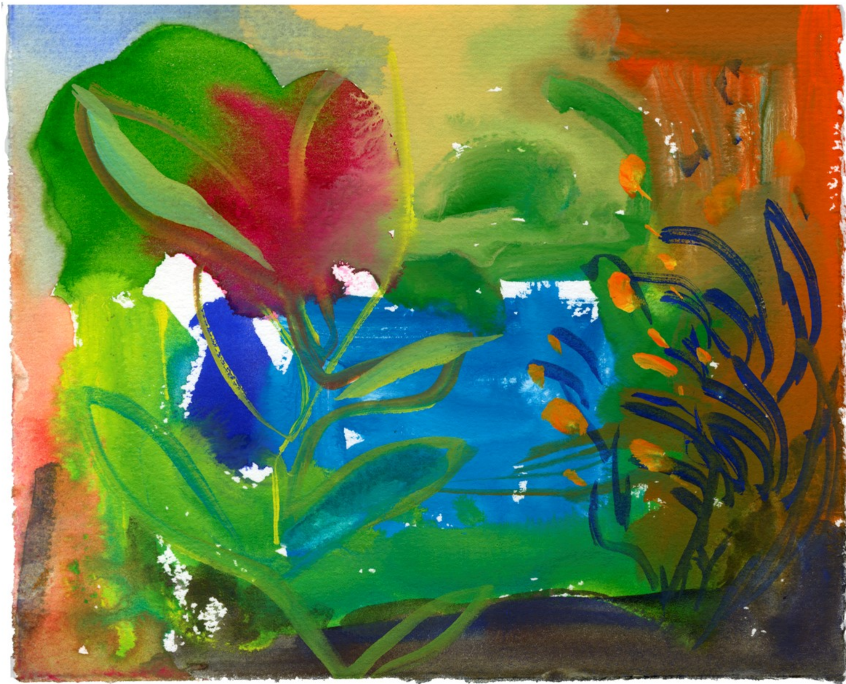
REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING



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REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

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Letter from the Editors

Arlene Reilly-Sandoval

Abstract: This serves as the introduction to Volume 24, Number 2 (Summer 2018). This issue includes general submissions as well as submissions for the Teaching and Learning section.

Keywords: Louisiana disaster, thousand-year flood, gerontology, aging, men's studies, miscarriage, teaching, disclosure, intersectionality, social class

What a treat we have for the reader in this issue of *Reflections*! Each of the articles in this issue provides new insight in the field of social work or discusses a topic that is not commonly broached in the profession. We start with Dr. Allen and Ms. Wright's excellent description of the thousand-year flood in Baton Rouge, Louisiana in 2016. This devastating flood dropped more than two feet of rain in a little over two days in some areas, and it swamped levees in the area. At least 11 people died, and more than 30,000 people were evacuated (Dickey, 2016). Loyal readers may remember Allen and Scott's (2017) excellent article in a previous issue of *Reflections*, discussing the thousand-year flood and the 2016 presidential election. Dr. Allen and Ms. Wright continue this tradition in the article, "Remembering the Forgotten Flood," which includes the experiences of two survivors. The authors remind us that regardless of ethnicity, socioeconomic status, or other diverse characteristics, disasters do not discriminate in their devastation. Human suffering also reminds us that we are one community. Climate change and urbanization contribute to increasing the likelihood that significant populations will experience disasters in the future, and social workers should consider how to respond, as well as how to respond while also recovering from a disaster themselves (Lee, Choi, & Jun, 2017). Indeed, this issue of *Reflections* encourages the reader to consider social workers as active participants in the human environment.

Dr. Netting and Dr. Thibault's article, "Reflections on Aging from Both Sides Now," and Mr. Brown's intense article, "Men and Miscarriage: An Insider's Story from the Outside," both ask the reader to consider the experience of social workers as they, too, experience life's circumstances.

Dr. Netting and Dr. Thibault ask us to consider a topic that most U.S. citizens would rather avoid: aging. In the United States, almost 80% of people over 60 years old have reported age-related discrimination. Yet, in thirty years, older adults are expected to comprise 20% of the population in the U.S. (Drury, Hutchison, & Abrams, 2016). Utilizing a variety of theories about aging, the authors reflect on their professional experiences as social workers and their use of theories to assess and help clients, and they apply them to themselves as retired social workers. The result is a critical look at the usefulness of aging theories and a compelling case for remembering the importance of human relationships and the dignity and worth of the person. This narrative also reminds social workers that we, too, are human and experience challenges, developmental changes, and environmental stressors in common with our clients.

Mr. Brown describes his own experience when he and his wife had several miscarriages. As he sought resources for himself, Mr. Brown was inundated with information about how men can support their partners through miscarriage, but nothing was available about how he should deal with his own feelings or even if what he was experiencing was normal. The topic of support for men who have experienced the emotions of losing a child pre-term is not well researched and is a topic rarely broached in the United States. As a result, Mr. Brown writes that he was unsure if his experience was common among men in his situation. The result was a qualitative research study that helped the author understand his own experience and informed the social work literature on men and miscarriage. Mr. Brown describes his own struggle throughout the study with being an "insider" as he conducted his interviews with men who also experienced miscarriage with their partners.

Dr. Lesser reflects on her own storied career in the profession. In her article, "Reflections: My Career in Clinical Social Work," her description of micro and macro intervention with clients and her own journey of discovery of intersectionality of identities is a remarkable narrative. She succinctly describes her therapeutic use of intersectionality with clients and provides us with a lesson in working with clients from a variety of backgrounds. Dr. Lesser describes the use of self in social work and how a clear understanding of ourselves can help clients gain a better understanding of their own selves and their social interactions.

Dr. Campbell wraps up these reflections on social work with her thoughts about disclosure. Self-disclosure in social work is a topic debated among professionals in the profession. How much self-disclosure is enough, and when should self-disclosure be used? In her article, "Disclosure in Teaching: Using Personal Mental Health Experiences to Facilitate Teaching and Learning in Clinical Social Work Practice," Dr. Campbell reminds us that self-disclosure can be a crucial factor in the therapeutic relationship. Self-disclosure has been shown to increase trust, increase the use of self-disclosure by others, and even decrease power imbalances (Rasmussen & Mishna, 2008). Is disclosure in the classroom different from disclosure in a therapeutic relationship with a client or during supervision in the field? How does self-disclosure affect the instructor-student relationship? The author describes her own experience with self-disclosure, reviews the literature on the topic, and shares her criteria for disclosure in the classroom.

This brings us full-circle to Dr. Allen and Ms. Wright's article and the consideration of social workers as active participants in our environment. As social workers, we are constantly reminded that the therapeutic relationship is key in helping our clients develop a sense of hope and recovery. We do this through a judicious "use of self" in our relationship with clients. This issue of *Reflections* invites the reader on a journey of self-reflection, introspection, and consideration of how social workers are affected by the human condition and how we can, in turn, affect the human condition.

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Remembering the Forgotten Flood

Priscilla D. Allen and Amy L. Wright

Abstract: Louisiana, a southern coastal state in the United States, flanked by Texas and Mississippi, has seen its share of disasters in the past several decades: from epic Hurricane Camille in 1969 to Hurricane Katrina in 2005, with pervasive aftermath and local, national and global media coverage. This article describes the August 2016 *thousand-year flood*, meaning the extent of this magnitude only happens once in a thousand years. Experiences seem to be fading from the collective memory, despite massive loss of property, businesses, life and landscape. This article shares two flood stories: a single male who is a painter and who lost everything in a remote and rural place in French Settlement, and is still homeless, and a female doctoral student who was in a more populated suburb of Baton Rouge and has since rebuilt her home with her partner. Both people continue to be productive against the devastating loss of being physically displaced from their homes for months. The authors' intent is not to establish hypotheses or theory, but to share narratives nested in a time when humanity in coverage and science seems left to the political flavor of the day. The people persist, even when others don't pay much mind. Throughout the article, the authors use the "Great Flood," "Great Forgotten Flood," and the "Forgotten Flood" interchangeably to refer to the flood of August 2016.

Keywords: Louisiana disaster, flood reflections, thousand-year flood, environmental, personal resilience

Introduction

Few could have imagined the devastation the Great Flood, also termed the *1,000-year flood*, had on Louisiana during August 2016. The American Red Cross categorized the flood as the worst natural disaster in the United States since Hurricane Sandy in 2012. Emergency responders and, in many cases, neighbors and ordinary citizens, rescued over 30,000 individuals and 1,400 pets (Yan, 2016). A total of 13 deaths were reported across five parishes as a direct result of the flooding. Tens of thousands of people became homeless for months; many of them are still awaiting improvements or for new living opportunities as this piece is completed nearly a year later. The area is well acquainted with catastrophe, given Katrina

occurred in August 2005, Gustav following in August 2008, and Ike in the following month of September in 2008—all resulting in unprecedented devastation and loss of lives and property. The flood of August 2016 was enormously smaller, even still, and received less financial assistance and media coverage than many disaster events that impacted far fewer nationwide. There is no question that Hurricane Katrina was expansively and expensively more devastating than the Great Forgotten Flood. One cannot compare the financial heft of the Forgotten Flood with Katrina (e.g., $50M spent for the flood vs. $13B spent for Katrina, respectively). The 1,000-year flood was 1,000 times less expensive than Katrina, and the death toll was exponentially higher for Katrina compared to the flood (e.g., 1,833 deaths from Katrina vs. 13 deaths from the flood). Moreover, the overall number of damaged homes was much higher as a result of Katrina (e.g., 800,000 damaged homes after Katrina vs. 60,000 damaged homes after the flooding) (Yan, 2016). However, the number of people who suffer from a costly illness (e.g., mold-related illnesses) after being stranded in their homes following the flood could ultimately rise in the near future.

The flood for Louisiana residents will not be forgotten in the unique city of Baton Rouge, translated from French to mean *Red Stick*, which is home to some 700,000 people. We could have used that proverbial red stick to wade through the waters in August 2016 when 6.9 trillion gallons of rainwater, enough to fill 10.4 million Olympic-sized swimming pools, fell in the southernmost part of Louisiana within six days (Yan, 2016). Many rivers reached record levels, particularly the Amite and Comite rivers. Rainfall exceeded 30 inches within just 15 hours in Livingston Parish compared to 19 inches of rainwater that fell within the same duration in Baton Rouge. New Orleans, the state's largest metropolitan area downriver, was devastated 11 years earlier by Katrina, yet remained unharmed and dry during the Great Flood. In and surrounding the Baton Rouge area, more than 60,000 homes were damaged as a direct result of the historic flooding, with the vast majority of damaged homes located within Livingston Parish (Pallotta, 2016). An estimated $30 million in relief efforts are needed, with the possibility of the total cost rising, given the overall magnitude of the flood (Yan, 2016).

While these facts and features may be essential in starting up an article and outlining the problem, the content of the flooding is far more personal. Two examples of devastation and aftermath are briefly provided, and others are mentioned for a backdrop.

One of the authors was directly impacted by the flood with approximately one foot of water occupying and destroying her home. Part of her story is contained in this writing to elaborate the psychological spirit and the necessity of moving forward as a doctoral student navigating her own course of tide, and perhaps writing in and of itself aids the psychological recovery of individuals who've experienced loss and tragedy. The other writer has had a full-time flood evacuee living with her since August 2016 (nine months and counting), with no building occurring on his home anytime soon, given the landlord had 60 other properties to repair and rebuild. The modest, rural, rental cottage on the end of a winding road in an area that often floods was not a priority. Everyone in Baton Rouge was somehow touched by this flood, but the stories are starting to fade much like the removal of the watermark inside of the houses—torn

out and rebuilt. The memory of the impact and the enduring reality is harder to erase.

Cajun Navy

As is often the case, it is not the well-orchestrated and high-paid federal cavalry first on the recovery scene after floods and fires, but the regular people who show up to help. Cliché as it may sound, the small town heroes and heroines are the ones that get things done. Such was the case with the "Cajun Navy." The Cajun Navy was literally everyday people going out in their private boats to pick up people and pets and deliver them to safer, dryer places. Without the goodwill of citizens working under their own steam and values, many of the flooded would've perished. People in this area have a bit of the native warrior image; as a result, they quickly started up boats and generators to assist people. The outcome of the flood was quite different than a hurricane due to the standing water and need to escape the area by boat or foot. An example of a kind neighbor who didn't turn his back on a man yelling to save him from his house surrounded by water is highlighted in Alan's story, which appears later in this article.

Shelter After the Storm

Due to large tax breaks, Louisiana houses a couple of sprawling movie studios that sit dormant for long spells at a time. Such a place is the Celtic Studio located at the city's periphery and near the Costco store (Gallo, 2016). Celtic Studio took in more than 2,000 storm evacuees, but as long as two days after, there were people sleeping on the floors and restricted from going into the staging unit where supplies were heaped. Well-meaning team-spirited moms and dads dropped off loads of water, blankets, Doritos, and diapers. Volunteers walked around unsure of who to help and what to ask. The social workers, however, were skilled, yet tired. One Louisiana social worker single-handedly coordinated the cots and the transportation after assessing that it hadn't been done (Gina Rossi, personal communication, August 15, 2016).

After the flood, multiple shelters were quickly set up: one on Louisiana State University's (LSU) campus, where a special needs shelter was established in the Maddox Fieldhouse; a large shelter at Lamar; and a new shelter at Celtic Studios. As is usual with disasters, planning and response was uneven due to the unprecedented number of evacuees.

To represent both the trauma of the event as well as the resilience, two reflective accounts

follow: Amy, a full-time social worker and full-time doctoral student at LSU, and Alan, a full-time house painter and dog breeder, who lost everything in the flood. Despite their losses, both were willing to share their stories.

Storm Story: Amy

I woke up to warning sirens from my cell phone around 9 o'clock in the morning on Saturday, August 13, 2016, after receiving little sleep. About three hours preceding the warning sirens, I had submitted 45 written pages of my PhD comprehensive examination to my dissertation committee. After restless tossing and turning that night following the submission of my comprehensive exam, I finally fell asleep with expectations of waking up the following morning in order to pack for a highly anticipated conference in Olten, Switzerland. My mentor and I were planning to fly out of Baton Rouge the following day in order to represent Louisiana State University's (LSU) School of Social Work program and present at the third annual International Sexuality and Social Work Conference of 2016.

Instead, my partner and I awoke to witness people in our neighborhood lining their garages with sandbags and hastily loading their cars with their belongings. Our neighbors, with distraught expressions on their faces, told us that the floodwaters were starting to flow down O'Neal Lane, less than three miles from our home, and were headed directly toward us. Instead of packing one suitcase for what I thought was going to be a week of international traveling, my partner and I followed suit of our neighbors. We quickly packed as much as we could of clothes, toiletries, and valuable belongings. We put anything of financial or sentimental value on high ground, unplugged all electrical outlets (or at least the ones we could remember), gathered our anxious pets and evacuated with both cars to my parents' house in New Roads, LA, about an hour northwest of Baton Rouge.

Needless to say, I opted against attending the conference in Switzerland in order to be on standby. Sunday and Monday came and went while my partner and I were glued to the local news at my parents' house with nothing to do but cross our fingers, wait, and hope that our friends, family, and neighborhood were all safe. On Tuesday the 16th, three days after evacuating, the majority of road closures were still enforced and we had not yet heard any news specifically related to the status of our neighborhood. Our nearby friends had also evacuated and were waiting to receive updates regarding their homes. Not knowing any of our neighbors' phone numbers, as we were fairly new to the subdivision, my partner and I became desperate to learn of the status of our house. After spending three hours fighting traffic and trying five different routes to access our neighborhood on Tuesday (i.e., the majority of streets were closed off or inaccessible due to the high water), the closest area to our house that we could access was over six miles away, and the sun was about to set. We were unsuccessful, and we were still in the dark as to the status of our home. Feeling defeated, we drove back to New Roads with hopes of trying again the next day.

The following day, Wednesday the 17th, four days after evacuating, we drove back to Baton

Rouge. This time, we were able to access a closer area to our house, as the floodwaters were beginning to recede. My partner and I parked in a neighborhood located over two miles away from our house, and we began walking. With backpacks in tow and a large stick to help navigate flooded areas, we walked in waist-deep floodwaters for over two miles in order to reach our home, while National Guard helicopters with surveillance cameras flew loudly over our heads. We were not alone. Several others were doing the same. While trudging through the floodwater, I met one gentleman who said that he was trying to check on the status of his pets as he was forced to leave them behind while he evacuated his home. One woman I met said she just learned of the status of her home and expected it to be a total loss, as she received about 10 feet of water.

After reaching the halfway point of our journey, we saw an eerily vacated 18-wheeler stranded at an intersection. We had to somehow find a way around the large truck. We crossed over a flooded gas station parking lot, and as I was attempting to cross over to the other side in order to gain access to the neighboring parking lot, I fell into a six-foot floodwater pit. My cell phone was in my pocket; it was obviously destroyed. After hoisting myself up and over the ledge, and after briefly laughing in disbelief as if I were in denial as to what exactly was happening, my partner and I continued to walk the remaining mile to our house.

The Cajun Navy

After about two hours, we finally made it. Our house, as I had expected, had taken in a substantial amount of water, along with almost every other house in the neighborhood. After inspecting the house, taking several pictures in order to document the losses, and throwing out some of our household items such as the broken refrigerator with its spoiled contents, drenched area rugs, my partner's artwork that she saved from her high school years, and Christmas ornaments that my mother had purchased for me as a baby, my partner and I set our sights back to the car. One young man with a kayak occupied by his black Labrador retriever offered us a

lift. After pushing the kayak for about a mile before the water started to recede again and the young man could not proceed any further, we got back on our feet and were then stopped by a local reporter asking us to be interviewed on camera for the local news regarding the flood. Once completing the impromptu interview, we continued to our car and were then offered a ride by a polite, middle-aged couple in a large pick-up truck who disclosed to us that they also received several feet of water in their home.

The three months that followed were beyond difficult in an emotional, mental, physical, and financial sense that neither my partner nor I could anticipate. We had no flood insurance, as our house was not located in a floodplain, as was the case for thousands of other homeowners. After completing the majority of the house-gutting ourselves, we decided to hire contractors for the majority of the work that needed to be done. Some contractors I worked with were reliable, timely, and trustworthy; others demonstrated poor craftsmanship and professionalism, as they were out to seemingly only make a profit, and had damaged some of our property further. I was forced to put my doctoral dissertation research on hold for almost a semester as there was virtually no free time between working full-time at a local hospital as an emergency room social worker, where the census kept rising following the flood, and working around the clock to repair our own house. My partner and I both experienced a significant increase in our anxiety and depression. I spent over two hours in the car virtually every day of the week in order to drive back and forth from New Roads to Baton Rouge for three months for work and flood-related house repairs.

Typical property damage in flooded area.

Three months later, we finally moved back into our home. There is still a laundry list of items that need to be repaired, both on the interior and the exterior of the house. The vast majority of contractors are overbooked and are unable to accept new clients or projects until further notice. Huge piles of debris and trash that seem to increase in size on a daily basis still sit at the front of each house's property in our neighborhood, given that the amount of debris landfills in the area

are significantly lacking. Certain materials needed for the remainder of our repairs are on backorder until further notice simply due to the overwhelming need in the community.

My partner and I were among the luckier ones. We were fortunate enough to have family members that were able to fly in from out of state to assist in the repair process, and we had local friends and family who dropped everything to help us dig trenches to install a drainage system and clean the interior of the house, and some even donated money for the home repairs. Several other people in the surrounding areas were not so lucky. People are still displaced from their homes and are not even past the gutting phase of the repair process. Some people I know personally were forced to declare bankruptcy and walk away from their mortgage and are currently homeless. Some lost their vehicles in addition to their homes and are without transportation. Some lost their family members or pets to the flood. Such a person is Alan.

Storm Story: Alan

When I woke up Sunday morning my house was completely surrounded by water. I was trapped. I knew I had to get out of there, somehow, by boat. I was yelling to people who had their boats out in the streets, yelling for them to get me. My neighbor yelled back and said he could try to get me after he took his kids home. I left about 9:00 a.m. We could only go so far until there was dry land. Then I had to walk. I had to walk 100 yards or so, then I had to sit for hours and hours and wait 'til another boat came to get me out of there. There was no place to go. I didn't know that. It was me and my three dogs. It was difficult. I had food for my dogs, but not for myself. The second boat got me out, and I thought I was going to my vehicle, but it was parked at the Moonlight Inn, and we learned that the restaurant/bar was completely under water, so they took me to the Baptist Church, which was dry.

Alan's beloved Jeep Grand Wagoneer under water at the Moonlight Inn.

After that, the guy took me and my three dogs to Brignac's, my friend's, house about three miles away. I stayed with them for three days and then Dennis and Suzanne (my friends) picked me up Tuesday night and we found a way to get out of there. I stayed with them for a couple of weeks. I got back to check my house about a week later. It was a mess. Everything was upside down and turned over. We had to throw everything to the street. I'm still waiting. The house was gutted on Labor Day.

There's nothing else to do now. It's frustrating. I stayed with some other friends outside of

Covington, LA who offered to put me up. I stayed there with my dogs, and I helped them paint their outside kitchen. Out of the blue, after the work was done, they asked me to leave. I've been staying with Lilly ever since. Two of my dogs have been staying with other people, and I don't think I'll get them back. My house is still gutted and I am still homeless.

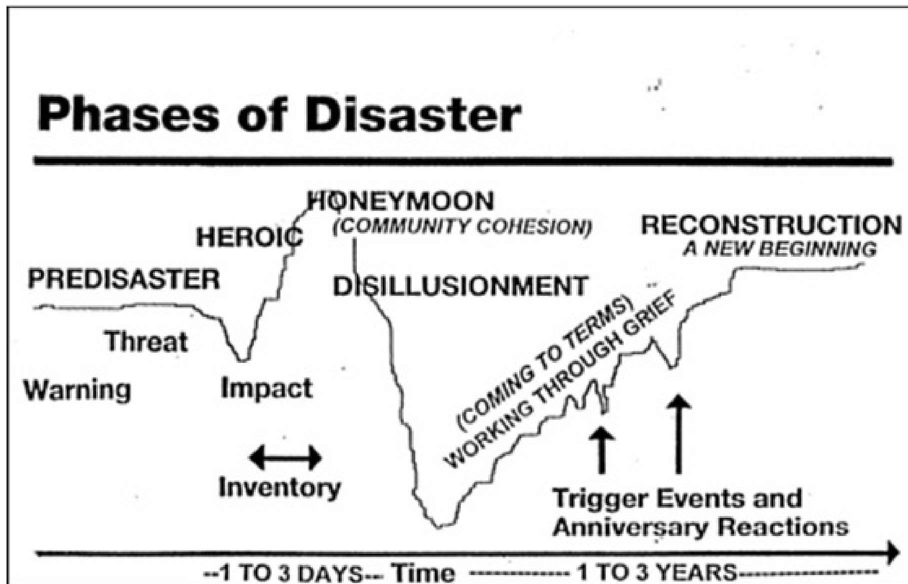
Minimal Media

Pallotta (2016) likened the magnitude of the Louisiana flood to an entire city burning down; he noted that if this was an act of human terrorism, it would be an international catastrophe (Pallotta, 2016). Obviously, the comparison may seem less relevant since it wasn't an act of terrorism as we know it, yet even so, the media coverage of devastation was curiously spotty and short. It was noted that the timing may have been part of the low-coverage issue. The 2016 presidential election was underway and the Summer Olympics were in their final lap. The waters flowed into subdivisions and rural tracts, making their way to filling homes to 10 feet. Other things may have interfered with the coverage. Is it possible that the demographics of the victims were less compelling to the environment of news? Some say yes, that Hurricane Katrina was more compelling due to the racial component and that media focuses on the victimization of people of color—the graver the outcome, the more coverage is made. Given the majority of the media have been focusing on political issues surrounding the 2016 presidential election outcome, the rest of the country is virtually oblivious to the current state of Louisiana following one of the most historic natural disasters in modern-day history. Undeniably, political coverage following the election is important and vital to our democracy. Notwithstanding, horrific post-flood conditions and trauma for a large proportion of Louisianans is very much alive.

Loaded Dice

Hayhoe states that "Louisiana is always at risk of floods, naturally, but climate change is exacerbating that risk, weighting the dice against us" (as cited in Mooney, 2016). Urban sprawl is often to blame for devastation after natural disasters. An example in Pennsylvania strikes similarities with the Louisiana problem: With miles and miles of concrete and asphalt roads and parking lots, rainwater has nowhere to drain. Instead of seeping naturally into the ground, the water runs quickly into streams, causing overflow, and taking with it pollutants like fertilizer and oil picked up along the way. "'The term sprawl is used a lot, and that's one of the impacts of sprawl,' said Baldassare." (Ward, 2004, para. 13). He continued, "We keep adding more impervious surfaces with roadways and driveways" (Ward, 2004, para. 13).

Overall, it seems that it was easier to place the blame on the national response following Katrina on racial disparities since lower socioeconomic status neighborhoods were most affected in New Orleans during Katrina. With the Great Forgotten Flood, however, there is no racial component to blame, given that the majority of people who were affected were middle-class, white people. This, coupled with the other points I've mentioned above, would be why I would think there was a lack of flood coverage within the media.



Psychological Preparedness for Disaster (Guterman, 2005)

There are theoretical and real phases of disaster, from warnings to threats to activation of heroism, and there is even a honeymoon phase when people may lighten the experience without feeling the responsibility and trauma of what actually happened and what lies ahead (Guterman, 2005). Many have noted how their lives have significantly changed, some even say for the better. We can only hypothesize at this juncture the buffering effects, but anecdotally most attribute well-being and adjustment and a sunnier outlook to social support, faith, and resiliency. So, if and when people come to terms with the reality, the waiting, the rebuilding, the scheduling to rebuild, and the financial and emotional toll, and as the anniversary is soon to roll around, a new beginning is possible. These stages, however, are not linear, nor are they the same for any one person, community, or group. Social work and other health professionals can anticipate the stories, the solidarity, the isolation, and the hope that tomorrow brings with disaster. We have sought to share the stories of the Great Flood of 2016, given its environmental and psychological impact, and given this journal's readers' awareness of the key intersection between the two. The more stories are shared, the more healing and reconstruction can occur to reshape lives, plans, and the contextual-symbolic as well as physical and tangible necessity of home.

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Reflections on Aging from Both Sides Now

F. Ellen Netting and Jane M. Thibault

Abstract: As professional colleagues in gerontological social work and close personal friends, the authors jointly reflect on their own aging process as retirees. They revisit the theories they used to understand aging and the tools they used to assess older adults. The authors relook at aging theories and assessment instruments now that they are being used to understand their own lives. They share their reflections on the ongoing self-reassessments in which they seem to be engaging every time they have a conversation with one another.

Keywords: assessment, engagement, friendship, gerontology, retirement

There seems to be a trend for aging gerontologists to publish reflections about their own experiences in light of what they have studied, taught students, and practiced as professionals in the field. For example, Beckett (2008) edited, *Lifting Our Voices: The Journeys into Family Caregiving of Professional Social Workers*, with the intent of having social workers talk about lessons learned when they had to step out of their professional role and be the family member who cared for an older relative or friend. More recently, Pruchno (2017) edited a special issue of *The Gerontologist*, "Aging—It's Personal," in which 19 contributors wrote memoirs of their experiences with loved ones or reflected about their own aging process. This was the first time this journal had published narrative rather than purely scholarly work. Also recently, Palmore (2017), known in gerontological circles for his Facts on Aging Quiz, published his reflections on being 80 years old in light of what he knows about theories of optimal aging and their application to his own aging process.

It was somewhat fortuitous last year when we were asked to do a joint presentation during a series on aging at the University of North Carolina Wilmington (UNCW). We were in the process of trying to support one another in not overcommitting to doing formal presentations. We had retired from our respective universities over six years ago, and we had learned that the freedom to commit (or not) to a professional event could suddenly become secondary, given unexpected health events (our own and those of loved ones) that would take priority over formal commitments. We had also spent hours on the phone delving into the unexpected feelings we were having as informal networks frayed and dear friends died, leaving holes in the tapestries of our lives. So when we were asked to do something on aging, we responded with some ambivalence and were forced to think through what we felt we could do and what we could not do. One of the biggest challenges for introverts like us is that it sounds like a good idea at the time, but as the event draws near, we can never fully be prepared for how we will feel about performing when the time comes.

One criterion we have repeatedly discussed is that it depends on who is asking us. If we do not have a relationship with the person making the request, then it is much easier to say no. But if we know the person and have a meaningful relationship, then saying yes requires consideration. The invitation from UNCW came from two mentees from our respective university jobs. In

addition, they had conspired to offer us the opportunity to get together for a visit, something we could rarely ignore. We decided that we could not commit to a formal academic presentation in which we lectured, nor could we distance ourselves from the subject that we were living every day. We could, however, be informal, personal, and reflective. In fact, thinking through our own aging process would be helpful to us and, hopefully, spark interaction. They were fine with our terms, so we accepted their invitation.

We decided we would look at aging from both sides now, reminding us of the song, "Both Sides Now," written by Mitchell (1966) and sung beautifully by Judy Collins many years ago. We wanted someone to sing that song to introduce our conversation, and our mentees found the perfect person. We chose these lyrics because we are looking at life from both sides now—as professionals who taught about and studied older people and as older people ourselves. And we find that our illusions, those cognitive beliefs and ideas on which we built our professional lives, are now being challenged and may even be misleading impressions of reality, as we are experiencing our own old age.

That is how our joint narrative began—as a reflection from both sides now. We share our joint story written from our many conversations over the six years since we retired and which we presented last fall at UNCW.

Ourselves, Our Relationship, and Our Purpose

Ellen is 68, a macro social work educator/practitioner who retired from Virginia Commonwealth University's School of Social Work. Jane is 71, a clinical social work educator/practitioner who retired from the University of Louisville's School of Medicine. We both got into the field of aging early, when gerontology classes were just being offered. We were only-children of older parents, growing up in a world of adults. Ellen is from Tennessee and Jane grew up in Massachusetts. We are married, Ellen to Karl and Jane to Ron. We have no children of our own, and our parents and their siblings (aunts and uncles) have all died over the years. We consider ourselves "sister-friends."

It was when we came to the University of Chicago for our doctorates that we met the first day of orientation. Our eyes met as we listened to male colleagues discuss their desire to take econometric modeling in the business school because they felt the statistics courses in the School of Social Service Administration might be too easy for them. We left that room, walked outside the building, and Ellen invited Jane to come to hers and Karl's married-student apartment to have a cup of Russian tea. (Remember Tang, the drink that the astronauts drank in space?) We got through the multiple doors and locks, stood in the 1898 apartment on Ingleside Avenue and let out a joint primal scream. Somehow we would make it through this doctoral program together, despite the intimidation we were feeling. Over the course of that first semester, we bonded as only-children of older parents and as children, who during adolescence, lost our mothers. At that point we conjured up the concept of the Dead Mothers Club and often credited our mothers as having found ways to get us together. So when the call from UNCW came for us

to do a joint presentation, we laughed about how the dead mothers never let us down—they always found ways for us to get together.

In telling our story, we want to acknowledge that we are privileged white, academic women. Karpen (2017) wrote, “But this is a fact of academic life: most gerontologists speak from positions of privilege, removed from the experiences of the majority of old people we write and theorize about” (p. 103). Thus, we hasten to say that we speak only for ourselves and our experiences.

After agreeing to go to UNCW, we agreed upon three reasons for the conversation we would have:

1. To revisit—from the perspective of our own aging experience—the theories we used to understand aging and the tools we used to assess an older adult’s current status and present and future needs.
2. To relook at aging theories and assessment instruments now that they are being used to understand “us.”
3. To reflect on the ongoing self-reassessments in which we seem to be engaging every time we have a conversation with one another.

For example, when we go to the doctor for our Medicare wellness exam, we can anticipate the questions of a mini-mental status test: What day is it? Where are you now? What year were you born? For years, we used to ask “old people” these questions; now they are asked of us.

Gerontological Theories of Aging to Which We Refer

We decided that four theories had driven much of our gerontological career: activity, disengagement, continuity (and life span development), and socioemotional selectivity theory. We referred to these four theoretical perspectives during our conversation. We also mentioned the multiple domains of various tools we had used to assess older people, in Ellen’s case management experience and in Jane’s clinical geriatric practice. These we summarized as follows to provide a framework around which we constantly were reexamining our own selves now:

The Domains of Tools Used to Assess Older People

1. Domains of a Comprehensive Geriatric Assessment:
    - Functional status, including physical health, ADLs, IADLs, and fall risk assessment (including senses, mobility, perceived energy)
    - Cognitive function
    - Emotion and psychological conditions
    - Nutrition status

2. Additional Domains in Multidimensional Assessment Tools
    - Social resources, support, interaction
    - Economic/financial
    - Environmental conditions

3. Other Domains Studied (but not always in multidimensional tools)
    - Spiritual/meaning/purpose
    - Quality of life/well-being/life satisfaction

Specific assessment tools include: Older American Resources and Services (OARS), the first comprehensive tool to assess health of elders (Pfeiffer, 1975); Comprehensive Assessment and Referral Evaluation (CARE) (Gurland, et al., 1977); and the Philadelphia Geriatric Centre Multilevel Assessment Instrument (PGCMAI) (Lawton, Moss, Fulcomer, & Kleban, 1982).

Having mentioned these theories and assessment domains in order to frame our conversation, we identified the following themes/reflections around which we have been reflecting for the last six years since we retired.

1. Balancing activity and disengagement theories is a challenge.
2. Recognizing that continuity theory makes sense, except when it doesn't!
3. Assuming that socioemotional selectivity theory makes sense, what happens when choices are not within our control?
4. Respecting heterogeneity of an aging population means standardized assessment tools are limited.
5. Knowing a lot about gerontology doesn't mean we aren't continually amazed at "This is not what we expected."
6. Emphasizing that the importance of "story" has become increasingly more meaningful.

Balancing Activity and Disengagement Theories Is a Challenge

What does it mean to be engaged? We've talked a lot about how we use our time and the choices we make when we are accountable to ourselves and not tethered to a work place. Activity theory is often equated with physical activity, but what about mental activity? We are people who find stimulation in ideas, yet we could be perceived as inactive by those who want to be "on the go" all the time. We've witnessed people who race from one thing to the next and volunteer for everything, replacing working roles with volunteer roles, almost fearful of thinking too much. (We have been told, "You think too much!) Yet, thinking is so much a part of us as educators, we are perplexed that anyone would see us as thinking too much, but both our husbands likely see us that way.

We've talked about how successful aging has often been linked to activity theory to the point of seeing people who are introverted, or not as visibly active, as less successful. We haven't seen much in the literature about introversion versus extroversion in retirement and suspect that

introverts may tend to appear more “disengaged” than extroverts. Are we engaged enough? This is a question we bring up over and over again, assuring one another that there is no one right way or “best” way to engage; this is highly individualistic.

We’ve talked about our struggle with what types of activities are “important” because they are “visible” or “formalized.” Civic engagement is viewed by advocates as important. Taking cookies to a neighbor or actively listening to a friend is not as visible, yet we are learning that these acts can be priceless. When Jane’s neighbor gets sick, she automatically bakes cookies to take over. Ellen sends cards for every occasion. When a friend calls and needs advice about an aging relative, we both drop everything to listen. But in the scheme of things, these are such small actions. How do we remain flexible so that we can drop everything and be there for others? Maybe the important thing is being available to truly listen when a friend needs to talk or to drop everything when a neighbor needs to get to the emergency room.

What is valued? What do we value? It seems that society values “doing” over “being” when defining aging as successful. We’ve had many conversations about what formal activities we should continue or take on for the first time. Should Jane stay on ElderCounsel? Should Ellen accept a position on the United Methodist Homes Board? Should we protect a day, even two, per week to not schedule anything? What criteria do we use to determine what we should say yes to or no to?

How do we determine what is a valuable use of time and not feel guilty if we stay home for a day and aren’t “productive” in traditional ways of measuring productivity? Ellen laughs at husband Karl’s way of summing up retirement by saying, “I love retirement; I can do nothing better than anyone I know.” She marvels at his pride in making a statement that goes against all the assumptions underlying activity theory. How do we judge ourselves and others, based on the privileging of activity theory?

Jane reflects on a married couple she sees occasionally. The husband loves his music and could sit and listen to it all day. His health is declining. The wife is anxious to get into a continuing care retirement community (CCRC) from where she can remain active in her community. He views the CCRC much like a leper colony, where there is fear from contagion, and old people are age-segregated from the larger community. He doesn’t want a more active lifestyle or communal living; she does. We ask ourselves: What happens with someone who is disengaged more or whose health is compromised earlier or differently from their partner’s? What you dread is right in front of your eyes every day, as this older woman watches her spouse of many years withdraw into his music. Yet, he seems content.

From a macro perspective, Ellen contends that we make policies that privilege activity over disengagement. She remembers how the senior nutrition program would deny mobile meals to anyone who was able to get out so that they would go to congregate meal sites for lunch, but also for forced socialization. Or she thinks about the Serve America Act which privileges formal volunteer roles into which older people are recruited, when so many people are engaged in the

quiet tasks of caregiving behind the scenes and keeping their relatives and friends alive. Yet, it is the formal role that is viewed as the engaged role, but there is nothing so engaging as caring for a loved one.

Recognizing that Continuity Theory Makes Sense, Except When it Doesn't!

The continuity theory of aging states that middle aged and older adults make adaptive choices as they attempt to sustain existing psychological and social patterns by applying familiar knowledge, skills, and strategies. Yet, continuity theory only "works" if a person can make those adaptive choices. What about persons who experience cognitive decline or develop a dementia and cannot maintain continuity? What about the person whose choices and coping strategies have not worked well in earlier life? Is cognitive restructuring needed to disrupt those patterns? In other words, we are more of who we are except when we're not!

We've had a lot of political conversations ever since the presidential election. Our many conversations about President Trump and the debate in the media about whether a 71-year-old man can change, or will he continue to apply the same patterns he has used prior to his presidency? Isn't this a question about continuity theory? And is the assumption of his age meaning he can't change an ageist accusation? How ironic that we have had this conversation so often in the last year because we were ardent Hillary supporters. But as gerontological social workers, we have to question the ageism inherent in assuming that age is the critical factor here.

We have also talked about what provides continuity for us personally, and we've had to ask ourselves, "For whom are we dancing?" We have danced for various people in different periods of our lives and know how it feels not to have to dance without an audience in retirement when no one is watching. We have talked at length about how those persons for whom we danced were anchors, motivators, even critics that we tried to please. They provided continuity. Now, many of the people for whom we danced have died or are no longer in our lives.

Just in the last year Jane has lost Rich, Peter, and Celeste. Ellen has lost Pat and Emily. These people were part of our autobiography, and there is a sense of deep loss. Hagestad and Settersten (2017) articulate it well:

> A central aspect of understanding aging as interpersonal is that the older we are, the more likely it is that we have experienced the pain of losing longstanding relationships with others who constitute the "library of our lives." Some authors use the terms "consociates" . . . or "co-biographers" or . . . "convoys of support." (p. 137)

And what about the continuity of place (houses, communities, parts of the country)? Jane comes from Fall River and Somerset, near Boston, MA. Ellen has deep southern roots in East Tennessee. We often talk about Rowles' (1981) distinction between physical, social, and autobiographical insideness. Where we live is symbolic of our independence, thus we have talked about what happens if we have to give up those symbols, realize we may be seeing some

of these places for the last time, or they become unrecognizable as the landscape/architecture morphs and changes.

Assuming that Socioemotional Selectivity Theory Makes Sense, What Happens When Choices Are Not Within Our Control?

This theory maintains that, as time horizons shrink, as they do with age, people become increasingly selective, investing greater resources in emotionally meaningful goals and activities. In short we become more present rather than future oriented. This begs the questions: What do we like or want to do? What really interests us? Do we really know what means the most to us after years of dancing to societal norms? We have spent a good deal of time asking ourselves who are we versus what we do. Are we the sum of the choices we make?

Ironically, some of the people we would choose to spend more time with or keep in touch with are no longer with us. Each day we recognize how fortunate we are to have a close friendship, and we bargain with one another: If we live to a very old age, let's hope we can still hear well enough to talk on the phone, or let's move into the same retirement home in the same city as proximity becomes more critical. We realize that what we can control diminishes and we find ourselves negotiating about small things we can control.

We also have talked about the limitations of socioemotional selectivity: What if there is no one to take care of you? What happens when the person(s) you would have selected is no longer there? What if you have to depend upon "the kindness of strangers" because there are no preferred choices of caregiver? Perhaps this is what "love is an intimate stranger" means—should there come a time when we no longer have anyone or anything familiar in this life, then from whomever we receive care would be a "stranger."

Respecting Heterogeneity of an Aging Population Means Standardized Assessment Tools Are Limited

We know that older people are the most diverse of any age group because they have become more and more individualized over time, yet standardized tools are often not normed to diverse groups. People are moving targets—people change over time, change which often cannot be predicted. Yet standardized assessment tools are used. We have to remember that any assessment, no matter what tool is used, is only a snapshot in time. Things can change overnight. We have talked about the need for multiparadigmatic, multidisciplinary, and multidimensional approaches.

The same is true for assessors/practitioners—assumptions change over time depending on which paradigm is popular, on the result of new evidence, or on dominance of the prevailing culture. We can standardize a tool but not a client nor a practitioner. There are different ways of judging normalcy. Sometimes we need to reframe what is normal.

Ellen's aunt, Doris, lived in an independent unit within a CCRC, and the assisted living facility was in the process of being constructed. Doris couldn't remain in independent living, so she was given the option of temporarily moving to the nursing wing until her room was ready. Going to the nursing wing was like the kiss of death because it was rare that anyone was discharged to a lower level of care, and the people with whom Doris would be living had many more disabilities. Ellen and her aunt contrived a metaphor for this six-month period so that Doris would not become institutionalized. They called this a camping opportunity, and Doris would take very few possessions (just the bare essentials) and would read her large print books to get her through. She didn't want a calendar to remind her that there were months before she could move into assisted living, but one day a nurse arrived to administer the required mental status test, and when she asked the day of the week and the date, Doris hadn't a clue. Frightened that she would be deemed mentally incompetent to move out of the nursing wing, she called Ellen, who provided her with a calendar so she could keep track of the days/dates. When the nurse reassessed Doris, she got all the answers correct, and when her assisted living apartment opened, she entered with much relief. In this situation, an assessment administered out of context (Doris' desire to not keep track of time so time would go more quickly) could have kept her at a higher level of care than needed.

We know that there is a need for frequent reassessment due to the unpredictability of change. But we are now painfully aware of how assessment tools are used to determine our competence and how vulnerable we are if we don't perform well.

Knowing a Lot About Gerontology Doesn't Mean We Aren't Continually Amazed at "This is not what we expected"

How often have we said, "I didn't think it would be like this!" People expect us to know a lot, yet knowing about something is far different than experiencing it. In a way, this reflection is like a joint auto-ethnography in which we explore our own aging.

We have both had life threatening experiences in the last few years. Jane developed lymphoma, and when she was diagnosed at stage four, it changed her entire life. Months of chemotherapy mandated that she drop out of her normal routine and concentrate on a rigid treatment regimen that weakened her already-vulnerable system. This experience changed her life. Ellen had an acute episode with an allergic reaction in which she was temporarily cognitively impaired. In the emergency room they administered the clock test in which she was to draw a clock and place the hands at a given time. She remembers saying to the neurologist: "I know what this test is for. I've even given this test to older people, but I have no idea how to draw this clock." Fortunately, after five days in the hospital and a month of recuperation at home, her cognitive skills returned, but getting in touch with the vulnerability one feels under these circumstances remains.

In fact, we know enough to worry about all the things that can happen to us, most of which may never happen. But we have seen a lot of different scenarios about how people live (and die) in old age. This sets up a contingency planning approach in which we recognize that it's hard to

plan at all because we have no idea of what to expect or when to expect it.

We are married to two wonderful men, but we also find ourselves projecting onto them possible scenarios. Karl has a gallows humor, having been a hospice chaplain for years, so when he was sent to the sleep clinic and told he needed a Continuous Positive Airway Pressure (CPAP) machine, he looked at the nurse and said, “Everyone I work with wants to die in their sleep, so why would you want to keep me from doing that?” In a more serious vein, Jane’s husband Ron is in the process of planning to retire a business in changing times and struggling with how to divest, when to do it, and what to do. We’ve talked about how hard it is to be supportive of these men who don’t want to spend time chatting about the issues they face and who tell us we talk too much. We feel fortunate, however, for we talk with so many couples who are having tough adjustment issues when it comes to both being retired and sharing space in a new, more intensive way.

We’ve even talked about the game “spin the bottle,” but instead of a kiss, we wait to see who will have a serious illness, a financial burden, or even an unexpected death next. We’re not being morbid, just realizing that things change in a heartbeat and we may be going to a funeral or visiting someone in the hospital who was “okay” the last time we saw them. We’ve had to realize that intellectually we know a lot about gerontology, but emotionally there is nothing like being an old person to encounter what it means to be the person studied (instead of the person doing the studying).

We have talked about the uncertainty of not knowing what or when domains will change. Will it be our physical health, our cognitive state, our social support system, our economic resources, our quality of life? All of the above? Key questions are: Who will take care of us if we can’t take care of ourselves? What responsibility do we have to have a plan? How would we afford the cost of long-term care if our lives extend beyond what the actuarial tables project? Will we outlive our resources?

We have lots of conversations about how much time we have left, how much energy, stamina, and resilience we have, and how we increasingly need more down time to recover from things we used to do in less time and back-to-back with other things we were doing. Essentially, we are engaged in constant reassessment and an ongoing adaptation and accommodation process. The difference is that it is self-reassessment, not the reassessment of someone else.

Emphasizing the Importance of “Story” Has Become Increasingly More Meaningful

Our recent conversations have focused on the importance of story. Each person has a story, and many stories are never told. Professionals can become so intent on collecting assessment data that they don’t hear an older person’s story. Laptops can become barriers as we frantically type in answers to standard questions without making eye contact with the very person we are there to support, to help.

Jane recently experienced a situation in which she accompanied an older friend to the doctor's office. It became painfully obvious that the doctor had no context in which to understand this unique person's life, and he was not communicating with her. Ellen remembers how an older relative for whom she was doing long-distance caregiving had become "another blue hair" to the staff. We are both realizing that we are often the oldest person on a board or advisory council, the "elder" in a meeting, the only retired person in the room.

Hagestad and Settersten (2017) provide these insights:

> We see personal meaning as interpersonal. A sense of self is created and maintained through social mirrors, in webs of interdependent lives that span family generations and historical time. As societies change, so do socially constructed meanings. Consequently, the older individuals get, the more likely it is that they have core meanings that are not shared by many people around them, and they have few witnesses who know where they have been. To some extent, then, they become *strangers* to other people and even to themselves. (p. 136)

The presenting problem is often physical, but this is only the tip of the iceberg when it comes to fully recognizing the person. We cannot underestimate the importance of being recognized as a human being with a unique story. Too often we are "sight unseen," as if one domain defines us. Tools are multidimensional for a reason—because older people are multidimensional.

We find ourselves asking these questions over and over again as we seek to make meaning of this life stage.

- What do we think it means to be engaged? How are we currently engaged? How might that change as we age?
- What is our definition of successful/optimal aging?
- What gives our lives continuity? What values, people, and places give our lives autobiographical continuity?
- Instead of being asked, "What do you do?" or "What are you doing?," how would we answer if we were asked, "How are you being?"
- Are there people for whom we dance? If they were no longer watching, can we be as motivated?
- Who would we call in an emergency? Who would be our primary caregiver if Karl and Ron were not here?
- How well are we facing uncertainty?
- What factors, people, events, or experiences frame our stories?

Conclusion

To paraphrase the words of Mitchell's (1966) song:

> We've looked at life from both sides now
> From up and down, and still somehow
> It's life's illusions we recall.
> We really don't know life at all.

We have spent our lives interested in, studying, teaching about, and talking with older people. We hope we have listened well to their stories, learned from these interactions, and given good advice to our students. Now we are part of the older generation. We worried at one point that once we were no longer employed full-time, we might not have much to talk about; after all, we had spent many years sharing the insights, the ups and downs of our professional lives. Now we find that it's important to call one another as often as we can, for there are new discoveries to be made every day. Sometimes our gerontological backgrounds aid in our understandings, and other times we marvel at how our lives are not exactly as we had envisioned. We come to a conclusion one day, then change our minds the next. Are we just fickle old women, or is this what growing older is all about: finding new meanings in our daily lives; realizing that relationships become more and more important; and thanking our dead mothers for somehow, some way connecting us in the universe so that we have a trusted friendship to guide us along the uncertain pathway ahead?

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Men and Miscarriage: An Insider's Story from the Outside

Jeremy Brown

Abstract: This narrative is a story of the author's experience of miscarriage from a father's perspective combined with his role as an insider researcher qualitatively studying men's experiences of miscarriage. The author explores the dimensions of being an insider and outsider in the role of a father of miscarried children as well as in the role of a researcher. This is also a story of discovering how disenfranchised death separates us and has the potential to connect us. Lastly, this is a revelation about the unexpected disconnection that stems from being an insider researcher.

Keywords: men's studies, miscarriage, grief, qualitative research, grounded theory, pregnancy, insider research

We frequently think of loss as a disconnection, and yet I find that death often brings people together. Mourners join in support of memories shared as well as in grief for opportunities that will never come. In this way, loss both separates us and brings us together. My wife and I experienced two miscarriages some years ago, and so few people asked about how the loss was for me that I began to wonder about the uniqueness of my experience. Despite a broad societal presumption that men do not want to talk about their emotions, I certainly wanted the opportunity. So, too, did nearly all the men I invited to participate in my grounded theory research on men's experiences of miscarriage, many of whom had never been asked to tell their story.

A Ceremony for Two

My wife and I had nearly made it to the three-month mark when she and I learned that our first pregnancy had miscarried. She had started spotting on a Friday. While we knew this didn't necessarily indicate a problem, we were nonetheless scared. It was possible that the bleeding was from the placenta imbedding to the uterine wall. However, the bleeding persisted over the weekend, and on Monday afternoon we scheduled an ultrasound.

Having feared the possibility of a miscarriage for twelve weeks, I had thought about this moment many times. Yet, I hadn't known how to approach the event when it arrived. I dressed up in a three-piece suit, the one I reserved for special occasions. After all, whether alive or not, I was preparing to see our baby for the first time. There wasn't anything I could do to change this situation, but I felt that showing my respect in this physical way was something.

To learn that your child is neither alive nor dead inside the womb, but has instead passed on unnoticed some weeks ago, is information for which it is quite impossible to prepare. I simply had no framework for this situation. It was certainly not one of the two options for which I had worn my suit. We had missed the birth and the funeral. Where had we been when the baby died? Were we fantasizing about our family's future? Were we arguing over finances? Perhaps we

were having sex, or in the midst of an early morning dream, or reading a magazine on the toilet.

I responded to this news with a gamut of emotions. My grief was knotted with anger, confusion, and fear. As though those unwanted feelings were not enough, I also felt guilt and relief. I had seemingly innumerable emotional reactions with very little sense of how to experience them, when to experience them, who to talk to about them, and how and when to move on from them. All of that was the crux of what I was facing, and I felt alone.

Months later, sadness had continued to accumulate inside of me following a second miscarriage. My younger sister's belly was now enormously pregnant. In contrast, my wife's body was thin with a tiny dandelion seed inking, a trial placement for a tattoo to commemorate our lost babies. I felt darkly moody, indecisive, and exhausted. Should I be outside with her or just remain lying in melancholy on the couch? It seemed it wouldn't matter what I did until my leveed grief broke within me. My sadness pulled at me just enough that I felt its tug, but not enough for me to know from where the pull came. Like a magnet rather than a taut rope, I couldn't seem to easily follow the tug to its source; I only felt its force reacting within me.

The first crack started when I felt sorry for myself for not building a snowman with my wife. Such childhood activities ought to always make one happy and satisfied with life, right? Well, not so, not now. My wife came in, sat on the couch, and the crack silently seeped. Eventually, she spotted my tears, and the levee was rent. "I miss our babies...I miss our babies...I miss our babies…," on and on and on inside my head, yet the words never made it out of my mouth. As my tears began to subside, "I miss our babies...I miss our babies...I miss our babies…," and again I cried. I was afraid that, without the words repeating in my head, the levee would seal itself back up.

I turned to my wife and asked her why she chose a dandelion seed to commemorate our babies. It just came to her, she replied. She explained that most people think of dandelions as weeds, something to get rid of, but they're both food and medicine for humans. I thought about when a dandelion is pulled out of the ground; it always wants to break apart, it would seem. You can remove it from sight, but it remains deeply rooted to sprout again despite all efforts to pluck it away.

Later I decided I also wanted two dandelion seed tattoos. One would be on the inside of my forearm where it would remain public. For the other, I shaved a space over my heart on my chest, tattooed the symbol, and then let the hair grow back to obscure this more private remembrance of our loss. At times, I wanted to be asked about my pain and sadness, while at other times I wanted to keep it hidden from sight, just knowing it to be so close. I didn't want to forget it, but I didn't always want to be reminded of it either.

It was painfully clear that family, friends, and even health care providers didn't know how to respond to a man's pain from miscarriage. I tried finding resources to normalize my experience, but the vast majority of what I found focused on men's supportive role with very little, if

anything, about their own experiences of grief. Compared to the information and support available for expectant women (though also limited), bereaved men have significantly less social support regarding the loss of their child. In fact, the majority of information regarding miscarriages typically focuses solely on reinforcing the necessity of men's care-giving roles toward their partners. Consequently, men are expected to support and care for their wives after early pregnancy loss while receiving little support and care themselves.

One day while making lunch for an adolescent client in a residential program, the boy asked: "You don't have kids, do you?"

Despite all the other times people have asked me that question in one form or another, I didn't know how to respond in this instance. This particular question was uniquely penetrating, leaving me wondering what part of me was divulging this information without my knowing. What of my inside was I unknowingly revealing on the outside.

Wanting to be truthful and yet cautious about crossing boundaries, I responded, "No, but my wife and I are trying."

"Yeah, I knew you didn't," he stated as a matter of fact.

Had my behavior betrayed me? Was there something I would have done differently had our babies lived? I wondered if there is something inherent in a parent of children who enters this world breathing and heart beating that I, somehow, lacked because our babies didn't make it that far? I imagined that somewhere there must be, hidden outside of my wife's and my view, a chart that measures whether the pregnancies were considered viable enough, alive enough, hope-inducing enough, that we could use to judge whether we were justified in labeling ourselves parents. Social taboo, it would appear, kept this chart tacked up on the inside of its front door, just out of sight of visitors at the doorstep, like us. It seemed that I couldn't call myself a parent, and yet we had created two children.

Among the worst were the times when people would ask my parents: "Do you have grandchildren yet?" ("You had better fucking say that you are grandparents," I would howl at them in my head.) Yet I realized that had they said yes, they would have had to answer the inevitable line of questions starting with "How many?" and "How old?" Did I really expect my parents to respond, "Well we had two grandchildren, but they were only 10 and 12 weeks when they died from miscarriage"? Those curious folks didn't want that much truth; it would have been too much. I knew very intimately how much it was indeed, and I agree, it did feel like too much. (Information like this changes things; it alters assumptions.) But all the same, I wanted to be seen as a suffering parent, not a potential parent, nor an almost-parent, but an actual parent, a father.

In all honesty, sometimes I responded to queries of my parenthood with the easy "not yet." At other times, I told inquirers about the miscarriages. Some questions were not easy to navigate

because they depended on so many known and unknown factors. Moments likes these were good for me to remain mindful of when asking others questions, especially other men. And partly because so few people asked me about my experience, I decided that I was going to find out what other men thought and felt about their experiences of miscarriage.

A Father on the Inside

In the parlance of qualitative research, I was an "insider" and my experiences were dubbed "received knowledge." In the grounded theory study I conducted, it became important for me to identify where the knowledge I had received through my experiences overlapped that of the other men. Even more, in my inner life, it was imperative that I try to identify my responses to my miscarriage experiences as well as to my research so that these internal collusions didn't take me over or obtrude on the study.

I began by considering not just what I had wanted others to ask me but also what I hadn't wanted them to ask of or say to me. I considered very carefully what I was not going to ask these men and, more importantly, why I was not going to ask these questions. The potent questions that men don't ask each other are made impotent by our fear that we will have trespassed or inadvertently singled ourselves and our experiences out as abnormal.

Early on, I wondered how much of my own story to divulge in these interviews. During one interview, I experienced a compulsion to share my story with the participant in an attempt to acknowledge and affirm the validity of what was being shared with me. On a few occasions, I did actually speak about my own experience, but most of the time I just noticed that I was feeling compelled to do so. Instead, I conveyed my understanding to the participant through reflexive listening without the risk of the participant overlapping my story with his own.

Many of the men I interviewed were courageously open about their emotions. In my first interview, I had forgotten to bring tissues. I wondered afterward what this said about me to the man I was interviewing. Had I given him the impression that I had not expected him to cry?

Not surprisingly, a lot of the participants' stories resonated with my own. Through these interviews, I began to recognize just how entwined the stories of these fathers were with their wives and just how much on the outside of the miscarriages they felt. Far more often than not, when I asked them to tell me about their stories, to describe what happened, they would recount what they witnessed and what they imagined their partners were going through at the time.

A Researcher on the Outside

If I am totally honest with myself, I had expected that conducting this research would bring me connection with other men through our experiences of miscarriage. And while, in ways, this was the case, it was also certainly a lonely and isolating experience. Being a researcher afforded me the opportunity to seek out men willing to tell me their stories and the possibility to make the

connections for which I longed. In that position, however, I had to uphold, to the best of my ability, my role as an unbiased researcher. I vacillated between wanting to connect and share with the men, to feel like an insider, and yet recognizing the obligation to keep my experience out of their stories. And so it was that my experience would continue to remain on the outside.

The greatest challenge of my study was the struggle to find a way to allow space for my experience without obtruding upon my participants' stories. The title insider researcher seemed such a painful misnomer to me. As a qualitative researcher I was responsible for remaining as unbiased as possible. To me, the difference as an insider researcher meant that I had to wrestle with this responsibility even more so. At times, I did share. Men frequently wanted to know if I knew what they were telling me, if I could relate to them. No matter how much I ended up sharing, I felt I was always going to remain on the outside, wondering whether I had shared too much. I frequently wanted to let out my emotions and tears, but as a researcher I felt compelled to keep all that hidden inside, quite the opposite from months earlier when I struggled to let my sadness out following our own miscarriages.

I had sought out men to hear their stories and discovered, all the while, the important challenge of keeping mine to myself. Yet, what I really wanted was for all of us to know that our stories were not so different. In the end, I came to realize that I had engaged in this study in part because I wanted to feel like an insider, yet my role as the researcher created distance between me and the other men. Overwhelmingly, the research revealed that we had all felt like outsiders in one way or another—outside of our partners' experiences, outside of other men's experiences, outside of the visions we had of our now-miscarried children. And ultimately, being outsiders was a key experience that had connected us.

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Reflections: My Career in Clinical Social Work

Joan Granucci Lesser

Abstract: This article presents the author's reflections when she closed an independent clinical social work practice in a small northeastern city. She discusses how the intersectionality of her social identity and her transition from working-class roots to professional status influenced her personally and professionally. She highlights intersubjectivity, multiculturalism, and social justice as theoretical frameworks that guided her practice, and she illustrates with practice examples.

Keywords: social class, intersectionality, social justice, multiculturalism, intersubjectivity

Introduction

At the end of 2016, I closed a 24-year independent clinical social work practice in a diverse small city in the Northeast. I have been a clinical social worker since I graduated from Columbia University School of Social Work in 1976. I held clinical, supervisory, and administrative positions in New York in schools, hospitals, and community mental health before opening an independent practice in collaboration with my husband, a family practice physician, to provide "a holistic approach to patient care" that integrated mental health services and primary care medicine in one practice location, making services accessible and less stigmatizing because "the services were accessible in the familiar health care environment" (Lesser, 2000, p. 119).

The practice opened in Holyoke, MA a mid-size, ethnically diverse, northeastern town. Most clients had managed care insurance plans, Medicare, or Mass Health, which enabled them to seek treatment not otherwise available in an independent practice setting. Additionally, many of the clients were new to counseling services, and the location of the practice within a medical building/practice setting eased the transition to mental health services (Lesser, 2000). My goal was to make private mental health services available to a wide socioeconomic range of clients and provide them with a choice that many disadvantaged and marginalized clients may not have always had. I was able to do this by becoming a provider for most insurance plans, including Mass Health, which provided opportunities for a treatment option generally afforded only to the middle and upper classes (Cooper & Lesser, 2015). Over time, I expanded my solo practice into Pioneer Valley Professionals; a multidisciplinary community-based independent group practice with a commitment to therapy for clients who were generally underserviced in private practice.

I worked with children, adolescents, adults, and the elderly from different races, ethnicities, social classes, countries of origin, abilities, and religions. These included white ethnic Polish, Italian and Irish Americans, French Canadians, Puerto Ricans, Latino immigrants from the Dominican Republic, Africans from different countries, Hindu and Muslim Indians, Holocaust survivors and their descendants, Jewish and Christian refugees from Russia, veterans of several different wars, and aging survivors of World War II. Some of the children and adolescents were under the guardianship of the Department of Children and Families. Several were

first-generation Americans with a bi-cultural identity who were referred by the courts, schools, parents, doctors, mental health professionals, and insurance plans. I saw clients with trauma histories, mental health disorders, physical disabilities, neuro-developmental challenges, mood disorders, cancer, and a wide range of psychiatric and situational problems.

As I reflect on my years of clinical social work practice, I realize I have been strongly impacted by "a powerful identification with my class of origin and structures of experience" (Botticelli, 2007, p. 122). The consciousness of class was part of my earliest life experience growing up in a small Italian American neighborhood just south of Greenwich Village, the towering arch of Washington Square, and the sprawling buildings of New York University. Although an avenue (Houston Street) separated my family and neighborhood from "The Village," it represented such a class divide that my parents, who were born in the United States, referred to those living north of Houston Street as "The Americanas." I attended neighborhood Catholic schools through high school and graduated from City College in 1974. I was awarded a National Institute of Mental Health Training Grant to attend Columbia University School of Social Work.

I crossed a major class boundary when I went from City College to Columbia University, where I began to appreciate the complex significance of my internalized class representation (Russell, 1996). The intersectionality of my own social identity—race and ethnicity (White Italian American), religion (Roman Catholic), gender (female), and sexual orientation (heterosexual)—has impacted my self-concept, demonstrating the "profoundness of internalized class relations" (Botticelli, 2007, p. 124). I also came to appreciate and subsequently support my clients in recognizing that class identity is the result of the institutional structures often based on privilege and disadvantage (Kim & Cardemil, 2012). Not surprisingly, class has been the variable most subject to countertransferential challenges as I transitioned from a working-class identity to a professional identity. I remember struggling in my work with a professional African American woman who came from a working-class background similar to my own and was able to access the kind of college education that was not within my reach. In this instance, I recognized that despite some advantages this client had, her struggles with ongoing racism as a black woman and my privilege as a white professional woman were constants (Cooper & Lesser, 2012).

Since "identities are complex, contextual and situational" (Lesser & Pope, 2011, p. 22), class knowledge requires an understanding of its interconnectedness with other diversity components such as race, culture, gender, and ability. The connection between race and class is very powerful in America because the vast majority of the working poor and unemployed are persons of color (Kochhar & Fry, 2014). Class contributed to my understanding of the double jeopardy of being a person of color from a working-class background when a single, female woman shared the numerous microaggressions she suffered through the years in her work as an administrative assistant. When she protested, she was silenced and her valid concerns were minimized with the "pejorative stereotype of the angry black woman" (Ashley, 2014, p. 27). This woman came to therapy with symptoms of depression related to her years of struggling to prove herself as competent and worthy of a promotion, while she watched her less-skilled white

colleagues advance. She had worked hard to get herself through college and tried to win approval by overfunctioning and by working extended hours. Despite this, she remained in her administrative position with little opportunity for advancement and/or financial remuneration for her efforts. Bonilla-Silva and Baiocchi (2001) write that the significance of racism in the post-civil rights era is often minimized, which is exactly what occurred in this case. Therefore, treatment of this client's depression also focused on my giving voice to the discrimination she was experiencing as a black woman. I said: "It seems to me that you are being systematically discriminated against which is something important for us to talk about." It also involved dialogue about how she felt about working with me—a white woman—under the circumstances she was describing as well as how I felt about hearing what she disclosed and working with her—a black woman being discriminated against by white people like me. I continued: "Is this something we can discuss together? I'll share that it makes me a bit uncomfortable, but I think it's important because I know I have benefitted as a white woman in my career in ways that you have not benefitted as a black woman in your career." She told me it was the first time she heard this from a white woman, and it opened a dialogic conversation, which focused on her history of racial discrimination as a black woman growing up in the segregated South. Leary (1997) describes the significance of talk about race as an "intimate and enduring aspect of personal social identity" (p. 179) and not something to get past in therapy. Our conversations moved to my supporting her in filing a complaint with the Massachusetts Commission Against Discrimination.

Class challenged me to reflect on the intersectionality of class and race when working with clients who had class privilege but were from oppressed racial groups, such as highly educated students and professional persons of color. One African American student remarked on her surprise when she felt identification with her clients of color but realized that they did not necessarily feel the same sense of identification with her. She told me that these clients identified her more by her class than by her race, and she felt blindsided by this possibility. Collins and Arthur (2010) affirm: "Many clients hold multiple and sometimes conflicting cultural identities that impact their worldviews" (p. 219). I also remember a session with an African American man who shared his experience as a first-generation college student. He told me that when he first heard an African American professor refer to "persons of color," he didn't know "who the hell she was talking about, because when [he looked] in the mirror [he didn't] see a person of color, [he saw] a Black man." I suggested that race and class, which is what he was talking about, were pretty complicated issues: "With us, race difference is in the room, and perhaps with your professor, class differences were in the room." He thought about this and said: "I don't expect you as a white person to get who I am, but I expect more from my own people."

Class impacted my ability to understand and support white working-class clients to stretch and appreciate the profoundness of race in our society. A young, white, working-class woman shared: "I'm actually afraid to talk in my psychology class because I am afraid I will be told to check my privilege. I don't even understand this because I struggled so much financially." Within the framework of white identity development, my client's attitude was ethnocentric, as my own was as a young white woman from a working-class family those first days at Columbia,

when I had absolutely no idea where I fit in. I clearly was not one of the few students in the racial minority at the time, but I certainly did not identify with the financially and socially privileged middle and upper middle class white students (Sue & Sue, 2015); I used my personal experience to empathize with this young woman while also asking her "to consider the ways in which being a white woman struggling financially may be different from being a black woman struggling financially or being a black woman." I shared: "I also struggled to appreciate that difference in my young years, but that is exactly what white privilege is about, which is seeing the world through white eyes and assuming those are the only eyes." I added: "Considering the question enabled me to check my own privilege while also being self-compassionate about my own journey from a working-class family and identity."

Over the course of my social work education and beginning years as a clinician, I moved toward the stage of dissonance, when I was more directly in touch with being privileged as a white person in spite of economic hardships (Sue & Sue, 2015). This was an emotionally uncomfortable time, especially working with diverse clients who were in their own subjective stages of class and racial identity formation. I moved to a stage of introspection where I had to explore what being white in America means, including my own implicit racism, in order to truly engage with clients in dialogic conversation about privilege and oppression as it impacted their lives and my own (Sue & Sue, 2015). My own white identity development enabled to me to discuss and validate this client's personal history and struggles and empathically support her in enlarging her class-based perspective to appreciate the myriad ways in which race overshadows class in our society (Stracker, 2004). This is especially significant in contemporary America, where racism is minimized and dismissed as no longer a major factor in determining opportunities in America (Bonilla-Silva & Dietrich, 2011; Bonilla-Silva, 2012, 2015, 2018; Kochhar & Fry, 2014).

Watts-Jones (2010) discusses how the therapist's self-disclosure of social identity can be used to address identity differences in the therapeutic relationship as well as outside of it. She challenges therapists to consider the location of self-interactions, asking: "How does a White therapist say to clients of color that s/he fears unknowingly saying something racist," or "How does a Black therapist say to a White client, I wonder if you will be able to take me seriously given the history of racism in this country?" (Watts-Jones, 2010, p. 409).

I used many different theoretical frameworks to guide my practice with clients over the years, including psychodynamic, cognitive behavioral, narrative, solution focused, and internal family systems, among others. However, multicultural theory, intersubjectivity, and social justice were the metatheoretical frameworks that contributed to my becoming a culturally competent social worker.

Intersubjectivity Theory

Intersubjectivity is a postmodern, metapsychoanalytic theory that examines the subjective relatedness between the therapist and the patient. The components of the therapist's and the

patient's subjectivities are the emotional conclusions that each has drawn from lifelong experience of the emotional environment. Although the therapy is always for the patient, the emotional history and psychological organization of patient and therapist are equally important to the understanding of any clinical exchange. Personal history shapes and limits a therapist's capacity for empathic introspective understanding because it influences the emotional availability to any given patient (Stolorow, Brandchaft, & Atwood, 1995; Natterson & Friedman, 1995; Benjamin, 2004). As Natterson and Friedman (1995) write: "The therapist's subjectivity plays a continuous role in shaping the therapeutic process" (p. 4). "What we inquire about or interpret or leave alone depends upon who we are" (Natterson & Friedman, 1995, p. 9).

Bowles (1999) describes the concept of the third space in the theory of intersubjectivity as the interactional field created "when the subjectivities of the therapist and the patient come together, allowing both to practice new ways of interacting with another" (p. 359). I engaged in many third-space conversations with my clients that involved the different intersectionalities of our social identities (Benjamin, 2004). I did not leave my working-class background behind when I moved into a middle-class professional space. It evolved in the work I did with countless clients over many years as I listened and grew alongside them. This is what both solidified my roots and enabled me to coalesce the identity I now have. Liu et al. (2004) describes class as being fluid and relational, resulting in a shift in perceptions, feelings, and experiences related to our class identity. I developed a class competency that, according to Strier (2009), includes: "knowledge, skills, theoretical approach, and critical awareness required to effectively help clients oppressed by class structure" (p. 240).

Intersubjectivity theory recognizes that the therapist is never able to be completely anonymous. There are inevitably self-disclosures as the therapist and the client communicate with each other both verbally and non-verbally. Natterson and Friedman (1995) address this when they write about the therapeutic relationship: "This is the reality of a relationship, and in this context a huge array of beliefs, memories, values, ideas, and expectations in each person become knowable to the other, and innumerable influences upon each other occur" (p. 70).

However, within an intersubjective framework, the therapist also consciously, deliberately, and judiciously uses self-disclosure. The therapist makes specific decisions about self-disclosure based the meanings of such disclosures for the patient and therapist, and whether such disclosures are likely to facilitate or obstruct the therapeutic process (Natterson & Friedman, 1995). I made a conscious decision to let Jane, a devout Roman Catholic with a tendency to be obsessional about confessing her sins, know that I am Roman Catholic. I gently told her: "I appreciate your devotion to confession and absolution because I was raised in that tradition, but I think it might be important to consider the ways in which scrupulosity is actually interfering with your desire to feel spiritually connected." She felt understood and was able to then engage in identifying when this occurred, taking small steps to reframe her thinking and actions. Maroda (1999) writes about mutual recognition and the importance of the therapist "following the patient's lead regarding what he needs at a particular time" (p. 480).

I also shared my Roman Catholic religious tradition with a woman who had been sexually abused by a Roman Catholic priest and felt guilt about disclosing what occurred and seeking justice. She initially felt that I was not able to understand the power of the priesthood or her allegiance to the church and was relieved when she learned that I could meet her in a particular transitional space related to a shared worldview. Ganzer (2007) refers to this as when "the therapist's use of self becomes an interactive, subjective, and empathic means of furthering therapeutic action and portending a positive outcome to the treatment" (p. 119). I cautiously and purposefully left my own comfort zone related to spiritual self-disclosure in this exchange with my client, considering Watts-Jones' (2010) cautionary words: "It is not easy to figure out how to foray into these issues at the level of depth that they often operate and maintain the possibility of therapeutic relationship" (p. 409).

Foster (1999) introduces the concept of "cultural countertransference," the "clinician's own culturally based life values; academically based theoretical beliefs and clinical practices; emotionally charged prejudices about ethnic groups; and biases about their own ethnic self-identity" (p. 270). Cultural countertransference is a concept that can be extended to multiple identities including class, ableism, gender, sexuality, education, and faith, among others. Therefore, the entire range of racial, sociocultural, and political identities and subjectivities the therapist and patient bring to their relationship, including issues of oppression and privilege, are all topics for challenging and growth-enhancing conversations for both the client and the therapist (De Lourdes Mattei, 1999).

Natterson and Friedman (1999) believe our work with clients is to some extent always influenced by the patient's psychological life as well as our own. They write: "An interpretation is always an intersubjective event" (p. 79). In my work with a client suffering from metastatic cancer, I recognized the depths of despair I felt each time I sat with her and how it was clouding my ability to listen attentively and remain empathically attuned. Listening to her story brought me back to my own father's death at age 54 from cancer when I was just beginning my graduate studies in social work. I distanced from that pain by immersing myself in my work, but now, years later, I had a chance to do things differently. I regrouped and listened to this man talk about preparing his will and saying good-bye to those he loved before he was no longer able to do that. I replied: "I see how important it is for you to get your affairs in order and be able to say good-bye to your family while you feel you are able to." In order to be able to construct an interpretation, I had to be open to my own pain so that my attention could focus on the patient's subjective state, informed by the new insights I achieved about my own relationship to pain. As Noonan (1999) shares: "The patient feels understood when the therapist feels understanding" (p. 127).

I worked with a young woman who had lost both her legs as a child in a horrific accident. I had to reach into myself to truly listen to the daily struggles she faced when she woke up, when getting out of bed and dressed required a great amount of effort. "Don't try to get me to talk about what I went through after I lost my legs," she would yell at me. "I won't have my legs no matter how much I talk about it. All I want is for you to see that I can't find a job no matter how

smart or educated I am because people don't want to hire someone with no legs. Do you understand that?" I felt her anger and then said, "I am beginning to understand why you get so angry at people because they, like me, in these sessions with you, just don't really get it, and I'm very sorry about this." After I owned my limitations in being able to really understand and/or appreciate what my client was struggling with on a daily basis, she was able to be more authentic with me as we worked on "co-creating subjectivities as a critical component in fostering this new relationship" (Katz, 2010, p. 314). In numerous therapy sessions, the intersectionalities of our social identities mixed and mingled as we dialogically created a third space that included her experience of a discrimination that I would never know, and I worked to create a space to talk about it. Katz (2010) describes the therapeutic relationship as providing a "new interaction" that enables the therapist and patient to engage in "new relational possibilities" (p. 314). I supported this client in filing a civil rights complaint against a previous employer and helped her address her impulsive, angry, and often-inappropriate responses to people, which contributed to her interpersonal challenges. Gasker and Fischer (2014)note: "Relationship is central to a social work understanding of social justice" (p. 51).

Multicultural Theory

I was initially trained as a psychoanalytic psychotherapist, and over the years, I realized the importance of not privileging that particular theoretical framework. I studied cognitive behavioral and mindfulness therapies as well as distinct models of trauma informed psychotherapy, among others, recognizing how different theoretical lenses influence our clinical assessments. Multicultural theory supports the use of different theoretical models and clinical practice skills to be effective with diverse clients (Sue & Sue, 2015). Selecting the most appropriate theoretical lens is an important aspect of multicultural practice, but it is not the only aspect that merits attention. Multicultural counseling competencies have expanded beyond those for specific populations. Greater attention is now given to the intersections of racial, socioeconomic, class, age, religious, spiritual, gender, sexual orientation, ability identity, and cultural context of clients and communities, especially for those from a historically marginalized status and a social justice scholarship base (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Collins and Arthur (2010) recommend a conceptual framework that includes an appreciation of cultural factors, personal identity factors, contextual factors, and universal factors, including differences in experiences between dominant and non-dominant groups in society.

A multicultural model also stresses the importance of the therapist's own engagement in cultural identity development, recognizing the helping relationship as a significant interpersonal context in which culture must be discussed. Cultural sensitivity and cultural competence require this type of relational engagement, building on cultural strengths and tailoring treatment to cultural values (Kaplan, 2004; Santiago, Kaltman, & Miranda, 2013). I worked with a number of middle-aged Latina women who expressed gratitude for the help they received by cooking and baking samples of their ethnic foods. I always accepted these gracious gifts and often took a first bite during the session to show my appreciation.

Yan and Wong (2005) suggest a multicultural perspective that shares some similarities with the theory of intersubjectivity and recognizes that "one's understanding of one's own culture is always developed through interaction with others" (p. 186). Both the clinician and the client engage in "intersubjective reflection, which is a dialogic process in which both worker and client interactively negotiate, understand, and reflect on their cultures with reference to their understanding of the problem presented by the client" (Yan & Wong, 2005, p. 186). This includes social justice-oriented inquiry about community and societal being, including "oppression, stigma and other abuses or violations of human rights" (Cooper & Lesser, 2015, p. 46). Each learns from the other in ways that provide new experiences and contribute to change.

Social Justice

The value system underlying the social work profession is social justice. The Code of Ethics of the National Association of Social Workers (2017) lists social justice as a core value and "the challenge of social justice" (p. 5) as an ethical principle. Therefore, psychological accounts of painful personal history should not necessarily be privileged over narratives where individual experiences may be caused by sociopolitical issues. Bell (2007) reminds us that diversity and multiculturalism are also tied to unequal power differences among different groups in society. Dietz (2000) affirms: "In order to challenge oppression, social workers must support [their] clients in naming their experiences of oppression" (p. 503). We, as therapists, have to understand when a problem stems from racism or bias in others so that clients do not inappropriately personalize problems.

Clinical practice and psychotherapeutic solutions should include socioeducational dialogue that communicates an understanding to clients about the impact of social and historical forces on their personal psychological development. Appio, Chambers, and Mao (2013) discussed the significance of "validating clients' experiences of institutional barriers" and supporting them to "actively challenge oppressive institutional practices and work towards social change" (p. 160). Gibbons (2011) also writes about this type of empathic connection: "An enhanced feeling of power grows out of the healthy interaction with empathically attuned others, contributing to the capacity to act in the environment with a sense of self-efficacy and purposefulness" (p. 245). Therapy can then include supporting individuals to take steps in the sociopolitical arena on their own behalf as part of their recovery from traumatic experiences. We can enable participants to develop a critical consciousness that is fundamental in moving from a position of powerlessness, internalized oppression, and self-blame to one of empowerment toward individual and social change. I worked with many young clients who had behavioral problems that were related to undiagnosed conditions such as ADHD, dyslexia, and anxiety. These children and adolescents were academic underachievers with compromised self-esteem. Advocating for appropriate educational testing often resulted in individual education plans that focused on providing the type of assistance needed for these youngsters to have academic success, which decreased negative behaviors. Clients need encouragement to explore options and make informed decisions about actions to pursue (Appio, Chambers, & Mao, 2013).

Janie was a college student whose life was impacted by professors who were lax about safeguarding her confidentiality regarding her accommodations as a student registered with the Office of Disability Services at the college. She was sad, anxious, and disheartened by her college experience. An empathic therapeutic approach with this client included helping her address the anxiety and shame she felt as a result of these experiences. It also included opening a conversation focused on psychoeducation, guidance, and support in filing a complaint with the State Education Department's Office of Civil Rights. The result was a feeling of empowerment for this young woman when her complaint was validated and resulted in the college having to institute appropriate education for the college's Office of Disability Services as well as those professors who had violated her civil rights so that their actions did not extend to other vulnerable students. This young client and many others with similar struggles also taught me biases "about preferential teaching and learning styles, which are also embedded in the socio-environmental milieu" (Lesser, 2017, p. 2).

A step in supporting my clients to pursue social justice for traumatic injuries was to recognize and discuss how injustices and inequalities may be implicitly enacted in the therapeutic practice. An example of this occurred when I was repeatedly challenged by a patient with serious posttraumatic stress disorder who projected his sense of rage at the world onto me. I felt emotionally depleted and found myself suggesting that he might not be happy with me as a therapist and may want to seek a consultation. He challenged this and said: "Oh I see now you are using your power to get rid of me and you're doing it like you're doing me a favor, right?" I started to object but realized that was exactly what I was doing and responded: "You're right, I did do that. I was feeling frustrated and got angry at you." He calmed down and said: "Maybe I make other people feel that way also when I am always angry." I replied: "Well, I just want to say that may be the case and we can talk about it, but I still want to own that I could have handled things differently, and that's about me and not about you."

It is important to identify systemic barriers associated with sociocultural forms of oppression in order to establish more egalitarian therapist-client relationships that do not focus solely on the personal and the interpersonal (Strier, 2009). This particular client had suffered not only abuse by an alcoholic father but also the indignity and injustice associated with having a learning difference in an educational setting that did not recognize or assist him, and that contributed to profound damage to his young self-esteem due to discriminatory educational practices. His educational experiences led to a compromised ability to support himself with something other than minimum wage positions, which took a toll on him physically and psychologically. Addressing his anger included recognition of his value as a hard working, blue-collar man now faced with a self-perceived shame of applying for social security disability benefits. Although we shared working-class roots, I had the ability to achieve upward social mobility, which this client did not. As Ganzer (2007) notes: "The relational self of the clinician, as well as the patient, is acquired through and defined in the context of relationships; and these relationships operate in social, cultural, and political contexts" (p. 118).

What I found in my many years of practice in Holyoke, MA was that poor and working-class

people need economic opportunity. However, they also need clinicians who practice within a social justice framework, who want to inquire about and listen to the impact social forces have on their lives. They can then share feelings, reach for new goals, and do so within the "parameters of a safe interpersonal alliance" (Smith, 2005, p. 692). The social work literature would benefit from additional research in this area so that integrative models can be developed and practiced.

Summary

Noonan (1999) talks about the importance of the therapist's "affective needs, which include the need to feel valued and significant to another, and in the case of the patient, both as a therapist and as a person" (p. 39). I realize that my own affective needs include mourning the end of my practice and my relationships with clients I saw regularly and, in some cases, for many years. I was privileged to be trusted with painful memories and experiences. I worked with many clients to deconstruct trauma narratives, enabling them and myself to achieve personal growth because, in spite of differences, we were able to share the common human experience of connectedness (Sue & Sue, 2015). I felt empowered professionally by my ability to see people grow in self-esteem and self-assurance psychologically and, in many cases, socioeconomically. Each step in a client's growth was also a step in my own growth in self-esteem and self-assurance, psychologically and socioeconomically. I feel incredibly thankful to all of my clients for the opportunity they gave me to support their changes and to be changed by them minute by minute, hour by hour, in countless conversations over many years. During our final good-byes, many clients told me that I would always be with them, and I told them they would always be with me. I have deeply internalized each and every one of them, and for this I am eternally grateful.

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Disclosure in Teaching: Using Personal Mental Health Experiences to Facilitate Teaching and Learning in Clinical Social Work Practice

Rosalyn Denise Campbell

Abstract: Disclosure is often used as a teaching tool in a variety of learning and teaching contexts, settings, and disciplines. This paper shares one instructor's view on disclosure in teaching clinical social work practice courses. It discusses how disclosure is used in the classroom and explains why the instructor sees it as a valuable education tool.

Keywords: teaching, disclosure, social work, higher education

"When I attempted suicide…" I had said it. I did not mean to say it, but there it was. I was standing in the classroom responding to a student who struggled to understand the depths of despair that fueled a client's suicidality, and I said it. I had just disclosed to my students that I had attempted suicide. I kept talking as my eyes scanned the room. Some students stared at me intently. Others averted my gaze. The room was silent now. No keyboard clicks. No rustling of pages. My words simply hung in the air. I then moved away from the topic, not that I was embarrassed or scared; I just simply continued with the lesson of the day. But I did wonder: "Was that too much?"

I had been teaching mental health-oriented practice classes in social work for five years at that point. I had been struggling with my own mental health issues a great deal longer. After years of suffering, hiding, recovering, sharing, and healing, I had gotten to a place where I felt comfortable discussing the topics of mental health, illness, and wellness, even my own. So, when I stood in front of the class that day, I was ready. I was ready to instruct students in an area where I felt at home, if you will. I was ready to make, if need be, my typical "when I was depressed…" or "when I was diagnosed…" or "my therapist told me…" statements to simultaneously illustrate the mental illness experience while destigmatizing it. But I never intended to tell my students that I had once…well, really, twice…attempted to kill myself. But I did tell them. I had disclosed.

The Use of Disclosure

Disclosure is a term and a technique we are very familiar with in social work. As social work practitioners, we talk about it often. We talk about the need of disclosure from our clients and how them being open and honest assists us in effectively assessing them. We talk about the use of disclosure as a practice technique, a method that allows us to use ourselves as a mirror to reflect back to clients how they are being seen, heard, or understood (Raines, 1996). We also talk about the rules and risks of disclosure alongside its ethical practice (White, 2007/2008). However, we talk far less often about *personal* disclosure, the kind that is more private. In one study that investigated social workers' attitudes towards and engagement in self-disclosure, they

"generally expressed positive attitudes towards self-disclosure" for what they saw as a "therapeutic benefit" to clients, but this involved "reactions to and thoughts about the client in the here-and-now," not "self-involving disclosures" (Knight, 2012, p. 303). And even when talking about the latter type of disclosures, we discuss whether or not we tell a client if we are married or have children but not about disclosing details of one's mental health status or experiences.

In education, disclosure is often used as a teaching tool in a variety of learning and teaching contexts and settings. Scholars across disciplines have explored and evaluated its use and have found disclosure to be valuable, especially in the classroom (Butler, Wolkenstein, Ruiz-Novero, & Wallace, 2015; Deiro, 1997; Simpson, 2009; Tobin, 2010). From enhancing student learning to improving student-teacher connection and rapport, disclosure, when pertinent and done well, can be an asset to the teaching and learning processes (Deiro, 1997).

Research found that teachers who disclose tended to be more open and "appear[ed] to freely share of themselves" (Simpson, 2009, p. 93). Whether these disclosures were spontaneous (Simpson, 2009) or strategic (Tobin, 2010), they were done purposefully and intentionally (Butler et al., 2015; Simpson, 2009; Tobin, 2010). However, most disclosures were found to be more professional than personal and were done in a one-on-one fashion (Simpson, 2009, p. 94). While beneficial, some caution against the casual use of disclosure. Because it is effective and because it increases the positivity of the lens through which the student views the teacher, instructors must guard against "teaching themselves rather than their subject matter" (Ejsing, 2007, p. 240). In other words, disclosure loses its power as an intervention when it becomes more about you, the person disclosing, than about the content of your disclosure.

What about when the disclosure *does* lean more toward the personal, particularly around health and health status? In a study of physicians, disclosures between faculty and students around personal health were "accepted [and] perceived as a powerful teaching method" (Butler et al., 2015, p. 704). Still, the standards developed around the practice were highly variable and arose after reflecting on the disclosure experience or by determining what did and did not work successfully in the exchange. Further, the study found that the limits and risks may not be fully considered when disclosing (Butler el al., 2015). Similarly, Knight (2012) found that social workers who used or valued disclosure did not do so based on theoretical or research evidence of its utility; they simply found it useful. But for the physicians, they see the risks ("being judged, creating discomfort in trainees, or being perceived as seeking sympathy or attention") as "limited," and they believe "the method influences resident acquisition of clinical knowledge and skills" (Butler et al., 2015, p. 704). So, what about me? Did I consider the limits around disclosure? Did I think about the potential risks?

My Use of Disclosure

I often use disclosure when teaching social work practice courses. Whether it is to explain variations in depression symptom presentations or to demonstrate why clinicians should hold the

hope for clients until they can hold it for themselves, when appropriate, I disclose information about my own personal and/or practice experiences. I have spoken about my own struggles with depression and anxiety, and I have even shared some bits of information about my father's substance use and recovery (he was aware of this disclosure). I have also used my experiences to illustrate the role of culture in diagnosis, treatment, and recovery as well as the involvement of family members in the health and help-seeking experiences of their loved ones. For me, it is important that students understand that there is a person behind the diagnosis, that mental illness can impact anyone, and that clinicians should never grow fixed on a particular clinical picture. Yes, I put myself out there. For my students' learning, I open myself up like a cadaver so they can poke around, explore, and better understand mental health problems and the use of clinical interventions to address them. I believe a case study can only go so far, and, ethically, we can only pull a client apart so much. So again, when appropriate, I present myself to students as a living case study. I have been asked why I do not use a guest speaker for the same effect, but would it really have the same impact? In short, I do not think so. I committed to this field. I believe that by opening myself up, I am showing students not only how much I believe in the clinical helping process but how much I trust their ability to handle disclosures with sensitivity and respect.

I also use disclosure to increase my students' vulnerability. It is my firm belief that if we as clinicians are going to ask clients to be open and vulnerable, that we, too, must be willing to do the same. Being vulnerable can teach you so many things as a social worker. It can deepen your ability to empathize with a client. It can increase your willingness to accept critical feedback from supervisors and clients alike. It can also expand your capacity for growth and learning in the area of direct practice. So, when I am vulnerable, when I take a calculated risk in the classroom for the benefit of my students' learning, the hope is that they will be willing to take a calculated risk for the benefit of their clients' healing; that they, too, will be willing to give something up—namely the need to be the expert full of knowledge and skills—to align more naturally with their clients through empathy and humility. I hope to help them realize that having and sharing experiences is not necessarily unprofessional (as some students have felt my disclosures were), but that it helps one connect, build rapport, and be seen as someone who understands (as many more students, and clients, report feeling about my disclosures).

Using disclosure in the classroom can also mark you as someone who truly understands mental illness. When you are open to talking about your own mental health, students with mental health issues often see you as someone they can turn to to discuss their own mental health problems. Like White (2007/2008), who disclosed her own mental illness struggles while teaching in a social work classroom, students sought me out to discuss their private mental health struggles or for advice on how to get help. This was especially true for my African American students. As a Black woman who comes from a culture that underutilizes mental health services, stigmatizes those who experience mental health problems and/or seek help, and, when they do accept the presence of a problem, turns to more informal sources of help, it was important for these students to see that Black people do, in fact, have mental health problems, can seek professional help, and feel better. It shows them that they do not have to suffer or simply pray (though I truly

value prayer) their way through, that working with a professional mental health practitioner is also an option for them.

Being open about mental health problems and recovery also made me a type of role model for my students. They saw me as someone they could look to as they figured out how they, too, could balance addressing the mental health needs of others while managing their own. A number of my students told me how they often wondered if they would ever be able to practice social work when they had their own mental health issues. But after being in my classroom and hearing about my experiences as a clinician on a recovery journey, they had hope that they, too, could manage their health and find success in the field.

So, do I go too far? Is talking about suicide too far? Perhaps, for some. But my approach to teaching, with its use of disclosure, is intentional and purposeful. While I, like the social workers in Knight's (2012) study, did not initially consult the research or work from a theoretical base, I used disclosure decidedly, after considering the risks (students' feeling they may have to take care of me) and consequences (what others may think of me). Now my decision to disclose is very much a part of my teaching philosophy and is informed by research, theory, and experiential knowledge. I now rely on the evidence, both empirical and anecdotal, when explaining why it is important to my teaching pedagogy.

So, I will continue to disclose. I will do it to strip away the stigma that exists around mental health, illness, and wellness. I will do it to show my students that if I could speak on something so personal, surely, they could for the sake of their personal and professional development. I will do it to improve their learning experience, so they see mental illness as something real and close. Yes, I will continue to disclose. For the student who can't just yet, for the client who must, for the integrity of the work, I will disclose.

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