her own coming-out process, the assumption of her personal and professional identities, and the impact on her teaching and research.

Finally, the theme of outsider continues in "Second Chances," in which Dr. de Jong addresses the bias faced by incarcerated men and the development of alternate identities. Specifically, Dr. de Jong describes the men's development of a professional identity as they participate in a social work course offered in the prison. Dr. de Jong favors us with his own perspective, which includes a background as a teenager in the Netherlands, a country that takes a different approach to incarceration compared to the United States. While by necessity we do not know what the future holds for the men in Dr. de Jong's class, we get a glimpse of the hope that education and support can provide on the micro level, while gaining a clearer picture of the challenges faced on the mezzo and macro levels once these men are released from incarceration.

Mahatma Gandhi stated, "The best way to find yourself is to lose yourself in the service of others." This issue of *Reflections* is a good place to lose yourself, to consider the ways that our experiences and service changes us, and to emerge with a better understanding of how we have come into our own personal and professional identities.

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Schools Fall Short: Lack of Therapeutic Continuum of Care in Public Schools

Katherine De Vito

Abstract: Public schools usually provide mental health counseling as a service during the school year. However, most do not provide counseling throughout school breaks. The risks from interrupted care may become more evident when summer break arrives. This may pose great risk for students, especially those with a history of attachment difficulties, who may decompensate over the lengthy summer break without consistent therapeutic support. This paper discusses school-based counseling, its effectiveness, and what happens when counseling services are disrupted, especially in the case of a student with attachment issues. I will use a case study to illustrate the decompensation of one student over the summer break and why it is vital that public schools offer continued mental health counseling throughout the summer months.

Keywords: attachment theory, school-based counseling, insecure attachment, behavioral disabilities, special education, affect regulation, solution-focused therapy, disrupted therapeutic care, therapeutic alliance, gangs, summer break

My office is located in a quiet wing of a middle school building. I am a child study team school social worker whose primary job is to provide supportive mental health counseling to general and special education students. I also provide case management to special education students. I collaborate with outside therapists, speech and language specialists, probation officers, child protective services, law enforcement, guidance counselors, occupational therapists, school psychologists, learning consultants, teachers, and administrators to provide the best services for my clients. School counselors assist students in developing skills that will help them be successful in the world. School counselors offer skills training, individual and group counseling, crisis intervention, and work with teachers, parents, and administrators (Allen-Meares, Montgomery, & Kim, 2013). School counselors can produce positive changes with students and bring changes within the school environment. A counselor can be an ally, advocate, and someone they can trust to go to in the school for help. School-based counseling is successful in aiding in children's distress, implementing changes, and making a difference in children's lives (Cooper, Fugard, McArthur, & Pearce, 2015; Allen-Meares et al., 2013; Rupani, Haugheya, & Cooper, 2012).

My new client, Kyle, a 13-year-old African American male, was due to come in for his first session. Kyle was a new student in the Behavioral Disabilities Program, a self-contained special education classroom. Kyle appeared at my door and looked hesitant as his teacher, Mr. S, accompanied him into my office. “He's refusing to come for counseling. He says he doesn't like or trust women. He said he does not want counseling and is not going to participate.”

As there were no male counselors in my school building, his only option was a female counselor. Kyle was dressed in his school uniform, a neatly pressed white shirt and pants. He sat down in the chair in front of me with his head hanging down between his legs, his eyes averting my gaze.

I introduced myself as the school social worker and said, “That's okay if you do not want to talk

right now. Perhaps we can just sit together for a few minutes while I explain what school-based counseling is and what it can do for you, if that is okay with you."

Without looking up, Kyle slightly shrugged. The teacher gave me the thumbs-up sign, along with an eye roll, and left my office, leaving us alone together. I explained that counseling is a place where students could discuss and receive help for problems that they have at home or in school. I said that it is also a place where students can feel comfortable to say anything because it will be kept confidential unless students are going to hurt themselves or others or if someone is hurting them. The silence was heavy as I continued talking; there was no response from Kyle.

I tried to think of a way that I could get Kyle talking, so I decided to bring up the reason he was placed in the Behavioral Disabilities Program.

I leaned forward and quietly said, "So the reason you are in this new program and counseling is because you were involved in a pretty violent fight in the school building. The other student was hospitalized as a result. There have been numerous consequences for you as well. Can you tell me what caused you to attack this student?"

Kyle shrugged, clenched his fists, then looked up, finally making eye contact with me. I was startled because he suddenly seemed to have a fire in his eyes.

"Because he said something about my mother. Nobody, and I mean nobody, says anything about my mother. He does not know what she did to me. No one here does," Kyle said.

Those words sent chills down my spine as Kyle promptly got up, turned around, and left my office.

Imagine experiencing repeated loss, rejection, and abandonment during the most important developmental years as a child. Consistent loss can have far-reaching effects throughout one's lifespan (Bowlby, 1988; Schore & Schore, 2010). Attachment theory states that relationships early on in life shape us and affect us emotionally and socially over our lifetime (Bowlby, 1988; Schore & Schore, 2010). Those who have a difficult attachment history may have difficulties with relationships and a consistent therapeutic relationship is key to helping. A clinical relationship can remediate damage sustained from previous relationships, help the client form better relationships, and enable the client to handle life's demands better (Bowlby, 1988; Mallinckrodt, Gantt, & Coble, 1995; Schore & Schore, 2012).

School-based counseling can be a very effective resource for students with emotional or behavioral difficulties (Cooper, et al., 2015; Allen-Meares, et al., 2013; Rupani, et al., 2012). Schools may be the only place where students receive mental health services. Therefore, school counseling can be a vital resource for children. School-based counseling may offer a way to bypass client resistance by offering counseling in a convenient location. I believe that it reduces the stigma of seeking outside counseling services, since students are given a pass within the school day to come to my office. It is also convenient for guardians because they do not have to go through the hassle and expense of outside counseling. However, the problem arises when the

summer break comes and students are left with two and a half months of no counseling support.

The purpose of this paper is to discuss school-based counseling, its effectiveness, and the problems that can arise with no consistent therapeutic support during the summer break, especially with students with attachment issues. Public school districts do not usually provide hours for counselors during the summer months to provide counseling to students. What happens to these students then? Because students form an attachment to their counselor, it makes sense and is important for students to continue with that same counselor throughout the summer without having to start fresh with a new person. It is especially vital for students who have difficulties with attachment to have a counselor that they can see regularly and have as a consistent secure base. There is no literature about the consequences of lack of continuum of school-based counseling throughout the summer months. This is a call to social workers and school personnel to do research on this topic. The case study of Kyle, a student with a history of attachment difficulties, will illustrate these points.

Methodology

In this paper, I use the case study method to illustrate the importance of public school districts providing school-based counseling throughout the summer months. It is a useful way of gaining insight into a person's intimate experience. The case study method is utilized to gather information by studying different phenomena in a real-life context (Meyer, 2001). It also allows researchers to obtain a holistic view of events or phenomena (Noor & Mohd, 2008). The case study gives a rich and compelling example that exemplifies a point. The need for school-based counseling in the summer is best illustrated by using the case example of Kyle. This is a case example and it is not intended to be generalizable or a systemic analysis. It is used to highlight a particular area of practice. I also used pseudonyms and disguised the case material.

Kyle

May 2012
The study hall classroom was bustling with chatter as 25 sixth-grade students were talking about the latest daily gossip. The teacher recounted the events of that morning. The teacher was taking attendance, with his focus on the computer screen and away from the students. Suddenly, there was a loud crash and the sound of desks sliding across the floor and bodies hitting the ground. Before anyone could intervene, a fight had broken out between two students, Kyle and Billy. Kyle jumped on top of Billy and punched him repeatedly in the face. There was blood everywhere. Students were screaming, but no one made a move, because everyone stood paralyzed while they watched the gruesome scene unfold. The teacher first frantically pressed the buzzer for security and then attempted to intervene. Once security arrived, it took three adults to get Kyle off Billy. Billy's left side of his face was shattered and bloodied. Later, doctors assessed that he had a broken eye socket. After Billy was taken to the hospital via ambulance, Kyle was taken to the principal's office.

The principal asked, “What made you so angry that you would do that to Billy?”

Kyle shrugged his shoulders, and said, “Because he called my mother a whore and said she should never have had me. He has no idea. I just lost it.”

Because of the severity of the incident, Kyle had to attend a 45-day interim placement at an out-of-district school for students with severe behavioral disabilities. That placement was filled with students involved in gangs. During that time, he became involved in gang activity. His locker was searched, and he had gang paraphernalia and knives. He was fascinated by gang activity and the gang lifestyle, possibly trying to follow in his father's footsteps. His father had been heavily involved with gang activity and had been in and out of prison for ten years. Because of the nature of the incident, a superintendent suspension hearing took place. A result of that hearing was that Kyle had to undergo a Child Study Team evaluation. The result of that evaluation yielded a classification of emotionally disturbed, which made him eligible for special education and related services. Our consulting neuropsychiatrist also diagnosed him with oppositional defiant disorder. He was placed in the Behavioral Disabilities Program, housed at the middle school. The Behavioral Disabilities Program is a special education program where students with behavioral disabilities are kept separate from the other students in the building by staying in one classroom all day. They are bused to and from school on a separate bus and leave slightly earlier than the rest of the school. They have one special education teacher all day and their class size cannot go higher than six. They also receive weekly school-based counseling.

As a result of the fight, Billy's family brought charges against Kyle, and he received probation and court-ordered anger management counseling. His probation officer was very involved with his case. She said that he was classified as a high risk to re-offend because he refused to participate in the anger management counseling sessions. Reportedly, he sat with his head lowered, hanging between his legs, for the eight sessions, and he never uttered one word.

When speaking with her one day, she said, “I had the father when he was on probation too. He was very involved with one of the more dangerous gangs in our area. He is out of prison now and I would like to think is trying to live life on the straight and narrow. I hope that you can help Kyle to stay on the right path and not choose the path that his father chose to take.”

Sept. 2012
Kyle entered the Behavioral Disabilities Program and met me, his school counselor and case manager. Our first meeting was a quiet one, as Kyle was mostly silent, sitting with his head lowered, hanging between his legs. Kyle lived with his guardians who were his paternal grandparents, Mr. and Mrs. M. I called Mrs. M, a sweet woman in her 70s, and explained that he was not enthusiastic on his placement or counseling. She said, “Listen, honey, Kyle is not a bad kid. But he is a tough kid. I am going to tell you his sad story.” She gave me a summary of Kyle's background, which was filled with abuse, neglect, and repeated abandonment. His parents split up when he was a baby, and he lived in deplorable conditions with his mother. During this time, he experienced abuse and neglect at the hands of his mother, who was a drug abuser. His father was in and out of prison, heavily involved in a gang, so he was not around. He was removed by the Division of Child Protection and Permanency and placed with his paternal grandparents. His father was recently out of prison and living with them, but he was not involved. Kyle's mother had three other sons, 12, 10, and 7 years old, who all lived with their

paternal grandmother in South Carolina. They had a different father than Kyle. She also had two daughters, 5 and 2 years old, with another man, who currently lived with her. Kyle had difficulty with the fact that he could not live with his mother, yet the daughters were able to live with her. He also had difficulty with the fact that she was not consistently in his life. Mrs. M spoke about how close Kyle was to his grandfather. Mrs. M said, “Kyle and his grandfather are like two peas in a pod. They are very close. However, he does not trust women because of his mother. Good luck with him. You're going to need it.”

My Work with Kyle

Oct. 2012-June 2013
Mrs. M was right. It took about two months before Kyle finally lifted his head up and began to open up with me. Those months seemed like they dragged on forever since most of those sessions were spent in silence. Kyle would come into my office, sit down in the chair with his head hanging down between his legs, in complete silence. I felt like I was doing nothing, but that is how the attachment bond began to grow. It grew because I was there with him, not giving up on him, even though we were sitting mostly in silence. My work with him took patience and persistence. But I never gave up on him. He saw that I was not going anywhere and that I was consistently there for him.

During our sessions when he was silent, I said, “Kyle, you do not have to talk, but I need you to know that I am not going anywhere. I am going to be here for you in school every day.”

Eventually, over time, his walls began to come down. I remember the first day he finally began to speak to me. He just began talking about the bond with his grandfather and how much their relationship meant to him.

“My grandfather took me to church this weekend. Everyone loves him in the community. He's cool,” Kyle said.

Our therapeutic alliance began to build from there.

I modeled appropriate affect and a secure base for Kyle within the walls of the school. As a theory, classical attachment theory is concerned with the notion of a secure base. In the therapeutic relationship, the therapist can model and become a secure base (Ainsworth, 1989). It is important to create a sense of safety and security for the client. Establishing a safe and secure relationship with the therapist can affect other relationships in the person's life (Hollidge & Hollidge, 2016). Once the therapist gains the client's trust, a sense of safety and security will follow. Trust and a secure attachment will then enable the therapist to have access to the client's emotions and then work can be done. A therapeutic relationship may help to repair the damage of insecure attachment and in turn help the client to cope with stressors of everyday life (Schore & Schore, 2012). The client can then begin to explore memories and to reconstruct the lived past and form a better future with better experiences and relationships.

Over time, Kyle developed a very close bond and attachment to me as his counselor in school. I

also knew he was involved with a gang, but he would not admit to it. Whenever I asked, he would give me a knowing smirk and say, “Nah, I'm not into that stuff.” I was very involved with his probation officer in reporting his behaviors in class and with school work. We worked as a team. If he was not complying with something on my end, she could reinforce it as a part of his probation requirements. I also was involved with his child protective services worker and kept him informed of his progress in school. It was important that he develop more appropriate attachments, as opposed to turning to a gang, which could be used in the place of an attachment figure. Perhaps seeing me as an attachment figure, and maintaining that attachment, could potentially dissuade gang involvement because he would not be looking for another attachment figure. Seeing Kyle being attracted to the gang lifestyle already was frightening for me to witness. I had seen many students be lured into the false promises that the gangs offer. Those students wound up either in jail, permanently injured, or dead. It is very upsetting to hear of these students once they have graduated from middle school. I always think, was there something more I could have done while they were under my care? These students had such promise and it was wasted. I did not want that for Kyle. I wanted him to rise out of what had been a less-than-ideal upbringing, with gang influence already, and become successful.

In working with Kyle, I used solution-focused therapy. Kyle's main goal was to get out of the Behavioral Disabilities Program. To achieve that goal, we worked on smaller goals along the way. Kyle needed to improve his behavior to get out of the program and back into mainstream classes. We worked on coping skills, anger management skills, and stress reduction techniques. He learned the skills taught to him and implemented them in an appropriate manner. For example, Kyle would have difficulty ignoring people who were trying to get a rise out of him. While being in the Behavioral Disabilities Program, it is difficult to ignore the other students, as they are all there for behavioral issues. In working with Kyle, I helped him identify triggers for anger. Kyle could identify that other students talking about his mother would set him off. One day, another classmate, Jeremy, started jumping up and down on the floor pretending to jump on Kyle's mother's face to antagonize him. He laughed the entire time he did it, taunting him, by saying, “Look at your momma, laying on the floor. That is her face I'm jumping on!” Normally, this would enrage Kyle, such as with the incident that got him into this program. However, I had been working very closely with Kyle on how to regulate his emotions and anger. So when this incident presented itself, Kyle employed the tactics that I taught him. Kyle was instructed that if he became annoyed or frustrated with the other students, to become aware of his body and his anger warning signals. Kyle's warning signals were his heart racing, sweaty palms, and clenching his fists. Once he could identify problem situations and physiological changes occurring in his body, he would then be able to begin implementing strategies to calm down. Some strategies included removing himself from the situation by asking for a safety officer to walk him around, asking to go to my office, deep breathing, and progressive muscle relaxation. Outside of school, he was participating in martial arts as a way of reducing stress. During this incident, he just calmly asked to see me and walked over to my office. He wound up punching the bookcase in my office to let out some frustration. However, he said, “It is better than punching Jeremy's face.” He was right! He was praised for using the coping skills and strategies learned, as this was a huge step for him. It was also a step in the right direction to achieving his goal of getting out of the Behavioral Disabilities class and into mainstream classes again.

I also used Kyle's strengths and the strengths of his social support system. Great focus was placed on Kyle's paternal grandparents, as they were a great source of strength, stability, and comfort for him. It is not the norm in our district to have parents or guardians who are very involved. However, Kyle's grandparents were willing to work with him at home as well. Mrs. M and I would have weekly conversations about Kyle. I kept in very close contact with her. During one of our conversations, she mentioned to me that she and Mr. M were very involved in their church community. I suggested that perhaps it would be a positive thing to try to get Kyle involved in that community. I thought that perhaps he could be around some positive influences. Mrs. M said, “I am trying to get him more involved in our church community. Mr. M and I are active members of the church community, so I think that having him attend church and getting involved with good influences would help him.” In working from a strengths perspective, Kyle's strengths are that he is very intelligent, and he has the capacity and love for learning. Kyle was working on or above grade level and had a high average full scale IQ score. He learned the skills taught to him and implemented them in an appropriate manner.

Kyle did very well in the Behavioral Disabilities Program. There were no behavioral problems at all during his first year in the program during seventh grade. In the middle of the school year, I started to transition him to in-class resource classes, as his academic ability was very good. In-class resource classes are classes taught by both a general and special education teacher, containing a mix of general and special education students. At the end of the school year, it was recommended that he transition fully out of the Behavioral Disabilities Program.

A Tragic and Unexpected Loss

June 2013
One warm spring day, I received a phone call from Mrs. M. She was very somber and having a difficult time speaking and getting words out.

She managed to tell me, “Mr. M died last night. He had a heart attack with no warning and now he is gone. Kyle will not be in school for a while.”

I sat there, speechless for a minute, trying to find the words to say. I knew that the only thing that I could do was to offer my support. I offered to come to the house and do a home visit. His teacher, Mr. S, came with me. We sat in the car for a few minutes to compose ourselves, knowing this was going to be emotional. When we rang the doorbell, Mrs. M, looking disheveled with puffy eyes and a tear-streaked face, answered the door. We walked into the dark house, which had no lights on, and into the kitchen. When Mrs. M turned the light on, I was amazed by what I saw. Every surface in the kitchen, including most of the floor, was filled with food!

Mrs. M took note of my reaction and said, “Our friends, family, and members of our church have been really good to us. We are very grateful.”

We sat at the kitchen table, while Mrs. M told us some stories about Mr. M, while waiting for Kyle to come downstairs. When he finally appeared, Mrs. M asked him what had taken him so

long.

“I was pressing my shirt.”

Mr. S said, “It's just us! You didn't have to get so dressed up just for us.”

Kyle replied, “My grandpa always said to look your best. So, that is what I was doing.”

We then went outside to sit on the porch with him, and he did not do much talking at all. He just sat there, head hanging down between his legs. After some time, we needed to leave.

He gave each of us a hug and said, “Thank you for coming.”

Several days later, the family held the viewing. Numerous staff members and students attended. During the viewing, Kyle became so emotionally upset, that he ran out of the main area of the church and locked himself in the bathroom for a half hour. One of the students came running to find a staff member and stumbled upon Mr. S. Mr. S talked to him through the door.

“Kyle, you need to come out, buddy. We're all here for you.”

After some time, he finally opened the door, but pushed past the crowd of people who had gathered, including Mr. S, and ran out into the night. Mr. S ran after him in hot pursuit and finally caught up to him at a local park. He collapsed on Mr. S's shoulder, his entire body shaking uncontrollably while he was sobbing.

“Why?” he repeated over and over again.

Mr. S held onto him, hugging him, trying to console him.

“I know, buddy. I know. We're all here for you no matter what.”

Mr. S eventually got Kyle back to the church and with his grandmother.

The day of the funeral, Mr. S and I arranged a bus to take the entire Behavioral Disabilities class and staff to Mr. M's funeral. It was a beautiful sunny day that day. The sunlight streamed through the Baptist church, which was alive with life and joy. It was a beautiful service. The patrons were singing, dancing, and telling stories to celebrate the life of Mr. M. However, during this celebration of life, Kyle sat forward, hunched over, with his head hanging down between his legs, the entire time. We were not sure if he noticed that we were even there. At the end of the service, all of us went up to Kyle and the rest of the family to express our condolences. At that point, Kyle turned to each of us, shook each of our hands, and said quietly, “Thank you for coming.” Kyle was part of our school family. When one of us was grieving, all of us were there to support him or her. After the funeral, it took a while for Kyle to come back to school. When he did come back, it was evident that something had changed in him.

The Aftermath

With the school year rapidly ending, there would be no counseling in place for Kyle over the summer during a very critical period of his life. I gave Mrs. M outside counseling referrals, asking her to please follow up in the summer, as I felt that Kyle would be at a high risk for choosing bad options, such as gangs, to comfort him without having therapeutic support. She assured me she would get him a counselor. I thought about him every day that summer and worried about how he was doing with the loss.

Sept. 2013
The first day of school, I telephoned Mrs. M. She said that the summer break did not go well.

"I was feeling so overwhelmed with grief myself, that I was never able to get that counseling for Kyle. I'm so sorry. I feel like what happened to Kyle this summer was my fault because I did not get him help," she said.

I asked her what had happened.

"Oh he got involved with the wrong crowd, honey. He would come home late smelling like alcohol and marijuana, or sometimes he would not come home at all. He was stealing money from me too."

This was especially disappointing for me to hear, as Kyle had said to me, "I will never touch drugs or alcohol because of what my mother did to me while she took that stuff."

What Mrs. M said next caused me to feel a deep sadness.

"I am afraid that I just don't have the strength to care for him by myself. I cannot control him. As a last resort, I am thinking of sending him to live with his other grandmother in South Carolina."

Since his probation had ended prior to summer break, the probation officer no longer had any say over consequences for his actions.

A few weeks into the school year, a student reported the smell of marijuana in the boys' bathroom. The video cameras were checked and Kyle was seen leaving the bathroom. When Kyle was questioned by the principal, he denied smoking marijuana; however, due to our suspicion, he was sent out for a drug test, which came back positive. At that point, Mrs. M had had enough. Shortly after, Mrs. M sent Kyle to live with his half siblings and their paternal grandmother in South Carolina. She called me up that final day and said, "I just want to thank you for everything you have done for Kyle and our family. However, I just do not think that I can handle him anymore. I am sending him to live with his paternal grandmother. Kyle asked me to call you up and say good-bye for him, as he is too emotional to do it himself." I let her know that if I could ever do anything in the future to please let me know. After I hung up the phone, I sat there for a while with my own thoughts, wondering what if he had had counseling with me throughout the summer? Would it have made a difference in the outcome for this child's life? I

feel strongly that it would have made a huge difference in preventing this outcome.

Attachment Theory

Kyle had a difficult early childhood and had difficulty with attachment. He learned to keep his feelings to himself because he did not always have someone who he could trust and rely upon his entire life. Kyle needed to have a secure relationship with someone to be able to learn how to form a secure base. According to attachment theory, an infant's view of the world begins with the primary caregiver showing him how to see the world. Infants can form a secure, insecure, or disorganized attachment to their caregivers based on their relationships with the caregivers. Bowlby (1988) states that a secure attachment is formed when the caregivers have provided a consistent, safe, and secure base for the children, where they can explore their environments, and return to the caregivers when needed for comfort. Kyle likely did not have a secure attachment to his mother based on how she treated him. He likely formed an insecure attachment to her. An insecure attachment is formed when the caregiver is inconsistent with care or neglectful and is not providing what the child needs on a regular basis for him to feel safe and secure (Bowlby, 1988). These caregivers do not show consistent nurturing care to the infant. If a secure attachment is not formed, the child may have a lifelong difficulty with regulating affect and managing emotions (Bowlby, 1988). These were some of the difficulties that I saw with Kyle. He had difficulty regulating his affect and managing his emotions. He did not want to trust anyone because his experience of trust and caregiving resulted in abandonment and abuse. His mother was not attentive to his needs because of her drug usage and was also physically abusive. In addition, his father was not around because he was incarcerated and thus was not able to provide a secure base either.

One type of insecure attachment, disorganized attachment, is seen in children who have been abused or neglected (Hesse & Main, 2000; Main & Solomon, 1990; Hill, 2015). Children who are being abused and neglected are stuck in an impossible situation. Their source of safety and caregiving is also their source of pain and fear. Children will be attacked no matter what they do. The fear and violence is unpredictable because the primary caregiver is a source of danger (Hill, 2015). Therefore, there is no solution for them. Based on his history, it appeared to me as if Kyle had experienced a disorganized attachment to his mother. Children with disorganized attachment are not used to having reciprocal, positive emotional interactions with adults; therefore, therapy can be challenging since they are guarded and resistant to treatment (Hughes, 2004). As Kyle became older, he turned to gang involvement as a way of coping with the lack of having a consistent attachment figure. He likely found it appealing possibly because he had had so many significant key relationships disappear. He may have been looking for a secure base in the gang membership, so he would have a replacement family, searching for that stability.

Anger, Behavioral Difficulties, and Attachment

Kyle had a history of behavioral management problems. Insecurely attached children have a higher incidence of developing behavioral problems, whereas securely attached children can regulate themselves more easily, especially in a school setting (Kim & Page, 2013). The source of many of their behavioral problems in school tends to stem from attachment issues (Parker &

Forrest, 1993). Parker and Forrest (1993) detail the behaviors children with attachment issues engage in, such as bullying, acting out behaviors, and being physically aggressive with other children. These behaviors are readily seen in schools daily. Anger is one of the most difficult emotions to deal with as an adolescent and can lead to physical and mental health problems (Konishi & Hymel, 2014). Some problems include bullying, gang involvement, low academic performance, dating violence, substance abuse, and being rejected by peers (Konishi & Hymel, 2014). During middle childhood years, children who have difficulty with managing and regulating their emotions will have difficulty in relationships with peers (Kim & Page, 2013). With their peers, they can exhibit behaviors such as aggression, withdrawal, helplessness, or dominance with peers (Hollidge & Hollidge, 2016). The anger that is experienced could be anger that is really directed toward the attachment figure, but may be showing up as anger directed toward peers. This misdirected anger was seen with Kyle and the severe fight. When the student mentioned his mother, it set off a series of reactions and feelings within himself that he did not know how to process and with which he did not know how to cope.

Kyle's difficulties with controlling his anger were the result of him having a difficult time with affect regulation. Affect is how one's emotion is communicated through facial expressions, body movements, and tone of voice (Hill, 2015). Hill (2015) states that the caregiver helps the infant to develop the capacity for affect regulation. Kyle entered into states of affect dysregulation easily and had a difficult time regulating himself out of them because of his history of insecure attachment. During infancy, it is the primary caregiver's job to regulate the child during states of hyper- or hypo-arousal (Hill, 2015). When an infant experiences an insecure attachment, the child will then have difficulty regulating himself out of states of hypo- or hyper-arousal. These states exist when the emotions exceed an individual's capacity to tolerate them. For example, hypo-arousal is when an individual is in a state of sadness that cannot be tolerated. Hyper-arousal can be when an individual is in a state of anger that cannot be tolerated. Kyle's difficulty regulating himself led to the severe fight. When that student made a comment about his mother, instead of having the ability to ignore, walk away, and self-soothe, Kyle became dysregulated immediately and without thinking, attacked the student. In addition, when his grandfather died, Kyle could not regulate himself out of sadness either. Without the appropriate consistent therapeutic support at the time, Kyle was unable to regulate himself. He did not have his counselor available to him to aid in helping him regulate his emotions, so he spiraled downward into a state of dysregulation and depression, unable to recover. Kyle could not get himself back to a regulated state effectively. He needed therapeutic intervention and support to regulate him, which were unavailable during either of those times. He may have tried to regulate himself by turning to drugs and alcohol, and he may have sought secure attachments through gang affiliation.

Counselor as a Secure Base

Ainsworth (1989) suggested if a primary caregiver cannot provide a secure attachment model, another adult can fill that role. A school counselor could take on that role. During the therapeutic relationship, the client relies on the counselor, which mimics early attachment relationships. As his counselor, I stepped into the role of an attachment figure for Kyle. As the new attachment figure, the counselor can have access to the internal working model of the client (Pistole, 1989).

The counselor can help to correct the problems that arose earlier in life and can help the client with current and future relationships. Students can explore their school environment using the counselor as a secure base, safe haven, and advocate for their needs. Students may realize that not all adults are like attachment figures of their past and can become positive models for them. A lot of the work that I did with Kyle in the clinical relationship was about learning how to express himself and his feelings in a healthy manner. This way, when someone made a comment about him or his family, his first response was not to become enraged and lash out physically. I modeled appropriate ways to handle his emotions and ways to soothe oneself. He could learn how to manage emotions more effectively. The counselor can help model emotion regulation and can also reach out to the caregivers to help them with skills in regulating their own emotions as well (Kim & Page, 2013).

Loss of Therapeutic Care

Parts of the therapeutic relationship that show attachment include feeling supported, proximity seeking, and looking toward the therapist as a role model (Obeji, 2008). Therefore, with someone with a history of attachment difficulties, attachment to the therapist can become so strong, that any absence or lapse in treatment for any length of time can cause negative reactions. When the relationship is disrupted, negative reactions like anxiety or distress can arise (Webb, 1983). Other negative reactions include anger, distrust, and abandonment (Farber, Lippert, & Nevas, 1995). For example, if a counselor has an unexpected illness or takes a vacation, or if there is a gap in treatment for any reason, this can cause reactions in the clients (Obeji, 2008). Webb (1983) found that counselors noted more anxiety and hostility during longer vacation periods and therefore would take shorter more frequent vacations. When working with children—especially those with attachment issues—in a school-based counseling program, school breaks can cause difficulties. There is a risk of regression and problems when students are left with no support for almost three months.

Kyle had suffered many losses. Kyle lost his mother due to drugs, abuse, and abandonment. He lost his father to gangs and prison. He lost his grandfather due to sudden death. Finally, he lost his grandmother because she sent him to live with another relative. He also lost me, as his counselor, when he was forced to move. In Kyle's case, I stepped into the role as consistent caregiver for him, especially when his grandfather passed away suddenly. I provided a sense of safety and stability within the school environment for him. Counselors provide a sense of consistency and reliability and provide that secure base (Pistole, 1989). In addition, the school provided a second family for him with me being his consistent attachment figure. The other students, teachers, and administrators were also a part of this family. Unfortunately, because the school is closed in the summer and school counselors do not have summer hours, he was not able to take advantage of that consistent support throughout the summer, when he needed it the most. All children receiving school-based counseling would benefit from continued support throughout the summer. But children with insecure attachment issues, especially disorganized attachment, need that consistent secure base even more so. Since the therapeutic relationship was interrupted during a key time for Kyle, his attachment was broken, thus causing a downward spiral due to lack of consistent therapeutic intervention. Kyle's case is just one example of how a student can break down without that consistent support throughout the summer months. Having

that continuum of care is of vital importance.

Concluding Thoughts

School-based counseling in a public education setting can be a very effective resource for students. However, the difficulty arises when, as can be seen in Kyle's case, summer break approaches. His case is an example of what can happen without services in the summer. If caregivers do not follow through on getting outside services, then the at-risk youth are left with no support during those months. Public school districts usually do not provide hours for counselors in the summer to counsel students. Kyle's case shows just how vital it is that public school districts provide hours for counselors to continue treatment over the summer. Counselors would need to be provided assigned office hours for students to have regular appointments throughout the summer months. As an alternative, counselors now refer to outside counseling agencies. However, the problem with this is that there is not a lot of follow through, and clients also need to from a relationship with a new person. In Kyle's case, starting fresh with another counselor would have proven to be very difficult. Since he had difficulty attaching to counselors, it would have been more appropriate for him to continue with me, since we already had a trust and a bond in our therapeutic relationship.

Educators and parents often are concerned with the negative impact of the long summer break on learning (Cooper, 2003). The negative impact could be that students, especially special education students, may regress educationally and may learn better when services are not interrupted (Cooper, 2003). But what about the effect of a lapse in counseling services? If students are receiving counseling through school-based counselors during the school year, why are they not offered services over the summer in public schools? Out-of-district schools for 22 students with emotional and behavioral needs offer extended school year programs with counseling for their 23 special education students so they do not regress. Both special education and general education students should be offered continued counseling services throughout the summer in public schools as well so there is no emotional and behavioral regression. If services are offered during the school year, it is unethical to abruptly stop them for several months. I feel that the ethical solution is to offer counseling year-round for students who are in need.

The large barrier to achieving consistent therapeutic services in schools is funding. I am sure that most districts, if given unlimited funding, would provide ample mental health services to students. It should be noted that it could be more cost-effective to offer mental health counseling in the summer as a preventative measure. It could lower the rate of costlier outcomes, like out-of-district placements and child study team evaluations. School officials spread funding throughout various programs in the district, so funding should be allocated for summer mental health services. Ideas for future research include finding ways to shine a spotlight on the importance of making mental health funding a priority and finding ways to get school officials to realize the importance of the continuum of therapeutic care through the summer months for at-risk students.

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The Ripple Effect in the Expressive Therapies: A Theory of Change Explored Through Case Studies

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Abstract: The expressive arts therapies use the arts to facilitate growth and healing and to create social change for both individuals and communities. Expressive arts therapists are certified or credentialed therapists who are specialists in using the arts (or one specific artistic medium) as therapy. In this article, the authors describe theories of how the expressive therapies cause personal and social change and explain why the arts are uniquely poised to produce such change. They also present the metaphor of a ripple to describe the effects of such change as it spreads from the individual to that individual's inter-personal relationships, and to that individual's many communities. In this metaphor, it is the art that is the figurative pebble causing the ripples of change, growth, and healing. Four narratives are presented from the United States, Israel, and Canada, giving an international look at ripples caused by use of art therapy, dance/movement therapy, and music therapy. In each of these narratives, the authors explain how the relational process of the expressive arts therapies provided an opportunity for clients to utilize their own creative abilities to explore their world, to produce a tangible artifact of that exploration, and to be the seed of social change via the artistic process.

Keywords: art therapy, dance/movement therapy, expressive arts therapies, healing, music therapy, ripple effect, social change

The genesis of this article was a conversation among five expressive arts therapists. We all use the arts to facilitate growth, to promote healing, and to create social change for individuals and communities. During our conversations, we shared our insights about how and why each of our preferred media (visual art, music, and movement) is a powerful tool for therapy. We found that we were describing a similar process: The arts create a ripple of growth that starts with the client and expands out to affect the clients' relationships and communities. We further agreed that the power of the arts in this process was often not recognized outside of the expressive arts therapies. In this paper, we explain what the expressive arts therapies are, and why they are unique in both their ability to cause change or growth in the individual and their ability to affect the wider community.

Expressive Arts Therapies

The expressive arts therapies include art therapy, music therapy, dance/movement therapy, and drama therapy. Expressive arts therapists are certified or credentialed therapists who have been trained in the use of the arts (or one specific artistic medium) as therapy. Since the arts provide a non-verbal access to experiences, thoughts, personal history, and healing, they offer a unique way for clients to deepen their self-knowledge (Allen, 1995). Expressive arts therapists are skilled in using the arts to help people access a deeper understanding of themselves and an increased capacity to learn and grow. As therapists, we use our own art to understand our reactions and deepen our understanding of our clients, thus we also benefit from this non-verbal,

non-linear way of knowing.

Much of the art, movement, and music that we describe here is called “improvisational.” By this, we mean that both the client and therapist are approaching the medium with an openness to paint, move, or create music, as guided by their imagination. The improvisational aspect implies that there may not be an attempt to paint an accurate picture of what can be seen, to move in a choreographed manner, or to play music off a score. Although expressive arts therapists may use scripted material, Halprin (2002) noted that the power of improvisation is that it offers the opportunity to express feelings that need release, face traumatic events from the past, or feel the pure joy of our bodies, minds, and spirits in communion. She suggests that in this creative realm a person can try things out, make discoveries, take risks, and do it again if it does not feel right. As a person expands their repertoire of ways to learn, know, and express, he or she is also expanding an ability to play (Haplrin, 2002).

Creativity and Play at the Center

Play is a central element in much of the work done by expressive arts therapists. Play encourages and permits the exploration of the reality and boundaries of external society and of one's inner world; it is therefore crucial for the development of health and healthy relationships (Chavez-Eakle, Eakle, & Cruz-Fuentes, 2012). According to Winnicott (2012), it is in playing that a child or adult can be creative, and it is only while in the non-purposive state of creative self-exploration that a person can grow or discover the self. Moreover, suggested Knill (2005), since creativity is tied to the development of the imagination, creativity can be a tool to liberate one from the limitations of analytic thought and functional logic, encouraging and allowing an expanded understanding of what is possible. Knill suggested that experiences in creativity and play may result in a person becoming a more active participant in life, feeling less alone, and recognizing available choices and possibilities. In this way, the creativity can lead a person to become less of a victim of circumstances.

Throughout history there have been instances when individuals were stripped from all personal belongings, rights, and dignity, yet have found a way to be creative in some form. Frankl (1959), who wrote about his horrific experiences in the Auschwitz concentration camp during World War II, suggested that creativity can emerge even when we think it is not possible. The barren concentration camp was devoid of creativity; Frankl was seen as less than human and treated barbarically. Yet, even there, Frankl was able to connect to aesthetic pleasure. Years after the war, he remembered and described a moment when he saw a beautiful flower and took in every part of that flower, its perfection, and grace. Without anyone knowing or forbidding him to do so, he was able to engage with the creative source. Frankl credited this engagement with giving him the will to survive.

Pioneering art therapist Allen (1995) noted that many individuals who are disconnected from their soul become sick in some way. Creativity, she said, is the path to restore one's connection to the soul. Indeed, Rogers (1993) argued that all individuals have not simply a desire, but a deep need to fulfill their creative capacities. A reconnection to the innate human impulse for creation allows one to access the energy of the foundational life force that is constantly moving in us and

around us. Through creativity, one develops a capacity to tolerate tension and learns how to integrate new insights; eventually this leads to the release of static or constricting forms that block the healthy and creative flow of life energy, the very flow that makes change possible (Halprin, 2002).

Although the connection of the creative arts to the soul may be abstract, the connection to our senses is more concrete. The creative arts give us opportunities to use all parts of our brain: painting provides a visual manifestation of the inner world; music allows one to listen to oneself and others; and drama and movement allow the acting out of or moving through an experience. Furthermore, each art form accesses various parts of one's conscious, unconscious, and physical planes, providing access to a greater, more complete understanding of oneself (Rogers, 1993). As such, the arts begin an intra-personal ripple of witnessing, awareness, and transformation.

The Ripple of Change

The actions, and thus the growth and health of any individual, will affect the larger communities of which that individual is a part. As Holland (2014) argues, social systems such as communities cannot be isolated; when one part of the system is changed, the entire system changes. Because the expressive arts can be shared with and witnessed by others, they are particularly potent in creating such a ripple through a social system. In the field of music therapy, Pavlicevic et al. (2013) noted that when music therapy is conducted in nursing care settings, the music has a “temporal, social and physical contagiousness” (p. 660), which does not stay limited to the client-therapist relationship. They found that the music therapy helped the patients increase their own verbal and non-verbal communication, and then, because it could be heard in the space, it rippled out to affect the patients' relationships with their caregivers. Eventually the music therapy work was drifting “around the entire social and physical space” (p. 674). The music did not stay constrained to a single time or place, but instead became part of the daily context of the nursing facility. This example from the literature described the ripple effect on three levels: an intra-personal level occurred when the patients increased their attention and communication as a result of the music therapy; an inter-personal level occurred when the music was heard in the space, thereby engaging the care-givers and affecting the relationships with the patients; and a cross-community level occurred as the music affected the whole nursing facility. These levels are described in more detail below.

Intra-personal

Many expressive therapists (Boxill & Chase, 2007; Halprin, 2002; Johnson, 1982; Knill, 2005, McNiff, 2014) have described the intra-personal awakening of a client. Regarding the expressive therapies in general, Knill (2005) suggested that the arts provide a doorway into the unknown, as unconscious forces are tapped to create an artistic expression of one's inner world. Such expressions in verbal and non-verbal media create avenues to alleviate one from distress, to penetrate barriers to the soul, to create new thinking and behavioral possibilities, and to develop self-efficacy and resilience, all in the process of emotional growth (Knill, 2005). Knill challenged traditional pathology-based theories by suggesting that the unconscious, rather than being the source of disorder, actually contains the seed that can begin the ripple of individual

psychic growth.

Therapists in each of the individual creative arts therapies have described similar processes. Movement therapist Halprin (2002) posited that movement is the primary language of the body, and therefore that an individual's psychic history is revealed in his or her movements. Expressing ourselves in movement can bring us to revelations of whatever resides in our body—memories, feelings of despair, confusion, fear, anger, or joy. Halprin claimed that blocking the energy from one's creative source can cause an inward collapse and descent into depression or anxiety. She suggested that conversely, opening up the creative channel can restore access to the unconscious and to the interior world of the intuitive self, allowing one's thinking mind to flow freely, to meander, and to stumble upon the material that wants to emerge.

While movement may reveal history, drama provides a means to revisit moments. Through play, action, or reliving those moments, drama gives a tool with which one can move through and resolve inner conflicts or blockages that stem from different life stages. Drama therapist Johnson (1982) suggested that the overall goal of drama therapy is to increase the range of an individual's expression and responses to the outside world. For a person to revisit moments and situations armed with a new repertoire of responses can be transformational; it may lead to resolved inner conflicts and increased interaction.

If drama therapy provides increased expression, Boxill and Chase (2007) suggested that music therapy might provide increased awareness. They described "A Continuum of Awareness" (p. 97) in which the music therapist first works to contact the individual through music. This contact may itself cause a greater intra-personal awareness for the client, described by Evans (2007) as "…coherence between the person and some aspect of his or her experience" (p. 94). This intra-personal awareness, or awakening, transforms the client's awareness; eventually a new piece of self is recognized and integrated. The therapist gradually works to bring the client's conscious awareness along the continuum to greater awareness, to expression, and eventually to purposeful outer action (Boxill & Chase, 2007). In this case, it is the music that first awakens the client and then causes growth in an outward direction.

McNiff (2014) stated that art-making can be a way for all people to become more aware of their own experience in the present moment; this can help one understand, accept, and transform an experience. The resulting artifact has additional value because the creator and others can observe it. Thus, small creative acts may spread to other aspects of one's life, and can then stimulate "a larger contagion in social experience" (McNiff, 2014, p. 41). As others witness the art, and the effects of the art spread beyond the individual, the phenomenon enters the inter-personal realm.

Inter-Personal

In a therapeutic relationship, the therapist may be the first to experience an individual's art. McNiff (2014), a pioneering art therapist, suggested that a key role of the therapist in the client-therapist relationship is that of an active, supportive witness. Through non-judgmental witnessing, the therapist holds a safe, creative space where clients can explore, express, and understand themselves and their relationships. McNiff stated that the presence of such a witness

establishes a partnership that enables people to do things they would not have done if alone. The therapist/witness becomes a supportive anchor allowing the client to experiment and ultimately reconnect with Self. That inter-personal relationship may then model or encourage healthy relationships with others (McNiff, 2014).

Such interactions can develop through degrees of improvisational forms in all art modalities. Movement therapist Marian Chace used techniques in group work that encouraged each individual to first increase awareness of self and then gradually interact with others as part of a greater whole (Chace, Sandel, Chaiklin, & Lohn, 1993). Chace's techniques included detailed stages in group development: in the warm up phase, the therapist and group members acknowledged each participant's individual way of movement through verbal and kinesthetic mirroring; in the development stage the group members explored and shared expressions with each other; in the final stage they prepared to separate and move into their own communities.

The very act of creating together involves a shared experience, therefore affecting inter-personal relationships. Overy and Molnar-Szakacs (2009) found that when people create music together they experience being together on a measurable neurological level. Overy and Molnar-Szakacs suggested that music becomes a “shared affective experience” (para. 5) because music activates mirror neurons, those brain cells that fire not only when a person performs an action, but also when the person sees someone else do the same action. Thus, they concluded, music is not simply a passive auditory stimulus; instead, it is an activity that communicates social and affective information, in the moment of creation. Indeed, thanks to increased knowledge of mirror neurons, we understand that this is likely the case in many of the arts: the very act of creating together causes inter-personal ripples as people witness each other creating.

Cross-Community

Various arts disciplines are increasingly being used in relational contexts in couples, family therapy, and group therapy (Gerson, 2001; Kaplan, 2007; Riley, 2004; Wiener, 2010). Kaplan described community-based expressive arts groups that address social issues, such as homelessness, violence, and trauma: the groups create art to explore the impact of these issues on the individuals and communities who are affected. Because community art projects can then be witnessed by those outside of the community, such art has a significant impact: the art carries messages about the social issues and realities being faced by that community. This starts a ripple of awareness and empathy that spreads to other communities, lending support to and awareness of the need to address these social justice issues.

Rogers (1993) emphasized that it is essential for individuals to access the realm of self-understanding so that they can put forth energy into the world to understand others. The feminist movement in the United States during the 1960s presented the notion that “the personal is political,” suggesting that one's actions in personal life are affected by and reflected in the socio-political context in which that person lives (Sajnani, 2012). Individual change is intrinsically linked to social change. Sajnani (2012) suggested that the expressive therapies encourage “response/ability, the ability to respond amidst suffering and against oppression” (p.191). In order to promote growth, expressive therapists must help clients examine how the

narratives (or stereotypes, beliefs and tacit knowledge) held in the larger society affect their own narratives about themselves (Hadley, 2013). According to Sajnani, expressive arts therapists are uniquely able to provide a platform for communicating human experience, and for causing individual changes that will ripple out into a larger socio-political community. If the dominant narratives in society are too narrow or restricting to a person, Halprin (2002) suggested that art can be used to understand those narratives and to create new stories about one's destiny.

Whitehead-Pleaux et al. (2012), in writing about therapists' responses to the LGBTQIA community, reminded therapists to first explore their own biases, and then seek training and supervision, thereby expanding their knowledge and understanding in ever-widening circles. Whitehead-Pleaux et al. suggested that therapists must begin the process of understanding themselves before they can examine the needs, issues, and norms of non-dominant communities. Thus, inward introspection is a necessary step for therapists, just as it is for our clients; not only for personal growth, but also so that therapists can support ripples of community growth. Reflective writing is one way to achieve this introspection; as expressive arts therapists, we find that we also use the arts for our own self-exploration and in our responses to clients.

The above literature describes how the creative arts can be a figurative pebble whose effects cause radiating change at each level: intra-personal, inter-personal, and cross-community. The following narrative case studies further illustrate this. They are drawn from our work in Canada, Israel and the United States, and they include work done with the media we are each trained to use: music, visual art, and movement. (As none of us are drama therapists, we have not included a case study using this medium.) It should be noted that these narrative studies also illustrate how the therapists use their artistic discipline as a way of knowing about and understanding their reactions to the clients. You will read that in the first narrative, the therapist used her own art to hold, understand, and reflect upon Joey's process. In the second narrative, movement was the tool that the therapist used to connect with and respond to Adam. In the third narrative about Alex, the group members and the therapist all responded musically to Alex's poetry in order to amplify, validate, and give it increased meaning for Alex and for the group. In the fourth narrative the therapist did not respond artistically during the group process. In this example, it was later that she engaged in research about her own artistic response to the topic.

Art also can be a way of presenting. The paintings and drawings reproduced in the first narrative, below, were the therapist's responses to the client and reflections on the sessions. She used art as a way of understanding the client and her own practice, and therefore the artwork is part of her narrative. Although music and movement can also be witnessed at the time of creation, it cannot be reproduced in an article as easily as visual art.

All of the clients' identifying information has been altered to protect confidentiality.

Narrative One: No Matter How Much He Bends, He Will Not Break

While working at a community art therapy studio in the Midwestern United States, I received a call from a woman looking for an art therapist to “fix” her 15-year-old son, Joey, who had been diagnosed with Asperger's Syndrome. The woman explained that her son had worked with many

different therapists using different approaches; they had all been unsuccessful. Joey suffered from episodes of extreme rage, in which he would black out, do horrible things, and not remember anything. One time he had choked his mother and pushed her down the stairs in a fit of rage. She was afraid of Joey. At times Joey would hide in the house and his family would not be able to find him for hours. He would also leave home for hours, walking through rain and snow, and not answer his cell phone or tell his parents where he was or where he was going. Joey often isolated himself, had attempted suicide numerous times, and had been arrested for breaking curfew and for theft.

The first moment that I met Joey, I knew he was special. I was expecting to see a large and menacing adolescent but instead met a slender, energetic young man. Joey would not make eye contact at our first meeting as he explored everything in the studio, from the murals painted on the walls to all of the art supplies. He thought art therapy was 'cool' even though he did not really know what it was or what he wanted to work on. Joey did not talk much during our beginning work together. This was challenging for me at times, but I forced myself to sit with the silence and hold the space. Per Joey's request, I created alongside him at every art therapy session. Thus, many of our sessions were spent creating in silence with me positioned slightly staggered across the table from Joey. A large portion of our work involved the witness: me witnessing Joey and his artwork coming to life, or Joey witnessing me and my artwork coming to life. My art provided both a container for the sessions, and a reflection of what was happening in our shared moments.

Joey had an extremely challenging time connecting to self and connecting to others. As our work deepened, Joey shared that he had been adopted from China, a fact that his mother had not mentioned. Joey said that he did not know who his birth parents were, and he would never know, because there were no records. I confirmed the adoption with his mother who also shared that when Joey was born there was cocaine in his system, resulting in numerous cognitive and behavioral deficits.

I went on to meet with Joey once or twice a week for over two years at the community art therapy studio. Joey's mother remained very involved in his treatment and continued to ask me to fix her son. Joey's father also came to the studio a few times with Joey over the course of the two years.

The overarching treatment goals were for Joey to not have any more episodes of destructive rage and for Joey to use art-making as a way to connect with himself, to self-express, and to manage his emotions. When Joey first began art therapy treatment, he would only use the controlled media of pencil and eraser on white drawing paper. He would re-create album covers from his favorite bands and create fictional characters. Joey was not interested in verbally processing his artwork; most of his communication happened non-verbally. He eventually moved on to create on a variety of surfaces and began to use more colorful, fluid, and malleable media such as markers, sharpies, paints, and model clay. His willingness to use more fluid media seemed to mirror emotional growth in other areas.

Some of the images I created during sessions with Joey are shared below; I will not be sharing

any of Joey's artwork as it contains identifying information. My images are my artistic reflections of the sessions. They provided a witness and holding container for Joey, his creations, and the sessions. Much of my imagery portrayed the constant dance of connection between Joey, myself, and our artwork. The studio provided a safe place for Joey to artistically explore and play with connection; I could only hope that he might eventually take some of it outside the studio.

Figure 1 reflects my attempt to connect with Joey, which was no easy feat. I see myself in the pinks, yellows, oranges, and even the purples. I had a constant flow and was attempting to hold the space for Joey to piece himself together. I see Joey in the purple and black: although he was verbally quiet much of the time, he had quite a presence and took up a lot of space.

Figure 1. Untitled, M. Hedlund Nelson, 2012, 10" x 7", markers on matte board

Figure 2 was a more playful image. Again, it reflects my attempt to reach out and connect, as demonstrated by the tentacle-like arms coming off of the circles. The more I reached towards Joey with my presence, art-making, and energy, the more he retreated.

Figure 2. Untitled, M. Hedlund Nelson, 2010, 8" x 12", markers on drawing paper

Figure 3 captures a repetitive movement using acrylic paints. Before this session, Joey had only created with resistive media that he could readily control, but on this day, Joey decided he would like to experiment with acrylic paints, which are more fluid and harder to control. Thus, this image is a dance and celebration, reflecting my response to Joey's expansion, experimentation, and letting go of control.

Figure 3. Untitled, M. Hedlund Nelson, 2010, 10" x 8", acrylic paints on matte board

Figure 4 depicts my response to the tremendous anxiety present in this session. The many pieces in the drawing are pieces of Joey, who had contemplated suicide some days prior to this session. This piece represents the artistic grounding I provided as I held the space and held Joey in his creation.

Figure 4. Untitled, M. Hedlund Nelson, 2011, 12" x 8", markers on drawing paper

Figure 5 was a reflection of Joey as he went further in treatment and began developing characters in his artwork. The pieces in black and purple are disconnected and reaching for one another. I intentionally left space in this creation as I energetically left space for Joey at the studio. It was during this time that Joey began to assimilate some of what he learned about himself through the art-making process.

Figure 5. Resiliency, M. Hedlund Nelson, 2011, 6" x 12", markers and ink on matte board

Much of the time that I worked with Joey I wondered if anything I was doing was making a difference. I struggled with how much verbal communication I should share during each session; there were many times Joey would not speak unless asked a question. I had to sit with the silence and trust the process, as Joey continued to return to session after session and create. I desired to explore Joey's response to his adoption and help him process any anger or grief he may have had, amongst other things, but I found myself pulling my energy back during the sessions to make space for Joey. He needed a safe place to come and create and to be in connection with himself and another. Although Joey had been let down by the school system, friends, and his birth parents, I never saw him cry over the two years. He never verbally addressed any of his emotions; rather he shared them non-verbally in his artwork. Many of his images were of characters that had weapons and the same slender physique as himself.

Joey's images told a story of who he was in the world and how he viewed the world. Joey shared that he was a 'rockstar' and a drummer, and he greatly connected with old-school rock 'n roll

bands that he idolized and emulated. In early sessions he had re-created album covers in pencil; in later sessions he transitioned to creating characters he developed in colored inks, paints, and model clay. As he progressed in treatment, Joey let go of control more and more, which was evidenced by his media selection. Joey began to tell stories about his characters, who were full of life. His favorite character was Jungo, a strong and powerful half human and half mutant who had no family. Jungo went on to destroy individuals who harmed people, but over time he became more and more connected to others. As treatment progressed, Joey created a wife and a home for Jungo. Jungo no longer fought atrocities by himself, but instead he connected with his community and developed a family of his own. It appeared that Joey was working out his own story through his imagery. As Jungo became more and more comfortable and accepting of who he was, so did Joey. Jungo was incredibly resilient, a half human and a half mutant. He was ridiculed and ostracized by society, much like Joey had been by the public school system and his birth parents. Yet, Jungo grew, found his way, and brought good to his community.

The ripple effect started the moment Joey started coming to treatment. His mother would check in weekly with me, giving me the gift of knowing the influence of the art therapy treatment. After two months, Joey no longer had destructive fits of rage. During the time we worked together, he was not arrested; he joined a few social clubs at school and two different bands; he performed to a live audience for the first time; he obtained his driver's license; and he developed a healthy romantic relationship with a young woman.

I have not worked with Joey for quite some time. Recently, his mother emailed me to share that Joey had started college and was enjoying school. The ripple effect was initiated during our first session, when Joey used a pencil and eraser to add marks to a white piece of drawing paper. He gradually transformed himself, gained a greater understanding of self, learned to express himself more effectively, and changed his behaviors. This rippled out to affect his family, school, and community. Had Joey not engaged in art therapy treatment, he may have gone down a very different path, perhaps ending in death or imprisonment.

The ripple of Joey's growth also affected me. Many of my reflections were contained in the artwork I created during our sessions. Art was my way of knowing Joey, understanding his energy, and holding the space for the sessions, just as it was Joey's way of learning about himself. He taught me a great deal about non-verbal communication, connection, patience, resilience, and trusting the client's process. Joey had not been fixed by art therapy, as one cannot be fixed, but he was able to connect with an inner strength and a resiliency that reminded him time and time again that no matter how much life and circumstances caused him to bend, he would not break.

Narrative Two: Dance Movement Therapy in a Youth Obesity Clinic in Israel

Adam, an 11-year-old adolescent who suffered from obesity, was treated in a youth clinic in an Israeli medical center. His interdisciplinary treatment plan included meetings with a physician-nutritionist and individual expressive therapy sessions. When I first met Adam, his weight was seriously impacting him physically, mentally, and emotionally. He was struggling with his studies and had only a few friends. Adam's parents had a complex relationship. As their

only child, he was subjected to their frequent fights, finding himself in the middle of them while trying to care for his mother. Adam and his mother maintained a close and affective relationship, which was both symbiotic and over-protective. Whereas Adam's mother treated him like a small child, his father was loving but did not know how to manifest his affection.

At the beginning of our sessions Adam spoke very little, mumbling when he did speak. He seemed to lack the skills to express his feelings or thoughts. His clothes were over-sized and he looked like he was drowning in the layers that surrounded his body. In the initial stages of our sessions, Adam sat aloof on a large pillow on a mattress and just looked at the room, reluctant to move or engage in any kind of play. Adam was polite, but unaware of the ways in which one could create a mutual relationship. I felt that he needed to be reassured and be given the time to explore his surroundings while learning how to engage with another.

I began to create our relationship through an invitation to engage in play and movement: I introduced several balls of different sizes, ropes, and sticks. Our connection started as he taught me different games that he wanted us to play together. Gradually Adam asked for my attention and my presence as he began to seek mutual interaction through his games. After a few sessions Adam said, “Now, you choose. What do you like to do?” I found myself being in a role of a big brother, a mentor who could provide him the guidance he lacked. Both our individual and our shared movements allowed him to start recognizing emotions and physical sensations: pleasure, excitement, his heartbeat, and the heat of his own body. He commented out loud that he had never thought of those sensations in relation to his body.

Following this dawning of awareness of himself and his own body, Adam's games increasingly became more physical and aggressive, as he unconsciously reenacted his relationships with his peers. He would vigorously throw pillows and balls at me, and I had to escape from them. As I was attacked by the pillows, I reflected on the ways in which creating relationships by taunting or minimizing the presence of another was part of Adam's learned patterns. The movements caused me to wonder what Adam was re-creating during our sessions—Where and what was he subjected to? Through our interaction and by sharing my reactions about our activities, Adam learned to share his own. As we processed content that surfaced, Adam started to get in touch with his feelings about his social environment. He realized he did not enjoy the company of the friends who were hurting and belittling him. He began to reflect about the way he would have liked to be treated, about his concept of friendships, and about the people he felt he could connect with in light of these realizations.

Through the course of his treatment, Adam started to lose weight, and his physical checkups demonstrated positive physical changes. As he gained awareness of bodily sensations, Adam had begun to connect with his body and to relate to the inner and outer layers of his transformation: “I look at the mirror and I don't recognize myself. My face is thinner and I see someone else, my clothes are too big, my pants are falling... I need new clothes that fit me. But there are two Adams. Inside I don't feel like that.”

Every session, Adam would arrive with his mother, her hugging him while he was leaning on her. I started commenting on his leaning, and Adam, who had initially been reluctant to address

any content that related to his family, started to share stories about his childhood. His pain was present in the room, and I could feel the tension in his body. At that time, he started to look for activities that allowed him to express his rage and his strength. He would jump on a trampoline, or he would punch a punching bag and then sit on it. We started to discuss his relationship with his parents and home surroundings while we were moving and playing. Adam expressed his feelings of powerlessness and anger, being in the middle of his bickering parents. Eventually, Adam also recognized feelings of frustration towards his mother who was comforted by his presence and reluctant to let him grow. Adam stated, “I can't decide anything around here. How can I grow up like this?” After I had several discussions with Adam's parents, they became aware that their struggles negatively impacted Adam, and they realized the need to seek counseling. As Adam's parents started their own counseling process and his mother realized that her own difficulties impeded his emotional growth, it appeared that the relationship between her and Adam began to shift.

While changes were occurring in his family circle, Adam, who was initially extremely shy, started to create new friendships. He was surprised to discover that other children liked his company and that his ideas were appreciated when he chose to share them with his peers. As we were in the ending stages of his treatment, Adam entered the room one day.

He said, “I need to tell you two things, I looked at myself in the mirror today and I cried. It is not that I don't recognize myself; it is that I see myself and I am different and I feel different, I feel it. And the other thing is that they put me in this group with a few of my new friends at school.”

I asked, “What kind of group?”

“Well, we are together and we do activities together, and talk about what we feel, you know like with you… but in a group. So, one of my friends didn't want to join, he didn't want to talk at all, and I told him 'you should come, you should talk'. I was once different and I didn't talk at all and I was not happy, and if you do this it helps, a lot of things can change.”

Adam looked at me and said, “I just had to tell you this.”

I was profoundly touched and impressed. Adam had seen the value of our shared work and he was now different than the Adam I had first met. He had grown to be an adolescent who could be in touch with his inner strength, and could communicate his feelings.

This narrative case study provides a vivid example of how the experience of movement initiated a ripple of change. Adam's movement in our sessions revealed his unconscious reality while he was reenacting the way he was being treated by others. As the therapist, I responded to Adam and his movements, and created a connection via movement and play. In this regard, movement was a catalyst for a ripple that started with him reflecting on inner feelings, sensations, and thoughts, and then extended to his relationship with me. The effects of his growth gradually spread to the outer circle of Adam and his family; ultimately this growth affected his relationships with his community of peers and friends.

Narrative Three: Cultural Connection Through Lyrics and Flowing Poetry

"Lyrics and Floetry" (Floetry, 2006) was a weekly music therapy group held on a male psychiatric unit in the Bronx, New York. The group consisted primarily of African American males who had high-functioning schizophrenia and who were in their mid-twenties to early thirties. While the men were required to attend regular music therapy sessions for bonus points toward their conduct report, "Lyrics and Floetry" was an additional group created for patients who enjoyed hip-hop and R&B. The members attending this group had the freedom to express themselves using rap, poetry, and improvised lyrics over contemporary beats. The music therapists were present to support the group musically, encourage lyrical interaction, and facilitate discussion around the lyrics.

Members often portrayed raw, unapologetic emotions through their lyrics. In order to provide grounding and consistency in the flow of music, I often created a melody that reflected the emotional content of the lyrics and a chorus that reflected key words. This also served to support and validate the member who provided the lyrics. I tried to keep the words and melody of the chorus simple enough so that all of the members of the group could sing together. This created support and unity among the group in a powerful, non-verbal medium.

With every session, members became increasingly eager to have their lyrics heard; some of them would come prepared in advance, with lyrics and poems scribbled on ripped notebook paper. The topic of the group members' lyrics varied from past life experiences, hopes of being discharged, future goals, and even the type of women they liked. As they exchanged lyrics, the group members began to strengthen bonds through the shared music that they were creating together. There was a deepening sense of inclusion and belonging for those involved in the weekly lyrical exchange. Yet there was still a bit of bravado and tendency not to reveal too much about sensitive topics.

At one of the sessions during this stage of the group, a patient who I will call Alex came in with a prepared set of lyrics. Alex was an African American patient who was in his early thirties and had a calm disposition. He was staying on a short-term unit, but he had been there for several months. He seldom participated in the regular music therapy groups, as the genres of music used there were often not his preferred style. He did, however, seem interested when the music transitioned to hip-hop or R&B in those groups. He was pleased to be in the "Lyrics and Floetry" group because he was an aspiring rapper who planned to eventually pursue his dreams on a professional level.

The lyrics Alex brought that particular day were a direct reflection of how he felt within the unit. He rapped about 'being an angel with clipped wings' and not being able to 'feast with the big kings.' Other parts of the song reflected his desire to be free. The lyrics implied that he didn't feel as though he belonged in this current situation, that he should be 'feasting' or enjoying his life out of the ward with 'big kings,' or rather, people who were not in the same situation as him. The group processed the meaning of the lyrics after the rap was finished. Every member was engaged in the conversation and they showed support by validating Alex's feelings. In addition to the lyrical analysis, the group continued to process and respond to the lyrics by adding their own

freestyle rap, as I added my own musical reflections. This ordinary rhyme cypher became a platform for these men to reveal their truths, to hear them amplified in the music, and to have them be accepted by others. It seemed to me that members opened up more on that day. I first thought that it was an isolated event, but I soon realized that the group had moved to a deeper level of authenticity.

Alex's introspection played an integral role in this shift in group dynamics. Through self-disclosure and willingness to share authentic lyrics, he began a ripple that prompted other members to take part in the same process. As Alex shared information through lyrics and poetry, other members felt safe to include their own lyrics without feeling judged or scrutinized. The art that we all created in support of and in response to Alex's art could be heard and felt.

Alex started the ripple in the group by first revealing his own truths. I believe that all ripples start similarly—from within. When one is able to express their truths in an authentic way, others may also find it safe to reveal parts about themselves. The members of this group wanted to be heard; like so many of us, they had a deep desire to be accepted. Music provided a unique platform for empowering the members and giving them a shared purpose. This small ripple, which first cultivated cohesion among the group, also helped them to form stronger inter-personal skills outside of the group setting, thus promoting healing in other venues. The members' willingness to provide feedback and support to one another became a group norm, not only during the music therapy session, but also outside of their lyrics and flowing poetry.

Narrative Four: Ripples of Forgiveness in an Art Reflection Group

In expressive arts group sessions, the insights that are gained during art-making can be witnessed amongst the members. This creates a ripple effect from individual art experience to the whole group, enriching and amplifying the experience for each group member. For this reason I find it profoundly rewarding to facilitate art-making in reflection groups. The art reveals the uniqueness of each person's inner process while providing something visible that can be shared with others.

This narrative case study describes my facilitation of a group that was held in a church in Canada for people who were interested in using art-viewing and art-making as a way to reflect upon the process of forgiveness. The purpose of the group was to facilitate and deepen understanding of what forgiveness is and is not, and to explore the concept of forgiveness spiritually, psychologically, and personally through artistic reflection. Participants in this group were mostly members of the host church; a few were guests. The church was already actively involved in interfaith relations, social justice, and was interested in expression through all of the arts.

Each of the three sessions of the group included: a psychoeducational component about forgiveness that I, as a therapist, provided; a short Bible study that examined scriptural insight on forgiveness that a pastoral co-facilitator provided; and a group discussion about forgiveness. The three sessions were titled as follows: “Be Angry and Sin Not,” “Forgiveness is a Choice,” and “Empathy as a Bridge to Peace.” In the first session participants viewed videos as a tool for examining the impact of injustice; we presented psychoeducational and biblical perspectives on

the role of anger in forgiveness when confronting injustice, and the group discussed what forgiveness is not (i.e. excusing or minimizing an offence). In the second session, one week later, participants were invited to use art-making to process their thoughts and feelings about forgiveness. The art form offered was collage, using papers, paint, light fabrics, and images from a variety of magazines, as this art form is very accessible to anyone regardless of artistic experience. In the final session on the last week, we returned to viewing music videos and then discussed compassion and empathy for the victim, as well as how to work toward re-humanizing the offender through understanding their context. Empathy in forgiveness was the focus of the final session. This included exploring victim and offender identity and examining how offenders have also been victims at times. This was powerfully witnessed in the music video 'Hurt' as performed by Johnny Cash (Leopoldino, 2010). Many participants stated that the video's powerful artistry had a profound effect on their experience of empathy towards offenders. In this session, we reflected on all three sessions by using pastels, markers, and crayons to create drawings that integrated the many components of the experience and information from the sessions.

Art-making was used to process and develop personal understanding of the material presented and was later shared and discussed in the group. To ensure safety and privacy, while everyone was invited to share their artwork and their process in art-making, participants were told that sharing was not mandatory and that they should only share what they wanted to share; participants could still benefit from witnessing the sharing from others. Creating art was not the only way that art impacted the process. Participants said that viewing music videos affected art-making and brought out rich emotional discussion of the topics. The music, lyrical poetry, and visual effects, as well as the opportunity to explore in the visual arts, provided the group with much more than a cognitive exploration of forgiveness.

I was touched by what participants shared with the group, what they had learned by processing content through their own art-making, and how both viewing and creating art affected their awareness and understanding of forgiveness. The art components helped participants internalize and explore the emotional components of forgiving as they created images that expressed inner realizations and showed new insight as to what forgiveness may look like. The group members were able to witness those new insights and realizations as they listened to each other explain the symbolism, metaphors, and meanings in their own art. I noticed how this created a ripple of deeper perspective on what it is to forgive, as members discovered the sensory, emotional, and cognitive layers in each others' art. Some participants appeared to be very moved by the process.

For example, one participant had been intensely engaged in art-making and in witnessing the art of others. I felt the emotional depth of her artistic experience reflected in her facial expression as she showed her art to the group. She chose not to share verbally as it appeared that she was too emotional in the moment to share the meaning with the group. She later explained to me that the art-making had a profound impact on her. She had then taken the art she made in our group to a personal therapy session to work through what the art had illuminated.

Within the group, some members stated that creating with others and hearing about the group members' process had helped them to understand how forgiveness may look in inter-personal

situations that they were working through. Participants found that the act of sharing their art process served to illuminate relational dynamics in their lives and thus provided more clarity in their forgiveness process.

The group's effects extended to a community and social justice level. The reverend of the church where the group was held had attended the first two sessions of the group. In the final week of the group, the church was defaced with swastikas and racial slurs directed at the Black reverend and congregants. A nearby synagogue and a mosque were similarly graffitied with hateful slurs that week. In response, the Reverend joined several other leaders of faith to arrange a peace movement against such hate crimes. Although the Reverend was already an established figure and leading authority on the topic of forgiveness, he gained an insight from our group that he then shared with his congregation: It is not the offence that is being forgiven, as the offence is wrong and unforgivable; rather, it is the offender, a person, who can be forgiven. In this spirit the Reverend planned to visit the offender after court proceedings were completed to offer forgiveness in hopes of extending and fostering mutual empathy through restorative justice.

The group of eleven participants consisted of four men and seven women. A post-group questionnaire/worksheet was given to participants. Results from the questionnaire indicated that when compared with psychoeducation and Bible study alone, art-making was rated slightly higher in providing insight into personal experience of forgiveness on an intra-personal level. Comments from participants during the group discussions indicated that this rippled into inter-personal, relational, and community attitudes, perspectives, and interactions. While the demographics of those involved in this group may indicate that they were already highly motivated, the survey results suggested that there is value in art-making and witnessing for facilitating a deeper understanding of what it is to forgive. The participants indicated that they were highly interested in continued discussion on the topic of forgiveness and in participating in more art exploration encounters.

I had attended workshops on forgiveness prior to this without the inclusion of art-making and found that the addition of art-viewing and at making offered a framework of exploration for the participants that generated more diversified, symbolic, metaphorical, and personal/sensory reflection than did verbal discussion alone. Whereas verbal discussion engaged the cognitive process that brought out emotional content, art-making was a place to explore the emotional content for deeper understanding. The experience of witnessing what happened in this group increased my own interest in pursuing further academic insight into the phenomenon of how art can affect the process of forgiveness. Shortly after the conclusion of this group, I started a separate research project to examine how art affected my own personal process. This group's art-making started a ripple that moved from intra-personal self-understanding, to inter-personal relations, to community impact, and for me, to future academic work.

Conclusion

The five of us find it exciting and enriching that we use a medium that draws upon visual, symbolic, and metaphorical expression, as well as sensory, somatic, and kinesthetic processes. By using the arts, we are providing a uniquely engaging alternate or addition to traditional

therapy that can help our clients and ourselves move beyond cognitive understanding and verbal processing. We have each witnessed the ripple effect of the arts in a variety of contexts, via a variety of the arts modalities. As the above narrative cases describe, visual arts and movement were catalysts of change for Joey and Adam; their growth rippled out to affect their families and friends. The musical arts offered Alex and his peers the opportunity to be heard and accepted, changing the dynamic within their mental health facility, and perhaps providing a platform for being respected and understood beyond that setting. For the forgiveness group, the ripple into issues of social justice was clear: the impact of the art touched the Reverend, his community, other faith-based communities, and perhaps even the perpetrator of a hate crime.

As more information and research about expressive therapies is released, there is an increased interdisciplinary interest in the profound impact that the arts have in therapy, psychoeducation, and social justice. Some of this has reached the popular media. The cover of *National Geographic Magazine* had a lead story that described Walker's healing work, in which she used mask making to help veterans express what they were feeling about their experience of war (Alexander, 2015). ABC evening news gave a report about the critical value of music therapy in Congresswoman Gifford's recovery of her ability to speak after brain injury (Moisse, Woodruff, Hill, & Zak, 2011). Dance and movement therapists are being lauded in the treatment of psychiatric patients (Chace, Sandel, Chaiklin, & Lohn, 1993). Reports of these recent high-profile arts-based treatments have opened conversations about the value of art in other disciplines, such as nursing, pastoral care, and school support. This has also resulted in increased integration of the expressive therapies in various theoretical approaches and counseling applications (Degges-White & Davis, 2011).

The arts offer a different epistemological approach to self-awareness and healing; they give us a different way of knowing ourselves and our clients. Most uniquely in the therapeutic realm, the arts are impactful in creating social change as they provide a way of translating individual and community experiences of the human condition into modalities that can be shared and experienced by others, creating bridges of realization and empathy. As stated by Solzhenitsyn (1970), " … the only substitute for an experience we ourselves have never lived through is art." In all of the arts there is the capacity to hold the expression of lived experience, transformed for others to see, hear, feel, and experience with the art maker. Being witness to the unfolding of insight through art is not only helpful to the art makers, it is also an honor and privilege for all of us who witness the art and view the revelatory creative process of others.

Implications

The metaphor of a ripple is used in this article to describe the relational process of expressive arts therapies. As described, expressive therapies provide a catalyst for unleashing the clients' creative capacities to explore and ultimately influence their world. Nonetheless, further research is needed to gain insight into the rippling effect caused by the use of expressive arts therapies as the ripple extends from individual circles to the larger community. Additionally, acknowledging the power of the arts as catalysts for improved emotional and mental health in a community context could promote the use of expressive therapies in related disciplines. As other professionals such as psychologists, social workers, and counselors gain greater understanding

of the therapeutic rationale for using the expressive arts therapies and the way they can spark a ripple, the therapeutic disciplines will gain valuable methods and insights regarding the impact of art in facilitating healing processes of health and human relationships.

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How Narrative Therapy Changed Us

Nancy Turnbull

Abstract: While there was some literature written about new practitioners of narrative therapy from teachers' perspectives, there is virtually nothing written about this topic from the new practitioner's perspective. As a first-year-in-practice MSW, I share my insights, challenges and how I've grown professionally and personally as a result of using the narrative therapy approach. “Jill” also offers what her experiences of narrative therapy were and what she has learned along the way.

Keywords: narrative therapy, new practitioner, reflection on practice, catharsis

The story I am about to share with you is one of katharsis, meaning one of emotional movement and personal transformation when witnessing or experiencing a significant event (White, 2007). Not only was there catharsis for the woman consulting with me but also for myself, as a four-month-old practitioner of narrative therapy. We've independently grown and transformed during our time together: She is on a path to her preferred way of being and I am moving towards the narrative practitioner I would like to become. It is also a testament to White's two-way account of therapy (White, 1997 in Beres, 2014) that I am forever changed by witnessing “Jill's” (name changed to maintain confidentiality) beautiful transformation, but let me start at the beginning.

Four months before meeting Jill, I was hired straight out of my MSW graduating class by the Thames Valley Family Health Team (FHT) to be the Social Worker for a group of family doctors' patients. At the time I was hired, I had visions of what this would mean: counselling people who were living with a new diagnosis, helping people navigate programs and services, treating mild to moderate depression and anxiety, grief counselling, facilitating groups, and the like. At the outset, I did not expect to be working with people who were experiencing multiple and severe mental health issues, nor did I feel skilled enough to help.

As a new graduate, I was passionate, excited and nervous as all get-out! Despite my most influential clinical course during my MSW having been in the theory and practice of narrative therapy, I hesitated in using it in the beginning because the physicians at the clinic hadn't heard of this approach before. Then, after about a month of floundering around trying this technique and that technique with little effect, I decided to go with my training in narrative therapy. So with this in mind, I practiced and consulted, read, and journalled my follies and successes. I worked, ate, relaxed and slept narrative therapy those first few months. I was trying to don the narrative therapy approach rather than just learn the techniques that Hibel and Polanco (Hibel & Polanco, 2010) and Beres (2014) suggest could be a stumbling block for new practitioners of narrative therapy. Enter Jill.

Jill, a thirty-year-old single mother of two, came to consult with me about her ongoing experiences of anxiety. She told me a fourteen-year-long story of mental health diagnoses, lost dreams, missed opportunities and frustration. She told me that by the age of 16, she was diagnosed with a generalized anxiety disorder that included panic attacks and a major depressive

disorder. Further diagnoses were assigned to Jill, she told me, at the age of thirty that included severe anxiety (mostly social), mild obsessive compulsive disorder, manic depression, as well as being told she possessed cluster C personality traits that may indicate a personality disorder—all symptoms that had been declared to be resistant to pharmaceuticals. Jill shared with me during our first meeting that she found it very difficult to leave her house alone and that she had not been able to work for a number of years. Jill had some success with antidepressant trials for a period of time, but she reported either a dwindling effect or no effect at all. She had not found previous psychotherapy to be useful to her. After the births of her children, and more recently a divorce from a person who was very controlling, she found that anxiety took her to a point where she was unable to bear it any longer on her own.

Oftentimes, during an assessment, an over-arching theme of something reveals itself. In this case, it appeared that Jill's dominant storyline rested in the broader narrative of mental dis-ease and all of the stigma and trappings of the machine of mental health services that she had bumped into over the years. It occurred to me after this initial meeting that Jill had likely felt 'hijacked' by anxiety and depression for a very long time. More than this, I was concerned that Jill was feeling powerless to deflate the problems in her life and that she may have felt unknowledgeable as to how to take charge of her problems. Right from the beginning of meeting with Jill, I suspected that narrative therapy's stance—that the problem is the problem, not the person is the problem, and elevating the person's intimate knowledge, insight and wisdom about how to usurp the problem would be a beneficial match (White, 2007). However, my new-practitioner self-doubt made me ask, "How on earth am I going to be able to make a difference in Jill's life with narrative therapy?" Then I stopped and told myself to take it step by step, conversational map by conversational map.

Double Listening, Sparkly Moments, and Wait-a-Minute Marvels

I was taught to use the conversational maps as a loose guide for therapeutic conversations. White used the map metaphor to explain how the consultant would share the conversational journey with the person from what is "known and familiar" about the Problem towards what is "possible to know" (White, 2007). These maps and I have a love-hate relationship. In my eagerness to ensure I complete a map in a session, I tend to rush the "known and familiar." In my experience, rushing this aspect of the conversation can minimize the person's own expert knowledge of the problem. I crave the maps' guidance and reassurance. It seems so easy and logical before I meet with someone; however, sometimes I find that I can lose my way in trying to guide the conversation. I've also had instances where I feel boxed into a conversational map when what I really want to do is chase after something the person has said/not said that I feel might be really important. Most of my conversations with Jill at least started with a map.

Double Listening

What I've come to realize is that White's 'double listening' is crucial. Double listening entails becoming curious about soft whisperings that something outside of the Problem wants to be heard, which was a concept originally developed by White in his creation of the Absent but Implicit conversational map but with his untimely death, Beres has further developed (Beres,

2014). Double listening is a skill I didn't think I possessed as a new practitioner. I was so busy trying to ask 'narrative questions' and remember the steps of the map that, at times, I caught myself not listening at all, never mind "double listening." But when I really settle into a conversation with someone, like I did with Jill the day we externalized anxiety, something really special happens.

The "Wall"

Seeing how anxious she appeared during the first consultation, my little baby Social Work practice wisdom suggested I start working with Jill's anxiety rather than the depression. Using the externalizing conversation map to deconstruct the problem, Jill began to teach me that anxiety began settling in with her at a very young age, perhaps 12 years or so. Holding her hands up as if to feel it, Jill described anxiety as a "Wall" that has kept her from doing things over the course of her life: making new friends, finishing high school with her peers, pursuing post-secondary education, getting her driving license, and much more.

When I asked her to evaluate the effects of the "Wall" on her life, how she sees herself, her relationships, and her career, she was clear that it was all negative. I sensed and observed a shift in her demeanor and posture when I asked her to evaluate how she felt about anxiety's effects on her and her life. She stopped fiddling nervously and sat up straighter. She became outraged and angry, but she seemed surprised to feel that way. I asked her to stop and name her reaction and she said she was 'pissed off with anxiety' and fed up of it getting in the way of so much in her life.

I asked her what might be possible for her now that she had acknowledged all of this, and she plainly said, "I'm so ready to break up with anxiety." She laughed at that and I did too. Her frankness and humour impressed me, as did her feisty outrage at anxiety. Jill taught me that taking a playful approach to the problem actually takes some power away from it. This is a concept I use with other people on a regular basis now. That moment has stood out for me as pivotal to our work together, in that Jill was taking a very strong stance against anxiety. I saw the magic of narrative therapy that day, and it gave me the confidence to continue to use this with Jill.

While in the middle of this wonderfully moving externalizing conversation, Jill gave me a hint of something sparkly.

Sparkly Moments

Do you know how thin, thin ice looks on tree branches in the morning sun? The thin coating of ice clearly defines each branch, even the smallest ones that may have escaped your notice before. The smallest branches are offshoots from the larger branches that seem like a tangle of pick-up sticks. But when that watery winter sun dances its beam on that small branch it is wonderfully lit up for your pleasure. I stop to notice and appreciate the effort, the intent and will in that little branch to grow out of the larger one. I marvel at the tree that can hold itself up under the ice. Time deserves to move a little slower, my senses are heightened, I feel so connected to

the tree and the branch, I feel humbled to have witnessed this moment. These are the 'sparkly moments' I experience with practicing narrative therapy.

Jill's sparkly moment was as spectacular as that little branch covered in ice being tractor-beamed in the sunlight. It was our third session together and we had heard a lot of how social anxiety had been shutting Jill down from her life. But then she mentioned one thing in passing, an off-the-cuff-remark. It would have been so easy for my attention to not go there and to stay with the problem storyline (White, 2007). She was telling me how hard it was to make friends like her long-time friend "Ally." I became curious and asked Jill how the friends had influenced each other over the years, but especially way back when they were in grade school. Jill spoke of their true acceptance of one another's quirks and sense of humour and of their fierce but friendly public-speaking competition that went on for years. A sparkly moment had arrived because I was double listening.

Wait-a-Minute Marvels

I stopped writing notes, sat up straighter and took my glasses off. "Wait a minute. Just wait a minute, Jill. Did you just say 'competitive public-speaking'?" I asked. Jill had shared with me how social anxiety keeps her from taking her children to school, from driving, from meeting new people, from working. How did Jill muster up the courage to get up in front of a crowd of people and give a speech, I wondered aloud. Jill paused and shyly said, "And I won quite a few times too."

I suspected that this was an opportunity to thicken this alternative storyline (White, 2007) with Jill so that we could lift up her exhilarating experiences of public-speaking, of being self-assured enough to present her ideas in front of people and of Jill being a valued friend to someone despite anxiety trying to assert itself. The responsibility of getting the next few questions 'right' weighed heavy on me. Which way should I go: ask more about the speeches, about the friendship?

"Jill, can you tell me how you came to do competitive public-speaking?" I asked. Jill told me a story about the required school speeches in elementary school, and how she and her friend Ally would practice together. Jill spoke of their supportive but competitive friendship driving her into the finals and later the regional competitions. It wasn't all easy for Jill, she remembered feeling frightened before facing the crowd to deliver her speech, but once she was out there and said the first line, her nerves were forgotten, she told me. This moment in the conversation felt very important, therapeutically pivotal, in fact (Duvall & Beres, 2011). Time seemed to move slower and my vision seemed sharper. I felt very connected to Jill in that time and space of her prepping for competitive speaking and her successes. I was marvelling at this new side of Jill I was learning abou,t and I was certainly hoping to thicken this memory of her being courageous for Jill. My brain was leaping to all sorts of possibilities this next part of the conversation could have for Jill in un-sticking anxiety.

"Does talking about the competitive speech delivery bring to mind any other times you pushed through the Wall of Anxiety?" Jill then told me of her love of drama and performing on stage

back then. I asked how this came to be, how she became interested in this. She shared that her father was a community actor and he encouraged her to enter the world of theatre with him. At about the same time, Jill started working at an art gallery, which suggested a broader interest in the arts that I became curious about. This led us to talking about what this reminiscing about her life-long passion for being creative and artistic might make possible for her in her near future. In response to this, Jill stated she wanted to go to college, to further her education and maybe explore a career related to the Arts.

Jill's Experiences of Narrative Therapy

I offered Jill some questions to help her reflect on what her experiences of narrative therapy were on her, her identity, and her present and future preferences. I've included the questions, as Jill responded to them.

What was your experience of therapy this time?
"My experience of therapy this time around was purely positive. It differed from other psychotherapy sessions that I had experienced in the past in that I felt much more comfortable and in control of the process. Feeling at ease to share is especially detrimental for me with my anxiety. If I do not feel comfortable, I am not going to share things that may be pertinent to the process. In my past experiences of psychotherapy, I have purposely left out things that I thought would be judged, or that made me embarrassed to admit about myself. I have even acted like everything was better so that I would no longer have to attend therapy. From our very first session together, Nancy really hit home that any issues that I was experiencing in my life were completely separate from me as a person. My time with Nancy was a judge-free zone where we could discuss anything that had happened, or that I was thinking."

Are there sparkling moments from our sessions that stand out for you?
"While there was no one pinpointed epiphany for me during my sessions with Nancy, being gently guided to meander through the offshoots of those tree branches of my life, being taught that each branch in my life-tree had many offshoots from where to see different perspectives, and that all of those offshoots were connected back to my branches, to my life-tree, to my roots—making up what shaped me as a person—was the most important thing that I learned. I think that in life we sometimes get so stuck only looking at the bigger picture that we forget to see that there are many different things affecting us. We aren't trapped in any one place in our life-tree. We are able to explore millions of brilliant offshoots and create infinitely more."

Could you reflect on any changes to your perspective of anxiety throughout the course of treatment? "Going into treatment with Nancy, I felt stuck. Stuck in anxiety, stuck in life. By the end I no longer felt that anxiety was trapping me. I no longer felt that I was my anxiety. In separating the anxiety from my person, I began to see that it was something that I didn't need to carry with me everywhere. The anxiety then became a hurdle that was possible to push through."

How did you see yourself before treatment? "Before treatment, my confidence in myself was completely shattered. I felt trapped, like there was no hope that I would ever break free of this

negative thing that had such a hold on me."

Has there been any change to how you see yourself afterwards? "I think that all my life I have been searching for a way to eliminate anxiety permanently from my life. Through my therapy with Nancy, I've realised that I will probably always have issues with anxiety, but I now have a different way of looking at things so that the anxiety no longer defines me. Knowing that the anxiety is not me, that I now have the skills to work through it, really makes all the difference in my confidence, happiness, and hope for the future."

My Catharsis

That one sparkly moment was the turning point in narrative therapy with Jill. Becoming curious about the small invitation Jill delivered to me set a very different course on the map of our work. I developed even more respect for Jill than I did in the beginning in her ability to persevere despite anxiety; now I respected her ability to take charge of it. My whole view of Jill transformed during that conversation.

On a personal note, witnessing Jill's transformation has been humbling in that I have a deeper appreciation for how disruptive anxiety can be. It has also been incredibly uplifting to see Jill rise up from the flames of anxiety and begin to re-claim her life, so uplifting that I was moved to tell her story here.

On a professional note, my self-confidence in my ability to adopt the narrative therapy approach has begun to bloom. The philosophy of the post-modern narrative therapy approach is that the person is the expert on the problem. They know it better than we do. Jill taught me this: to trust the client's internal wisdom. Jill had the knowledge and wisdom to break free from anxiety; I just helped her to dust it off. I now feel much freer to share my narrative therapy techniques and approaches with the FHT practitioners, especially when they are so curious about the significant changes they see in their patients after meeting with me only one or two times. I tell them now about narrative therapy, where I certainly shied away from this when I first started at the FHT. I like to think that I am simply learning to play the instrument of narrative therapy, and while I'm still learning, I can't help but feel connected and pleased with the harmony and music that is produced.

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Using a Client-Centered Approach to Guide the Development of a Culturally-Specific Hip-Hop Intervention for African American Adolescent Substance Users

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Abstract: This article portrays and reflects on the social work process of program development using a client-centered, bottom-up approach as a tool to improve client satisfaction and program retention. It is important to discuss this process and to highlight the possible strengths and limitations to using this approach. Moreover, this narrative examines the feasibility of developing and testing a culturally sensitive hip-hop intervention among urban African American substance-using youth and the importance of the collaborative work to establish "buy-in" from key stakeholders. Conclusions highlight the importance of adapting clinical interventions within the context of the client population.

Keywords: substance use, African American, youth, intervention, hip-hop

Introduction

Social work practice continues to evolve in regards to the type of practice specialties and positions. One such role within most community based settings is that of a clinical or program director. Within this role, there are several aspects of the position which are vital to the ongoing functioning and sustainment of effective clinical care. Within our previous role of clinical director at our respective agencies, a few of the many responsibilities that we had included ensuring proper staffing structure, reviewing clinical documentation, monitoring, reporting on treatment outcomes, and program development. While all of these aspects are critical to the position and overall agency sustainment, we agree that the role of program development was one of the more complex processes to undertake within the clinical setting.

During our years of practice and research, we have found that the process of program development is one that takes on many different approaches and can be daunting for new and even experienced clinical directors or administrators. While the literature discusses social work practice and direct care with clients in great detail, there is less information around effective program development approaches for use within an agency setting. As such, we felt a strong need to reflect on the process that we utilized to develop a culturally sensitive intervention for African American urban youth in substance use disorder treatment. A large majority of the youth were referred to the program by the state juvenile justice agency and had multiple treatment episodes. Additionally, given the complexity of most urban environments (poverty, crime, drug trafficking, and health disparities), a large majority of youth entered treatment with multiple areas of concern. This article will provide the overall clinical context used for the process of program development within this complex population. Following the theoretical framework, the paper will discuss the overview of the clinical setting followed by the utilization of a bottom-up adapted approach which was used to ensure successful program development and outcomes among key agency stakeholders and the client population currently enrolled in the substance use disorder treatment program. This seven step approach consisted of: problem identification, brain

storming, review of literature and feasibility, curriculum development, intervention formation and presentation, and pilot testing.

Theoretical Framework

As we started thinking about program development within the complex clinical system, it was imperative for us to identify and decide on a framework that could be used for the development phase of the program. This was not a task that we took on lightly given the many complexities as it relates to agency policies as well as consumer buy-in. During the development period, we had to address multiple competing interests which came into play such as agency programmatic needs and what was reimbursable in regards to service type versus what the client wanted in regards to effective treatment (Sobell, Sobell, & Ward, 2013). While it is easy to think that these ideas are in alignment at all times, there are times when they result in conflict. This conflict results in poorer treatment outcomes such as retention, poor patient satisfaction in addition to a reduction in billable services (Lindhiem, Bennett, Trentacosta, & McLear, 2014).

These complex issues typically occur when agencies make programmatic changes using a top down approach (Biesta, 2007). This approach is when the board of directors or senior administrators decide to adopt specific programs or make changes to existing programs without consulting with the potentially effected clients. The decision to implement or modify a program is often driven through their overall understanding of a theoretical perspective or best practices which have generally been accepted within the field, and then an intervention is developed or adopted (Petersén, & Olsson, 2014). While this approach is typically the gold standard for clinical programing interventions, most are often influenced due to outside stakeholder preferences (funding sources, insurance companies, etc.), and it does not always result in the anticipated outcomes (treatment outcomes, revenues) (Petersén, & Olsson, 2014). An example of this can be made using the well-known evidence based practice of cognitive behavioral therapy. While this approach has been widely accepted and utilized across diverse populations, a meta-analysis indicated and expressed caution when applying this model to blacks and Hispanics (Windsor, Jemal, & Alessi, 2015). Utilizing a top-down approach, this model has been adopted widely among those populations for which research has cautioned and called for further investigation into the overall effectiveness (Wilson & Cottone, 2013). While the top-down approach has been the primary approach used with program development, we will discuss the feasibility and ease of using a client-centered approach to program development.

The process of using a client- centered framework was an approach that encompassed input from current and previous clients to inform overall program development (Scholz, Gordon, & Happell, 2016). In contrast to the top-down approach, a client-centered approach would be considered a bottom-up approach. According to research, bottom-up program development:

> Can involve three different approaches to incorporating theory. First, developers might adopt an atheoretical approach, that is, they do not concern themselves with why their intervention may work; instead they may focus solely on whether the intervention works. Second, developers can incorporate theory in a discovery-based fashion, that is, they build their model as they discover new findings and as their experience grows. Third,

> developers can seek inspiration in existing theories to explain why their interventions are effective. Different portions of multiple existing theories are then eclectically combined into a new model (Vansteenkiste, Williams, & Resnicow, 2012, p. 4).

It is important that we emphasize that the client-centered, bottom-up approach which we used was influenced by several factors. These factors included our clinical intuition and experience, a reported increase in clinical problems, and the lack of success with the current intervention coupled with the agency's expressed desire to create more effective approaches. As part of our ongoing understanding of this approach, we found that utilizing a client-centered, bottom-up approach is not without a theoretical context. Within this process, we found an overwhelming need to complete a thorough review of theoretical frameworks which we used to explain our proposed intervention and targeted outcomes following the development and testing period.

During the initial development phase of the program, we found many benefits and limitations to using a client-centered development approach. One of the many benefits is the empowerment of clients to engage in the development of a clinical intervention which could potentially increase their own treatment related outcomes. Given the client population that we typically worked with (Department of Juvenile Justice-referred youth), we felt that it was important to provide the youth with an opportunity to engage in the creation and development of a program that would ultimately affect their treatment outcomes. The desire to have the clients engaged in the program development process is exemplified in the following excerpt between the clinical directors following a meeting with the board of directors:

> CD1- *The meeting with the board was very productive. I discussed our program development strategy and they seemed pretty open. One of the members expressed concern about having clients involved in the process because he felt it would delay the start of the program. It seemed like he was more concerned about the revenue generating aspects as opposed to a balance between revenue and client satisfaction. I had to make it clear that having clients be a part of this development process was key to buy-in and overall engagement. He seemed to get on board.*
>
> CD2- *Wow, I hope they understand how key client engagement is to the development of this program. They have to see the results of the programs they just implemented without any client input. They haven't been successful. Using this approach, clients will be empowered and engaged. I hope they get that we are doing this to improve the agency's outcomes.*

From our perspective, empowerment was a major component in our client-centered approach. According to Freeman (2013), increasing client empowerment has led to improved clinical treatment outcomes. Another benefit that we found using this approach was the ease and flexibility of program changes which occurred during and following the intervention development. While there were many advantages to using this approach, we had to also keep in mind the known limitations such as time required for the process and including clients in the decision making components. While the agency where we developed this approach was open and understanding of the program development process, most agencies are sensitive to

implementation time and try to maximize service delivery through faster implementation. Another limitation is the lack of testing related to an agency-developed intervention. There is often hesitancy among clinicians regarding the usefulness of interventions which have not been shown to be effective through the process of vigorous research and evidence based practice standards (Gray, Joy, Plath, & Webb, 2013).

Given our previous use of both approaches, the limitations expressed are appropriate. However, an example of a client-centered, bottom-up approach is the well-known clinical intervention of motivational interviewing (MI). According to Miller and Rollnick (2009), “MI was not a product of rationale deduction from theories. Rather it represented a clinical method, and later a growing body of empirical findings, in need of theoretical explanation” (p.134). Motivational interviewing was developed from clinical intuition and out of the need for a different “less confrontational” approach to working with alcohol dependent clients (Miller, Taylor, & West, 1980; Miller, 1983). As research has demonstrated, MI has continued to evolve and is moving on its way to becoming a theoretical framework (Miller & Rose, 2009). More to the point, MI has increased in its overall utilization and is widely adaptable across several related behavioral conditions (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).

Overview of the Clinical Setting

The treatment center where we developed this clinical intervention was located in a large urban city on the east coast. As an important note, the treatment center was well established and has been in operation for over 20 years. This added another complex layer for the program development process because we were met with some viewpoints of “if it ain't broke, don't fix it,” meaning the staff had an existing belief that the interventions being used were effective. The treatment center has been providing dual diagnosis service to youth and adults affected by substance use and co-occurring mental health disorders. The agency programs include both inpatient and outpatient services; however, we only implemented this approach within the context of the outpatient setting. Our original focus on developing a culturally sensitive treatment intervention was grounded in the belief that a large majority of individuals enter substance use disorder treatment programs through an outpatient program. This belief was supported by the 2015 National Survey of Substance Abuse Treatment Services (N-SSATS) research findings which indicated that 89 percent of substance abusing individuals receive an outpatient modality of care upon their entry into treatment (Substance Abuse and Mental Health Service Administration [SAMHSA], 2017).

The outpatient program provided treatment services to a large population (approximately 80%) of African American clients. Through several conversations with the board of directors, we successfully made the case for the development of a culturally sensitive clinical intervention, which was appropriate given the context of the client population. Prior to engaging in the program development process, it was important for us to understand the complexity of their outpatient treatment setting. There are a wide variety of clinical services that were provided which included substance use disorder treatment, mental health therapy, medication management, psychological testing, educational service, health screenings, and nursing services. As an added benefit to the youth treatment program, transportation services were also provided

to youth who resided in the catchment area. The youth program consisted of the following program levels and duration:

- Traditional outpatient program: less than 6 hours of treatment per week
- Intensive outpatient program: 6-20 hours of treatment per week
- Partial hospital program: 21-30 hours of treatment per week

In order for a youth to receive substance use disorder treatment, they had to sign all necessary consent forms and complete a clinical assessment which assessed current functioning in the following areas: Substance use, family, education, legal, medical, mental health, and social/peer relationships. Following this assessment, the youth were assigned to a treatment condition based on the American Society of Addiction Medicine-Patient Placement Criteria-2nd revision (ASAM-PPC-2R) (Stallvik, Gastfriend, & Nordahl, 2015). A detailed description of the program and expectations was provided with the youth and their parent/guardian as part of the orientation. Within the program, youth were discharged for the following reasons: 1) completion of treatment, 2) premature termination, 3) therapeutic discharge, 4) discharge due to incarceration, 5) discharge due medical reason, and 6) discharge due to death. The typical program length of stay was approximately 90 days with an incremental step-down approach. Prior to undertaking any program development process, it is important to understand how the agency operates. Following this stage in the process, we proceeded with the program development phase using a structured framework which we will discuss next. The framework was important so that we could keep track of where we were in the process but also as a means to inform key stakeholders of the process and next steps.

Application of Client-Centered Program Development in a Community-based Setting

Step 1: Understanding the Need—Problem Identification

There are several factors which we considered during the problem identification period. Most important was to consult with agency administration and engage them in the collaborative process which required input from multiple stakeholders. One of the main areas identified by the leadership and the clinical staff was the need to increase retention among the youth enrolled in the program. This particular need arose from several quality assurance audits which revealed a high incidence of premature termination from treatment (approximately 70-80%). From our perspective, this was highly problematic since research has shown that when individuals stay in treatment longer, they have better treatment related outcomes such as decreases in substance use, improved academic achievement, increased family functioning, decreases in mental health symptoms, and less contact with the legal system (Centers for Disease Control and Prevention, 2010). More to the point, we felt that this issue of premature termination from treatment is a current and relevant issue for social workers and the social work profession. According to research, “the social work profession has a unique role in preventing and treating alcohol and other drug problems” (Burke & Clapp, 1997, p. 552), which includes the prevention of premature termination from substance abuse treatment. From our initial discussion regarding outcomes, we found that the issue of premature termination was also a problem noticed by the youth engaged in the program as well as outside agencies and funders.

Step 2: Hypothesize Solutions—Brain Storming

Following the problem identification process, we engaged in a process of formulating preliminary hypotheses as to why youth were leaving treatment prematurely. This was particularly interesting to us, as we had the opportunity to hear from clinicians and clients. We felt that providing clients with an opportunity to discuss why they felt the need to leave treatment early was an important step within the client-centered approach. During this stage, focus group sessions were conducted with the sole purpose of answering the following questions:

- Who are the youth that leave treatment prematurely?
- What are the factors that contribute to youth leaving treatment?
- When are youth leaving treatment?
- Why are youth leaving treatment?
- How can we prevent premature termination from treatment?

To ensure that the focus group sessions were productive and engaging, we consulted with agency administration to gain better understanding of how to group the participants. From this consultation we arranged the groups in the following manner: Clinicians, 14-17 youth, and 18-21 youth. Our approach to the group arrangement proved to be advantageous to answering the questions and gathering varying perspectives regarding premature termination from treatment. Among the clinicians, several themes and hypothesis were developed which included clients being in denial, lack of motivation, problems with problem identification, and boredom. To take the focus group session further, we asked clinicians for suggestions that addressed how to prevent premature termination from treatment. Clinicians provided great insight regarding possible interventions. This process revealed the need to increase motivation for treatment as well as provide youth with different treatment options. When we ask how to prevent youth from leaving treatment during the focus group, the clinicians provided several insights from their perspectives:

> “I think we need to find a way to motivate the clients. They have so much going on and treatment doesn't seem as important for them compared to all the other issues going on.”

> “We need to find a way to turn these external motivators into internal motivators. A lot of our youth are sent here by their POs, parents, or others, and they don't necessarily see the importance of treatment.”

> “I wish we could implement or create something that is more interesting or engaging for our youth. For example, the female group really enjoys making collages as a way to address issues of self-esteem and body image. It has led to great conversations.”

> “We've used journaling time and that has been really telling with several issues. I think we could try this as an approach. This has worked even when my youth couldn't read or write well. It has provided a way for youth to communicate with me.”

During the process, we believed the inclusion of clinicians during this phase of the development

process was important for several reasons. Most of the clinicians were interacting directly with the youth and were able to speak to factors from their clinical intuition. More to the point, it was imperative to incorporate clinicians in the intervention development process to elicit and improve buy-in from those most likely to implement and champion the newly developed clinical intervention.

We decided to get input from groups of clients, drawing on focus group methods. As we conducted the focus groups, we found that the client groups provided a more practice-oriented and user-friendly aspect to the overall intervention. Within the 14-17 youth group, several important themes became relevant during the process such as boredom, over-saturation (hours per day and days per week), lack of problem identification, and lack of cultural relevance. These themes were conveyed by a large majority of the youth who were enrolled in the treatment program as well as the older 18-21 youth group. We found that the 14-17 youth group provided a variety of novel and creative solutions which were not previously thought about by the clinicians. Youth within the group made the following suggestions:

> "Can we do something fun? We are here for 3 hours a night, and always talking about drugs gets boring. I like when we can do different things."
>
> "We talk about drugs all the time, can we do something different? I get that this is a drug program, but drugs is not all that I do."
>
> "Let's use hip-hop."; "I like to draw, can we do something with that?"; "How about poetry?"

We were surprised by the level of engagement and interaction that clients were demonstrating during the focus groups. We were able to see their excitement and willingness to be a part of the process. When the youth were discussing the idea of using hip-hop in treatment, there was an overwhelming response from the group which was positive and seemed to increase the conversation. There were many ideas and discussions about how and what youth would like to do with using hip-hop. This overwhelming response to using hip-hop was interesting to us and became a focal point, as it showed great promise as an approach to increasing engagement among youth (Travis, 2013).

Similar to the 14-17 youth group, the 18-21 youth group provided information which offered insight from a slightly different perspective. The themes that emerged were similar in regards to boredom, lack of problem identification, over-saturation, and lack of cultural relevance. However, this group also discussed barriers to treatment such as seeking and maintaining employment. This perspective highlighted the need for age-appropriate treatment options which addressed various developmental perspectives. Given that a large majority of the older youth were either graduates or did not finish high school, having a focus on employment, vocational training, and/or higher education was appropriate. The 18-21 youth group demonstrated insight into the problem of premature termination, but also identified the ongoing need for treatment to provide age-appropriate skills-based interventions. Consistent with the 14-17 group, there was an overwhelming response which supported the use of music, more specifically hip-hop, as a

possible approach for intervention to engage youth in treatment. The focus on engagement has been established in the literature as a predictor of retention among a wide variety of clinical interventions and health related research (Dunne, Bishop, Avery, & Darcy, 2017).

One of the main goals of using this approach was to ensure continued collaboration and strengthen buy-in. With this in mind, we were purposeful in sharing responses from each group in a collective setting. We felt this was necessary to get clinicians and clients in the mindset of working together on the program development process. Through this collaborative process, both clinicians and youth were able to voice their concerns and possible solutions to the identified problem. Overall, through this process we were able to determine that because of factors such as boredom, lack of engagement, and lack of problem identification, youth were less likely to remain in treatment (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Furthermore, youth wanted something that was culturally sensitive (hip-hop was derived from the focus groups) and allowed for self-expression (Harper, Rhodes, Thomas, Leary, & Quinton, 2016).

Step 3: Understand the Literature and Feasibility

Following the focus group sessions, we engaged in an extensive literature review to gain a better understanding of the mechanisms available which can help guide the development process. Prior to going deep into the literature, we consulted with agency administration to better understand their thoughts regarding results from the focus group and "non-traditional" treatment approaches. This was a unique approach for this particular program development process, given the strong focus on hip-hop as suggested by the youth. While hip-hop has a strong cultural presence among urban youth, the literature reveal that not much has been developed which looked at using hip-hop in a clinical setting (Turner-Musa, Rhodes, Harper, & Quinton, 2009). Conversely, hip-hop has been used in several health promotion endeavors which include stroke literacy (Williams et al., 2015), and HIV/AIDS prevention (Hill, Hallmark, McNeese, Blue, & Ross, 2014).

We also found that the use of hip-hop as a group intervention was not a new idea; however, there was limited information of its use as an intervention in a clinical substance use disorder treatment setting (Turner-Musa et al., 2009). In previous clinical settings, hip-hop was used as a means to facilitate culturally relevant group work among clients (Levy, Emdin, & Adjapong, 2017). The premise for the use of hip-hop among this population was the significant amount of youth that are exposed to the messages within the hip-hop culture. As a result, the association between hip-hop and the African American youth culture has been well established (Harper et al., 2016).

Despite the lack of literature available which identified hip-hop as a treatment intervention for substance use disorders, we were able to find a significant amount of literature which discussed the use of alternative therapies such as art, music, and dance therapy, which are closely associated with the hip-hop cultural tenets (graffiti, hip-hop/rap music, and break dancing). There have been several studies using music to assist behavior change, such as decreasing aggression and anxiety (Gutiérrez, & Camarena, 2015; Hakvoort, Bogaerts, Thaut, & Spreen, 2015). Moreover, research has demonstrated that the use of music promoted healthy lifestyles

among substance users in a group setting by enhancing communication skills and group cohesion (Hwang, & Oh, 2013). The use of music as a clinical intervention has been associated with positive treatment outcomes. More to the point, the use of music has been shown to improve perspectives regarding a number of complex issues (Harper et al., 2016). Given this close relationship found in the literature, the use of hip-hop in substance use disorder treatment seemed feasible and adaptable within the current clinical setting.

Step 4: Focus Group—Topic Development

Following our extensive review of the literature, we conducted follow-up focus groups with all the youth to gain a better understanding of what they were looking for within their proposed hip-hop intervention. Overwhelmingly, the youth indicated that they wanted to incorporate music into the program. When we probed further, they elaborated that they would like to have opportunities to "freestyle," which is a form of rapping. Interestingly enough, there were also recommendations to incorporate drawing as part of the program. As we continued the focus group, we asked the youth to identify possible topics or themes that they wanted to address as part of the intervention. We placed youth into smaller work groups and asked them to record their suggested topics (in rank order) on paper for inclusion into the intervention. This approach continued the collaborative process with youth involvement, but also provided us with information to take back to the clinicians for further discussion into a clinical context for group work.

Upon completion of our focus group with the clients, we re-engaged the clinicians to ensure they were able to provide input into the identified topics proposed by the youth. During this phase, we worked closely with clinicians to review and discuss all of the lists and proposed topics in great detail. Following the final review with the clinicians, which included them rank-ordering topics in order of importance, we again brought the youth back into the process to engage with clinicians in a reconciliation process. Our process provided for collaborative discussion between the clinicians and youth, therefore also increasing engagement among the participating youth. A final set of topics were rank-ordered as agreed upon by the collaborative group (youth and clinicians) for inclusion into the proposed program.

- Substance use education (various types of drug and effects of use)
- Crime and violence (community violence)
- Dating and relationship issues (objectification of female, and health dating)
- Sexual Health Education (STI prevention and identification, safe sex practices)
- Relapse prevention and recovery skills
- Academic issues (dropout and misconceptions around fame, money, and usefulness of education)
- Financial responsibility (money management),
- Family functioning (fatherlessness, single parenting, poverty)
- Healthy Eating (specifically to urban environments)

Our collaborative focus group discussion was essential and provided a forum were youth were able to express the good and not so good things about the program. This level of feedback was

important for consumer satisfaction, clinical growth, and as a guide for program evaluation and changes. While we could have engaged in this process from a top-down approach in order to expedite the development and implementation process, buy-in from both the youth and clinical team was placed at a higher priority than speed of implementation. As the process evolved and through ongoing consultation with agency administration, we were able to fully understand the complex competing interest and the importance of prioritizing and then deciding on the best approach to address agency needs.

What Does It All Mean?—Understanding the Process

Understanding the process of program development can be tedious depending on the scope and aim of the actual intervention. For this particular intervention, our overall scope was to increase retention among youth in drug treatment. We set out to develop and test a client-centered intervention, specifically as an add-on intervention to determine the overall effectiveness on retention. Given the stated scope and aim of the intervention and the expressed desire of the board of directors, clinicians, and youth to improve retention, it was relatively easy for us to present the proposed program as developed by youth and clinicians to the board of directors for approval. As one of our overall goals, we did not want the creation of the intervention to disrupt normal agency functioning, nor did it take away from the existing treatment approach. For the approach we used, there was no anticipated down-side to the agency.

Using client-centered interventions was not a new concept to the field of behavioral health treatment. Our overall belief that clients could participate and provide a certain level of expertise to others experiencing similar situations arose from the following assumptions derived from Doughty and Tse, 2011, pg. 252:

1. Clients might better identify or understand the issues associated with mental illness and/or substance abuse if that information comes from their peers, who have unique contributions because of their experiences.
2. Clients might encourage participation of consumers in treatment services.
3. Clients might be able to facilitate change attitudes towards mental illness and/or substance use.

Moreover, our utilization of a client-centered approach has previously demonstrated increased positive outcomes within social work practice (Graham et al., 2014). For example, Young, Chinman, Forquer, Knight, Vogel, Miller, Rowe, and Mintz (2005) conducted a study to evaluate the effectiveness of an innovative, consumer-led intervention, which was designed to improve provider quality, empower mental health consumers, and promote mutual support. Findings from this study supported the consumer-led intervention, which increased provider education, teamwork, competency, and recovery orientation.

It is important to note that during this process, we engaged in and strongly encouraged ongoing consultation with agency administration. We found that, unless you have independent decision-making capacity, it was not advisable to get to this point of the process without incorporating and getting feedback from key stakeholders. Failure to get feedback and

consultation could lead to delays in implementation or an overall decision not to proceed with the intervention. This could have adverse consequences such as anger and frustration on the youth participating in the intervention development process. While this may seem counter-intuitive to a client-centered approach, there was an ongoing need and requirement to work within the context of the agency to ensure compliance with all federal, state, and local regulations as well as agency policy and procedures.

Step 5: Formalize the Intervention and Determine Buy-in

Our use of collaborative focus groups provided valuable feedback for clinicians and youth regarding the overall feasibility of including the proposed topics in the intervention. This feedback was important to the formalization process which initially occurs within the context of the clinical team. During this process, the selected topics were translated into standard clinical language. This was the point where we incorporated the literature to guide the development of the intervention and, when applicable, discussed possible theoretical perspectives for inclusion.

For the proposed hip-hop intervention we found that there were several aspects which were discussed in the literature that clinicians wanted to incorporate as a result of the collaborative focus groups. As previously mentioned, the participating youth emphasized the importance of music being part of the intervention. While this appeared to be a simple request, we used a purposeful and strategic process to ensure that appropriate music was selected and agreed on by the focus groups. Youth were asked to recommend various songs and artists to include in the hip-hop intervention. They were made aware that the recommended songs would be screened by the clinical team for overall appropriateness. The music selection process was conducted using a four-point rating system which was completed by three clinicians familiar with hip-hop. The purpose of the rating system was to group the music based on the type of message it conveyed (negative, positive pro-social, and undecided). All the music selected for the intervention was the edited clean version, given the age group of the youth.

Another important aspect of the intervention that was requested by the youth was the ability to "freestyle" as part of the intervention. The clinical team agreed that the use of "freestyling" could be used as a therapeutic process and could convey clinically relevant messages which may not otherwise be discussed among this population. As a result, the clinical team expanded the development to include poetry and the addition of journaling. The journaling aspect of the intervention was two-fold: it gave the youth an opportunity to have a tangible record of their lyrics or poems, and it offered the youth a private way to communicate with their clinician if needed (Miller, 2014). For youth who were unable to "freestyle" either through rapping or poetry, an art therapy component was added as an alternate form of hip-hop expression, namely graffiti (Goicoechea, Wagner, Yahalom, & Medina, 2014). The focus groups conducted during the development phase allowed us to discuss the benefits of using art therapy and other alternative forms of communication with this population, given the complex clinical issues such as poverty, crime and violence, drug trafficking, poor academic achievement, mental health issues, as well as substance use (Meyerson & Grant, 2014).

The intervention formalization process was not a quick task for us to complete. This required

several reviews and revisions among several stakeholders (youth, clinicians, clinical director, administer/board of directors). Our purpose for the review process was to provide stakeholders with ample opportunity to critique and provide constructive criticism about the proposed intervention. Additionally, this was a time when the program development team could provide additional information to ensure understanding and "buy-in" from stakeholders. Once all the recommended revisions and critiques were resolved, the intervention was ready to be finalized.

Step 6: Present Final Intervention

The final presentation of the intervention was the completed version as approved by the involved stakeholders. As a part of our process, the final intervention presentation was not a surprise to anyone involved, given the collaborative client-centered approach we used. We felt the final presentation was essential to the success of the intervention. This was where having clinician and youth "buy-in" during the development phase came into play. While the clinicians were presenting the hip-hop intervention, the youth who participated in the development process served as champions and promoted interest in the intervention among their peers.

More to the point, our final presentation phase included a presentation to the administration/board of directors. Our approach used members from the clinical team and selected youth participants to walk through the intervention during the presentation. This demonstrated a strong showing of the collaborative efforts between clinicians and youth, which built credibility towards the implementation of the intervention. It was important to discuss the scope and purpose for the developed intervention as well as the detailed process of the client-centered approach utilized.

Example of the Group Approach—Hip-Hop Therapy: The Flow Project

This clinical intervention was designed for an 8-week, 1.5 hour group-based curriculum which incorporated the above mentioned approach. Each week a new topic theme was presented which allowed for a continuous open-group approach consistent with substance use disorder treatment settings. During the week, youth were provided with 15 minutes each day to journal, which included writing or drawing about issues of the day. Our process for implementation is described below.

Session 1: What's real?

Clinician Role: Present youth with hip-hop songs related to topic for the week
Youth Role: The youth engage in a discussion which identifies what is real or fake as presented within the music.
Therapeutic approach: Problem identification, narrative feedback, stage or change assessment, cognitive restructuring
Related Homework: Identify songs which present pro-social messages related to current theme

Session 2: Identification and discussion of pro-social messages. This session incorporates discussion of songs that youth-identified from their homework.

Clinician Role: Counselor will facilitate group discussion regarding prosocial messages within youth identified songs. It is important that counselor has access to internet-based services in order to gain immediate access to the music for group discussion.
Youth Role: Youth will participate in ongoing discussion identifying their reasoning and justification for song selection. The student will make a connection with the week's current theme.
Therapeutic approach: Cognitive restructuring
Related Homework: Create a demonstration of a positive message using hip-hop medium (freestyling, poetry, artwork, etc.)

Session 3: Presentation and discussion of hip-hop expression- this session allows for youth to perform or display their use of hip-hop to convey their understanding of prosocial messages related to the weekly topic.

Clinician Role: Facilitate discussion regarding youth expression using hip-hop therapy
Youth Role: Present and discuss their own interpretation of prosocial messages conveyed through hip-hop medium.
Therapeutic approach: Narrative art therapy, expressive therapy
Related Homework: Write in journal over the weekend and bring back the following week

Example of Hip-Hop Expression

Below was an example of the level of collaborative work used between the clinical team and youth participants. This use of hip-hop music itself was used by the clinical director as an ice-breaker for the youth. The purpose was to show youth that anyone, regardless of skill level, could create a narrative expression based on current experiences.

Visions of You

Our youth are slowly dying and about to blow it,
Visions of potential dreams gone and they don't even know it,
you see the street life is seductive and will draw you in,
only to find out later, it really wasn't your friend.

The media shows our youth as violent and thugs,
And gives false narratives such as they won't amount to much because of fatherlessness and drugs,
But see, that's such a slanted one-sided view,
Come and walk with me, there's so much more I can show you.

See what I see through the eyes of our youth,
Stop for a moment and hear their truth,

they have hopes, dreams, and future aspirations,
Much bigger that winding up in a run-down police station.

You see, they dream of being doctors, lawyers, and maybe even the president,
But the environment they live in has them living their life like a resident,
Gun shots, police violence, and drug deals galore,
I can definitely understand how it's hard to want for more,

Survival of the fittest is the code of the street,
And it's really hard to trust anyone new that you meet,
But I am here for you to help you cope,
And show you there's much more than gangs and dope.

Let me help show you what this all means,
And show you a life that is sober and clean,
Achieve the highest heights of your given potential,
Help you win this game by using your mentals.

And when the day is over and all is said and done,
My hope is that you can shout it from the highest peak, that you've played the game and won.
Written by Streetz (Clinical Director)

Step 7: Pilot Test for Effectiveness.

Upon our completion and acceptance of the developed hip-hop intervention by all stakeholders, the intervention needed to be tested for effectiveness. The pilot test for the effectiveness phase was developed based on the desired outcome of retention, which was established early during the collaborative approach. For the agency in this case study, the target outcome was a reduction in premature termination from substance use disorder treatment. This was a highly accessible outcome and could be measured in days or weeks, or by completion status. This measure was dependent on the agency's quality assurance/improvement metrics and their ability to capture the necessary data.

To test the effectiveness of this newly developed intervention, we used a straight forward approach. Given the identified problem, we already had access to an established baseline regarding the percentage of youth who prematurely discharge from treatment. Therefore we decided to use control versus experimental group design. Using this approach, we assigned youth to either the treatment-as-usual group or the treatment-as-usual + hip-hop intervention group. We were able to provide the administration and the clinical team with the ability to assess the effectiveness of the hip-hop intervention on improving retention among youth.

As an example of the effectiveness of the intervention, preliminary results from the wave 1 focus group, which occurred 4-weeks following the implementation, were summarized by themes. We determined this to be an appropriate time period where youth were able to get an introduction into the hip-hop intervention, and clinicians had begun utilizing it as an add-on treatment.

Noteworthy themes that emerged from our focus group were described: excitement about treatment, treatment is fun, understanding of drug use, problem recognition (external), issues with community violence, and better understanding of safe sex.

Revise and Re-test as Needed

As an important note, we developed this intervention with the understanding that revisions and re-testing of the intervention would be ongoing processes during the development period. It was important for us to continue to meet with the clinical team and the youth to elicit subjective feedback regarding the intervention. Additionally, ongoing quantitative metrics were continuously used to assess the effectiveness of the intervention on the target outcome of retention. If additional changes were needed, we continued program evaluation using the client-centered process to determine what would be most beneficial and enhance the intervention.

Clinician Feedback about Hip-Hop Intervention

After spending a year studying hip-hop therapy, I have come to realize its benefits in treatment. This approach allows clinicians to get back to the basics by starting where the client is. Clinicians work on appreciating the context: the roles of both music and culture in the lives of the clients whomthey serve. The purpose is to give our clients a voice through hip-hop. It allows them to express themselves in a creative way. This type of treatment gives clients an opportunity to feel heard, allows them ownership of their feelings, and keeps them empowered, and helps draw awareness to their lived experiences.

Many skeptics view hip-hop as violent, drug promoting, misogynistic, or sexually offensive. With the right guidance, clients can use hip-hop as an outlet. In addition this approach helps clients explore and appreciate rap's positive attributes, which have a history in the black community. This form of therapy offers a way for clients to communicate in an unconventional way. As clients deal with their day-to-day lives and issues, they find catharsis in freestyling, writings, and drawings.

Because of these benefits, we have started a hip-hop recovery group. The group consists of 10 adolescents, three female, and seven males. Participants' ages range from 15 to 19. Clients have stated that they enjoy the group. They stated that they were able to explain their experiences to their counselor and felt like they were understood. Hip-hop therapy is a great tool for clinicians to use, not only to build rapport but to give their clients a voice" **Clinician 1**.

Conclusion and Implication to Social Work Practice

During the initial phase of our work, we learned some important lessons which guided how we operated within this agency. As part of the overall process, it was important to reflect on these lessons as crucial to the program's development approach. Additionally, if used as a guide, the lessons learned could inform future program development within agency settings.

> Lesson 1: Interest and desire did not always equal support. We found that even though the administration expressed a need and interest for creative interventions, we were met with multiple cancelled meetings, "busy" schedules, and overall skepticism prior to even starting our work.
>
> Lesson 2: Divide and then conquer. When we first attempted to get buy-in, having large groups of stakeholders created opportunities for conflict and group-think. We had some individuals who were "stuck in their ways" and tried to get people to "side" with them. We also had people for and against the possible changes to the clinical program. We decided early on that we would have to separate stakeholders into smaller, more manageable groups.
>
> Lesson 3: Understand the social network of the agency. We had to identify those with influence within the agency. Sometimes it was not necessarily those in leadership positions. We found it easier to get buy-in from stakeholders if we had buy-in with the agency influencers.

The importance of utilizing a client-centered, bottom-up approach to ensure that the voices of those most likely to be affected by the intervention are heard should be further discussed in the program development literature (Doughty, & Tse, 2011). This approach is imperative for incorporation into social work administration practices as well as effective client-centered interventions. While the top-down approach is widely used and accepted by most social work organizations, there is a need to get back to empowering clients to engage in their treatment process (Freeman, 2013). Utilizing this approach was successful for the given case scenario for increasing retention among urban African American youth in substance use disorder treatment. It is imperative that social work practitioners and clinical directors advocate for the use of this approach when engaging in clinical program development.

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Uniting Macro and Micro Practice Enhances Diversity Training

Millicent Jeanette Carvalho-Grevious and Tawana Ford Sabbath

Abstract: Social workers with two different practice orientations developed a diversity training format that draws upon the major components of each approach. Using cultural-relational critical thinking theory as a foundation, the team engaged participants at two different types of settings to learn about racial and class microaggressions and micro-inequities. The goal of the training and workshop was to have participants assume responsibility in identifying and advocating against such oppressive behaviors.

Keywords: microaggressions, micro-inequities, cultural-relational, critical thinking, shame, cognitive dissonance, White privilege, equality and equity, diversity and inclusion

The year 2015 marked the coming together of two African American social work practitioners with different perspectives on the field. Dr. XYZ is a macro-practitioner, with years of experience as a trained mediator and organizational analyst. Dr. ABC is a micro-practitioner with family therapy systems training and years of clinical practice. We combined forces to enhance professional development for social workers to address race and class inequities in work and social environments with special attention to microaggressions. Our collaboration is a combination of systems assessment and individual experiences. The result is an approach that makes the discussion of such potent and uncomfortable topics as race and class possible for small and large groups.

Our goal is simply to facilitate respect and appreciation for diversity and to build multicultural competency. We aim to increase the desire for cross-cultural connections by providing safe opportunities for participants to reflect upon their own cross-cultural experiences, while valuing different perspectives and differing points of view. Disconnections in interpersonal and group relations fuel oppression. Positive connections over time push up against racism and oppressive ideology, thereby supporting the building and sustaining of diverse and inclusive communities.

By implementing interactive diversity training, as part of professional development, we can expose hierarchical and lateral microaggressions and offer a dialogic response for transforming diversity conflict. Thus, we facilitate not only diversity at all levels, but also bring all perspectives into the discussion while identifying a plan of healing and reconciliation. We want participants to commit to identifying what they can do to make a difference. Our purpose in working with groups is not to engage the individuals in a cathartic experience from which they leave feeling vindicated and having done the necessary work. Ours is a transformational work that requires each person to take on the role of a leader responsible for addressing microaggressions.

Aim of Diversity Training

Aim #1: Increase awareness and recognition of microaggressions in social work practice situations of one's own unconscious biases, and of the impact of those on practitioners and service to client populations

> Aim # 2: Enhance appreciation of the difference between equality and equity and the impact on opportunity and access
>
> Aim # 3: Manage shame and cognitive dissonance that result when new information conflicts with existing beliefs or values by increasing critical thinking skills
>
> Aim # 4: Manage expectations and negative experiences with past training that may discourage participants from fully engaging

Defining Microaggressions

Why is raising consciousness of racial and class microaggressions training important in social work? As we consider the question of microaggressions, we must appreciate that they are the tool of oppression and they limit opportunity for equity and fairness by portraying and relating to another person as “less than.” Microaggression is a term first identified by psychiatrist Charles M. Pierce, a former Harvard University professor and researcher in the 1970s. Microaggressions are everyday occurrences. They are defined as brief, subtle, and often not entirely understood behaviors, slights and indignities that convey that an individual or group is lacking or unworthy. Microaggressions can also be expressed as bias and stereotypes enacted both consciously and unconsciously by a group with perceived higher status over a group with perceived lower status, known as hierarchical microaggressions (Young, Anderson. & Stewart, 2015).

We tend to think of microaggressions in the context of a hierarchical and power differential, where one group (the in group) has greater power, authority, and privileges over another group (the outgroup). In the United States this gets expressed as Whites with privilege over Blacks, who are oppressed. Ross (2014, p. 24) explains, “we usually see people in the context of the ideas we have developed about 'those kinds of people.'” That kind of bias can lead to paranoia and the need to be on guard for an attack on one's character and abilities. This is the problem that many Blacks confront daily. Dr. ABC shares the following from when she was a graduate student:

> When I was a master’s-level social work student, I was one of ten African American students, the largest number in the history of that program, entering the first semester of study in Fall 1969. As you might imagine, we often found ourselves as the only student of color in a course of 15 to 20 students. As we were studying Montalvo, Guerney, Rosman, Schumer & Minuchin's (1967) *Families of the Slums: An Exploration of their Structure and Treatment* in our first-year practice class, I was asked by a fellow student what it was like living in the projects. Since that had not been part of my experience, I assured her that I could not speak to it. The subject was dropped without the instructor taking advantage of a teachable moment to explore the assumptions inherent in the question and to challenge all students about prejudging situations. That microaggression caused me, from that point on, to be on guard for the expectation of my white classmates to assume things about my background or their expection that I should represent my people.

Hierarchical microaggressions can also negatively affect access to opportunities. They can

hinder work relationships that would otherwise provide mentoring and other supportive opportunities. They undermine leadership and can negatively affect worker performance, while chipping away at organizational effectiveness. Young et. al (2015) point out that roles have an impact on why organizations may tolerate microaggression. In higher education, one's status and rank impact privileges and authority. For example, students have less authority than faculty, and staff generally have less authority than faculty, especially tenured faculty. Yet Black faculty and faculty of color often have problems being perceived as authoritative and knowledgeable by White students and White colleagues. When a person is in an adjunct or instructor role, this problem can be even more apparent. This was Dr. XYZ's dilemma as an adjunct instructor teaching a required graduate social work course on multicultural competency to a class of mostly White students.

> During the first class after students had an opportunity to introduce themselves, I asked them to briefly share their previous experiences with racism. I was hoping to hear situations they experienced directly or knew from someone they interacted with who was treated negatively because of their skin color or race. Perhaps they had a reaction to one of the readings on racism or a reaction to something they read outside of class or saw on television or social media. To my surprise, students opined that they wanted to give me, their Black instructor, an opportunity to share. They wanted to show me compassion and give me time to share my story. However, it felt like subtle disrespect. I remember thinking: How did I become the subject of their experiences with racism? Were they expecting this class to be about me and my experience with racism? Not feeling particularly oppressed that day, I turned the situation around and asked them to share their experiences with white privilege. That didn't go over very well.

In the scenario described above, students expected to examine racism from a "white privilege" perspective of compassion, notwithstanding the instructor could not share in white privilege as an African-American woman. White privilege permitted well-intentioned students to challenge the authority of the instructor and, at the same, de-value the instructor's knowledge while relating to the instructor as an oppressed person. Asking students to examine their experiences of being white could have opened the door to a wonderful learning opportunity, which highlights their own concerns, assumptions, and misconceptions about their own experiences. Unfortunately, individuals often attack when they feel uncomfortable.

> I used the situation to engage students in a dialogic process to better understand what just happened—to be transparent about the emotions behind their reactions and my response.

Suspending judgment opens the door to critically thinking about different points of view, assumptions, biases, worldviews, and the decisions we make. A lesson learned is to first recognize and acknowledge the multiple identities that students and the instructor may have. Some social identities may be visible, while others may be hidden. An open discussion that acknowledges the experiences of individual students helps to keep everyone engaged. Students learn how we may have different experiences, yet share similar concerns about racism and oppression. This not only effectively manages students' expectations, but lays the groundwork for making positive connections.

Takeaway: A discussion of racism should appreciate, respect and value the experiences of individuals who have experienced discrimination because of sexual identity, gender, ethnicity, nationality, age, or ability. However, participants should be guided to recognize their own personal bias and broaden their understanding of racism and discrimination from different perspectives.

A final consideration in identifying microaggressions is connected to professional status and client advocacy. Social workers should be trained to be keenly aware of how racial and class microaggressions may be experienced by the communities we serve and members of our profession on at least two levels. A dilemma faced by social workers that results in a type of double whammy is the fact that they must often confront oppression in their professional roles while also looking out for negative factors confronting the communities served. In child welfare, frontline practice, for example, social workers generally have less authority to mandate outcomes than attorney advocates, judges, psychologists, and physicians.

An example of the resulting oppression is how social workers are increasingly expected to cope with the cross pressures of advocating for children and their families, while navigating organizational microaggressions that significantly limit their effectiveness. For racial minorities and women, especially, these microaggressions can escalate into racial and gender micro-inequalities, which over time have a cumulative effect. Rowe (1990) posits that micro-inequities limit opportunities for professional development and advancement, and can lead workers to lose confidence and focus. Unfortunately, micro-inequities are often overlooked because they operate below the compliance radar of organizational Equal Employment Opportunity mandates.

Considering that reality, we offer a safe space for social work professionals to focus solely on taking care of themselves. Our training exposes these hierarchical and lateral microaggressions and micro-inequities by employing a relational-cultural framework and critical thinking to guide participants in a process of self-reflection, assessment, and reevaluation. This process facilitates an awareness of one's own experiences and perspectives in response to microaggressions.

Beginning Where Participants Are

Social workers come to the training experience with their own worldviews (e.g., beliefs, values, and experiences) and different ways of knowing. High engagement creates a learning environment where participants are open to information that challenges their held beliefs and assumptions in ways that promote learning. Engagement supports connections. Whereas Miller and Stiver (1998) argued that the desire for more connections is not only how relationships are formed but offers the opportunity for healing connections, especially for women.

Sue (2015) argues that people shut down, withdraw, avoid, and deflect to draw attention from their own implicit acts of subtle oppression. In diversity training situations, deflective actions often take the form of blaming the instructor to avoid engaging and confronting racism and classism. Some diversity training, to encourage inclusion, tries to make everyone comfortable by avoiding hot topics, with little attention to building connections among participants.

Unfortunately, such accommodations often result in placing those who experience disparate treatment in the uncomfortable position of having to convince members of the “privileged” group of the importance of identifying racial and class microaggressions and micro-inequities that are the “norm.” In those instances, culture and identity are held onto at the expense of another person.

What can facilitators/trainers do to engage participants in discovery about their own assumptions and interpretations, as they experience diversity training? Our approach is to engage participants within the first fifteen minutes of training to develop connections among participants and us. In addition, we facilitate a shared emotion with which everyone can relate before beginning training to lay the foundation for our learning community's connecting with each other. We model and nurture the necessity to stay connected throughout the training. Making connections is what allows us as diversity trainers to take a deep dive with participants into complex and difficult discussions on race and microaggressions with ease.

We have found, also, that too often in discussions about racial and class microaggressions and micro-inequities, the terms equality and equity are used interchangeably. However, the terms are quite different in meaning and application. Clarification of the differences is necessary, since such usage does not fit the experience of those who confront disparate treatment. Equality is defined as freedom from discrimination according to the Equal Employment Opportunity Commission (https://www.eeoc.gov). Historically, gains in equality have not resulted in access to opportunities and full inclusion. Clarification of the difference is needed since “equality” does not always reflect the experiences of African Americans. Structural barriers can remain intact when equality is the goal, whereas equity requires an assessment of the barriers and action to remove them.

> Regarding an experience she had at the age of eleven, Dr. ABC stated:
> *I was exposed to the most horrific experience of my life. I was told that the school I attended would be closed because the county in which I was living at the time refused to integrate. The “separate but equal” legal orientation of our country was being challenged because the schools for Black students in Prince Edward County, Virginia, while separate were nowhere near equal to those attended by Whites. The county became part of the landmark Brown v. Board of Education case; however, the public schools remained closed for five years while public monies were directed to private schools for White students. The purpose of that lawsuit was for equity and not just equality.*

We made the decision as trainers to incorporate the African American experience because much of the anti-racism work in North American society is to get Whites to listen to African-American voices to effect social change. However, White participants often have difficulty participating in discussions that confront bias, bigotry, and racism. Fear and shame can limit candid sharing of experiences. Roy (2002) explains the problem this way: These discussions are “surrounded by thick institutional forces that, often unintentionally, define the universe as white and discourage diverse participation” (p. 1). As trainers, we offer a safe space for all participants, where individuals can focus on taking care of themselves, e.g., share their experiences with oppression respectfully, without the pressure or need to counsel others.

The training that we have developed exposes the microaggressions that African Americans confront from racism, which is not to negate similar experiences of others. Because skin color is the most immediate differentiator of inclusion/exclusion globally, hierarchical, and lateral microaggressions and micro-inequities experienced by the African American can shed light on experiences shared by other groups. Managing affective, cognitive, and behavioral reactions is an important part of facilitating diversity training and should not be overlooked. Rowe (1990) warns that people of color are perceived differently, and subtle discrimination and subtle negative messages that people of color receive can have a cumulative negative effect. Left unchecked, these problems can cause disconnection and make the training environment caustic and potentially dangerous.

We believe that all participants have their own unique story to tell, and it is the telling of the story that creates the connections that are necessary for the work to occur. The challenge is to maintain that connection during the training. Employing a relational-cultural framework (Miller et al., 1998) supports a process of self-reflection and reevaluation that, as we have found, facilitates an awareness of each participant's own experiences and perspectives in response to microaggression, and lays the foundation for participants to effect change outside of the training. Every training is different; however, it is necessary to facilitate the feeling of connectedness among participants and between the participants and trainer(s) within the first 15 minutes of the training.

What Participants Gain

Participants tell us that they value the opportunity to share their experiences without having to defend or justify their perspective. They learned the value of sharing their truth and building the courage needed to stand up for that which they care. They wanted to detect personal bias and incivility and challenge assumptions. There was evidence of some change in approaching the identification of microaggressions, while holding onto a non-confrontational mode. Finding their voices encouraged them to speak out and risk participating in difficult conversations about racism and classism. Participants shared:

> "I need to challenge my assumptions, conduct research, and lean into discomfort."
>
> "Be honest about feelings and acknowledge my power to change."
>
> "When I realize I made a mistake [microaggressions], I will apologize to the other person and listen to others' experiences and what I could do differently."
>
> "'I am going to ignore the ignorant,' as my grandmother said. I want to keep doing my best to be my best."

Our Work

During a college presentation titled "Killing Me Softly: Raising Campus Consciousness of

Racial and Class Microaggressions," we engaged diverse members of the campus community in a 6-hour diversity training and dialogue. We began by introducing them to a relational-cultural framework for building community that integrates race, socioeconomic diversity and inclusion with critical thinking, equity, and civility perspectives. The purpose was to facilitate a deeper understanding of that diverse community's need for awareness, appreciation, and connections (nurturing relationships). Since culture impacts relationships, we employed Paul and Elder's (2012) critical thinking model to enhance critical thinking about diversity and promote positive connections and equity (fairness) within the campus community. We aimed to promote change by detecting and reducing microaggressions that lead to chronic disconnection within the campus. A relational-cultural approach to diversity and inclusion involves a four-step process:

Step #1	Checking implicit personal bias and incivility
Step #2	Thinking critically about difference
Step #3	Understanding the diversity culture
Step #4	Repairing relationships damaged by diversity tension

In the second half of the training, we facilitated a diversity dialogic process for actively listening, especially when diversity tensions are high. Participants were divided into small groups with dialogue facilitators. Through guided discussion and the application of the ethic of discourse (e.g., sincerity, openness, respect), we guided and modeled non-judgmental listening—without giving advice or attempting to question the motive behind the perspectives shared.

We also worked with a group of African American social workers where we conducted a two-hour workshop titled "Microaggressions and Micro-inequities in Social Work Practice." This training exposed the types of hierarchical and lateral microaggressions (devaluing) and micro-inequities that African American social workers often confront within their professional roles. Participants freely shared about the tension between advocating for consumers in systems of service that consistently deny them fair treatment while needing to protect themselves from the same system that can deny them equitable treatment and professional advancement. The workshop afforded participants the opportunity to experience a powerful dialogic tool for addressing microaggressions when equity is sought. Take-aways included the importance of self-care and finding mentors to support and nurture their professional development. They learned strategies for navigating hierarchical microaggressions, so as not to expend energy unnecessarily convincing others of the legitimacy of their experiences with oppression. Considering recent events covered in the media regarding race and the criminal justice system, we offered participants a critical analysis of what happened, while engaging participants in a collective sharing and understanding of oppression, power, and culture.

Conclusion and Recommendations

We affirmed the value of combining micro and macro social work practice in our approach to diversity training. Together we addressed both structural oppression and personal implicit bias. The joining of our micro-macro perspectives was needed to guide participants through a very challenging process. Without diminishing the significance of experience with racial and class

microaggressions and micro-inequities, we effectively helped participants to stay in the moment to encourage growth as opposed to revisiting old wounds. Diversity trainers have an obligation to limit the potential for harm to participants, especially when training is a requirement for continued employment or professional development. Diversity work necessitates a good degree of transparency on the part of participants. Trainers must establish trust at all levels, that is, trust in the trainer's ability to facilitate difficult conversations and trust in the dialogue process. Our collective experience ensured that we could successfully meet the participants at their point of need and leave them with a desire for more.

Diversity education and training must be more than an academic pursuit. A necessary component is one that builds capacity to learn new information, especially when it challenges held beliefs and values. Engaging students and professionals in a process that starts them on an ongoing learning track will be most beneficial. Our approach seeks to sustain interest on the part of participants in confronting microaggressions and micro-inequities relative to race and class. This approach should be included in new-worker orientation as well as ongoing professional development. Our hope is to have macro and micro practitioners recognize and value that each perspective lends to interventions that holistically and strategically address the problems of exclusion and inequities.

The next level of training must not only expose participants to the reality of microaggressions, especially, but also to strategies for managing them. The perpetrators must be held accountable for their thinking that allows them to voice and act out oppressively, while the targets learn how to address the microaggressions head on, thereby not absorbing the pain and shame. Further work is needed to make sure the result is equitable treatment by all parties.

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Reflections on the Impact of Privilege, Marginalization, and Story on My Social Work Practice, Research, and Pedagogy

Mary Elizabeth Tinucci

Abstract: Through this personal narrative, I reflect on pivotal personal, educational, and professional experiences to understand their influence on who I am and who I am becoming as a social work educator. I describe growing up in a context of privilege and, later, coming to experience marginalization in my adulthood. I recount my path to teaching, my motivations, and the outcomes of my pursuit of a doctorate in social work (DSW). I investigate the place of privilege, marginalization, story, and witness in my development as a social worker and social work educator. I articulate how these ideas matter to teaching and learning, to the classroom environment, and to my evolving pedagogy.

Keywords: personal narrative, privilege, marginalization, story, teaching, social work educator, teaching philosophy, pedagogy

Making Sense of Mysteries

I wanted to be grown
up late with them
but the youngest are sent
up and away, banished.

Disjointed stories of adult lives bubble up stairway banisters
and conversations are muffled under ice clinking drinks
while truths and children
drift further and further away.

Desperation fills my lungs
I grasp at air to catch my breath,
to catch up, but I choke
on the thick smoke of their silence.

As an adult I rise up
heavy with the soot of their secrets
still wanting the mysteries of them
to dissolve.

My growing up was a smooth ride in a homogenous world and marked by imperceptible difference. In a small Midwestern town, although only 15 miles from a larger city, I couldn't have been further away from the diversity of people living so nearby. Steeped in a childhood of privilege—white, middle/upper middle class, able-bodied—I had everything I needed and more. It wouldn't be until college that I would begin to understand the realities and impact of unearned privilege described by McIntosh (1988) in her seminal essay on the subject. I am the youngest of seven children—five boys, two girls—and was raised by parents who owned their own business.

By the time I came along, I was a clear beneficiary of their success and enjoyed the sense of pride and experience of belonging that came with this large Italian/Irish Catholic family. We enjoyed annual family winter vacations to Florida, summers at the lake, and always had something or someone to celebrate with dinner parties and presents. My parents paid for my college education, my first car, and everything in between. All that the world held for me unfolded easily; nothing stood in the way of my dreams.

In addition to growing up in privilege, I also grew up in a family of silence and in a religious and cultural context in which my own not-yet-understood differences would soon become problematic and become my secret.

> *It is 1976 and I'm ten years old. My brother has taken me to a local community festival and I am excited to use a ticket to meet with a real fortuneteller. The fortuneteller takes my hand to read my palm. I'm listening to her forecast my future, "You will grow up to fall in love and marry a beautiful woman." She is saying more, but I am too upset to hear it. So embarrassed and trying diligently not to cry, I slink out of the fortune teller's tent in tears for being mistaken (again), I assumed, for a boy.*

As a child, I spent summer days riding my bike around town, playing football with the neighborhood boys, going fishing with my brothers, climbing oak trees to the top, driving go-carts and playing in tree-houses built by my brothers, catching frogs, and being regularly mistaken for a boy. I was a tomboy. I didn't fit the gender expression and role expectations of the world, and especially, of my mother. I heard constant messages about what was lady-like, what clothes were acceptable for a girl, and how to fix my hair appropriately. There was an undercurrent to the messages about gender expression, of course. But I knew not to ask. This was the one way in which I experienced "difference" and the world's response to it. Years later, I would wonder if I had met a real fortune teller.

If I were to create a visual depiction of my family (McGoldrick, 2011), it would reveal several generational cutoffs, each set within a sea of silence. In the two generations before me, a man who was my grandfather and a woman who was my aunt disappeared into their own lives far away. No explanation. No story. Don't ask. And later, don't tell. My grandfather left his family when his oldest child, my mother, was seven. My aunt, my mother's sister, left her small town in 1959 in her mid-20s and never looked back, never returned. Throughout my childhood, their disappearances were mysteries to me. The reasons for their departures, their stories, were clearly off limits. I remember finding photos and asking my dad, "Who is this?" He would respond quietly, "That's your Grandpa," or "That's your mom's sister, but don't ask mom about them." I didn't ask, "Why did they leave? Where did they go?" It was clear from his responses that I was not to know about these ghosts. I was profoundly affected by this silencing of their stories, especially as I began to understand, more clearly, my own.

In elementary school, being a tomboy was relatively innocuous, and almost functional, but by middle school the rules changed. At age 13 and in the seventh grade, I was not like the other girls. I did not belong to the new club that seemed to be forming, where an interest in boys, make-up, and looking a particular feminine way were all parts of the secret password, the ticket

for admission to this new club. I felt my place and sense of belonging in the world shifting, but beyond feeling different from others, I could not find words to name it. By high school, this feeling of being different, somehow, only grew more intense. I had no words yet to understand the underlying heterosexism and homophobia saturating the culture. I just knew that, "One of these things is not like the other, and it is me."

As I entered high school, the evolving cultural conversation was about something called AIDS.

> *It is 1981 and I am in 10th grade. As I walk into my second-hour Spanish class, I overhear two classmates talking, "Did you see the new choir teacher? What a fag! He better stay away from me!" I freeze. They are still talking and laughing, but I am too nervous to hear much more. What if others find out that my difference is like that of the new choir teacher? Students are ruthless. Suddenly, difference is dangerous.*

Simmering gossip, conversations, and words like "gay," "fag," and "AIDS" became part of my school day. It was an isolating time, and again, I found myself further swallowed in silence for the secret that was mine. At home, I remember reading something in the Catholic newspaper to which my parents subscribed. In reference to gay people and concerns about AIDS, it referred to the nature of gay people as "intrinsically disordered." Again, I knew not to ask. All the while, privilege was a silent partner in my life and I was blind to it. It was invisible to me. I didn't have words to name aspects of my difference rooted in gender and sexuality. Living in such a homogeneous small town, I didn't have much exposure to difference and I didn't have opportunities to think about how class privilege, white privilege, sexual orientation, marginalization, oppression, or intersectionality (Crenshaw, 1991) held any meaning for me.

In my Catholic upbringing, my parents conveyed one of their deeply held values, "You must always care about those who are less fortunate than you." This didn't seem an unreasonable or challenging idea. To do my part, each Sunday morning at 8 o'clock mass, I proudly put my envelope into the collection plate. As a senior in high school, I initiated a food drive to benefit a local social service agency for a National Honor Society project requirement. I organized a week of events focused on educating others about hunger in our community. My high school was located in a newly developing suburb of relative wealth, and I thought we could generate a substantial amount of donations. I welcomed a speaker from my church, who gave a lecture on the issue of hunger in the United States, and the director of a local food drive to bring to life the needs in and near our own community and to educate students about how we might make a difference on this issue. I was horrified by the statistics and upset by the reality that people living so near our school might be hungry. I was equally horrified and upset that an overwhelming number of my peers seemed indifferent. Try as I might, I couldn't seem to engage them in my food shelf idea. Although it was not a complete failure, only a small amount of food was collected for the drive. I was left disappointed and angry, but more importantly, I was beginning to wake up to the ideas and experiences of privilege and class.

Waking Up and Coming Out: Story as Survival

As the public discourse about gays and lesbians in the early- and mid-1980s increased, it was

most frequently and directly linked to the health crisis of AIDS. All negative. Fear. Whispers. Secrets. In 1984 the silence in the broader culture regarding gays and lesbians was deafening, and it troubled me.

> *It is 1984 and I am 18 years old. I have arrived at a Catholic women's college for my freshman year of college. I am studying music on a voice scholarship, singing a lot, and enjoying our renowned choral director. But oddly, by the start of the second semester, and without fanfare or a word, he was gone. A new choir director took his place, but no one offered an explanation. Quickly rumored, and much later confirmed, his departure was due to illness. AIDS.*

Here was the pattern again, secrets and silence, exemplified in the disappearance of this choral director from the college. New place. Same rules. By the time I arrived at college, I arrived with my own secret, with fear, and with a word to name my earlier feelings of difference. Lesbian. I was terrified someone would find out. I did not have the courage to enter into the conversation with anyone about understanding my lesbian identity. The primary context I had to understand myself was limited. Privilege. Catholicism. Secrets. I don't remember how, but somehow I found my way to the counseling center on campus. I spent two years grappling in the privacy of my own head about being a lesbian. My desperate internal mantra was, “This cannot be who I am.” It would take until my junior year before I could utter the words to my therapist, when I finally found the courage to tell her about my new relationship with a woman. During this year I met my first partner and began to take steps toward wholeness. I found a safe place in therapy for my stories. I was finding my way. For my entire college career, I kept my secrets from my family and most everyone else, but her office became a haven and place for me to learn about the necessity and power of shining a light on all that had been hidden. I was finding my voice, and a place of safety and belonging as it related to my differences.

In my senior social work field placement, while I worried about where I belonged and where I would or would not be welcomed if people knew who I was, I learned about the power of group work in social work practice. My internship supervisor's skills and commitment to group work were evident, his belief in the value of group process contagious, and his effective modeling of group work encouraging. He used the group as a vehicle to hold a space in which everyone could belong. Girls groups. Boys groups. Friendship/social skills groups for students who had trouble making friends. Groups for children who had an incarcerated parent. Grief groups for kids who had suffered loss. Groups for students who were relegated to the social margins, picked on, or struggling for one reason or another. Some children told stories of the secrets in their homes, of alcohol, of neglect, of loss, of poverty, and sometimes of violence. I witnessed the power of groups in action. Groups became a safe place where stories could be told and the burden of secrets set down. A place where we could foster connections and a sense of belonging for children and where healthy relationships thrived. It wasn't long before I found my way to such a place, both as a facilitator and as a client.

This same field placement provided me with another opportunity to wake up. My field placement was in an elementary school in the city, with many students receiving free or reduced lunch and growing up in families living in poverty. It took no time at all for one child, without

apology, to mirror back to me what I was projecting to her. “She's rich!” she proclaimed to her third-grade classmates. Responding to the gold necklaces and rings I was wearing, this child announced my socioeconomic status, different from hers, and as she saw it. I was startled as I realized what my jewelry symbolized here and what messages I was sending. I felt dumb for being so oblivious to how these children might perceive me. I wondered about my place in the world of social work. My previously limited context for understanding ideas of privilege and class began to crack open, to shift.

> *It is 1988. I am 22 years old and have graduated from college. I have my first job as a community social worker, and I have a car, a partner, an apartment, and a community of friends to whom I am out. I am a part of the GLBT community. In all of these ways, I belong. At my first appointment, I tell all of this to my new lesbian therapist. Inquiring about my coming out process, she asks, “Are you planning to come out to your family?” I gasp, “No, and never! I can never, and will never, come out to my family. There's no way. Not now, not ever.”*

She listened politely and supportively as I stated the anticipated costs of coming out to my family. She encouraged me to join the lesbian support group she facilitated. With immense trepidation, I did. I listened to how others were navigating the coming-out process with their families. I expressed my fears about doing the same. I experienced the much-needed sense of belonging, emotional safety, and new friendships—the same experiences I had just witnessed for the children in my internship. Within this group, and with my therapist, I found spaces and built a community in which I could set down the secret and be open and honest about my lesbian identity. I experienced the positive power of telling my story and the hopeful experience of being the recipient of compassionate witness. From this position of being a client in therapy and in the group, I began to fully understand the centrality and power of story for myself. Later, I would understand the power of story from the position of a practitioner.

Therapy—Marking One Year

For the 52nd time I climb the 48 steps
to hoped-for epiphanies and her office
in the noisy city, always arriving early
so as to not miss a minute of her listening.

What is the sound of understanding and
how many tears have fallen here?
What happens to those with no one,
no place to hold their stories?

Out these 3rd story windows, blue gray
clouds hang on every word, heavy with rain
and anticipation, hope. The sky holds all of this
and more, while both bare witness, and listen in.

It is 1989 and I'm 23 years old. Just one year after proclaiming I could never come out to my family, I gather my courage and let the proverbial cat out of the bag. "Dear family member…," I write, composing coming-out letters to my parents and each of my siblings and in-laws.

The responses of my family members ranged from silence and a refusal to speak to me ever again (four siblings), to rage and telling me I was not welcome at their home or near their children (two siblings), to more silence and refusing to speak to me and hanging up on me mid-way through a phone conversation (my dad), to expressing anger and regret, "Had I known sooner, I would have taken you to a psychologist" (my mom). Grasping at straws, hoping for compassion, I said, "Mom, if someone finds out, I might lose my job or my apartment." And with no hesitation she said, "You will have to accept those consequences as they come." This very short phone call launched a stalemate, resulting in no further discussion between us for a year. But after several invitations along the way, my parents finally agreed to come to one therapy appointment with me. When the therapist asked my mother if I could come home for Christmas (without my partner) my mother stated quickly and plainly, "If she comes home for Christmas, none of my other kids will come. So no. She cannot come home." That fast, what I feared most, happened. Rejection. No discussion. I lost my place. A few months later, a letter arrived from my parish priest. "Your sister and brother in-law have requested that you be removed as the Godmother of your niece." My place was eliminated, a sacrament erased.

Used to Be

I used to be among them, afraid and silent walking
daily with weighty secrets, heavy in my pockets.

I used to wonder how long they'd hold,
those pockets, the fabric of silence and lies.

One day they broke free
spilling hard truths
but now I'm free.

I was left with the grief of immense loss and a choice. I could jump from the nearest bridge for my grief or be a rage-filled lesbian for the rest of my life for this injustice. The struggle was to find my way to a third choice. The telling of my story became synonymous with this choice, with survival. Over and over again in my mind I replayed the experience of being turned away. I told and retold the story—to my therapist, my partner, my friends—and each provided essential witness to my grief. Telling my story resulted in self-understanding, self-acceptance, connection, support, and a sense of belonging.

Speaking Up and Speaking Out: Making a Difference Through Story

It is 1991, and after three years working at the community agency, I have landed a school social work job in the public schools. It is the first day of my new job and I am reporting

> *to work at a junior high school in the city. I am greeted by a 7th grade African American girl who is clearly expecting the new staff member. "Hey, bulldagger!" she shouts. I freeze. My heart races. "You ain't the new social worker, are you?" Bulldagger. I have never heard this word, but I know immediately what she means.*

The first day on the job in the school system, I was terrified. What were the rules here? At my previous and first job at the community agency, significant weight loss due to the stress of coming out to my family during that time made flying under the radar challenging. My supervisor and colleagues could tell something was wrong and cautiously and graciously inquired. I felt safe enough with them to be honest. I came out and they were very supportive. But here in the schools, could I lose my job if they found out I was a lesbian? Gratefully, my external calm (heart racing on the inside) and authentic response turned the tide quickly with this student. "Yeah, I know. I look like a boy, right? A lot of people mistake me for a boy. That's all right. My name is Mary. What's yours?" The student quickly softened and returned to the kinder vibe of a 7th grade teenager. She seemed ready for fight and surprised by my response, likely expecting some sort of authoritative blow-back as a result of her name-calling. Instead, she simply pointed me in the direction of my new office in the special education program.

> *It is my second day working as a school social worker and I find myself in another part of the school where I crossed paths with an 8th grade boy. "What are you doing here?" he exclaimed. Again, I freeze. My heart races.*

For the preceding few months I had been volunteering at a community center in the city facilitating a support group for GLBT youth. This boy was a member of the support group, and the last place we expected to see each other was school. "I work here now, and I'm as surprised as you are!" His next words said it all. "Please don't tell anyone!" Of course, I reassured him I would keep his business confidential, but the truth is we were both afraid of being found out. Within six months, I came out to a few colleagues and learned there was a newly instituted non-discrimination policy in the school district that included sexual orientation as a protected class. This offered some relief, and set my professional life in a new direction.

My negative coming-out experience in my family occurred simultaneously to my early and developing professional life. While I was working diligently to make sense of my experience of privilege, my identity as a lesbian woman, and the rejection and exclusion from my family, I was building an identity as a young social work professional. I was grappling with how my personal and professional experiences and identities intersected. Gratefully, after my family's rejection, I turned my grief and anger toward activism, and consequently, my story of coming out became central to my professional and personal paths. My lesbian identity and painful coming-out experience fueled my activism and sharpened the focus of my social work practice. In the telling and re-telling of my story, professional opportunities emerged. I wanted to support those GLBT youth who were facing the same fears I had about coming out. I had been volunteering at a community agency co-facilitating a support group for GLBT youth, and I was glad to be able to hold space for youth in the same way space had been held for me. I was happy to be a professional creating a place for youth to tell their stories.

With a developing sense of self-confidence, it was becoming clear to me that I wanted to do more than volunteer on behalf of GLBT youth. I wanted to create a school-based program that would attend to the needs of GLBT youth and adults. Friends said, “Just keep volunteering, you'll never be able to get paid to work with GLBT youth in the schools. You'll never be able to be out as a school social worker.” Here is where my privilege ran deep. It seemed to me that I shouldn't have to give up my newly increased salary in the school system because I wanted to work with gay kids. Gay and lesbian youth were here. And so were gay and lesbian staff members. All of us were afraid. Having to give up my better public school salary because I wanted to work with gay kids seemed unfair, so I began to create what I would consider my dream job. I began investigating how I could design a school-based program in my school district to serve the needs of GLBT youth and adults.

I researched whether any school districts across the country were serving the needs of GLBT youth. The answer was “yes,” but the list was short: San Francisco, Los Angeles, and Cambridge, Massachusetts. Each program had emotional support and dropout prevention missions at their core. To create a program proposal for our own district, I drew from their basic structure and program design. With the help of several friends and colleagues, we created a model that held safe staff training, safe school climates, and support groups as primary components of the program. My supervisor was supportive of me and of my idea and guided me to key stakeholders in the district to whom I could pitch my ideas.

By the spring of 1994, telling my personal story was central to my professional life. I found myself telling my story to the district superintendent and to directors of nursing, guidance and counseling, and social work as a way to educate key power brokers about GLBT issues. It was the telling of my story that opened hearts and doors and was integral to my success in creating a new school-based program serving the needs of GLBT youth and adults in our school district. Telling my story ultimately made space for the stories of GLBT youth and provided witness, along with a sense of belonging, connection, and support for their self-understanding and self-acceptance. With the intention to make the world a better place for GLBT youth and their families, I successfully initiated and developed a school-based program serving GLBT youth in a large urban school district. For the next five years, when asked what I did for work, I would tease, “I am a professional lesbian, getting paid to tell my story and create safe space and support for GLBT youth and adults.”

Standing Up in Front: The Place of Story in the Classroom

As a result of my work in the public schools, I was invited to a college campus to share my personal and professional stories to undergraduate students in social work. As a guest speaker, I shared my experiences of activism and program development, and described my role as a social worker engaged in a social change effort. I was also asked to share my personal stories of growing up and coming out, how I made sense of my dichotomous experiences of marginalization and privilege, and how they were juxtaposed in my life. I had something to offer by way of walking in two worlds, and for me, these personal and professional stories are inextricably linked.

As a guest speaker, I had confidence and great intuitive clarity about the power and value of sharing my personal and professional stories in this context, but did not yet have the pedagogical language to articulate my rationale about its function in teaching. I enjoyed the chance to be in a conversation with undergraduate social work students. I talked with students about how my professional life was shaped both by my growing up in privilege and by being rejected by my family. I shared with them how as a result of watching my parents build their own business during my childhood, I created a professional life that mirrored that confidence in possibilities. I was steeped in their entrepreneurial spirit. For most of my 24 years in a public school system, I stood left of center and a bit outside of the traditional boundaries of what is typically seen as school social work. I designed and implemented new programs, thus creating unique roles and employment positions for myself. I discussed with students how, operating from this place, my privilege demanded a place in the schools. I also explained how, juxtaposed with growing up in a family of privilege, my painful experience with family rejection and exclusion fed my commitment to create safe spaces for GLBT youth in schools.

> *It is 2003 and I see on my caller ID that the Dean of Social Work, from the same college where I have been a guest speaker, is calling. "Hi Mary, I am calling to ask you if you would like to come teach in our department as an adjunct faculty member?"*

I held both an undergraduate and master's degree in social work and 15 years of social work practice, but I was baffled at this invitation. I didn't see myself as a scholar, an academic, or a teacher. I am certain the phrase "social work educator" was not a part of my awareness, lexicon, or identity. I was a social worker. I was a field supervisor. I was a guest speaker. I understood how and why I would tell my personal and professional stories as a guest, but didn't teaching require something else, something more than stories? Didn't it require more education and more training as a teacher? Though I was nervous and uncertain, I answered, "Yes!"

I found adjunct teaching to be like my professional role in the schools: non-traditional and holding a lot of autonomy. In my classroom, and in relationship to the academic environment, I functioned with free, although somewhat disconnected, agency. As a beginning adjunct faculty member, I received no instruction or preparation for teaching. I was welcomed, provided with an existing syllabus from which to work, and supported, indirectly. The door to the department was always open for my questions, and social work faculty members were accessible when needed. But I was not overtly taught to teach in the same deliberate way I was taught to be a social worker.

For months prior to teaching my first course, I poured over the two textbooks trying to soak up the facts, trying to become a content expert. I held an underlying belief that good teachers were content experts who could disseminate information through lecture, review the course readings directly for students, use PowerPoint slides, and present objective truths related to the subject matter. I did not have language then for what I understand now as paradigms of teaching and learning. I believed that a more positivist pedagogical stance made one an effective teacher. While I always understood the place, value, and power of story, storytelling, and witness in my personal development, social work practice, and guest speaking opportunities, once I became an adjunct faculty member teaching classes of my own, I devalued their place in the classroom.

The first course I taught was an undergraduate macro practice course, General Methods for Social Action. Once I found myself at the front of the class, I did what was intuitive. I relied on stories to teach important concepts. Although it seemed my approach was working, I didn't know why, and I lacked confidence in the value of my approach to use stories as a teaching tool. I continued telling stories, but without language to name it, I kept this teaching strategy to myself. I minimized what I would later recognize as my constructivist leanings, and devalued my intuition and understanding of story and conversation as legitimate and central to my teaching methods.

It was not until my recent pursuit of a doctorate in social work that I gave any consideration to my identity as a teacher, or social work educator, or to why I teach the way I teach. I had no idea how to articulate any of what I simply knew intuitively. I didn't know there were words for such things.

Social Work Doctoral Student: Coming Out as a Constructivist Educator

“No, and never!” This had been my emphatic and consistent response when asked if, or when, I would pursue my Ph.D. in social work. Pursuing a Ph.D. was absolutely not my plan. Since graduating with my BSW in 1988, and completing my MSW in 1997, I was engaged and enjoying my career as a social worker in the public schools and grateful to be done with my graduate education. By 2003, I felt content and lucky to add teaching as an adjunct social work faculty into my professional life. But plans change. In the spring of 2014, I learned about a newly developing clinical doctoral program in social work: a DSW program. I learned about the degree itself, with which I was unfamiliar. The university representative described the focus of the curriculum as “education as practice,” with a focus on teaching, scholarship, service, and leadership in social work education. Something clicked. I was surprised by the clarity that rose within me; I immediately knew I would apply. I often wondered who I could be as a teacher if teaching in higher education was my full-time career. This was my chance to pursue an education that would support the growth and development of my teaching practice and my identity as a social work educator.

My doctoral journey forced the realization that, although I had been teaching for more than 10 years, I didn't even know what I didn't know. In a course on pedagogy in social work education, my primary assignment was to articulate my teaching philosophy and my epistemology, my worldview as a teacher. I was stumped. In a course on theoretical perspectives in social work, my primary assignment was to identify my theoretical orientation to teaching and to create a practice model for teaching in social work education. Again, I couldn't answer. In a mixed-methods research course, I discovered my affinity for narrative inquiry and, subsequently, navigated a debate about whether such a postmodern research method held any validity in social work. Through each of these courses, I discovered language for my teaching philosophy and realized the central place, function, and power story holds in my research interests and teaching practices.

My doctoral journey provided an opportunity to further develop my identity as a social work educator and as a social work researcher. In the three courses noted above, I was provided

guidance, structured assignments, and key tools from my professors. I was introduced to new ideas and offered a language with which to understand my pedagogy, including: epistemology, ontology, and paradigms of teaching and learning (Graham, 1997; Rigoni, 2002); teaching philosophies in social work education (Owens, Miller, & Grise-Owens, 2014); theory deconstruction and theoretical perspectives (Forte, 2014); the value of lived experiences of professors (Hooks, 1994); and reflective practice and practitioner research (Brookfield, 1995; Schon, 1987). As importantly, I was directed to my memories and a reflexive process. Where have I come from? What were influential personal experiences on my path thus far? Who were key figures in my educational and professional experiences? How have any of these shaped my teaching practices? What research methods might I employ to investigate these ideas? And why does any of this matter in the roles and responsibilities I have as a social work educator? This doctoral journal helped me link my existing knowledge rooted in my lived-experience and social position with scholarship on pedagogy, paradigms of teaching and learning, and reflective practice.

As a doctoral student, I found myself in the margins again; or at least, I was left grappling with two perspectives of a polarized debate I didn't realize existed: a strong push for more science-based, evidence-based practice, and positivist research methods, and a devaluing of postmodernism in social work. I unwittingly found myself navigating this debate as I discovered my affinity for postmodern teaching practices and postmodern research methods like narrative inquiry (Reissman & Quinney, 2005), autoethnography (Ellis, Adams, & Bochner, 2010), scholarly personal narrative (Nash & Viray, 2013), and self-study research (Loughran, 2004).

During my doctoral program, I received my first hard copy of the *Journal of Social Work Education* and opened it, serendipitously, to the article entitled, “Postmodernism: A Dead End in Social Work Epistemology” (Caputo, Epstein, Stoesz, & Thyer, 2015). The title states these authors' thesis succinctly. They would likely take issue with my belief in story as legitimate pedagogy and my interest in narrative inquiry as a legitimate research method. Instead, they would contend I am contributing to the demise and “demotion of the profession's adherence to logic of science as the optimal method for determining the efficacy of practice” (Caputo et al., p. 643). Gratefully, and coincidently, in the same week that I read this article, I also read the foreword to Brene Brown's recent book, *Rising Strong* (2015), where she makes the opposite argument about the value of story in social work practice and research. Brown states, “And today I proudly call myself a researcher-storyteller because I believe the most useful knowledge about human behavior is based on people's lived experiences” (p. xiii). Brown's quote offered me clarity about my own place in the debate.

Through my DSW journey, I found explanations and language that helped me articulate my teaching philosophy and pedagogy that had been, until now, only intuitive. As a result of looking back on my life experiences and writing this narrative, my constructivist philosophy of teaching and learning and my pedagogical choices became more conscious and explicit. As a doctoral student, and as a social work educator, it has been extremely helpful to find language for my intuitive use of story as pedagogy. This process bolstered my understanding about how and why I teach as I do, and increased my confidence as a postmodern constructivist social work educator.

Conclusion

> *"If you ask me what I came into this life to do, I will tell you: I came to live out loud."*
> *~ Emile Zola*

As a result of writing this personal narrative, the place, power, and function of story in my development became evident. By remembering significant life experiences that shaped and continue to shape who I am, I was able to bear witness to my life and make meaning, again, of the stories themselves. Most importantly, writing this piece helped me discern how the telling of these stories matters - to me, my work as a social work educator, my students, and others who might be considering similar questions about teaching, constructivism, or the use of story and narrative inquiry in social work education. Throughout my life, telling my stories allowed me to make sense of my class and race privilege, marginalization, and lesbian identity. Telling my stories allowed me to break silences, survive rejection, and heal. Telling my stories allowed me to create a place and sense of belonging for myself and for others.

I agree with Elbaz-Luwisch (2001) when she says, "Telling our stories is indeed a matter of survival: only by telling and listening, storying, and restorying can we begin the process of constructing a common world" (p. 145). In the classroom, I use stories to construct such a world—one that can hold space for the many and diverse stories of my students and myself, and support us in discovering all the things we have in common, embracing all the ways in which we are different, and building a bridge between theoretical concepts and real-world social work practice.

For so many reasons, I tell my story in the classroom. My personal story opens the door for students to share their stories and to foster honest conversation and authentic relationships in the classroom. Telling my story breaks taboos, sets a tone, and creates an environment for learning that is profound and personal. I share my story because, as Elbaz-Luwisch (2001) suggests, "storytelling can be a way of admitting the other into one's world and thus of neutralizing the otherness and strangeness" (p. 134). GLBT students in the classroom benefit from seeing an out lesbian faculty member. For other students, it sparks an open conversation about difference. Through openness and conversation, we all gain from the collected stories and collective and shared wisdom in the classroom.

I believe a class of students is a group and teaching is group work. In both cases, I attend to the beginning, middle, and end stages of development, and I foster connections and a sense of belonging. Telling my story in the classroom sets the stage for a level of authenticity, genuineness, and safety for discussion and learning. I make space for stories of my lived experiences and for those of my students, and I link these stories to key social work concepts. Through conversation, we make connections between the textbook readings and our real-life and practice experiences. Sharing my coming-out story, for example, offers one way for us to enter into a discussion about working with GLBT clients, understanding identity development and stages of the coming-out process, and recognizing the potential issues of grief and loss too often associated with coming out.

My professional story opens the conversation about systems change work, activism, macro practice, justice, and group work. My stories make space for students to consider and understand their own social locations, their understandings of difference and bias, and their experiences of privilege and marginalization. My personal stories open a conversation about what it means for social workers to do their emotional work, and they foster critical self-awareness and self-reflection in practice. We talk about what it means to wake up to the disparities we hope to change in our world. Telling my story offers a chance to talk about the place of self-disclosure in social work.

As I wrote this personal narrative, it became evident how and why stories matter and why story is an essential element of my pedagogy. Ultimately, making space in the classroom for mine and for students' stories allows students to think about how they will, one day, be the ones to listen, hear, and bear witness to the stories of their clients—and know how and why this matters.

What Matters?

And does it matter, really?
This.
just one story.
or that it occurred at all?

Or is it that I've unfolded it
in just this one way
to reveal
what matters
most.

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Second Chances

Dirk H. de Jong

Abstract: This brief essay recounts the author's stint teaching social work courses in a prison. It also describes some of his reflections on that experience.

Keywords: prison, incarceration, social work, teaching, second chance

> *I enter the medium security prison in which I am to teach a social work course for the first time on a hot summer day in 2015. The formalities confirm my stereotypical expectations: Showing identification, taking off my belt in order to pass the metal detector, having my bag searched, getting my hand stamped. Then: an inmate-driven van transports me to the education building. Other inmates dressed in green (Why green? Wouldn't they be hard to spot if they were to escape into the fields surrounding the facility?) make their way from one building to another. Mostly, they are men of color.*

While prisons seem orderly and regimented in their physical manifestation, I have always thought of the process of imprisonment as an arbitrary one. As a teenager growing up in The Netherlands, I would pass the regional "house of detention," located behind tall brick walls in the downtown area I traversed on my way to school. Pondering its foreboding look, I would ask myself how it could be the fate of some people to be removed from society, if temporarily, by imprisonment—to be deprived of having breakfast with their kids, of taking the bus to work, of washing dishes after dinner, of saying good night to their spouse or partner. Yes, maybe the people behind those walls had done "bad things," but how could those actions be evaluated so as to lead to one's isolation from domestic and civic life? I knew, of course, about laws and courts, and about abstract notions of punishment and rehabilitation. But incarceration remained an arbitrary and unsettling phenomenon to me.

I believe that, if probed, many of us have a sense of unease when thinking about prisons, unease mixed with curiosity about life behind bars, about an alternate world to which we send those who transgress the social norms, an alternate world which we try to imagine in Hollywood productions and reality shows. Here are two unsettling questions to consider: If imprisonment is a reasonable, instead of arbitrary, measure, then why is the incarceration rate in the United States ten times that in the Netherlands? And if , on the other hand, it is arbitrary, are those inside the walls essentially no different from those on the outside?

> *The room in which I will teach is hot. There is no air conditioning. Two big fans, spinning at top speed, whir a noisy welcome. Unlike my well-equipped college classroom, there is no computer console or pull-down screen to show my tidy Powerpoint slides. The available whiteboard appears to have seen better days. The inmates file in. Mostly, they are men of color.*

Since that first day, I have taught two courses within the prison. The one thing that never failed to amaze me was the high-spiritedness among the students as they came through the door. They would be laughing, joking, high-fiving, and fist-bumping. Their booming voices would fill the

room: “How are you, Professor? How was your week? What are we gonna do today?” But when the banter subsided they would get serious, sometimes after one of the older students hushed a more rambunctious inmate. Then they were ready to listen, ask questions, discuss arguments. After a while I learned some of the reasons behind their energetic and animated demeanor. Class was not just a break from the monotony, it was also a time to escape the stigma of being a convict, to try on a new identity in the presence of like-minded peers, to envision a second chance, like when they practiced their social work interviewing skills.

> *The students have been paired up and are acting out the roles of client and interviewer. They are doing a great job as “social workers.” They explain confidentiality and its limits. They maintain appropriate eye contact and use minimal encouragers to prompt the interview along. They employ a mix of open- and close-ended questions and demonstrate empathic responding. They show specific interviewing strategies like reflecting, clarifying, and summarizing. They engage their “client” in collaboratively setting the agenda for a subsequent meeting. Great stuff! I can see any one of them working with troubled kids, substance abusers, homeless folks. But they do even better acting out the “client”—troubled, addicted, homeless. They take it over the top, occasionally giving the “worker” a hard time, using street lingo and mannerisms, being bad-assed, almost making the “client” into a caricature. The students who are looking on seem to recognize these caricatures. They laugh and give props to both actors after each role play. It feels like a celebration, as if they are saying goodbye to part of their past, with some fondness, but also with an understanding of its obsoleteness. They are ready for a second chance.*

It did not always work smoothly, of course. A student missed class because of the death of a loved one on the outside. “He is mourning”, his classmates told me. Other students, especially those with children, were clearly affected when we discussed risk factors for youth growing up in adversity. All of them, at one point or another, seemed to relate class content to their own life, as if it accounted for the path they had been on. Maybe such insights were also the reason for the role that religion (Christianity and Islam) seemed to play for several of the inmates. College courses and faith were used to help explain the arbitrary nature of life—maybe I could learn from that.

Alas, incarceration still seems an arbitrary phenomenon to me, to the extent that it is based on an individual and subjective judgement. It is not random though. A random process denotes the lack of a discernable pattern. Such is not the case here. Race clearly is a factor. However, I learned something else about incarceration, or rather about people who are incarcerated. I learned about the power of second chances. In truth, I wondered how realistic my students' dreams of a second chance were. Some of them still have years to go in their sentence. Once released, all of them will face a difficult transition to a rapidly changing world of social media, same-sex marriage, and Trump politics. Some of them will, by necessity, move back into the hood, trying to go straight amidst old temptations. Others will encounter discrimination in housing and employment. Under those conditions, how many will have the time and the resources and the energy to continue their schooling?

I think the students were aware of the obstacles that would await them well past my final exams.

For example, during the class role plays, one of them had named the imaginary counseling program for which he worked “Against All Odds.” However, my students seemed to find in that dream of second chances the inspiration to keep going, to take one course after another, to study, and to support each other. If those guys could believe in second chances and work as hard as they did on their redemption, in spite of the barbed wire and the quadruple gates and the barriers still to come, should not I be able to negotiate the arbitrary ups and downs of a much more privileged existence with the same belief and the same determination? And wouldn’t my second chances (and maybe third and fourth chances) similarly allow me to live a more intentional life?

> *It has been the last class of the fall semester. The students say goodbye and thank me. Their animated discussions continue as they walk out into the night. The holidays are upon us. I can’t imagine what that is like in this place. But at least I can imagine what it is like to move on.*

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